Legislative Council,
General Assembly
State of Delaware

Title 18

Insurance Code

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Part I
Insurance
Chapter 1
General Definitions and Provisions

§ 101. Short title.

This part constitutes the Delaware Insurance Code.

(18 Del. C. 1953, § 101; 56 Del. Laws, c. 380, § 1.)

§ 102. Definitions [For application of this section, see 79 Del. Laws, c. 172, § 6].

As used in this part:

(1) An "alien" insurer is a foreign insurer formed under the laws of any country other than the United States of America, its states, districts, commonwealths and possessions.

(2) An "authorized" insurer is one duly authorized to transact insurance in this State by a subsisting certificate of authority issued by the Commissioner.

(3) "Balance billing" means a health-care provider's demand that a patient pay a greater amount for a given service than the amount the individual's insurer, managed care organization or health service corporation has paid or will pay for the service.

(4) "Commissioner" means the Insurance Commissioner of this State.

(5) "Department" means the Insurance Department of this State.

(6) A "domestic" insurer is one formed under the laws of this State.

(7) The "domicile" of an insurer means:

a. As to Canadian insurers, the province in which the insurer's head office is located;

b. As to other alien insurers authorized to transact insurance in one or more states, as provided in § 532 (retaliatory provision) of this title;

c. As to alien insurers other than those referred to in paragraph (7)a. or b. of this section above, the country under the laws of which the insurer was formed;

d. As to all other insurers, the state under the laws of which the insurer was formed.

(8) A "foreign" insurer is one formed under the laws of any jurisdiction other than this State.

(9) "Insurance" means a contract whereby one undertakes to pay or indemnify another as to loss from certain specified contingencies or perils, called "risks," or to pay or grant a specified amount or determinable benefit in connection with ascertainable risk contingencies or to act as surety.

(10) "Insurer" includes every person engaged as principal and as indemnitor, surety or contractor in the business of entering into contracts of insurance; provided that with respect to a corporation established under Chapter 7 of Title 5, "insurer" means an insurance department or division of such corporation (but not the corporation itself) which maintains separate books and records in the same manner and to the same extent as if it were a separately incorporated subsidiary of such corporation, with separate capital accounts, assets and liabilities.

(11) "Person" means corporations, companies, associations, firms, partnerships, societies and joint stock companies and individuals as is provided in § 302 of Title 1. In addition, "person" includes trustees of common law trusts, syndicates, organizations, statutory trusts, business trusts, attorneys-in-fact and every natural or artificial legal entity.

(12) "Religious employer" means an employer that is both of the following:

a. A church, convention, association of churches, or elementary or secondary school that is controlled, operated, or principally supported by a church or convention or association of churches.

b. Qualified as a tax-exempt organization under 26 U.S.C. § 501(c) (3).

(13) "Third-party administrator" shall mean a person, firm or entity who directly or indirectly underwrites, collects charges or premiums from, or who approves, denies, adjusts or settles claims on residents of this State, in connection with health coverage offered or provided by an insurer. A third-party administrator shall be subject to the jurisdiction of the Department of Insurance. A third-party administrator shall not include any person, firm or entity who operates a billing and/or paying service only and who does not perform any of the other functions of a third-party administrator described above. Additionally, a third-party administrator shall not include any person, firm or entity which holds a certificate of authority as an insurer, health service corporation, MCO, or HMO under this title. The Commissioner shall promulgate regulations which shall provide for the registration, licensing and regulation of third-party administrators and enforcement of applicable provisions of this title to third-party administrators. Third-party administrators doing business in this State shall pay all fees and costs for registration as provided for in this title and shall pay all costs for examination, assessments, fines and/or penalties as provided for in this title or as the Commissioner shall establish by regulation. All revenues from the application of this provision to third-party administrators shall be deposited in accordance with the provisions of § 305 of this title.

(18 Del. C. 1953, § 102; 56 Del. Laws, c. 380, § 1; 67 Del. Laws, c. 223, § 17; 73 Del. Laws, c. 96, § 3; 73 Del. Laws, c. 329, § 60; 74 Del. Laws, c. 157, § 4; 79 Del. Laws, c. 172, § 4; 84 Del. Laws, c. 336, § 1; 84 Del. Laws, c. 402, § 2.)

§ 103. “Transacting insurance” defined.

In addition to other aspects of insurance operations to which provisions of this title by their terms apply, “transact” with respect to a business of insurance includes any of the following:

(1) Solicitation or inducement;

(2) Negotiations;

(3) Effectuation of a contract of insurance;

(4) Transaction of matters subsequent to effectuation and arising out of such a contract.

(18 Del. C. 1953, § 103; 56 Del. Laws, c. 380, § 1.)

§ 104. Application of Code as to particular types of insurers.

No provision of this title shall apply with respect to:

(1) Domestic mutual assessment property insurers, except as stated in Chapter 53 (Mutual Assessment Property Insurers) of this title;

(2) Domestic mutual benefit associations, except as stated in Chapter 55 (Mutual Benefit Associations) of this title;

(3) Fraternal benefit societies, except as stated in Chapter 62 (Fraternal Benefit Societies) of this title.

(18 Del. C. 1953, § 104; 56 Del. Laws, c. 380, § 1; 66 Del. Laws, c. 401, § 1; 69 Del. Laws, c. 111, § 2.)

§ 105. Particular provisions prevail.

Provisions of this title as to a particular kind of insurance, type of insurer or matter shall prevail over provisions relating to insurance, insurers or matters in general.

(18 Del. C. 1953, § 105; 56 Del. Laws, c. 380, § 1.)

§ 106. General penalty.

(a) Each violation of this title for which a greater penalty is not provided by a provision of this title or other applicable laws of this State, in addition to any applicable prescribed denial, suspension or revocation of certificate of authority or license shall, upon conviction thereof, subject the violator to a fine of not more than $2,300 or imprisonment of not more than 1 year, or both, except that if the violator is a corporation, the fine shall be not more than $6,900 as to each violation. Any director, officer, manager, employee or representative of a corporation shall be subject to fine and imprisonment as above provided.

(b) Prosecutions for any such violation shall be brought in the Superior Court of the county in which the offense occurred.

(c) At the discretion of the Commissioner and the Attorney General, any fine provided for above may be recovered on behalf of the State by a civil action brought against the violator.

(18 Del. C. 1953, § 106; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 278, § 1; 67 Del. Laws, c. 260, § 1.)

§ 107. Electronic notices and documents.

(a) In this section, the following words shall have the following meanings:

(1) “Delivered by electronic means” includes:

a. Delivery to an electronic mail address at which a party has consented to receive notice; or

b. Posting on an electronic network, together with separate notice to a party directed to the electronic mail address at which the party has consented to receive notice of the posting.

(2) “Party” means an applicant, an insured, or a policyholder.

(b) Subject to subsection (d) of this section, any notice to a party or any other document required under this title in an insurance transaction may be delivered by electronic means so long as it meets the requirements of the Uniform Electronic Transactions Act (§ 12A-101 et seq. of Title 6).

(c) Delivery of a notice or document in accordance with this section shall be considered equivalent to any delivery method required under this title, including delivery by first class mail, certified mail, certificate of mail, or certificate of mailing.

(d) A notice or document may be delivered by electronic means by an insurer to a party under this section if:

(1) The party has affirmatively consented to that method of delivery and has not withdrawn the consent;

(2) The party, before giving consent, is provided with a clear and conspicuous statement informing the party of:

a. Any right or option of the party to have the notice provided or made available in paper or another nonelectronic form.

b. The right of the party to withdraw consent to have notice or a document delivered by electronic means and any fees, conditions, or consequences imposed in the event consent is withdrawn;

c. Whether the party’s consent applies:

1. Only to the particular transaction as to which the notice or document must be given; or

2. To identified categories of notices or documents that may be delivered by electronic means during the course of the parties’ relationship;

d. 1. The means, after consent is given, by which a party may obtain a paper copy of a notice or document delivered by electronic means; and

2. The fee, if any, for the paper copy; and

e. The procedure a party must follow to withdraw consent to have a notice or document delivered by electronic means and to update information needed to contact the party electronically;

(3) The party:

a. Before giving consent, is provided with a statement of the hardware and software requirements for access to and retention of a notice or document delivered by electronic means; and

b. Consents electronically, or confirms consent electronically, in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for notices or documents delivered by electronic means as to which the party has given consent; and

(4) After consent of the party is given, the insurer, in the event a change in the hardware or software requirements needed to access or retain a notice or document delivered by electronic means creates a material risk that the party will not be able to access or retain a subsequent notice to which the consent applies.

a. Provides the party with a statement of:

1. The revised hardware and software requirements for access to and retention of a notice or document delivered by electronic means;

2. The right of the party to withdraw consent without the imposition of any fee, condition, or consequence that was not disclosed under paragraph (d)(2)b. of this section; and

b. Complies with paragraph (d)(2) of this section.

(e) This section does not affect requirements related to content or timing of any notice or document required under this title.

(f) If a provision of this title requiring a notice or document to be provided to a party expressly requires verification or acknowledgment of receipt of the notice or document, the notice or document may be delivered by electronic means only if the method used provides for verification or acknowledgment of receipt.

(g) The legal effectiveness, validity, or enforceability of any contract or policy of insurance executed by a party may not be denied solely because of the failure to obtain electronic consent or confirmation of consent of the party in accordance with paragraph (d)(3)b. of this section.

(h) (1) A withdrawal of consent by a party does not affect the legal effectiveness, validity, or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent is effective.

(2) A withdrawal of consent by a party is effective within a reasonable period of time after receipt of the withdrawal by the insurer.

(3) Failure by an insurer to comply with paragraph (d)(4) of this section may be treated, at the election of the party, as a withdrawal of consent for purposes of this section.

(i) This section does not apply to a notice or document delivered by an insurer in an electronic form before May 22, 2012, to a party who, before that date, has consented to receive notice in an electronic form otherwise allowed by law.

(j) If the consent of a party to receive notice or document in an electronic form is on file with an insurer before May 22, 2012, the insurer shall notify the party of:

(1) The notices or documents that may be delivered by electronic means under this section; and

(2) The party's right to withdraw consent to have notices or documents delivered by electronic means.

(k) (1) Except as otherwise provided by law, if an oral communication or a recording of an oral communication from a party can be reliably stored and reproduced by an insurer, the oral communication or recording may qualify as a notice or document delivered by electronic means for purposes of this section.

(2) If a provision of this title requires a signature or record or document to be notarized, acknowledged, verified, or made under oath, the requirement is satisfied if the electronic signature of the person authorized to perform those acts, together with all other information required to be included by the provision, is attached to or logically associated with the record or document.

(l) This section may not be construed to modify, limit, or supersede the provisions of the federal Electronic Signatures in Global and National Commerce Act, Public Law 106-229 [15 U.S.C. § 7001 et seq.], as amended.

(m) The provisions of this section shall apply to any regulatory requirement of or transaction with, the Department of Insurance which requires the filing or exchange of documents, notices, waivers, or forms.

(78 Del. Laws, c. 247, § 1.)

Part I
Insurance
Chapter 3
The Insurance Commissioner

§ 301. Commissioner; election; term.

(a) The Insurance Commissioner shall be the chief officer of the Insurance Department.

(b) The Commissioner shall be elected by the qualified electors of the State at a general election for a term of 4 years and shall be commissioned by the Governor.

(c) Subject to prior qualification by the oath required by § 302 of this title, the Commissioner shall assume office on the 1st Tuesday of January after election. The Commissioner shall hold office for the term for which elected and thereafter as provided by article XV, § 5, of the Delaware Constitution.

(18 Del. C. 1953, § 302; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1.)

§ 302. Oath.

Before entering upon the duties of office the Commissioner shall take and subscribe the oath or affirmation prescribed by article XIV of the Delaware Constitution.

(18 Del. C. 1953, § 303; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1.)

§ 303. Removal; vacancy.

(a) The Commissioner may be removed from office for reasonable cause, as provided by article III, § 13, of the Delaware Constitution.

(b) A vacancy in the office of Commissioner shall be filled by appointment by the Governor, as provided in article III, § 9, of the Delaware Constitution.

(18 Del. C. 1953, § 305; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1.)

§ 304. Seal.

The Commissioner shall have a seal of office of a suitable design and bearing the words “Insurance Commissioner of the State of Delaware.”

(18 Del. C. 1953, § 306; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1.)

§ 305. Office; Insurance Commissioner Regulatory Revolving Fund.

(a) The Department may operate 3 offices, the principal office in the Dover area and branch offices in Wilmington and Sussex County.

(b) There is hereby created within the office of the Insurance Commissioner a special fund to be designated as the Insurance Commissioner Regulatory Revolving Fund which shall be used in the operation of the office of the State Insurance Commissioner in the performance of the various functions and duties required of the office by law.

(c) (1) All of the following must be collected by the Commissioner pursuant to this title and deposited in the State Treasury to the credit of said Insurance Commissioner Regulatory Revolving Fund to be used in the operation of the office as authorized by the General Assembly in its annual operating budget:

a. Supervisory assessments.

b. Examination fees.

c. Rate filing and form filing fees paid by insurers.

d. Fifteen percent of all licensing fees of insurance professionals collected pursuant to § 701(23) through (31), (35) through (37), (41) and (42) of this title.

(2) Except as otherwise provided by law, other fees and taxes collected by the Commissioner may not be deposited in said Fund but shall be deposited in the General Fund of the State.

(d) Funds in the Insurance Commissioner Regulatory Revolving Fund shall be used by the Commissioner in the performance of the various functions and duties involved in the oversight of insurance companies as provided by law, subject to annual appropriations by the General Assembly for salaries and other operating expenses of the office.

(e) The maximum unencumbered balance which shall remain in the Insurance Commissioner Regulatory Revolving Fund at the end of any fiscal year is $5,000,000. At the end of each fiscal year, the unencumbered balance in the Insurance Commissioner Regulatory Revolving Fund in excess of $5,000,000 must be transferred to the General Fund.

(18 Del. C. 1953, § 308; 56 Del. Laws, c. 380, § 1; 60 Del. Laws, c. 283, § 1; 65 Del. Laws, c. 4, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1; 73 Del. Laws, c. 74, § 99; 74 Del. Laws, c. 68, § 77; 75 Del. Laws, c. 89, § 116; 81 Del. Laws, c. 109, § 1; 85 Del. Laws, c. 12, § 1.)

§ 306. Deputy Commissioner.

(a) The Commissioner may appoint and may remove a Deputy. Before entering upon the duties of office the Deputy shall take and file the constitutional oath of office.

(b) The Deputy may exercise such powers and discharge such duties as the Commissioner may authorize.

(c) The Deputy shall devote full time to the Department, shall not engage in any other insurance-related activity for fee or compensation and the State shall pay a salary at the rate provided by law in full compensation for all services.

(18 Del. C. 1953, § 309; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1.)

§ 307. Staff.

(a) The Commissioner may appoint and fix the compensation of such examiners, clerks, technical and professional personnel, and other necessary assistants as conduct of the office may require and may revoke such appointments.

(b) The Commissioner may from time to time contract for and procure such additional and independent actuarial, rating, legal and other technical and professional services as may be required for discharge of the duties of the office.

(18 Del. C. 1953, § 310; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1.)

§ 308. Prohibited interest; rewards.

(a) The Commissioner, the Commissioner's Deputy, or any examiner, assistant or employee of the Department, shall not be connected with the management of, nor have a material financial interest in, directly or indirectly, any insurer, insurance agency, or broker or insurance transaction, except as policy holder or claimant under a policy; except that as to matters wherein a conflict of interest does not exist on the part of any such individual, the Commissioner may employ or retain from time to time insurance actuaries, examiners, accountants, attorneys or other technicians, who are independently practicing their profession even though from time to time they are similarly employed or retained by insurers or others.

(b) The Commissioner, the Commissioner's Deputy, or any examiner, assistant, employee or technician retained by the Department, shall not be given nor receive, directly or indirectly, any fee, compensation, loan, gift or other thing of value, in addition to the compensation and expense allowance provided by or pursuant to the law of this State, or by contract with the Commissioner, for any service rendered or to be rendered as such Commissioner, Deputy, examiner, assistant, employee, or technician, or in connection therewith.

(c) Subsection (a) of this section shall not be deemed to prohibit receipt by any such person of fully vested commissions or fully vested retirement benefits to which entitled by reason of services performed prior to becoming Commissioner or prior to employment by the Commissioner.

(d) This section shall not be deemed to prohibit appointment and functioning of the Commissioner as process agent of insurers or of nonresident licensees as provided for in this title.

(18 Del. C. 1953, § 311; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1.)

§ 309. Delegation of powers; duties.

(a) The Commissioner may delegate to the Commissioner's Deputy, authorized representative, examiner or an employee of the Department the exercise or discharge in the Commissioner's name of any power, duty or function, whether ministerial, discretionary or of whatever character vested in or imposed upon the Commissioner under this title.

(b) The official act of any such person acting in the Commissioner's name and by the Commissioner's authority shall be deemed an official act of the Commissioner.

(18 Del. C. 1953, § 312; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1; 80 Del. Laws, c. 46, § 1; 80 Del. Laws, c. 376, § 1.)

§ 310. General powers; duties.

(a) The Commissioner shall enforce and execute the duties imposed by this title.

(b) The Commissioner shall have the powers and authority expressly vested by or reasonably implied from this title.

(c) With respect to enforcement of the payment of fees, charges and taxes, all the provisions of law conferring powers and duties upon the State Treasurer shall also apply to the Commissioner.

(d) The Commissioner shall have such additional rights, powers and duties as may be provided by other laws of this State.

(18 Del. C. 1953, § 313; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1.)

§ 311. Rules and regulations; promulgation; violation.

(a) The Commissioner may make reasonable rules and regulations necessary for, or as an aid to, the administration or effectuation of any provision of this title. No such rule or regulation shall extend, modify or conflict with any law of this State or the reasonable implications thereof.

(b) The Commissioner shall adopt and promulgate rules and regulations in accordance with the procedures set forth in the state Administrative Procedures Act, Chapter 101 of Title 29.

(c) Wilful violation of any such rule or regulation shall subject the violator to such suspension or revocation of certificate of authority or license, or to such administrative fine in lieu thereof, as may be applicable under this title, for violation of the provision to which such rule or regulation relates; but no penalty shall apply to any act done or omitted in good faith in conformity with any such rule or regulation, notwithstanding that such rule or regulation, after such act or omission, may be amended or rescinded or determined by judicial or other authority to be invalid for any reason.

(18 Del. C. 1953, § 314; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1.)

§ 312. Orders, notices in general.

(a) Orders and notices of the Commissioner shall be effective only when in writing signed by the Commissioner or by the Commissioner's authority.

(b) Except as otherwise expressly provided by law as to particular orders, every order of the Commissioner shall state its effective date and shall concisely state:

(1) Its intent or purpose;

(2) The grounds on which based;

(3) The provisions of this title pursuant to which action is taken or proposed to be taken; but failure to so designate a particular provision shall not deprive the Commissioner of the right to rely thereon except where expressly provided to the contrary.

(c) Except as may be provided by particular law or regulation, any order, notice, bulletin or the like may be given to the person or persons affected thereby by any 1 or more of the following methods:

(1) First-class or bulk mail, postage prepaid, addressed to such person at the person's principal place of business or residence as last of record in the Department. Delivery of said item shall be deemed to have been given when deposited in a mail depository of the United States Postal Service;

(2) By receipted ground or air commercial delivery service. Delivery of said item shall be deemed to have been given when a receipt therefor is obtained from said commercial delivery service;

(3) By publication in the Register of Regulations; or

(4) By publication on the Internet, including but not limited to the Department's webpage, the webpage of the National Association of Insurance Commissioners (NAIC), and the webpage of the National Insurance Producer Registry (NIPR).

(18 Del. C. 1953, § 315; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1; 73 Del. Laws, c. 312, § 72.)

§ 313. Enforcement through Attorney General.

(a) The Commissioner, through the Attorney General of this State, may invoke the aid of the Superior Court, through proceedings instituted in any county of this State, to enforce any lawful order made or action taken by the Commissioner. In such proceedings the Superior Court may make such orders, either preliminary or final, as it deems proper under the facts established before it.

(b) If the Commissioner has reason to believe that any person has violated this title or any other law applicable to insurance operations, for which criminal prosecution is provided, and, in the Commissioner's opinion, would be in order, the Commissioner shall give the information relative thereto to the Attorney General. The Attorney General shall promptly institute such action or proceedings against such person as in the Attorney General's opinion the information may require or justify.

(c) The Attorney General upon request of the Commissioner is authorized to proceed in the courts of any other state or in any federal court or agency to enforce an order or decision of any court proceeding or in any administrative proceeding before the Commissioner.

(18 Del. C. 1953, § 316; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1.)

§ 314. Records; inspection; destruction.

(a) The Commissioner shall carefully preserve in the Department and in permanent form all papers and records relating to the business of the Department and shall hand the same over to the successor in office.

(b) The Commissioner shall permit inspection of the papers, records, and filings in the Department in accordance with this State's Freedom of Information Act laws (Chapter 100 of Title 29).

(c) The Commissioner may destroy unneeded or obsolete records and filings in the Department in accordance with provisions and procedures applicable to administrative agencies of this State in general.

(d) Nothing in this title shall prohibit the storage of documents and records by use of electronic means or media.

(18 Del. C. 1953, § 317; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1; 83 Del. Laws, c. 312, § 1.)

§ 315. Official documents, certified copies; use as evidence.

Any instrument duly executed by the Commissioner, and authenticated by the Commissioner's seal of office, shall be received in evidence in the courts of this State, and copies of papers and records in the Department so authenticated shall be received as evidence with the same effect as the originals.

(18 Del. C. 1953, § 318; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1.)

§ 316. Interstate cooperation.

(a) The Commissioner shall communicate, on request of the insurance supervisory official of any state, province or country, any information which it is the Commissioner's duty by law to ascertain respecting authorized insurers. Any communication of documents, materials or other information, including confidential and privileged documents, materials or information, shall be in accordance with the provisions of this section, and any other applicable provisions of this title.

(b) The Commissioner may be a member of the National Association of Insurance Commissioners, the International Association of Insurance Supervisors or any successor organization and may participate in and support other cooperative activities of public officials having supervision of the business of insurance.

(c) The Commissioner may enter into agreements governing sharing, confidentiality, security and use of information consistent with this section and other applicable provisions of this title. The Commissioner shall maintain, as confidential, any confidential documents or information received from the National Association of Insurance Commissioners or the International Association of Insurance Supervisors, and such documents and information shall not be subject to subpoena and may not be made public by the Commissioner or any other person unless the prior written consent of the entity providing the documents or information and the company to which it pertains has been obtained. In addition, any documents or information received by the Commissioner from state or federal insurance, banking or securities regulators or similar regulators in a foreign country which are confidential in such jurisdictions shall be maintained as confidential by the Commissioner, shall not be subject to subpoena and may not be made public by the Commissioner or any other person unless the prior written consent of the entity providing the documents or information and the company to which it pertains has been obtained. The Commissioner may share any information, including confidential information, with the National Association of Insurance Commissioners, the International Association of Insurance Supervisors, or state or federal insurance, banking or securities regulators or similar regulators in a foreign country so long as the Commissioner determines that such entities agree to maintain the same level of confidentiality in their jurisdictions as is available in this State and are authorized to do so.

(18 Del. C. 1953, § 320; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 208, § 1.)

§ 317. Investigations authorized.

In addition to examinations and investigations expressly authorized, the Commissioner may conduct such investigations of insurance matters as the Commissioner may deem proper, upon reasonable cause, to determine whether any person has violated this title or to secure information useful in the lawful administration of any such provision. Except as otherwise provided in this title, the cost of such investigations shall be borne by the State.

(18 Del. C. 1953, § 321; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1.)

§ 318. Examination of insurers.

(a) The Commissioner or any of the Commissioner's examiners may conduct an examination under this section of any company as often as the Commissioner in the Commissioner's sole discretion deems appropriate, but shall, at a minimum, conduct an examination of every insurer licensed in this State but not less frequently than every 5 years. In scheduling and determining the nature, scope and frequency of the examinations, the Commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants and other criteria as set forth in the Examiner's Handbook adopted by the National Association of Insurance Commissioners and in effect when the Commissioner exercises discretion under this section. Examination of an alien insurer shall be limited to its insurance transactions, assets, trust deposits and affairs in the United States except as otherwise required by the Commissioner.

(b) The Commissioner shall examine, in like manner, each insurer applying for an initial certificate of authority to transact insurance in this State.

(c) In lieu of making an examination, the Commissioner may accept, in the Commissioner's discretion, a full report of the most recent examination of a foreign or alien insurer, certified to by the insurance supervisory official of another state.

(d) As far as practical, the examination of a foreign or alien insurer shall be made in cooperation with the insurance supervisory officials of other states in which the insurer transacts business.

(e) In lieu of an examination under this section of any foreign or alien insurer licensed in this State, the Commissioner may accept an examination report on such company as prepared by the insurance department for the company's state of domicile or port-of-entry state, so long as:

(1) The insurance department, at the time of the examination, was accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program; or

(2) The examination is performed under the supervision of an accredited insurance department, or with the participation of 1 or more examiners, who are employed by such an accredited state insurance department, and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(f) The Commissioner shall also conduct examinations as required by § 2301E of Title 19 [repealed].

(18 Del. C. 1953, § 322; 56 Del. Laws, c. 380, § 1; 68 Del. Laws, c. 51, § 1; 69 Del. Laws, c. 92, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 55, § 6.)

§ 319. Examination of agents, promoters and others.

For the purpose of ascertaining compliance with law or relationships and transactions between any such person and any insurer or proposed insurer, the Commissioner may examine, as often as the Commissioner deems advisable, the accounts, records, documents and transactions pertaining to or affecting insurance affairs or proposed insurance affairs of:

(1) Any insurance agent, solicitor, broker, general agent, adjuster, insurer representative or person holding oneself out as any of the foregoing;

(2) Any person having a contract under which the person enjoys in fact the exclusive or dominant right to manage or control an insurer;

(3) Any person holding the shares of voting stock or the policyholder proxies of a domestic insurer for the purpose of controlling the management thereof, as voting trustee or otherwise;

(4) Any person in this State, who is engaged in, or proposing to be engaged in, holding oneself out as engaging, proposing or assisting in the promotion, formation or financing of an insurer, insurance holding corporation, corporation or other group, to finance an insurer or the production of its business.

(18 Del. C. 1953, § 323; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1.)

§ 320. Conduct of examination; access to records; correction.

(a) The Commissioner shall conduct each examination in an expeditious, fair, and impartial manner. Upon determining that an examination should be conducted, the Commissioner or the Commissioner's designee shall issue an examination warrant appointing 1 or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the Examiner's Handbook adopted by the National Association of Insurance Commissioners. The Commissioner may also employ such other guidelines or procedures as the Commissioner may deem appropriate.

(b) Upon any such examination the Commissioner or examiner may examine, under oath, any officer, agent or other individual believed to have material information regarding the affairs under examination.

(c) Every person being examined, the person's officers, attorneys, employees, agents and representatives, shall make freely available to the Commissioner, or the Commissioner's examiners, the accounts, records, documents, files, information, assets and matters of such person, in the person's possession or control, relating to the subject of the examination and shall facilitate the examination.

(d) If the Commissioner or examiner finds any accounts or records to be inadequate or inadequately kept or posted, the Commissioner may employ experts to reconstruct, rewrite, post or balance them at the expense of the person being examined if such person has failed to maintain, complete or correct such records or accounting, after the Commissioner or examiner has given the person written notice and a reasonable opportunity to do so.

(e) Neither the Commissioner, nor any examiner, shall remove any record, account, document, file or other property of the person being examined from the offices or place of such person, except with the written consent of such person in advance of such removal or pursuant to an order of court duly obtained. This provision shall not be deemed to affect the making and removal of copies or abstracts of any such record, account, document or file.

(18 Del. C. 1953, § 324; 56 Del. Laws, c. 380, § 1; 68 Del. Laws, c. 51, § 2; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1.)

§ 321. Examination report.

(a) The Commissioner or the Commissioner's examiner shall make a full and true written report of every such examination made by the Commissioner or the Commissioner's examiner and shall therein certify under oath the report and findings.

(b) The report shall contain only information appearing upon the books, records, documents and papers of, or relating to, the person or affairs being examined or ascertained from testimony of individuals under oath concerning the affairs of such person, together with such conclusions and recommendations as may reasonably be warranted by such information.

(c) No later than 60 days following the completion of the examination, the examiner in charge shall file with the Department a verified written report of examination under oath. Upon receipt of the verified report, the Department shall transmit the report to the company examined, together with a notice which shall afford the company examined a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report. If the company so requests in writing within such 30-day period, the Commissioner shall grant a hearing as to the report and shall not file the report until after the hearing and after such modifications have been made therein as the Commissioner deems proper.

(d) [Repealed.]

(e) The report when so filed shall be admissible in any action or proceeding brought by the Commissioner against the person examined or against its officers, employees or agents. In any such action or proceeding, the Commissioner or the Commissioner's examiners may, however, at any time testify and offer proper evidence as to information secured or matters discovered during the course of the examination, whether or not a written report of the examination has been either made, furnished or filed with the Department.

(f) The Commissioner may withhold from public inspection any examination or investigation report for so long as the Commissioner deems such withholding to be necessary for the protection of the person examined against unwarranted injury or to be in the public interest.

(g) All working papers, recorded information, documents and copies thereof produced by, obtained by, or disclosed to the Commissioner or any other person in the course of an examination made under this chapter, or in the course of analysis by the Commissioner of the financial condition or market conduct of a company, shall be given confidential treatment and are not subject to subpoena and may not be made public by the Commissioner or any other person except to insurance departments of any state or country, or to law-enforcement officials of this or any other state or agency of the federal government at any time, so long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this section, unless the prior written consent of the company to which it pertains has been obtained.

(h) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information occurs as a result of disclosure to the Commissioner under this section.

(18 Del. C. 1953, § 325; 56 Del. Laws, c. 380, § 1; 68 Del. Laws, c. 51, § 3; 69 Del. Laws, c. 92, §§ 2,3; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 208, § 2; 83 Del. Laws, c. 106, § 1; 85 Del. Laws, c. 180, § 1.)

§ 322. Examination expense.

(a) The expense of examination of an insurer or of any person referred to in § 319(2) of this title (management or control of an insurer under contract) or § 319(4) of this title (promoters, etc.) shall be borne by the person examined. Such expense shall include only the reasonable and proper expenses of the Commissioner, and the Commissioner's examiners and assistants, including expert assistance, and a reasonable per diem as to such examiners and assistants as necessarily incurred in the examination.

(b) Such person examined shall promptly pay the examination expense upon presentation by the Commissioner, or the Commissioner's examiner, of a reasonably detailed written account thereof.

(18 Del. C. 1953, § 326; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1.)

§ 323. Administrative procedures; hearings in general.

(a) The Commissioner may hold a hearing without request by others for any purpose within the scope of this title.

(b) The Commissioner shall hold a hearing:

(1) If required by any other provision of this title; or

(2) Upon written application for a hearing by a person aggrieved by any act, threatened act or failure of the Commissioner to act, or by any report, rule, regulation or order of the Commissioner (other than an order for the holding of a hearing, or order on a hearing, or pursuant to such order, of which hearing such person had notice). Any such application must be filed in the Department within 90 days after such person knew or reasonably should have known of such act, threatened act, failure, report, rule, regulation or order, unless a different period is provided for by other laws applicable to the particular matter and, in which case, such other law shall govern.

(c) Any such application for a hearing shall briefly state the respects in which the applicant is so aggrieved, together with the grounds to be relied upon as a basis for the relief to be sought at the hearing.

(d) If the Commissioner finds that the application is made in good faith, that the applicant would be so aggrieved if the grounds are established and that such grounds otherwise justify the hearing, the Commissioner shall hold the hearing within 30 days after filing of the application unless postponed by mutual consent. Failure to hold the hearing upon application of a person entitled, as hereinabove provided, shall constitute a denial of the relief sought and shall be the equivalent of a final order of the Commissioner on hearing for the purpose of an appeal under § 328 of this title.

(e) Pending the hearing and decision, the Commissioner may suspend or postpone the effective date of the previous action.

(f) To the extent that it does not conflict with the provisions of this chapter, the Administrative Procedures Act, Chapter 101 of Title 29, shall govern all aspects of the Department's administrative proceedings, including, but not limited to, the following:

(1) Notice of hearing;

(2) Conduct of hearing;

(3) Ex parte consultations;

(4) Proposed order;

(5) Record retention; and

(6) Decision and final order.

(18 Del. C. 1953, § 327; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1.)

§ 324. Notice of hearing.

(a) Except where a longer period is expressly provided in this title, the Commissioner shall give written notice of the hearing to all parties not less than 20 days in advance.

(b) If any such hearing is to be held for consideration of rules and regulations of the Commissioner or of other matters which, under subsection (a) of this section, would otherwise require separate notices to more than 30 persons, in lieu of other notice the Commissioner may give notice of the hearing by publication in a newspaper of general circulation in this State, at least once each week during the 4 weeks immediately preceding the week in which the hearing is to be held; except that the Commissioner shall mail such notice to all

persons who have requested the same in writing in advance and have paid to the Commissioner the reasonable amount fixed by the Commissioner to cover the cost thereof.

(18 Del. C. 1953, § 328; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1.)

§ 325. Conduct of hearing.

The Commissioner may hold a hearing in Dover or any other place of convenience to parties and witnesses as the Commissioner determines. The Commissioner, or the Commissioner's designee, shall preside at the hearing and shall expedite the hearing and all procedures involved therein.

(18 Del. C. 1953, § 329; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1.)

§ 326. Witnesses and documentary evidence.

(a) As to the subject of any examination, investigation or hearing being conducted by the Commissioner, the Commissioner may subpoena witnesses and administer oaths or affirmations, and examine any individual under oath, or take depositions, and by subpoena duces tecum may require the production of documentary and other evidence. Any delegation by the Commissioner of power of subpoena shall be in writing.

(b) Witness fees and mileage, if claimed, shall be allowed the same as for testimony in a Superior Court. Witness fees, mileage and the actual expense necessarily incurred in securing attendance of witnesses and their testimony shall be itemized and shall be a part of the examination expense to be paid by the person being examined, where payment of examination expense by such person is otherwise provided for in this title, or paid by the person as to whom such proceedings, other than as part of an examination, are held if, in such proceedings, such person is found to have been in violation of the law, or by the person, if other than the Commissioner, at whose request the hearing is held.

(c) Subpoenas of witnesses shall be served in the same manner and at the same cost as if issued by a Superior Court. If any individual fails to obey a subpoena issued and served hereunder with respect to any matter or evidence concerning which the individual may be lawfully interrogated or required to produce for examination, upon application of the Commissioner, the Superior Court, in any county in which is pending the proceeding at which such individual is so required to appear, or the Superior Court in the county in which such individual resides, may issue an order requiring the individual to comply with the subpoena and to appear and testify or produce the evidence subpoenaed; and any failure to obey such order of the Court may be punished by the Court as a contempt thereof.

(d) Any person knowingly giving false testimony under oath or making a false affirmation as to any matter material to any such examination, investigation or hearing, upon conviction thereof, shall be guilty of perjury.

(18 Del. C. 1953, § 330; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1.)

§ 327. Testimony compelled; immunity.

(a) If any individual asks to be excused from attending or testifying or from producing any books, papers, records, contracts, correspondence or other documents in connection with any examination, hearing or investigation being conducted by the Commissioner, or the Commissioner's examiner, on the ground that the testimony or evidence required of the individual may tend to incriminate the individual, or subject the individual to a penalty or forfeiture and shall, by the Attorney General, be directed to give such testimony or produce such evidence, the individual must nonetheless comply with such direction, but the individual shall not thereafter be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter or thing concerning which the individual may have so testified or produced evidence, and no testimony so given or evidence produced shall be received against the individual upon any criminal action, investigation or proceeding; except, however, that no such individual so testifying shall be exempt from prosecution or punishment for any perjury committed by the individual in such testimony, and the testimony or evidence so given or produced shall be admissible against the individual upon any criminal action, investigation or proceeding concerning such perjury, nor shall such individual be exempt from the refusal, suspension or revocation of any license, permission or authority conferred or to be conferred, pursuant to this title.

(b) Any such individual may execute, acknowledge and file in the office of the Commissioner and of the Attorney General a statement expressly waiving such immunity or privilege in respect to any transaction, matter or thing specified in such statement, and thereupon the testimony of such individual or such evidence in relation to such transaction, matter or thing may be received or produced before any judge or justice, court, tribunal, grand jury or otherwise, and if so received or produced such individual shall not be entitled to any immunity or privileges on account of any testimony given or evidence so produced.

(18 Del. C. 1953, § 331; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1.)

§ 328. Appeal from the Commissioner.

(a) Except as to matters arising under Chapter 25 of this title (Rates and Rating Organizations), an appeal from the Commissioner shall be taken only from an order on hearing or as to a matter on which the Commissioner has refused or failed to hold a hearing after application therefor or issue an order on hearing as required by § 323 of this title.

(b) Any person who was a party to such hearing or whose pecuniary interests are directly and immediately affected by any such refusal or failure, and who is aggrieved by such order, refusal or failure, may appeal from such order or as to any such matter within 60 days after:

(1) The order on hearing has been mailed or delivered to the persons entitled to receive the same or given by last publication thereof where delivery by publication is permitted; or

(2) The Commissioner has refused or failed to make an order on hearing as required under § 323 of this title; or

(3) The Commissioner has refused or failed to grant or hold a hearing as required under § 323 of this title.

(c) The appeal shall be granted as a matter of right and shall be taken to the Superior Court in any county in this State.

(d) The appeal shall be taken by filing in the Court a verified petition stating the grounds upon which the review is sought, together with a bond with good and sufficient sureties to be approved by the Court, conditioned to pay all costs which may be assessed against the appellant or petitioner in such proceedings and by serving a copy of the petition upon the Commissioner. If the appeal is from the Commissioner's order on hearing, the petitioner shall also deliver to the Commissioner a sufficient number of copies of the petition and the Commissioner shall mail or otherwise furnish a copy thereof to the other parties to the hearing to the same extent as a copy of the Commissioner's order is required to be furnished to the hearing parties under § 323 of this title.

(e) Upon receiving the petition for review, the Commissioner shall cause to be prepared an official record certified by the Commissioner which shall contain a copy of all proceedings and orders of the Commissioner appealed from and the transcript of testimony and evidence or summary record thereof. Within 30 days after the petition is served upon him or her, the Commissioner shall file such official record with the Court in which the appeal is pending.

(f) Upon filing of the petition for review the Court shall have full jurisdiction of the proceeding. Such filing shall not stay the enforcement of the Commissioner's order or action appealed from unless so stayed by order of the Court.

(g) If the appeal is from the Commissioner's order on hearing, the review of the Court shall be limited to matters shown by the Commissioner's official record; otherwise, the review shall be de novo. The Court shall have the power, by preliminary order, to settle questions concerning the completeness and accuracy of the Commissioner's official record.

(h) In its discretion the Court may remand the case to the Commissioner for further proceedings in accordance with the Court's directions or, in advance of judgment and upon a sufficient showing, the Court may remand the case to the Commissioner for the purpose of taking additional testimony or other proceedings.

(i) From the judgment of the Superior Court, either the Commissioner or other party to the appeal may appeal directly to the Supreme Court of the State in the same manner as is provided in civil cases.

(18 Del. C. 1953, § 333; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 185, § 1; 70 Del. Laws, c. 186, § 1.)

§ 329. Administrative penalty.

(a) Notwithstanding any other provisions of this title or any regulation implementing said title, the Commissioner, upon a finding after notice and hearing conducted in accordance with the provisions of this chapter, that any person, insurer or insurance holding company has violated any provision of this title or any regulation implementing said title, may impose or order an administrative penalty in an amount of money that is reasonable and appropriate in view of the facts and circumstances surrounding the violation. In determining what the amount of penalty shall be, the Commissioner may take into consideration such matters as the nature of the violation, the amount of loss resulting from the violator's conduct, the intent of the violator, the damages caused by the violation, any efforts made by the violator to correct the violation and prevent a reoccurrence, and the recommendations of any hearing officer.

(b) Any administrative penalty imposed pursuant to this section may be in addition to any penalty, fine or sentence ordered by a court in any civil or criminal proceeding.

(c) Except as identified in subsection (g) of this section, any penalty that may be imposed or ordered by the Commissioner after the hearing shall be paid to the State Treasurer for deposit in the General Fund.

(d) In no event shall the administrative penalty per violation exceed $15,000 for those licensed under Chapter 17 of this title.

(e) Except as identified in subsection (f) of this section, in no event shall the administrative penalty per violation exceed $50,000 for insurance companies, insurance holding companies, and all other persons licensed under this title.

(f) An administrative penalty imposed for a violation of §§ 2503(a)(12) and (a)(15), 3342B, and 3556A of this title may not exceed the equivalent monetary value associated with the relevant violation.

(g) There shall be established a Primary Care Fund whereby penalties imposed under subsection (f) of this section are deposited. Funds in the Primary Care Fund shall be used by the Statewide Benefits Office and the Division of Medicaid and Medical Assistance in the performance of various functions and duties involved in implementation and support of §§ 5204(d) and 5224 of Title 29, and § 539 of Title 31, subject to annual appropriations by the General Assembly. The maximum unencumbered balance which shall remain in the Primary Care Fund after use at the end of any fiscal year is $5,000,000. At the end of each fiscal year, the unencumbered balance in the Primary Care Fund in excess of $5,000,000 shall be transferred to the OPEB Fund established under § 5281 of Title 29.

(65 Del. Laws, c. 165, § 1; 70 Del. Laws, c. 185, § 1; 85 Del. Laws, c. 348, § 3.)

§ 330. Immunity from liability.

(a) No cause of action shall arise nor shall any liability be imposed against the Commissioner, the Commissioner's authorized representatives or any examiner appointed by the Commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this chapter.

(b) No cause of action shall arise nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the Commissioner or the Commissioner's authorized representative or examiner pursuant to an examination,

investigation, or regulatory inquiry made under this chapter, if such an act of communication or delivery was performed in good faith and without fraudulent intent or intent to deceive.

(c) This section does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in subsection (a) of this section.

(d) A person identified in subsection (a) of this section shall be entitled to an award of attorney's fees and costs if they are the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of their activities in carrying out the provisions of this chapter and the party bringing the action was not substantially justified in doing so. For purposes of this section a proceeding is "substantially justified" if it had a reasonable basis in law or in fact at the time that it was initiated.

(68 Del. Laws, c. 51, § 4; 70 Del. Laws, c. 185, § 1; 80 Del. Laws, c. 46, § 2; 80 Del. Laws, c. 376, § 2.)

§ 331. Arbitration of disputes involving homeowners' insurance coverage.

(a) Every insurer providing insurance coverage for homeowners' risks shall be required to submit to arbitration, in the manner set forth in this section, any dispute relating to the amounts owed under any claim for losses or damages by an insured claiming to have suffered losses or damages under the contract. Disputes relating to whether coverage exists and under what terms and conditions the coverage exists shall not be subject to the arbitration process established in this section. Notwithstanding the foregoing, where the insurance policy provides an arbitration or appraisal provision in a form approved by the Insurance Department, the arbitration mandated by this subsection shall not apply.

(b) All arbitration shall be administered by the Insurance Commissioner or the Insurance Commissioner's nominee.

(c) The Insurance Commissioner or the Insurance Commissioner's nominee shall establish panels of arbitrators in accordance with the rules and regulations which shall be promulgated pursuant to this section. No cause of action shall arise nor any liability imposed against any individual appointed to the panel for any conduct performed in good faith while carrying out the provisions of this section.

(d) Any request by an insured for arbitration shall be in writing and mailed to the Insurance Commissioner within 90 days from the date an offer of settlement or denial of coverage or liability has been made by an insurer. Neither party shall be held to have waived any of its rights by an act relating to arbitration and either party shall have a right to trial de novo to the Superior Court so long as notice of appeal is filed with that Court in the manner set forth by its rules within 90 days of the date of the arbitration decision being rendered.

(e) The Insurance Commissioner shall establish a schedule of fees for arbitration which shall not exceed $75.

(f) The fee for arbitration shall be payable to the Department of Insurance at the time of the filing of the request for arbitration and shall be maintained in a special fund identified as the "Arbitration Fund," which shall remain separate and segregated from the General Fund. The compensation paid to the arbitration panel shall be payable from this fund.

(70 Del. Laws, c. 173, § 1; 70 Del. Laws, c. 186, § 1.)

§ 332. Arbitration of disputes involving health insurance coverage [Effective until Jan. 1, 2028].

(a) The following definitions shall apply with respect to this section:

(1) "Adverse determination" means a benefit denial, reduction or termination, a denial of certification, or both.

(2) "Benefit denial" means the denial, in whole or in part, of payment or reimbursement for health-care services rendered or health-care supplies provided to any person claiming benefits under an insurance policy delivered or issued for delivery in Delaware.

(3) "Carrier" in this section shall have the same meaning applied to it at § 3343(a) of this title.

(4) "Covered person" means a person who claims to be entitled to receive benefits from a carrier.

(5) "Denial of certification" means a determination that an admission or continued stay, or course of treatment, or other covered health-care service does not satisfy the insurance policy's clinical requirements for appropriateness, necessity, health-care setting and/or level of care.

(6) "Emergency review" means an IRP review involving an imminent, emergent or serious threat to the health of the claimant.

(7) "Health plan" shall have the same meaning as "health benefit plan" as defined at § 3343(a)(2) of this title.

(8) "Insurance policy" shall have the meaning assigned to it at § 2702 of this title, and shall also include all health plans and policies for the payment for, provision of or reimbursement for medical services, supplies or both issued by insurers, health services corporations or managed care organizations.

(9) "Internal review process" or "IRP" means the procedure for an internal review of an adverse determination pursuant to subsection (b) of this section.

(b) Every carrier shall establish and maintain an IRP approved by the Insurance Commissioner.

(c) The Insurance Commissioner shall approve those IRPs that meet the following minimum criteria:

(1) *Written notice.* — The IRP must provide for written notice of the internal review procedure to covered persons, annually and following any adverse determination.

(2) *Requests for review of adverse determinations.* —

The IRP must permit covered persons to submit requests for internal reviews of adverse determinations ("grievances") orally or in writing. Grievances must be submitted within 30 days of receipt by the covered person of written notice of an adverse determination. The carrier must provide written forms for submission of grievances. Upon receipt of an oral grievance or a written grievance that does

not contain sufficient information, the carrier must immediately provide the covered person with a written form upon which to make his or her grievance, and the carrier may require that an oral or insufficient written grievance be submitted in writing within 10 days of the covered person's receipt of the written form. A grievance shall be considered as received by the carrier when a written form, which the covered person purports to be complete, is received by the carrier.

(3) *Instructions on written form.* — The written form referred to in paragraph (c)(2) of this section shall inform the covered person of the information necessary to pursue an internal grievance of an adverse decision.

(4) *Prompt response to written grievances.* — The IRP shall provide that within 5 business days of receipt of a written grievance, the carrier shall provide written acknowledgement of the grievance, including the name, address and telephone number of the individual or department designated by the carrier to respond to the grievance.

(5) *Speedy review of grievances.* — That IRP shall require that all grievances be decided in an expeditious manner, and in any event, no more than:

a. 72 hours after the receipt of all necessary information relating to an emergency review;

b. 30 days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract; and

c. 45 days after the receipt of all necessary information in all other instances.

A grievance shall be considered decided when the carrier has made its final decision on the subject of the review and has deposited written notice of that decision in the mail, in accordance with paragraphs (c)(7) and (8) of this section.

(6) *Assignment of qualified personnel.* — The IRP shall provide that when the subject of the grievance relates to medical or clinical matters, including medical necessity and appropriateness of treatment, the health carrier shall assign licensed, certified or registered health care personnel with expertise in the field implicated by the request for review to conduct the review. The review shall be conducted by personnel other than those who made the initial adverse determination.

(7) *Written notice of decisions.* — The IRP shall provide that within 5 days after a grievance is decided in the manner described above, the insured shall be provided with written notice of the disposition of that grievance. In cases where the grievance has been decided in a manner that does not pay the claim in its entirety, the carrier shall provide the insured with a letter fully stating the reasons for the disposition (including specific policy language relied upon and any other documents relied upon) and the clinical rationale for the determination in cases where the determination has a clinical basis. The carrier's written notice shall also inform the insured of the appropriate manner for the insured to pursue an external review of the carrier's decision. Finally, the carrier's written notice shall inform the insured of the mediation services offered by the Department of Insurance, but shall clearly inform the insured in layman's terms that mediation does not change the deadlines imposed by § 6416 of this title or this section. The Department of Insurance shall inform any person with rights under § 6416 of this title or this section of those rights.

(8) *Manner of notice of decisions.* — Written notice of the review decision shall be deposited in the mail, addressed to the last known address of the covered person. In the case of emergency reviews, the carrier shall also make reasonable efforts to notify the covered person immediately following the determination of the grievance and the written notice of determination shall be deposited in the mail, addressed to the last known address of the claimant, within 48 hours after the receipt of all information necessary to complete the review. For cases involving a denial, reduction or termination of benefits where the external review may be conducted pursuant to this section, written notice shall be mailed requesting delivery confirmation by the United State Postal Service.

(d) Every carrier shall submit a report on its internal review process on an annual basis to the Insurance Commissioner in accordance with regulations established by the Department.

(e) With respect to adverse determinations that are subject to review by the Department of Insurance pursuant to § 6416(f) of this title, the Insurance Commissioner shall develop regulations providing for arbitration of such adverse determinations. Such regulations shall contain the following provisions:

(1) Requests for arbitration shall be in writing and mailed to the Commissioner within 60 days of the receipt of the written statement referred to in paragraph (c)(7) of this section.

(2) Arbitrators shall be chosen from an appropriate panel of arbitrators, and hearings shall be conducted according to rules established by the Department of Insurance.

(3) The arbitrator shall review written arbitration requests prior to holding any hearing or allowing any exchange of information between the parties in order to determine whether a written arbitration request is meritless on its face, and may summarily dismiss meritless requests for arbitration.

(4) Neither party shall be held to have waived any of its rights to seek relief in a court of law with respect to a covered person's legal rights to benefits by an act relating to arbitration or the rendering of an arbitration decision.

(5) Arbitration decisions shall be rendered within 45 days of the Commissioner's receipt of an arbitration request.

(f) The Insurance Commissioner shall establish a schedule of fees for arbitration. Fees chargeable to covered persons shall not exceed $75 per arbitration. The carrier shall be responsible for all costs of arbitration which exceed this fee regardless of the final ruling, and shall reimburse the Commissioner for the expenses related to the arbitration process. Funds paid to the Insurance Commissioner under this subsection shall be placed in the arbitration fund and shall be used exclusively for the payment of appointed arbitrators. The Insurance

Commissioner may, in his or her discretion, impose a schedule of maximum fees that can be charged by an arbitrator for a given type of arbitration.

(g) If the arbitrator makes a decision in favor of the carrier, that decision shall give rise to a rebuttable presumption to that effect in any subsequent action brought by or on behalf of the covered person with respect to the decision. Should the decision favor the covered person, the carrier shall have the right to appeal the matter to the court, in accordance with court rules. The outcome of that appeal, however, shall have no effect on the covered person, as to whom the decision of the arbitrator shall control. The assignment of counsel for an appeal by the carrier and the payment of expenses of that assigned counsel shall be as set forth in § 6416(b) of this title.

(h) Nothing in this section shall be construed to affect policies or contracts to the extent that those policies or contracts are exempt from state regulation under federal law or regulation, nor shall anything in this section be read to restrict any affirmative rights granted to patients or insureds under any other provision of the Delaware Code or the common law of the State.

(i) Notwithstanding any other language in the Delaware Code, the Department of Health and Social Services shall have the authority to carry out all duties assigned to it by this section.

(70 Del. Laws, c. 194, § 1; 70 Del. Laws, c. 186, § 1; 73 Del. Laws, c. 96, § 4; 73 Del. Laws, c. 315, § 6; 75 Del. Laws, c. 362, §§ 3-5; 78 Del. Laws, c. 226, § 3; 81 Del. Laws, c. 28, § 3; 81 Del. Laws, c. 29, § 1; 81 Del. Laws, c. 190, § 1.)

§ 332. Arbitration of disputes involving health insurance coverage [Effective Jan. 1, 2028].

(a) The following definitions shall apply with respect to this section:

(1) "Adverse determination" means a benefit denial, reduction or termination, a denial of certification, or both.

(2) "Benefit denial" means the denial, in whole or in part, of payment or reimbursement for health-care services rendered or health-care supplies provided to any person claiming benefits under an insurance policy delivered or issued for delivery in Delaware.

(3) "Carrier" in this section shall have the same meaning applied to it at § 3343(a) of this title.

(4) "Covered person" means a person who claims to be entitled to receive benefits from a carrier.

(5) "Denial of certification" means a determination that an admission or continued stay, or course of treatment, or other covered health-care service does not satisfy the insurance policy's clinical requirements for appropriateness, necessity, health-care setting and/or level of care.

(6) "Emergency review" means an IRP review involving an imminent, emergent or serious threat to the health of the claimant.

(7) "Health plan" shall have the same meaning as "health benefit plan" as defined at § 3343(a) of this title.

(8) "Insurance policy" shall have the meaning assigned to it at § 2702 of this title, and shall also include all health plans and policies for the payment for, provision of or reimbursement for medical services, supplies or both issued by insurers, health services corporations or managed care organizations.

(9) "Internal review process" or "IRP" means the procedure for an internal review of an adverse determination pursuant to subsection (b) of this section.

(b) Every carrier shall establish and maintain an IRP approved by the Insurance Commissioner.

(c) The Insurance Commissioner shall approve those IRPs that meet the following minimum criteria:

(1) *Written notice.* — The IRP must provide for written notice of the internal review procedure to covered persons, annually and following any adverse determination.

(2) *Requests for review of adverse determinations.* —

The IRP must permit covered persons to submit requests for internal reviews of adverse determinations ("grievances") orally or in writing. Grievances must be submitted within 30 days of receipt by the covered person of written notice of an adverse determination. The carrier must provide written forms for submission of grievances. Upon receipt of an oral grievance or a written grievance that does not contain sufficient information, the carrier must immediately provide the covered person with a written form upon which to make his or her grievance, and the carrier may require that an oral or insufficient written grievance be submitted in writing within 10 days of the covered person's receipt of the written form. A grievance shall be considered as received by the carrier when a written form, which the covered person purports to be complete, is received by the carrier.

(3) *Instructions on written form.* — The written form referred to in paragraph (c)(2) of this section shall inform the covered person of the information necessary to pursue an internal grievance of an adverse decision.

(4) *Prompt response to written grievances.* — The IRP shall provide that within 5 business days of receipt of a written grievance, the carrier shall provide written acknowledgement of the grievance, including the name, address and telephone number of the individual or department designated by the carrier to respond to the grievance.

(5) *Speedy review of grievances.* — That IRP shall require that all grievances be decided in an expeditious manner, and in any event, no more than:

a. 72 hours after the receipt of all necessary information relating to an emergency review;

b. 30 days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract; and

c. 45 days after the receipt of all necessary information in all other instances.

A grievance shall be considered decided when the carrier has made its final decision on the subject of the review and has deposited written notice of that decision in the mail, in accordance with paragraphs (c)(7) and (8) of this section.

(6) *Assignment of qualified personnel.* — The IRP shall provide that when the subject of the grievance relates to medical or clinical matters, including medical necessity and appropriateness of treatment, the health carrier shall assign licensed, certified or registered health care personnel with expertise in the field implicated by the request for review to conduct the review. The review shall be conducted by personnel other than those who made the initial adverse determination.

(7) *Written notice of decisions.* — The IRP shall provide that within 5 days after a grievance is decided in the manner described above, the insured shall be provided with written notice of the disposition of that grievance. In cases where the grievance has been decided in a manner that does not pay the claim in its entirety, the carrier shall provide the insured with a letter fully stating the reasons for the disposition (including specific policy language relied upon and any other documents relied upon) and the clinical rationale for the determination in cases where the determination has a clinical basis. The carrier's written notice shall also inform the insured of the appropriate manner for the insured to pursue an external review of the carrier's decision. Finally, the carrier's written notice shall inform the insured of the mediation services offered by the Department of Insurance, but shall clearly inform the insured in layman's terms that mediation does not change the deadlines imposed by § 6416 of this title or this section. The Department of Insurance shall inform any person with rights under § 6416 of this title or this section of those rights.

(8) *Manner of notice of decisions.* — Written notice of the review decision shall be deposited in the mail, addressed to the last known address of the covered person. In the case of emergency reviews, the carrier shall also make reasonable efforts to notify the covered person immediately following the determination of the grievance and the written notice of determination shall be deposited in the mail, addressed to the last known address of the claimant, within 48 hours after the receipt of all information necessary to complete the review. For cases involving a denial, reduction or termination of benefits where the external review may be conducted pursuant to this section, written notice shall be mailed requesting delivery confirmation by the United State Postal Service.

(d) Every carrier shall submit a report on its internal review process on an annual basis to the Insurance Commissioner in accordance with regulations established by the Department.

(e) With respect to adverse determinations that are subject to review by the Department of Insurance pursuant to § 6416(f) of this title, the Insurance Commissioner shall develop regulations providing for arbitration of such adverse determinations. Such regulations shall contain the following provisions:

(1) Requests for arbitration shall be in writing and mailed to the Commissioner within 60 days of the receipt of the written statement referred to in paragraph (c)(7) of this section.

(2) Arbitrators shall be chosen from an appropriate panel of arbitrators, and hearings shall be conducted according to rules established by the Department of Insurance.

(3) The arbitrator shall review written arbitration requests prior to holding any hearing or allowing any exchange of information between the parties in order to determine whether a written arbitration request is meritless on its face, and may summarily dismiss meritless requests for arbitration.

(4) Neither party shall be held to have waived any of its rights to seek relief in a court of law with respect to a covered person's legal rights to benefits by an act relating to arbitration or the rendering of an arbitration decision.

(5) Arbitration decisions shall be rendered within 45 days of the Commissioner's receipt of an arbitration request.

(f) The Insurance Commissioner shall establish a schedule of fees for arbitration. Fees chargeable to covered persons shall not exceed $75 per arbitration. The carrier shall be responsible for all costs of arbitration which exceed this fee regardless of the final ruling, and shall reimburse the Commissioner for the expenses related to the arbitration process. Funds paid to the Insurance Commissioner under this subsection shall be placed in the arbitration fund and shall be used exclusively for the payment of appointed arbitrators. The Insurance Commissioner may, in his or her discretion, impose a schedule of maximum fees that can be charged by an arbitrator for a given type of arbitration.

(g) If the arbitrator makes a decision in favor of the carrier, that decision shall give rise to a rebuttable presumption to that effect in any subsequent action brought by or on behalf of the covered person with respect to the decision. Should the decision favor the covered person, the carrier shall have the right to appeal the matter to the court, in accordance with court rules. The outcome of that appeal, however, shall have no effect on the covered person, as to whom the decision of the arbitrator shall control. The assignment of counsel for an appeal by the carrier and the payment of expenses of that assigned counsel shall be as set forth in § 6416(b) of this title.

(h) Nothing in this section shall be construed to affect policies or contracts to the extent that those policies or contracts are exempt from state regulation under federal law or regulation, nor shall anything in this section be read to restrict any affirmative rights granted to patients or insureds under any other provision of the Delaware Code or the common law of the State.

(i) Notwithstanding any other language in the Delaware Code, the Department of Health and Social Services shall have the authority to carry out all duties assigned to it by this section.

(70 Del. Laws, c. 194, § 1; 70 Del. Laws, c. 186, § 1; 73 Del. Laws, c. 96, § 4; 73 Del. Laws, c. 315, § 6; 75 Del. Laws, c. 362, §§ 3-5; 78 Del. Laws, c. 226, § 3; 81 Del. Laws, c. 28, § 3; 81 Del. Laws, c. 29, § 1; 81 Del. Laws, c. 190, § 1; 85 Del. Laws, c. 480, § 1.)

§ 333. Arbitration of disputes between insurance carriers and health-care providers.

(a) *Definitions.* — The following definitions shall apply with respect to this section:

(1) "Health-care provider" means a person, corporation, facility or institution licensed by this State pursuant to Title 24 or Title 16 to provide health-care or professional services or any officers, employees or agents thereof acting within the scope of their employment; provided, however, that the term "health-care provider" shall not mean or include the following:

a. Any nursing service or nursing facility conducted by or for those who rely upon treatment solely by spiritual means in accordance with the creed or tenets of any generally recognized church or religious denomination;

b. Any long-term care facility, as defined at § 1102 of Title 16 or its successor; and

c. Any hospital as defined at § 1001 of Title 16 or its successor.

(2) "Insurance carrier" means any entity that provides health insurance in this State. For the purposes of this section, "carrier" includes an insurance company, health services corporation, health maintenance organization and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers or settles claims in connection with health benefit plans.

(b) Every insurance carrier shall be required to submit to arbitration, in the manner set forth in this section, any dispute with a health-care provider regarding reimbursement for an individual claim, procedure or service by that health-care provider for health-care services, upon a request for arbitration by the health-care provider. A request for arbitration shall be made within 60 days after the receipt of the decision rendered by the insurance carrier. The Commissioner shall promulgate regulations addressing the manner in which health-care providers must be informed of the availability of arbitration under this section.

(c) By requesting arbitration pursuant to this chapter, a health-care provider shall be deemed to have agreed that it will not bill its patient for the difference between its charge and any reimbursement awarded by the arbitrator if it is forbidden from such billing by its contract with the carrier against whom the award is entered.

(d) The arbitration program shall be administered by the Department of Insurance.

(e) The Commissioner shall establish a panel of arbitrators, from which the Commissioner or the Commissioner's designee will select 1 person to hear each request for arbitration. No cause of action shall arise nor shall any liability be imposed against any individual appointed as arbitrator for any conduct performed in good faith while carrying out the provisions of this section. In establishing the panel of arbitrators required by this subsection, the Commissioner shall endeavor to appoint persons qualified to hear both legal and medical disputes.

(f) The losing party in an arbitration conducted pursuant to this section shall have a right to trial de novo in the Superior Court so long as notice of appeal is filed with that Court in the manner set forth by Superior Court rules within 30 days of the date of the arbitration decision being rendered.

(g) The Commissioner shall establish a schedule of fees for arbitration, which shall not exceed $100 per arbitration. The arbitrator may award to the health-care provider the cost of filing the arbitration if the health-care provider should prevail.

(h) The cost of arbitration shall be payable to the Department of Insurance, and shall be maintained in a special fund identified as the "Arbitration Fund," which shall remain separate and segregated from the General Fund. The compensation paid to the arbitrator shall be payable from the Arbitration Fund.

(i) The Commissioner may promulgate regulations exempting insurance carriers from the requirements of this section if the carriers maintain a substantially similar program to that created by this section.

(j) The following issues shall not be subject to arbitration under this section:

(1) Disputes as to whether the patient for whom health-care services were provided was a policyholder of the insurance carrier at the time services were rendered, or was otherwise entitled by contract to receive health-care services or reimbursement for health-care services.

(2) Disputes that are already pending before a court of law.

(3) Disputes that fall under an insurance carrier's own arbitration program, which has been granted an exemption pursuant to subsection (i) of this section.

(k) Arbitration under this section of disputes that are subject to arbitration pursuant to § 332 of this title, or resolution pursuant to § 6416 et seq. of this title, shall be stayed during the pendency of those proceedings. If a decision is entered under § 332 of this title or § 6416 et seq. of this title regarding an issue identical to one for which arbitration is sought under this section, and no appeal is pending, the decision entered under § 332 of this title or § 6416 et seq. of this title shall govern the outcome of the arbitration sought under this section.

(*l*) Health-care providers shall attempt to resolve disputes informally with insurance carriers before requesting arbitration pursuant to this section. The arbitrator may dismiss an arbitration petition without prejudice if the arbitrator finds that the health-care provider has not attempted to resolve the matter informally.

(m) Nothing in this section shall be construed to permit the alteration, amendment or modification of the substantive reimbursement terms of the insurance carrier's contracts with its members or health-care providers.

(n) This section shall be construed in a manner consistent with federal law and regulations.

(o) Arbitrations conducted pursuant to this section shall be subject to the provisions of §§ 10122 and 10125 of Title 29, provided that arbitrations shall not be conducted in public. Except as otherwise provided in this subsection, arbitration proceedings shall not be considered case decisions under Chapter 101 of Title 29.

(p) The Commissioner shall promulgate regulations for purposes of implementing this section.

(76 Del. Laws, c. 64, § 1; 80 Del. Laws, c. 404, § 1; 81 Del. Laws, c. 207, § 5; 82 Del. Laws, c. 73, § 1.)

§ 334. Office of Value-Based Health Care Delivery.

(a) The Office of Value-Based Health Care Delivery is established within the Department to reduce health-care costs by increasing the availability of high quality, cost-efficient health insurance products that have stable, predictable, and affordable rates.

(b) For purposes of this section:

(1) "Affordability standard" means as defined by the Department in regulations promulgated under this section using information collected under paragraphs (c)(2) and (c)(3) of this section and may include any of the following:

a. Trends, including any of the following:

1. Historical rates of trend for existing products.

2. National medical and health insurance trends.

3. Regional medical and health insurance trends.

4. Inflation indices.

b. Price comparison to other market rates for similar insurance products and medical services.

c. The ability of lower-income individuals to pay for health insurance.

d. Effective strategies carriers can use to maintain close control over administrative costs and enhance the affordability of products and encourage delivery of high quality, efficient healthcare services.

(2) a. "Carrier" means any of the following:

1. "Health insurer" as defined in § 4004 of this title and licensed under this title.

2. A health insurer or other entity that is certified as a qualified health plan on the Delaware Health Insurance Marketplace for plan year 2019 or a subsequent plan year.

b. Notwithstanding paragraph (b)(2)a. of this section, "carrier" does not mean any of the following:

1. A plan of health insurance or health benefits designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act, 42 U.S.C. §§ 1395 et seq., 1396 et seq., and 1397aa et seq., known as Medicare, Medicaid, or any other similar coverage under a state or federal government plan.

2. An entity selected by the State Group Health Insurance Plan to offer supplemental insurance program coverage under Chapter 52C of Title 29.

(3) "Primary care" means as defined by the Department in regulations promulgated under this section.

(4) "Primary Care Reform Collaborative" means as defined in § 9904A of Title 16.

(c) The Office of Value-Based Health Care Delivery shall do all of the following:

(1) Establish affordability standards for health insurance premiums based on recommendations from the Primary Care Reform Collaborative.

(2) Establish, through regulations adopted under this section, mandatory minimums for payment innovations, including alternative payment models, provider price increases, carrier investment in primary care, and other activities deemed necessary to achieve the purpose of this section.

(3) Collect data from carriers and providers, including any organization contracting with commercial carriers or government payers on behalf of Delaware-licensed clinicians, including physician organizations, health systems, hospitals, and outpatient facilities, and develop reports regarding carrier investments in health care to monitor and evaluate all of the following:

a. The calculation of the amount of claims-based and non-claims-based primary care spending in this State, including data from the Delaware Health Care Claims Database, under subchapter II of Chapter 103 of Title 16.

b. Carrier compliance with reimbursement rates for primary care required under §§ 3342B and 3556A of this title.

c. Health-care spending data collected and reported through the state benchmarking process.

d. The percentage of spending in primary care that is delegated to hospitals and related networks for care coordination through alternative payment models.

e. Carrier compliance with value-based care program offerings required under §§ 3342B and 3556A of this title.

f. Outcomes of value-based care reported on an annual basis including metrics relating to quality of care, efficiency, and patient experience. The Office of Value-Based Health Care Delivery shall develop, through regulation, a standardized set of measures and a methodology for assessing primary care provider performance against these measures.

(4) Annually evaluate whether primary care spending is increasing in compliance with the requirements of, and regulations adopted under, this title, with consideration of overall total health-care spending.

(5) Make recommendations to the Insurance Commissioner and the Primary Care Reform Collaborative about appropriate reimbursement rates for primary care.

(6) Develop and annually evaluate affordability standards, through an open and transparent process, in collaboration with the Primary Care Reform Collaborative.

(7) Establish, through regulations adopted under this section, value-based care program designs to increase provider accountability and improve provider access to enhanced investment.

(8) By January 1, 2029, promulgate regulations establishing limitations on covered persons' financial responsibility for covered services that are subject to the filing requirements referenced in § 2503(a)(15) of this title.

(d) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Office of Value-Based Health Care Delivery under this section or as a result of reporting as authorized in paragraph (c)(3) of this section. However, the Commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties.

(82 Del. Laws, c. 189, § 2; 83 Del. Laws, c. 237, § 7; 85 Del. Laws, c. 348, § 4.)

Part I
Insurance
Chapter 4
Workers' Compensation Self-Insurance Groups

§ 401. Scope.

This chapter shall apply to workers' compensation self-insurance groups of public and private employers. Groups which are issued a certificate of authority by the Commissioner shall be subject to this chapter and Chapters 1, 3, 7, 11, 13, 17, 21, 23, 25, 26, 27 and 59 of this title and subchapters IV and V of Chapter 23 of Title 19, as well as any regulations promulgated under those chapters, except as otherwise provided herein.

(70 Del. Laws, c. 540, § 1; 70 Del. Laws, c. 186, § 1.)

§ 402. Definitions.

For purposes of this chapter:

(1) "Administrator" means an individual, partnership or corporation engaged by a workers' compensation self-insurance group's board of trustees to carry out the policies established by the group's board of trustees and to provide day-to-day management of the group.

(2) "Commissioner" means the Commissioner of Insurance.

(3) "Insolvent" or "insolvency" means the same as "impairment" or "insolvency" as those terms are defined in § 5901(1) of this title as if the group were a reciprocal insurer.

(4) "Net premium" means premium derived from standard premium adjusted by any advance premium discounts.

(5) "Public employer" means a county, incorporated municipality, school district, parking authority or other instrumentality or political subdivision of the State itself.

(6) "Service company" means a person or entity which provides services not provided by the administrator, including but not limited to:

a. Claims adjustment;

b. Safety engineering;

c. Compilation of statistics and the preparation of premium, loss, and tax reports;

d. Preparation of other required self-insurance reports;

e. Development of members' assessments and fees; and

f. Administration of a claim fund.

(7) "Standard premium" means the premium derived from the filed rates adjusted by experience modification factors but before advance premium discounts.

(8) "Workers' compensation" when used as a modifier of "benefits," "liabilities," or "obligations," means both workers' compensation and employers' liability.

(9) "Workers' compensation self-insurance group" or "group" means a not-for-profit unincorporated association consisting of 5 or more private or public employers who are engaged in the same or similar type of business, who are members of the same bona fide trade or professional association which has been in existence for not less than 5 years and who enter into agreements to pool their liabilities for workers' compensation benefits and employers' liability in this State.

(70 Del. Laws, c. 540, § 1; 70 Del. Laws, c. 186, § 1.)

§ 403. Authority to act as a workers' compensation self-insurance group.

No person, association or other entity shall act as a workers' compensation self-insurance group unless it has been issued a certificate of authority by the Commissioner.

(70 Del. Laws, c. 540, § 1; 70 Del. Laws, c. 186, § 1.)

§ 404. Qualifications for initial approval and continued authority to act as a workers' compensation self-insurance group.

(a) A proposed workers' compensation self-insurance group shall file with the Commissioner its application for a certificate of approval accompanied by a nonrefundable filing fee in accordance with § 701 of this title. The application shall include the group's name, location of its principal office, date or organization, name and address of each member and such other information as the Commissioner may reasonably require, together with the following:

(1) Proof of compliance with subsection (b) of this section;

(2) A copy of the articles of association, if any;

(3) A copy of agreements with the administrator and with any service company;

(4) A copy of the by-laws of the proposed group;

(5) A copy of the agreement between the group and each member securing the payment of workers' compensation benefits, which shall include provision for payment of assessments as provided for in § 419 of this title;

(6) Designation of the initial board of trustees and administrator;

(7) The address in this State where the books and records of the group will be maintained at all times;

(8) A pro forma financial statement, on a form acceptable to the Commissioner, showing the financial ability of the group to pay the workers' compensation obligations of its members; and

(9) Proof of payment to the group by each member of not less than 25% of that member's first-year estimated annual net premium on a date prescribed by the Commissioner. Each payment shall be considered to be part of the first-year premium payment of each member if the proposed group is granted a certificate of approval.

(b) To obtain and to maintain its certificate of authority, a workers' compensation self-insurance group shall comply with the following requirements as well as any other requirements established by law or regulation:

(1) A combined net worth of all members of a group of private employers of at least $1,000,000. Specific and aggregate excess insurance in a form, in an amount and by an insurance company acceptable to the Commissioner for a group of public employers.

(2) Security in a form and amount prescribed by the Commissioner which shall be provided by a surety bond, security deposit or financial security endorsement, or any combination thereof. If a surety bond is used to meet the security requirement, it shall be issued by a corporate surety company authorized to transact business in this State. If a security deposit is used to meet the security requirement, securities shall be limited to bonds or other evidences of indebtedness issued, assumed or guaranteed by the United States of America or by an agency or instrumentality thereof; certificates of deposit in a federally insured bank; shares or savings deposits in a federally insured savings and loan association or credit union; or any bond or security issued by a state of the United States of America and backed by the full faith and credit of the state. Any such securities shall be deposited in accordance with § 1504 of this title and assigned to and made negotiable by the Chairperson of the Industrial Accident Board and the Commissioner pursuant to a trust document acceptable to the Commissioner. Interest accruing on a negotiable security so deposited shall be collected and transmitted to the depositor, provided the depositor is not in default. A financial security endorsement, issued as part of an acceptable excess insurance contract, may be used to meet all or part of the security requirement. The bond, security deposit or financial security endorsement shall be:

a. For the benefit of the State solely to pay claims and associated expenses; and

b. Payable upon the failure of the group to pay workers' compensation benefits that it is legally obligated to pay.

The Commissioner may establish and adjust, from time to time, requirements for the amount of security based on differences among groups in their size, types of employment, years in existence and other relevant factors.

(3) Specific and aggregate excess insurance in a form, in an amount and by an insurance company acceptable to the Commissioner. The Commissioner may establish minimum requirements for the amount of specific and aggregate excess insurance based on differences among groups in their size, types of employment, years in existence and other relevant factors, and may permit a group to meet this requirement by placing in a designated depository securities of the type referred to in paragraph (b)(2) of this section.

(4) An estimated annual standard premium of at least $250,000 during a group's first year of operation.

(5) An indemnity agreement jointly and severally binding the group and each member thereof to meet the workers' compensation obligations of each member. The indemnity agreement shall be in a form prescribed by the Commissioner and shall include minimum uniform substantive provisions prescribed by the Commissioner. Subject to the Commissioner's approval, a group may add other provisions needed because of its particular circumstances.

(6) A fidelity bond for the administrator in a form and amount prescribed by the Commissioner.

(7) A fidelity bond for the service company in a form and amount prescribed by the Commissioner. The Commissioner may also require the service company providing claim services to furnish a performance bond in a form and amount prescribed by the Commissioner.

(c) A group shall notify the Commissioner of any change in the information required to be filed under subsection (a) of this section or in the manner of its compliance with subsection (b) of this section no later than 30 days after the change.

(d) The Commissioner shall evaluate the information provided by the application required to be filed under subsection (a) of this section to assure that no gaps in funding exist and that funds necessary to pay workers' compensation benefits will be available on a timely basis.

(e) The Commissioner shall act upon a completed application for a certificate of approval within 60 days. If, because of the number of applications, the Commissioner is unable to act upon an application within this period, the Commissioner shall have an additional 60 days to act.

(f) The Commissioner shall issue to the group a certificate of approval upon finding that the proposed group has met all requirements or the Commissioner shall issue an order refusing the certification, setting forth reasons for refusal upon finding that the proposed group does not meet all requirements.

(g) Each workers' compensation self-insurance group shall be deemed to have appointed the Commissioner as its attorney to receive service of legal process issued against it in this State. The appointment shall be irrevocable, shall bind any successor in interest and shall remain in effect as long as there is in this State any obligation or liability of the group for workers' compensation benefits.

(70 Del. Laws, c. 540, § 1; 70 Del. Laws, c. 186, § 1.)

§ 405. Certificate of authority; termination.

(a) The certificate of authority issued by the Commissioner to a workers' compensation self-insurance group authorizes the group to provide workers' compensation benefits and employer's liability coverage. The certificate of authority remains in effect until terminated at the request of the group or revoked by the Commissioner, pursuant to § 423 of this title.

(b) The Commissioner shall not grant the request of any group to terminate its certificate of authority unless the group has insured or reinsured all incurred workers' compensation obligations with an authorized insurer under an agreement filed with and approved in writing by the Commissioner. Such obligations shall include both known claims and expenses associated therewith and claims incurred but not reported and expenses associated therewith.

Subject to the approval of the Commissioner, a group may merge with another group engaged in the same or similar type of business only if the resulting group assumes in full all obligations of the merging groups. The Commissioner may hold a hearing on the merger and shall do so if any party, including a member of either group, so requests.

(70 Del. Laws, c. 540, § 1; 70 Del. Laws, c. 186, § 1.)

§ 406. Examinations.

The Commissioner, pursuant to Chapter 5 of this title, may examine the affairs, transactions, accounts, records and assets and liabilities of each group as often as the Commissioner deems advisable. The expense of such examinations shall be assessed against the group in the same manner that insurers are assessed for examinations.

(70 Del. Laws, c. 540, § 1.)

§ 407. Board of trustees; membership, powers, duties and prohibitions.

Each group shall be operated by a board of trustees which shall consist of not less than 5 persons whom the members of a group elect for stated terms of office. At least $^{2}/_{3}$ of the trustees shall be employees, officers or directors of members of the group. The group's administrator, service company or any owner, officer, employee of or any other person affiliated with such administrator or service company shall not serve on the board of trustees of the group. All trustees shall be residents of this State or officers of corporations authorized to do business in this State. The board of trustees of each group shall ensure that all claims are paid promptly and take all necessary precautions to safeguard the assets of the group, including all of the following:

(1) The board of trustees shall:

a. Maintain responsibility for all moneys collected or disbursed from the group and segregate all moneys into a claims fund account and an administrative fund account. At least 70% of the net premium shall be placed into a designated depository for the sole purpose of paying claims, allocated claims expenses, reinsurance or excess insurance and special fund contributions, including second injury and other loss-related funds. This shall be called the "claims fund account." The remaining net premium shall be placed into a designated depository for the payment of taxes, general regulatory fees and assessments and administrative costs. This shall be called the "administrative fund account." The Commissioner may approve an administrative fund account of more than 30% and a claims fund account of less than 70% only if the group shows to the Commissioner's satisfaction that:

1. More than 30% is needed for an effective safety and loss control program; or

2. The group's aggregate excess insurance attaches at less than 70%.

b. Maintain minutes of its meetings and make the minutes available to the Commissioner.

c. Designate an administrator to carry out the policies established by the board of trustees and to provide day-to-day management of the group and delineate in the written minutes of its meetings the areas of authority it delegates to the administrator.

d. Retain an independent certified public accountant to prepare the statement of financial condition required by § 411(a) of this title.

(2) The board of trustees shall not:

a. Extend credit to individual members for payment of a premium, except pursuant to payment plans approved by the Commissioner.

b. Borrow any moneys from the group or in the name of the group except in the ordinary course of business, without first advising the Commissioner of the nature and purpose of the loan and obtaining prior approval from the Commissioner.

(70 Del. Laws, c. 540, § 1.)

§ 408. Group membership; termination; liability.

(a) An employer joining a workers' compensation self-insurance group after the group has been issued a certificate of authority shall:

(1) Submit an application for membership to the board of trustees or its administrator; and

(2) Enter into the indemnity agreement required by § 404(b)(5) of this title. Membership takes effect no earlier than each member's date of approval.

The application for membership and its approval shall be maintained as permanent records of the board of trustees.

(b) Individual members of a group shall be subject to cancellation by the group pursuant to the by-laws of the group. In addition, individual members may elect to terminate their participation in the group. The group shall notify the Commissioner and the workers' compensation agency of the termination or cancellation of a member within 10 days and shall maintain coverage of each canceled or terminated member for 30 days after notice, at the terminating member's expense, unless the group is notified sooner by the workers' compensation agency that the canceled or terminated member has procured workers' compensation insurance, has become an approved self-insurer or has become a member of another group.

(c) The group shall pay all workers' compensation benefits for which each member incurs liability during its period of membership. A member who elects to terminate its membership or is canceled by a group remains jointly and severally liable for workers' compensation obligations of the group and its members which were incurred during the canceled or terminated member's period of membership.

(d) A group member is not relieved of its workers' compensation liabilities incurred during its period of membership except through payment by the group or the member of required workers' compensation benefits.

(e) The insolvency or bankruptcy of a member does not relieve the group or any other member of liability for the payment of any workers' compensation benefits incurred during the insolvent or bankrupt member's period of membership.

(70 Del. Laws, c. 540, § 1.)

§ 409. Service companies.

(a) No service company or its employees, officers or directors shall be an employee, officer or director of, or have either a direct or indirect financial interest in, an administrator. No administrator or its employees, officer or directors shall be an employee, officer or director of, or have either a direct or indirect financial interest in, a service company.

(b) The service contract shall state that, unless the Commissioner permits otherwise, the service company shall handle, to their conclusion, all claims and other obligations incurred during the contract period.

(70 Del. Laws, c. 540, § 1.)

§ 410. Licensing of agent.

Except for a salaried employee of a group, its administrator or its service company, any person soliciting membership for a workers' compensation self-insurance group must be licensed as provided in Chapter 17 of this title.

(70 Del. Laws, c. 540, § 1.)

§ 411. Financial statements and other reports.

(a) Each group shall submit to the Commissioner a statement of financial condition audited by an independent certified public accountant on or before the last day of the sixth month following the end of the group's fiscal year. The financial statement shall be on a form prescribed by the Commissioner and shall include, but not be limited to, actuarially appropriate reserves for:

(1) Known claims and expenses associated therewith;

(2) Claims incurred but not reported and expenses associated therewith;

(3) Unearned premiums; and

(4) Bad debts,

which reserves shall be shown as liabilities.

(b) An actuarial opinion regarding reserves for:

(1) Known claims and expenses associated therewith; and

(2) Claims incurred but not reported and expenses associated therewith shall be included in the audited financial statement.

The actuarial opinion shall be given by a member of the American Academy of Actuaries or other qualified loss reserve specialist as defined in the annual statement adopted by the National Association of Insurance Commissioners.

(c) No person shall make any untrue statement of a material fact, or omit to state a material fact necessary in order to make the statement made, in light of the circumstances under which it is made, not misleading, in connection with the solicitation of membership in a group.

(d) The Commissioner may prescribe the format and frequency of other reports which may include, but shall not be limited to, payroll audit reports, summary loss reports and quarterly financial statements.

(70 Del. Laws, c. 540, § 1.)

§ 412. Taxes.

Groups shall be subject to subchapter V of Chapter 23 of Title 19 for the payment of premium tax.

(70 Del. Laws, c. 540, § 1.)

§ 413. Fees and assessments.

Groups shall be subject to subchapter V of Chapter 23 of Title 19 for the payment of fees and assessments.

(70 Del. Laws, c. 540, § 1.)

§ 414. Misrepresentation prohibited.

No person shall make a material misrepresentation or omission of a material fact in connection with the solicitation of membership of a group nor violate any provision of Chapters 17 and 23 of this title or any regulations thereunder.

(70 Del. Laws, c. 540, § 1.)

§ 415. Investments.

Funds not needed for current obligations may be invested by the board of trustees in accordance with Chapters 11 and 13 of this title.

(70 Del. Laws, c. 540, § 1.)

§ 416. Rates and reporting of rates.

(a) Every workers' compensation self-insurance group shall file and adhere to rates, rules and classifications pursuant to Chapter 26 of this title.

(b) Premium contributions to the group shall be determined by applying the rates and rules to the appropriate classification of each member which may be adjusted by each member's experience credit or debit. Subject to approval by the Commissioner, premium contributions may also be reduced by an advance premium discount reflecting the group's expense levels and loss experience.

(c) A group may contract with an advisory organization approved by the Commissioner for assistance in developing appropriate rates.

(d) Each group shall be audited at least annually by an auditor acceptable to the Commissioner to verify proper classifications, experience rating, payroll and rates. A report of the audit shall be filed with the Commissioner in a form acceptable to the Commissioner. A group or any member thereof may request a hearing on any objections to the classifications. If the Commissioner determines that, as a result of an improper classification, a member's premium contribution is insufficient, the commissioner shall order the group to assess that member an amount equal to the deficiency. If the Commissioner determines that, as a result of an improper classification, a member's premium is excessive, the commissioner shall order the group to refund to the member the excess collected. The audit shall be at the expense of the group.

(70 Del. Laws, c. 540, § 1.)

§ 417. Refunds.

(a) Any moneys for a fund year in excess of the amount necessary to fund all obligations for that fund year may be declared to be refundable by the board of trustees not less than 12 months after the end of the fund year with the Commissioner's approval.

(b) Each member shall be given a written description of the refund plan at the time of application for membership. A refund for any fund year shall be paid only to those employers who remain participants in the group for the entire fund year. Payment of a refund based on a previous fund year shall not be contingent on continued membership in the group after that fund year.

(70 Del. Laws, c. 540, § 1.)

§ 418. Premium payment; reserves.

(a) Each group shall establish to the satisfaction of the Commissioner a premium payment plan which shall include:

(1) An initial payment by each member of at least 25% of that member's annual premium before the start of the group's fund year; and

(2) Payment of the balance of each member's annual premium in monthly or quarterly installments.

(b) Each group shall establish and maintain actuarially appropriate loss reserves which shall include reserves for:

(1) Known claims and expenses associated therewith; and

(2) Claims incurred but not reported and expenses associated therewith.

(c) Each group shall establish and maintain bad debt reserves based on the historical experience of the group or other groups.

(70 Del. Laws, c. 540, § 1.)

§ 419. Deficits and insolvencies.

(a) If the assets of a group are at any time insufficient to enable the group to discharge its legal liabilities and other obligations and to maintain the reserves required of it under this chapter, it shall forthwith make up the deficiency or levy an assessment upon its members for the amount needed to make up the deficiency.

(b) In the event of a deficiency in any fund year, the deficiency shall be made up immediately, either from:

(1) Surplus from a fund year other than the current fund year;

(2) Administrative funds;

(3) Assessment of the membership, if ordered by the group; or

(4) Such alternate method as the Commissioner may approve or direct.

The Commissioner shall be notified prior to any transfer of surplus funds from 1 fund year to another.

(c) If the group fails to assess its members or to otherwise make up such deficit within 30 days, the Commissioner may order it to do so.

(d) If the group fails to make the required assessment of its members within 30 days after the Commissioner orders it do so, or if the deficiency is not fully made up within 60 days after the date on which the assessment is made or within such longer period of time as may be specified by the Commissioner, the group shall be deemed to be insolvent or impaired.

(e) Notwithstanding subsections (a) through (d) of this section, the Commissioner may at any time proceed against an insolvent group in the same manner as the Commissioner would proceed against an insolvent or impaired domestic insurer in this State as prescribed in Chapter 59 of this title. The Commissioner shall have the same powers and limitations in such proceedings as are provided under those laws.

(f) In the event of delinquency proceedings against a group, the Commissioner may levy an assessment upon its members for such an amount as the Commissioner determines to be necessary to discharge all liabilities of the group, including the reasonable cost of liquidation or rehabilitation.

(70 Del. Laws, c. 540, § 1.)

§ 420. Guaranty mechanism.

In the event of a liquidation pursuant to § 419 of this title, after exhausting the security required pursuant to § 404(b)(2) of this title, the Commissioner may levy an assessment against all groups to assure prompt payment of benefits. The assessment on each group shall be based on the proportion that the premium of each group bears to the total premium of all groups. The Commissioner may exempt a group from assessment upon finding that the payment of the assessment would render the group insolvent. The assessment shall not relieve any member of an insolvent group of its joint and several liability. After an assessment is made, the Commissioner shall take action to enforce the joint and several liability provisions of the insolvent group's indemnity agreement, and shall recoup:

(1) All costs incurred by the Commissioner in enforcing such joint and several liability provisions;

(2) Amounts that the Commissioner assessed any other groups pursuant to this section; and

(3) Any obligations included within § 419(f) of this title.

(70 Del. Laws, c. 540, § 1.)

§ 421. Monetary penalties.

After notice and opportunity for a hearing, the Commissioner may impose a monetary penalty on any person or group found to be in violation of any provision of this chapter or title or of any rules or regulations pursuant to § 329 of this title and Chapter 101 of Title 29. The amount of any monetary penalty shall be paid to the Commissioner for the use of the State.

(70 Del. Laws, c. 540, § 1.)

§ 422. Cease and desist orders.

(a) After notice and opportunity for a hearing, unless there are exigent circumstances, the Commissioner may issue an order requiring a person or group to cease and desist from engaging in an act or practice found to be in violation of any provision of this chapter or title or of any rules or regulations promulgated thereunder. Unless there are exigent circumstances, a minimum of 10 days' notice will be provided prior to a hearing. If exigent circumstances are present, the person or group will be offered a hearing within 10 days after the issuance of the order.

(b) Upon a finding, after notice and opportunity for a hearing, that any person or group has violated any cease and desist order, the Commissioner may do any or all of the following:

(1) Impose a monetary penalty of not more than $15,000, in the case of an individual, or not more than $50,000, in the case of a group or corporation, for each and every act or violation of the order; or

(2) Revoke or suspend the group's certificate of authority or any insurance license held by the person; or

(3) Place the group or person under supervision; or

(4) Permanently enjoin the conduct or enter any remedial order.

(70 Del. Laws, c. 540, § 1.)

§ 423. Revocation of certificate of authority.

(a) After notice and opportunity for a hearing, the Commissioner may revoke or suspend a group's certificate of authority if it:

(1) Is found to be insolvent or impaired;

(2) Fails to pay any premium tax, regulatory fee or assessment or special fund contribution imposed upon it; or

(3) Fails to comply with any of the provisions of this chapter and title or with any rules promulgated thereunder or with any lawful order of the Commissioner within the time prescribed.

(b) In addition, the Commissioner may revoke or suspend a group's certificate of authority if, after notice and opportunity for hearing, the Commissioner finds that:

(1) Any certificate of authority that was issued to the group was obtained by fraud;

(2) There was a material misrepresentation in the application for the certificate of authority; or

(3) The group or its administrator has misappropriated, converted, illegally withheld or refused to pay over upon proper demand any moneys that belong to a member, an employee of a member or a person otherwise entitled thereto and that have been entrusted to the group or its administrator in its fiduciary capacities.

(70 Del. Laws, c. 540, § 1.)

§ 424. Notice and hearings.

All notices and hearings shall be as provided in Chapter 3 of this title and Chapter 101 of Title 29.

(70 Del. Laws, c. 540, § 1.)

§ 425. Rules and regulations.

The Commissioner shall have power to make rules and regulations in order to implement this chapter.

(70 Del. Laws, c. 540, § 1.)

Part I
Insurance
Chapter 5
Authorization of Insurers and General Requirements

§ 501. “Stock insurer” defined.

A “stock insurer” is an incorporated insurer with its capital divided into shares and owned by its stockholders. Unless otherwise provided, the insurance department or division of a corporation established under Chapter 7 of Title 5 (but not the corporation itself) shall be deemed to be a stock insurer for purposes of this title, even though it has no capital divided into shares and owned by stockholders.

(18 Del. C. 1953, § 501; 56 Del. Laws, c. 380, § 1; 67 Del. Laws, c. 223, § 18.)

§ 502. “Mutual” insurer defined.

A “mutual” insurer is an incorporated insurer without capital stock and the governing body of which is elected by its policyholders. This definition shall not be deemed to exclude as “mutual” insurers certain foreign insurers found by the Commissioner to be organized on the mutual plan under the laws of their states of domicile but having temporary share capital or providing for election of the insurer’s governing body on a reasonable basis.

(18 Del. C. 1953, § 502; 56 Del. Laws, c. 380, § 1.)

§ 503. “Reciprocal” insurer defined.

A “reciprocal” insurer is an unincorporated aggregation of subscribers operating individually and collectively through an attorney-in-fact common to all such persons to provide reciprocal insurance among themselves.

(18 Del. C. 1953, § 503; 56 Del. Laws, c. 380, § 1.)

§ 504. “Charter” defined.

“Charter” means certificate of incorporation, articles of incorporation, articles of agreement, articles of association, charter granted by legislative act or other basic constituent document of a corporation or the power of attorney of the attorney-in-fact of a reciprocal insurer.

(18 Del. C. 1953, § 504; 56 Del. Laws, c. 380, § 1.)

§ 505. Certificate of authority required.

(a) No person shall act as an insurer and no insurer shall transact insurance in this State by mail or otherwise, except as authorized by a subsisting certificate of authority granted to it by the Commissioner and except as to such transactions as are expressly otherwise provided for in this title.

(b) No insurer formed under the laws of this State and no insurer from offices or with personnel or facilities located in this State shall solicit insurance applications or otherwise transact insurance in another state or country unless it holds a subsisting certificate of authority granted to it by the Commissioner authorizing it to transact the same kind or kinds of insurance in this State.

(c) Any wilful violation of this section by a domestic corporation shall constitute misuse of its corporate powers, and the Attorney General shall proceed for the forfeiture of its charter under § 284 of Title 8.

(d) Notwithstanding any other provision of law, and except as provided herein, any person or other entity which provides coverage in this State for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital or optometric expenses, whether such coverage is by direct payment, reimbursement or otherwise, shall be presumed to be subject to the jurisdiction and authority of the Commissioner unless the person or other entity shows that while providing such services it is subject to the jurisdiction of another agency of this or another state, any subdivisions thereof, or the federal government. The jurisdiction and authority of the Commissioner shall be governed by the following provisions:

(1) A person or entity may show that it is subject to the jurisdiction of another agency of this or another state, any subdivision thereof, or the federal government by providing the Commissioner the appropriate certificate, license or other document issued by the other governmental agency which permits or qualifies it to provide those services.

(2) Any person or entity which is unable to show that it is subject to the jurisdiction of another agency of this or another state, any subdivision thereof or the federal government shall submit to an examination by the Commissioner to determine the organization and solvency of the person or the entity, and to determine whether or not such person or entity is in compliance with the applicable provisions of this Code.

(3) Any person or entity unable to show that it is subject to the jurisdiction of another agency of this or another state, any subdivision thereof or the federal government shall be subject to all appropriate provisions of this Code regarding the conduct of its business.

(4) Any production agency or administrator which advertises, sells, transacts or administers coverage in this State, described in this subsection, which is provided by any person or entity described in paragraph (d)(2) of this section shall, if that coverage is not fully insured or otherwise fully covered by an admitted life or disability insurer, nonprofit hospital service plan or nonprofit health-care plan, advise any purchaser, prospective purchaser and covered person of such lack of insurance or other coverage.

(5) Any administrator which advertises or administers coverage in this State, described in this subsection, which is provided by any person or entity described in paragraph (d)(2) of this section, shall advise any production agency of the elements of the coverage including the amount of "stop-loss" insurance in effect.

(18 Del. C. 1953, § 505; 56 Del. Laws, c. 380, § 1; 64 Del. Laws, c. 348, § 1.)

§ 506. Exceptions to certificate of authority requirement.

A certificate of authority shall not be required of an insurer with respect to the following:

(1) Investigation, settlement or litigation of claims under its policies lawfully written in this State or liquidation of assets and liabilities of the insurer (other than collection of new premiums), all as resulting from its former authorized operations in this State;

(2) Transactions thereunder subsequent to issuance of a policy covering only subjects of insurance not resident, located or expressly to be performed in this State at time of issuance and lawfully solicited, written and delivered outside this State;

(3) Prosecution or defense of suits at law;

(4) Transactions pursuant to surplus lines coverages lawfully written under Chapter 19 of this title;

(5) Reinsurance, except as to domestic reinsurers;

(6) Underwriting-membership in a regulated insurance exchange.

(7) An automobile club so long as its activities are restricted to those defined in § 1707(b)(4) of this title.

(18 Del. C. 1953, § 506; 56 Del. Laws, c. 380, § 1; 62 Del. Laws, c. 192, § 1; 75 Del. Laws, c. 49, § 4.)

§ 507. General eligibility for certificate of authority.

To qualify for and hold authority to transact insurance in this State, an insurer must be otherwise in compliance with this title and with its charter powers and must be an incorporated stock or mutual insurer or a reciprocal insurer of the same general type as may be formed as a domestic insurer under this title, except that:

(1) No foreign insurer shall be authorized to transact insurance in this State which does not maintain reserves as required by Chapter 11 (Assets and Liabilities) of this title, as applicable to the kind or kinds of insurance transacted by such insurer wherever transacted in the United States, or which transacts business anywhere in the United States on the assessment plan or stipulated premium plan or any similar plan;

(2) No insurer shall be authorized to transact workers' compensation insurance in this State unless approved by the Department of Labor of this State under the provisions of Part II of Title 19;

(3) No insurer shall be authorized to transact a kind of insurance in this State unless duly authorized or qualified for authorization to transact such insurance in the state or country of its domicile.

(18 Del. C. 1953, § 507; 56 Del. Laws, c. 380, § 1; 71 Del. Laws, c. 84, § 25.)

§ 508. Ownership; management.

(a) No foreign insurer which is directly or indirectly owned or controlled in whole or substantial part by any government or governmental agency shall be authorized to transact insurance in Delaware. Membership in a mutual insurer or subscribership in a reciprocal insurer or ownership of stock of an insurer by the alien property custodian or similar official of the United States or ownership of stock or other security which does not have voting rights with respect to the management of the insurer or supervision of an insurer by public authority shall not be deemed to be an ownership or control of the insurer for the purposes of this provision.

(b) The Commissioner shall not grant or continue authority to transact insurance in this State as to any insurer or proposed insurer the management of which is found by the commissioner after investigation or upon reliable information to be incompetent or dishonest or untrustworthy or of unfavorable business repute or so lacking in insurance company managerial experience in operations of the kind proposed in this State as to make such operation, currently or prospectively, hazardous to or contrary to the best interests of, the insurance-buying or investing public of this State, or which the commissioner has good reason to believe is affiliated directly or indirectly through ownership, control, reinsurance transactions or other business relations with any person or persons of unfavorable business repute or whose business operations are or have been marked, to the injury of insurers, stockholders, policyholders, creditors, or the public, by illegality, or by manipulation of assets or of accounts or of reinsurance or by bad faith.

(18 Del. C. 1953, § 508; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 509. Name of insurer.

(a) No insurer shall be formed or authorized to transact insurance in this State which has or uses a name which is the same as or deceptively similar to that of another insurer already so authorized without the written consent of such other insurer.

(b) No life insurer shall be so authorized which has or uses a name deceptively similar to that of another insurer authorized to transact insurance in this State within the preceding 10 years if life insurance policies originally issued by such other insurer are still outstanding in this State.

(c) No insurer shall be formed or authorized to transact insurance which has or uses a name the same as or deceptively similar to that of any foreign insurer not so authorized if such foreign insurer has within the next preceding 12 months signified its intention to secure an incorporation in this State under such name or to do business as a foreign insurer in this State under such name by filing notice of

such intention with the Commissioner, unless the written consent to the use of such name or deceptively similar name has been given by such foreign insurer.

(d) No foreign insurer seeking admission to this State shall be authorized to transact insurance which has or uses a name the same as or deceptively similar to that of a domestic corporation which has been incorporated as an insurer but has not yet secured a certificate of authority until an expiration of 3 years from date of incorporation of such domestic corporation and of filing with the Commissioner a written notice of intent to use such name.

(e) No insurer shall be so authorized which has or uses a name which tends to deceive or mislead as to the type of organization of the insurer.

(f) In case of conflict of names between 2 insurers or a conflict otherwise prohibited under this section, the Commissioner may permit (or shall require as a condition to the issuance of an original certificate of authority to an applicant insurer) the insurer to use in this State such supplementation or modification of its name or such business name as may reasonably be necessary to avoid the conflict.

(g) Except as provided in subsection (f) above, an insurer shall conduct its business in this State in its own corporate (if incorporated) or proper (if reciprocal insurer) name.

(18 Del. C. 1953, § 509; 56 Del. Laws, c. 380, § 1.)

§ 510. Combinations of insuring powers.

(a) A reciprocal insurer shall not be a life insurer.

(b) A title insurer shall be a stock insurer and shall not transact any other kind of insurance. This provision shall not prohibit acceptance of reinsurance of title insurance risks by insurers not otherwise authorized to transact title insurance.

(18 Del. C. 1953, § 510; 56 Del. Laws, c. 380, § 1.)

§ 511. Capital funds required.

(a) To transact any 1 kind of insurance (as defined in Chapter 9 of this title), or combinations of kinds of insurance as shown below, an insurer shall possess and thereafter maintain in cash or cash equivalents unimpaired paid-in capital stock (if a stock insurer) or a capital account (if an insurance department or division of a corporation established under Chapter 7 or regulated under Chapter 9 of Title 5) or unimpaired basic surplus (if a foreign mutual or a reciprocal insurer), and when first so authorized shall possess and maintain free surplus, all in amounts not less than as follows:

Kind or kinds of insurance	Stock insurers		Mutual Insurers		Reciprocal insurers	
	Capital stock	Free surplus	Basic surplus	Free surplus	Basic surplus	Free surplus
Life	$650,000	$350,000	$650,000	$350,000	. . . . .	. . . . .
Health	$650,000	$350,000	$650,000	$350,000	$650,000	$350,000
Life & health	$650,000	$350,000	$650,000	$350,000	. . . . .	. . . . .
Property	$650,000	$350,000	$650,000	$350,000	$650,000	$350,000
Casualty	$650,000	$350,000	$650,000	$350,000	$650,000	$350,000
Marine & transportation	$650,000	$350,000	$650,000	$350,000	$650,000	$350,000
Surety	$650,000	$350,000	$650,000	$350,000	$650,000	$350,000
Multiple line	$650,000	$350,000	$650,000	$350,000	$650,000	$350,000
Title	$650,000	$350,000	. . . . .	. . . . .	. . . . .	. . . . .

Except:

(1) A domestic insurer holding a valid certificate of authority to transact insurance in this State immediately prior to January 1, 2024, may, if otherwise qualified therefor, for a period of 5 years after such date continue to be so authorized while possessing paid-in capital stock (if a stock insurer) or surplus (if a mutual insurer) as required for such authority immediately prior to such date. The Commissioner shall not authorize such an insurer to transact any other kinds of insurance unless it then complies with the requirements as to capital and surplus, as applied to all kinds of insurance it then proposes to transact, as provided by this title as to foreign insurers applying for original certificates of authority under this title.

(2) An insurer which otherwise possesses funds as required under this subsection (a) above, shall at all times maintain policyholders' surplus (combined paid-in capital stock, if any, and surplus) reasonable in amount, as determined by the Commissioner, in relation to the kinds and amount of insurance it has in force, or being written and retained by it, net of applicable reinsurance. In making any such determination the Commissioner shall give due consideration to any applicable standards approved or adopted by the National Association of Insurance Commissioners and to the desirability of substantial uniformity as to such requirements among the respective states. In no event shall an insurer's surplus be less than the amount set forth under subsection (a) of this section.

(b) Capital and surplus requirements are based upon all the kinds of insurance transacted by the insurer in any and all areas in which it operates or proposes to operate, whether or not only a portion of such kinds is to be transacted in this State.

(c) As to surplus required for authority to transact one or more kinds of insurance and thereafter to be maintained, domestic mutual insurers shall be governed by Chapter 49 of this title.

(18 Del. C. 1953, § 511; 56 Del. Laws, c. 380, § 1; 67 Del. Laws, c. 223, § 19; 68 Del. Laws, c. 70, § 1; 84 Del. Laws, c. 34, § 1.)

§ 512. Insuring combinations without additional capital funds.

Without additional capital or additional surplus, an authorized insurer is also authorized:

(1) If a life insurer, to grant annuities or issue funding agreements;

(2) If a health insurer, to insure against congenital defects, as defined in § 906(a)(12) of this title;

(3) If a casualty insurer, to transact also health insurance. Except, that this provision shall not apply to a domestic insurer authorized to transact casualty insurance pursuant to § 511(a)(1) of this title.

(18 Del. C. 1953, § 512; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 268, § 1.)

§ 513. Deposit requirements — In general.

(a) The Commissioner shall not authorize a foreign insurer (other than an alien insurer) to transact insurance in this State unless it makes and thereafter continuously maintains on deposit in this State through the Commissioner, or in another state, cash or securities eligible for such deposit under the laws of this State or of such other state of a fair market value not less than $100,000, for the protection of all its policyholders wherever located or all of its policyholders in the United States or of all its policyholders and creditors. The Commissioner shall accept the certificate in proper form of the public official having supervision over insurers in any other state to the effect that such deposit or part thereof by such insurer is being maintained in public custody or control pursuant to law in such state. The insurer shall at the time of filing its annual statement with the Commissioner as provided in § 526 of this title also file with the Commissioner a certificate from such public official showing the amount and character of the securities composing its deposit held in such other state.

(b) The Commissioner shall not authorize an insurer to transact surety insurance unless it makes and thereafter continuously maintains in this State through the Commissioner a special and additional deposit of cash or securities eligible therefor under § 1503 of this title, of a fair market value not less than $10,000, to answer any default of such insurer upon surety contracts issued by it in this State. The foregoing requirement shall not be applicable to any insurer having a paid-in capital and surplus of $10,000,000 or more and continuously maintaining on deposit in this State through the Commissioner, or in another state, cash or securities eligible for such deposit under the laws of this State or of such other state of a fair market value of not less than $400,000 for the protection of all its policyholders wherever located, or all of its policyholders in the United States or all of its policyholders and creditors.

(c) No insurer shall transact workers' compensation insurance in this State unless it makes and thereafter maintains in this State through the Commissioner a special and additional deposit of cash or securities eligible therefor under § 1503 of this title, of a fair market value of not less than $100,000 for the protection of persons in this State covered under the insurance so transacted. Upon any insurer's inability to pay workers' compensation claims as a result of a court of competent jurisdiction finding of financial impairment or insolvency, which prevents the regular payment of workers' compensation benefits, this deposit shall be immediately available upon their request to the Delaware Insurance Guaranty Association for continuation of claims benefits to eligible workers.

(d) The Commissioner shall not authorize a domestic title insurer to transact insurance unless it makes and thereafter continuously maintains on deposit in this State through the Commissioner cash or securities eligible for such deposit under § 1503 of this title of a fair market value not less than $25,000 for the protection of its policyholders in this State.

(e) All such deposits in this State are subject to the applicable provisions of Chapter 15 (Administration of Deposits) of this title.

(f) The Commissioner shall not authorize a domestic insurer, other than a title insurer, to transact insurance unless it makes and thereafter continuously maintains on deposit in this State through the Commissioner cash or securities eligible therefor under § 1503 of this title of a fair market value of not less than $100,000 for the protection of all its policyholders wherever located, or all its policyholders in the United States, or all its policyholders and creditors.

(18 Del. C. 1953, § 513; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, §§ 32-34; 64 Del. Laws, c. 269, § 1; 65 Del. Laws, c. 409, § 1.)

§ 514. Deposit requirements — Alien insurers.

The Commissioner shall not authorize an alien insurer to transact insurance in this State unless it makes and thereafter continuously maintains on deposit in this State through the Commissioner, or in another state, a surplus of assets in cash or securities eligible for such deposit under the laws of this State or such other state of a value not less than the combined capital and surplus initially required of a like foreign insurer transacting like kinds of insurance in this State. The deposit shall be held in trust for the benefit and security of all the insurer's policyholders and creditors in the United States or of all the insurer's policyholders in the United States.

(18 Del. C. 1953, § 514; 56 Del. Laws, c. 380, § 1.)

§ 515. Application for certificate of authority.

To apply for an original certificate of authority an insurer shall file with the Commissioner its written application therefor, accompanied by the applicable fees specified in § 701 of this title, stating under the oath of the president or vice-president, or other chief officer, and the secretary of the insurer, or of the attorney-in-fact if the insurer is a reciprocal insurer, the insurer's name, location of its home office or principal office in the United States (if an alien insurer), the kinds of insurance to be transacted, date of organization or incorporation,

form of organization, state or country of domicile and such additional information as the Commissioner may reasonably require, together with the following documents, as applicable:

(1) If a corporation, a copy of its charter or certificate or articles of incorporation, together with all amendments thereto, or as restated and amended under the laws of its state or country of domicile, currently certified by the public official with whom the originals are on file in such state or country;

(2) If an incorporated insurer, a copy of its bylaws, certified by the insurer's corporate secretary;

(3) If a reciprocal insurer, a copy of the power of attorney of its attorney-in-fact, certified by the attorney-in-fact, and, if a domestic reciprocal insurer, the declaration provided for in § 5706 of this title;

(4) A complete copy of its financial statement as of not earlier than the December 31 next preceding in form as customarily used in the United States by like insurers, sworn to by at least 2 executive officers of the insurer or certified by the public insurance supervisory official of the insurer's state of domicile, or of entry into the United States (if an alien insurer);

(5) A copy of the report of the last examination, if any, made of the insurer within not more than the 3 years next preceding, certified by the public insurance supervisory official of the insurer's state of domicile, or of entry into the United States (if an alien insurer);

(6) Appointment of the Commissioner pursuant to § 524 of this title as its attorney to receive service of legal process;

(7) If a foreign or alien insurer, a certificate of the public insurance supervisory official of its state or country of domicile showing that it is authorized to transact in such state or country the kinds of insurance proposed to be transacted in this State;

(8) If a foreign insurer, certificate as to deposit if to be tendered pursuant to § 513 of this title;

(9) If an alien insurer, certificate as to deposit in another state if to be tendered pursuant to § 514 of this title;

(10) If a life or health insurer, a copy of the insurer's rate book and of each form of policy currently proposed to be issued in this State and of the form of application therefor;

(11) If an alien insurer, a copy of the appointment and authority of its United States manager, certified by its officer having custody of its records;

(12) Designation by the insurer of its officer or representative authorized to appoint and remove its agents in this State.

(18 Del. C. 1953, § 515; 56 Del. Laws, c. 380, § 1.)

§ 516. Issuance, refusal of authority; ownership of certificate.

(a) If upon completion of its application the Commissioner finds that the insurer has met the requirements therefor under this title, the Commissioner shall issue to the insurer a proper certificate of authority; if he or she does not so find, the Commissioner shall issue his or her order refusing such certificate. The Commissioner shall act upon an application for certificate of authority within a reasonable period after its completion.

(b) The Commissioner shall issue certificates of authority under his or her seal of office, showing the date of actual issuance, the kinds of insurance the insurer is authorized to transact in this State, and such other matters as the Commissioner deems necessary. At the insurer's request, the Commissioner may issue a certificate of authority limited to particular types of insurance or coverages within a kind of insurance as defined in Chapter 9 of this title.

(c) Although issued and delivered to the insurer, the certificate of authority at all times shall be the property of the State. Upon any expiration, suspension or termination thereof the insurer shall promptly deliver the certificate to the Commissioner.

(18 Del. C. 1953, § 516; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 517. Authority conferred; surety insurers; certificate as evidence.

(a) The certificate of authority confers upon the insurer authority to transact in this State only the kind or kinds of insurance therein specified. No surety insurer shall be deemed thereby to possess power to act in capacity of executor, administrator, guardian, trustee, receiver, assignee, or agent, or in any other capacity than that of surety, notwithstanding contrary provisions in its charter.

(b) An insurer's valid and subsisting certificate of authority shall be prima facie evidence of its right to transact in this State the kind or kinds of insurance specified therein.

(18 Del. C. 1953, § 517; 56 Del. Laws, c. 380, § 1.)

§ 518. Continuance, expiration, reinstatement of certificate of authority.

(a) A certificate of authority shall continue in force as long as the insurer is entitled thereto under this title, and until suspended or revoked by the Commissioner or terminated at the insurer's request; subject, however, to continuance of the certificate by the insurer each year by:

(1) Payment on or before March 1 of the continuation fee provided in § 701 (fee schedule) of this title;

(2) Due filing by the insurer of its annual statement for the next preceding calendar year as required by § 526 of this title; and

(3) Payment by the insurer of premium taxes with respect to the preceding calendar year.

(b) If not so continued by the insurer, its certificate of authority shall expire as of midnight on the May 31 next following such failure of the insurer to continue it in force, unless earlier revoked for failure to pay taxes as provided in § 519 of this title. The Commissioner shall promptly notify the insurer of the occurrence of any failure resulting in impending expiration of its certificate of authority.

(c) The Commissioner may, in his or her discretion, upon the insurer's request made within 3 months after expiration, reinstate a certificate of authority which the insurer has inadvertently permitted to expire after the insurer has fully cured all its failures which resulted in the expiration, and upon payment by the insurer of the fee for reinstatement specified in § 701(1) (fee schedule) of this title. Otherwise the insurer shall be granted another certificate of authority only after filing application therefor and meeting all other requirements as for an original certificate of authority in this State.

(18 Del. C. 1953, § 518; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 519. Suspension or revocation of certificate of authority — Mandatory grounds.

(a) The Commissioner shall refuse to continue or shall suspend or revoke an insurer's certificate of authority:

(1) If such action is required by any provision of this title;

(2) If a foreign insurer and it no longer meets the requirements for a certificate of authority, on account of deficiency of assets or otherwise;

(3) If a domestic insurer and it has failed to cure an impairment of capital or surplus within the time allowed therefor by the Commissioner under this title, or is otherwise no longer qualified for the certificate of authority;

(4) If the insurer's certificate of authority to transact insurance therein is suspended or revoked by its state of domicile, or state of entry into the United States (if an alien insurer); or

(5) For failure of the insurer to pay taxes on its premiums as required by the laws of this State.

(b) Except in case of insolvency or impairment of required capital or surplus, or suspension or revocation by another state as referred to in paragraph (a)(4) of this section above, the Commissioner shall give the insurer at least 10 days notice in advance of any such refusal, suspension or revocation under this section, and of the particulars of the reasons therefor. If the insurer requests a hearing thereon within such 10 days, such request shall automatically stay the Commissioner's proposed action until his or her order is made on such hearing.

(18 Del. C. 1953, § 519; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 520. Suspension or revocation of certificate of authority — Discretionary and special grounds.

(a) The Commissioner may, in his or her discretion, refuse to continue or may suspend or revoke an insurer's certificate of authority if he or she finds after a hearing thereon, or upon waiver of hearing by the insurer, that the insurer has violated or failed to comply with any lawful order of the Commissioner, or has wilfully violated or wilfully failed to comply with any lawful regulation of the Commissioner, or has violated any provision of this title or any other title of the Delaware Code applicable to insurers other than those for violation of which suspension or revocation is mandatory, or, in lieu of such suspension or revocation, the Commissioner may, in his or her discretion, levy upon the insurer, and the insurer shall pay forthwith, an administrative fine of not over $5,000.

(b) The Commissioner shall suspend or revoke an insurer's certificate of authority on any of the following grounds, if the Commissioner finds after a hearing thereon that the insurer:

(1) Is in unsound condition, or is being fraudulently conducted, or is in such condition or using such methods and practices in the conduct of its business as to render its further transaction of insurance in this State currently or prospectively hazardous or injurious to policyholders or to the public;

(2) With such frequency as to indicate its general business practice in this State, has without just cause failed to pay or delayed payment of claims arising under its policies, whether the claim is in favor of an insured or is in favor of a third person with respect to the liability of an insured to such third person; or, with like frequency, without just cause compels insureds or claimants to accept less than the amount due them or to employ attorneys or to bring suit against the insurer or such an insured to secure full payment or settlement of such claims;

(3) Refuses to be examined, or if its directors, officers, employees or representatives refuse to submit to examination relative to its affairs, or to produce its accounts, records and files for examination by the Commissioner when required, or refuse to perform any legal obligation relative to the examination;

(4) Has failed to pay any final judgment rendered against it in this State upon any policy, bond, recognizance or undertaking as issued or guaranteed by it, within 30 days after the judgment became final, or within 30 days after dismissal of an appeal before final determination, whichever date is the later;

(5) As defined in Chapter 40 of this title, has failed to comply with § 4006 of this title;

(6) As defined in Chapter 40 of this title, has failed to accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the state Medicaid Plan;

(7) As defined in Chapter 40 of this title, has failed to respond to any inquiry by the State regarding a claim for payment for any health-care item or service that is submitted within 3 years of the date of the provision of such health-care item or service;

(8) As defined in Chapter 40 of this title, has denied a claim submitted by the State on the basis of lack of prior authorization; has denied a claim submitted by the State based solely on the date of submission of the claim, the type or format of the claim, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if:

a. The claim submitted by the State is made within 3 years of the date when the item or service was furnished; and

b. Any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim.

(c) The Commissioner may, in his or her discretion and without advance notice or a hearing thereon, immediately suspend the certificate of authority of any insurer as to which proceedings for receivership, conservatorship, rehabilitation or other delinquency proceedings have been commenced in any state by the public insurance supervisory official of such state.

(18 Del. C. 1953, § 520; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 278, § 2; 70 Del. Laws, c. 186, § 1; 76 Del. Laws, c. 190, § 1; 80 Del. Laws, c. 376, § 3.)

§ 521. Order and notice of suspension, revocation; effect upon agents' authority.

(a) All suspensions or revocations of or refusals to continue an insurer's certificate of authority shall be, by the Commissioner's order, given to the insurer.

(b) Upon issuance of the order, the Commissioner shall forthwith give notice thereof to the insurer's agents in this State of record in the Department, and shall likewise suspend or revoke the authority of such agents to represent the insurer.

(18 Del. C. 1953, § 521; 56 Del. Laws, c. 380, § 1.)

§ 522. Duration of suspension; insurer's obligations during suspension period; reinstatement.

(a) Suspension of an insurer's certificate of authority shall be for such period as the Commissioner specifies in the order of suspension, but not to exceed 1 year. During the suspension period the Commissioner may rescind or shorten the suspension by his or her further order.

(b) During the suspension period the insurer shall not solicit or write any new business in this State, but shall file its annual statement, pay fees, licenses and taxes as required under this title, and may service its business already in force in this State, as if the certificate of authority had continued in full force.

(c) Upon expiration of the suspension period, if within such period the certificate of authority has not terminated, the insurer's certificate of authority shall automatically reinstate, unless the Commissioner finds that the causes of the suspension, being other than a past event, are continuing, or that the insurer is otherwise not in compliance with the requirements of this title, and of which the Commissioner shall give the insurer notice not less than 30 days in advance of expiration of the suspension period. If not so automatically reinstated, the certificate of authority shall be deemed to have terminated as of the end of the suspension period.

(d) Upon reinstatement of the insurer's certificate of authority, the authority of its agents in this State to represent the insurer shall likewise reinstate. The Commissioner shall promptly notify the insurer and its agents in this State, of record in the Department, of such reinstatement.

(18 Del. C. 1953, § 522; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 523. General corporation laws inapplicable to foreign insurers.

The general corporation laws of this State as contained in Title 8 of the Delaware Code shall not apply as to foreign insurers holding certificates of authority to transact insurance in this State.

(18 Del. C. 1953, § 523; 56 Del. Laws, c. 380, § 1.)

§ 524. Commissioner as process agent for certain insurers.

(a) Before the Commissioner shall authorize it to transact insurance in this State, each insurer shall appoint the Commissioner, and his or her successors in office, as its attorney to receive service of legal process issued against the insurer in this State. The appointment shall be made on a form as designated and furnished by the Commissioner, and shall be accompanied by a copy of a resolution of the board of directors or like governing body of the insurer, if an incorporated insurer, showing that those officers who executed the appointment were duly authorized to do so on behalf of the insurer.

(b) The appointment shall be irrevocable, shall bind the insurer and any successor in interest or to the assets or liabilities of the insurer, and shall remain in effect as long as there is in force any contract of the insurer in this State or any obligation of the insurer arising out of its transactions in this State.

(c) Service of such process against a foreign or alien insurer shall be made only by service thereof upon the Commissioner.

(d) Service of such process against a domestic insurer may be made as provided hereunder, or in any other manner provided by law.

(e) At the time of application for a certificate of authority the insurer shall file the appointment with the Commissioner, together with designation of the person to whom process against it served upon the Commissioner is to be forwarded. The insurer may change such designation by a new filing.

(18 Del. C. 1953, § 524; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 525. Serving process.

(a) Service of process against an insurer for whom the Commissioner is attorney shall be made by delivering to and leaving with the Commissioner, his or her deputy, or a person in apparent charge of the Commissioner's office during the Commissioner's absence, 2 copies of the process, together with fee prescribed in § 701 of this title.

(b) Upon such service the Commissioner shall forthwith mail by certified mail 1 of the copies of such process to the person currently designated by the insurer to receive the same as provided in § 524(e) of this title. Service of such process shall not be complete until 3 days after the same has been so mailed.

(c) Service of process in the manner provided by this section shall for all purposes constitute valid and binding personal service upon the insurer within this State.

(d) The Commissioner shall keep a record of the day of service upon him or her of all legal process.

(18 Del. C. 1953, § 525; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; 73 Del. Laws, c. 90, § 1.)

§ 526. Annual statement and other required filings.

(a) Each authorized insurer shall annually on or before March 1, or within any reasonable extension of time therefor which the Commissioner for good cause may have granted, file with the Commissioner a full and true statement of its financial condition, transactions and affairs as of December 31 preceding. The statement filing shall be the annual statement form approved by the National Association of Insurance Commissioners ("NAIC") prepared in accordance with NAIC annual statement requirements and the NAIC accounting practices and procedures manual, except as otherwise prescribed or permitted by this title or by the Commissioner. The statement shall be verified by the oath of the insurer's president or vice-president, and secretary or actuary, as applicable, or, in the absence of the foregoing, by 2 other principal officers, or, if a reciprocal insurer, by the oath of the attorney-in-fact or its like officers if a corporation.

(b) The statement of an alien insurer shall be verified by its United States manager or other officer duly authorized, and shall relate only to the insurer's transactions and affairs in the United States, unless the Commissioner requires otherwise. If the Commissioner requires a statement as to such an insurer's affairs throughout the world, the insurer shall file such statement with the Commissioner as soon as reasonably possible.

(c) The Commissioner may refuse to continue or may suspend or revoke the certificate of authority of any insurer failing to file its annual statement when due.

(d) At time of filing, the insurer shall pay the fee for filing its annual statement as prescribed by § 701 of this title.

(e) Each domestic, foreign and alien insurer who is authorized to transact insurance in this State shall annually on or before March 1 of each year, file with the National Association of Insurance Commissioners a copy of its annual statement blank, along with such additional filings as prescribed by the Commissioner for the preceding year. The information filed with the National Association of Insurance Commissioners shall be in the same format and scope as that required by the Commissioner and shall include the signed jurat page and the actuarial certification. Any amendments and addendums to the annual statement filing subsequently filed with the Commissioner shall also be filed with the NAIC. Foreign insurers that are domiciled in a state which has a law substantially similar to this subsection shall be deemed in compliance with this section.

(f) In the absence of actual malice, members of the NAIC, their duly authorized committees, subcommittees and task forces, their delegates, NAIC employees and all others charged with the responsibility of collecting, reviewing and analyzing and disseminating the information developed from the filing of the annual statement convention blanks shall be acting as agents of the Commissioner under the authority of this section and shall not be subject to civil liability for libel, slander or any other cause of action by virtue of their collection review, and analysis or dissemination of the data and information collected from the filings required hereunder. All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the Department by the National Association of Insurance Commissioners' Insurance Regulatory Information System are confidential and may not be disclosed by the Department.

(g) Each authorized insurer must quarterly file a full and true statement of its financial condition, transactions, and affairs as of the quarter preceding the filing.

(1) The quarterly statement required by this subsection must be filed each quarter on or before May 15, August 15, and November 15.

(2) The Commissioner may grant for good cause a reasonable extension to an insurer to file the quarterly statement required by this subsection.

(3) The statement required by this subsection is the quarterly statement form approved by the NAIC that is prepared in accordance with NAIC quarterly statement requirements and the NAIC accounting practices and procedures manual, unless specified otherwise in this title or by the Commissioner.

(4) In addition to the annual and quarterly filings required by this section, the Commissioner has the authority, in the discretion of the Department, to prescribe additional filings by authorized insurers as necessary for the Department to monitor the ongoing financial condition of authorized insurers.

(5) The Commissioner may refuse to continue or may suspend or revoke the certificate of authority of any insurer that fails to file any statements or reports required under this subsection.

(h) The annual and quarterly financial statement filings required by this section must be submitted electronically through the NAIC in a format acceptable to the NAIC. All other filings required by this section must be in the form prescribed by the Commissioner.

(18 Del. C. 1953, § 526; 56 Del. Laws, c. 380, § 1; 68 Del. Laws, c. 50, §§ 1, 2; 71 Del. Laws, c. 327, § 1; 83 Del. Laws, c. 184, § 1.)

§ 526A. Supplement to annual statement [Repealed].

(65 Del. Laws, c. 270, § 1; 66 Del. Laws, c. 328, §§ 1, 3; 70 Del. Laws, c. 186, § 1; 71 Del. Laws, c. 373, § 3; repealed by 83 Del. Laws, c. 184, § 2, effective Sept. 17, 2021.)

§§ 527, 528. Resident agent, countersignature law; exceptions to resident agent, countersignature law.

Repealed by 70 Del. Laws, c. 376, §§ 1, 2, effective June 21, 1996.

§ 529. Cancellation of insurance agency contracts; arbitration.

(a) Every insurance company shall notify the Insurance Commissioner or the Commissioner's successor and the agency involved of the intent to cancel any written or verbal agency contract, except life insurance contracts, 30 days prior to issuance of the notice of cancellation.

(b) No insurance company may cancel an agency without giving 12 months notice, except where fraud exists or where an agency is more than 60 days in arrears of money owed to the insurance company in question. This notice shall be in writing and, upon the option of the company, may prohibit the agency from writing any new business for this particular company, but will allow the agency to renew all existing business in this 12-month period and will allow the agency to have binding authority to make endorsements or other changes to existing business and will provide for the same rate of commission for the 12-month period.

(c) The Insurance Commissioner shall appoint an arbitration board to arbitrate the cancellation of agency contracts. This board shall consist of 3 arbitrators, 1 of whom shall be from the Insurance Department, and 2 of whom shall be from the insurance industry.

(d) The purpose of this board is to determine whether an agency cancellation will adversely affect the public interest. If such a determination is made, the board shall prescribe a method of cancellation to be followed by both parties. The decision of the board of arbitration shall be binding upon the company and agency involved.

(e) (1) This subsection shall not apply in an instance where such company:

a. Employs an agent directly; or

b. Has an exclusive business arrangement with an agent.

(2) Notwithstanding any other provision of this section, a company may not cancel the contract of an independent agent for property and casualty insurance solely because of adverse underwriting experience in the line of private passenger insurance to the extent losses incurred by the insurer were not the fault of the insured.

(3) This subsection does not apply to adverse underwriting experience on losses incurred by the company on:

a. Bodily injury coverage;

b. Property damage coverage;

c. Collision coverage; or

d. To the extent that the losses incurred by the insurer were the fault of the insured, personal injury protection coverage and comprehensive coverage.

(18 Del. C. 1953, § 529; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 184; 70 Del. Laws, c. 186, § 1; 71 Del. Laws, c. 161, § 1.)

§ 530. Emergency requirements.

Whenever in the Commissioner's opinion a public emergency exists by reason of an abnormal disruption of economic and financial processes which affects the conduct of the business of insurance in a normal and ordinary manner, the Commissioner, with the concurrence of the Governor and the General Assembly, may declare the existence of a public emergency. During such emergency the Commissioner may make, alter, amend, revise and rescind rules and regulations, imposing any condition upon the conduct of the business of any insurer which may be necessary or desirable to maintain sound methods of insurance and to safeguard the interests of policyholders, beneficiaries and the public generally during the period of such emergency, which rules and regulations shall become inoperative when such emergency ceases, and an order to that effect shall be made by the Commissioner.

(18 Del. C. 1953, § 530; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 531. Emergency powers to regulate liability insurance cancellations and nonrenewals.

(a) (1) Whenever the Insurance Commissioner in his or her discretion finds that an abnormal disruption has occurred or is occurring in the liability insurance market, which has created or will create a situation where the availability of commercial, municipal or professional liability insurance is affected and such disruption will affect the normal transaction of business in this State, as to mid-term cancellations, or affect the health, safety and welfare of Delaware citizens as to nonrenewals, the Commissioner may promulgate regulations regarding cancellations and nonrenewals to safeguard the interests of policyholders and the public generally.

(2) When the Commissioner has reasonable cause to believe that a specific line of commercial, municipal or professional liability insurance is unavailable and that such unavailability is a threat to the public health, safety and welfare, he or she may declare such line to be "critical" and immediately suspend and enjoin any proposed nonrenewal of coverage of policies of insurance relating to such line and extend policy renewal dates pending a hearing. Within 30 days thereafter, the Commissioner shall hold a public hearing in accordance with procedures mandated by the Administrative Procedures Act [Chapter 101 of Title 29]. The Commissioner shall serve upon known affected insurers and any other persons involved a copy of such notice, including an order to extend the date of policy terminations pending the public hearing.

(3) Within 15 days after the public hearing the Commissioner shall find whether or not the specific line is in fact "critical." The Commissioner may find that the specific line is "critical" if he or she finds both that:

a. The type of coverage is generally unavailable in Delaware at any price reasonably related to the risk assumed; and

b. The unavailability of this type of coverage constitutes a threat to the public health, safety and welfare.

(4) If the Commissioner finds that paragraphs (a)(3)a. and b. of this section are present, he or she may declare the line of coverage is "critical." Such declaration shall be effective for 90 days from the date when first declared critical under paragraph (a)(2) of this section.

(b) Such regulation shall apply to commercial liability insurance policies, other than automobile, but including commercial multi-peril insurance policies and municipal or professional liability coverages. It does not apply to reinsurance, excess and surplus lines insurance, residual market risks, workers' compensation insurance, multi-state location risks, policies subject to retrospective rating plans, excess or umbrella policies and such other policies that are exempted by the Commissioner.

(c) Such regulation shall provide that no cancellation or nonrenewal of a policy under this section shall be effective in this State unless such cancellation or nonrenewal is based upon any 1 of the following reasons:

(1) Nonpayment of premium;

(2) Material misrepresentation or nondisclosure to the company of a material fact at the time of acceptance of the risk;

(3) Increased hazard or material change in the risk assumed which could not have been reasonably contemplated by the parties at the time of assumption of the risk;

(4) Substantial breaches of contractual duties, conditions or warranties that materially affect the nature and/or insurability of the risk;

(5) Fraudulent acts against the company by the insured or its representatives that materially affect the nature of the risk insured;

(6) Lack of cooperation from the insured on loss control matters affecting insurability of the risk;

(7) Bona fide loss of or substantial changes in applicable reinsurance. The insurer shall give 60 days' notice to the Insurance Commissioner and the insured under this section and shall supply such information at that time as the Insurance Commissioner shall require;

(8) Material increase in exposure arising out of changes in statutory or case law subsequent to the issuance of the insurance contract;

(9) Bona fide loss of or reduction in available insurance capacity. The insurer shall give 60 days' notice to the Insurance Commissioner and the insured under this section and shall supply such information at that time as the Insurance Commissioner shall require;

(10) Any other reasons approved by the Commissioner.

(d) This section shall not apply to an insurer issuing a notice of cancellation with respect to any policy which has been in effect for less than 60 days at the time the notice is mailed or delivered.

(e) A notice of cancellation or nonrenewal of insurance coverage by insurer shall be in writing, shall be mailed or delivered to the first named insured at the mailing address as shown on the policy. Notices of cancellation or nonrenewal shall be mailed or delivered at least 60 days but no more than 120 days prior to the effective date of the cancellation or nonrenewal. Notices of cancellation based upon nonpayment of premium shall be mailed or delivered at least 10 days prior to the effective date of cancellation. The notice shall state the effective date of the cancellation.

(f) The insurer shall provide the first named insured with a written statement setting forth the reasons for cancellation or nonrenewal where the named insured agrees in writing to hold the insurer harmless from liability for any communication giving notice of or specifying a reason for a cancellation or nonrenewal, or for any statement made in connection with an attempt to discover or verify the existence of conditions which would be a reason for a cancellation or nonrenewal under this section.

(g) For purposes of this section, the transfer of a policyholder between companies within the same insurance group is not a refusal to renew. In addition, changing deductibles, changes in premium, changes in the amount of insurance or reductions in policy limits or coverage are not refusals to renew, if such changes are reasonably related to the risk involved.

(h) Notice of nonrenewal is not required if:

(1) The insurer has offered to issue a renewal policy; or

(2) A named insured has obtained replacement coverage or has agreed in writing to obtain replacement coverage.

(i) Any cancellation or nonrenewal not in compliance with the notice provision of this section is not effective until proper notice is given.

(j) No policy of commercial, municipal or professional liability insurance subject to this section shall be extended beyond its termination date for a period of more than 90 days. The premium on such policies may reflect any change in rates approved by the Insurance Commissioner.

(k) Rate filings for any line or class affected by this section shall be approved or disapproved within 30 days of their filing.

(l) In addition to these provisions, the Commissioner may implement a market assistance plan providing for a voluntary group of insurers in order to aid insureds in obtaining commercial insurance coverages specified therein.

(65 Del. Laws, c. 264, § 2; 70 Del. Laws, c. 186, § 1.)

§ 532. Retaliatory provision.

(a) When by or pursuant to the laws of any other state or foreign country or province any taxes, licenses and other fees, in the aggregate, and any fines, penalties, deposit requirements or other material requirements, obligations, prohibitions or restrictions are or would be

imposed upon Delaware insurers doing business or that might seek to do business in such state, country or province, or upon the agents or representatives of such insurers, or upon brokers, which are in excess of such taxes, licenses and other fees, in the aggregate, or which are in excess of the fines, penalties, deposit requirements or other requirements, obligations, prohibitions or restrictions directly imposed upon similar insurers, or upon the agents or representatives of such insurers, or upon brokers, of such other state, country or province under the statutes of this State, so long as such laws of such other state, country or province continue in force or are so applied, the same taxes, licenses and other fees, in the aggregate, or fines, penalties or deposit requirements or other material requirements, obligations, prohibitions or restrictions of whatever kind shall be imposed by the Commissioner upon the insurers, or upon the agents or representatives of such insurers, or upon brokers, of such other state, country or province doing business or seeking to do business in Delaware. Any tax, license or other fee or other obligation imposed by any city, county or other political subdivision or agency of such other state, country or province on Delaware insurers or their agents or representatives shall be deemed to be imposed by such state, country or province within the meaning of this section.

(b) This section shall not apply as to personal income taxes, or as to ad valorem taxes on real or personal property, or as to special purpose obligations or assessments imposed by another state in connection with particular kinds of insurance other than property insurance, or as to guaranty association assessments or tax credits for such assessments, except that deductions, from premium taxes or other taxes otherwise payable, allowed on account of real estate or personal property taxes paid shall be taken into consideration by the Commissioner in determining the propriety and extent of retaliatory action under this section.

(c) For the purposes of this section the domicile of an alien insurer, other than insurers formed under the laws of Canada or a province thereof, shall be that state designated by the insurer in writing filed with the Commissioner at time of admission to this State or within 6 months after November 1, 1968, whichever date is the later, and may be any 1 of the following states:

(1) That in which the insurer was first authorized to transact insurance;

(2) That in which is located the insurer's principal place of business in the United States;

(3) That in which is held the largest deposit of trusteed assets of the insurer for the protection of its policyholders in the United States.

If the insurer makes no such designation, its domicile shall be deemed to be that state in which is located its principal place of business in the United States.

(d) The domicile of an insurer formed under the laws of Canada or a province thereof shall be as provided in § 102 of this title.

(18 Del. C. 1953, § 531; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 264, § 1; 73 Del. Laws, c. 178, § 1.)

§ 533. Immunity from liability for reporting fraudulent practices.

Repealed by 69 Del. Laws, c. 463, § 3, effective July 22, 1994.

§ 534. Location of headquarters.

(a) The headquarters of day-to-day corporate activity and management of any insurer engaged in the business of insurance as a subsidiary or division of a bank or trust company, which bank or trust company is authorized to act as an insurer and transact the business of insurance pursuant to authority granted by § 761(a)(14) of Title 5, shall be located within this State, and the principal books and records of each such insurer shall be located within this State.

(b) The Commissioner shall, by regulation promulgated after consultation with the Bank Commissioner, define the term "headquarters of day-to-day corporate activity and management," and provide for the maintenance and inspection of such headquarters and books and records to assure compliance with the provisions of §§ 929, 930 and 931 of Title 5, and § 2304(23) of this title.

(67 Del. Laws, c. 223, § 20.)

§ 535. Nondisclosure of nonpublic personal information; adoption of regulations.

No person regulated pursuant to this title shall disclose any nonpublic personal information contrary to the provisions of Title V of the Gramm Leach Bliley Act of 1999 (Public Law 106-002; [15 U.S.C. § 6801 et seq.]). The Commissioner may adopt rules and regulations necessary to carry out this section. Such rules and regulations shall be consistent with the provisions of Title V of the Gramm Leach Bliley Act of 1999. Nothing in this section shall be construed to create a private cause of action.

(73 Del. Laws, c. 53, § 1.)

§ 536. "Funding agreement" defined.

A "funding agreement" is an agreement for an insurer to accept and accumulate funds and to make 1 or more payments at future dates in amounts that are not based on mortality or morbidity contingencies (of the holder of the funding agreement).

(80 Del. Laws, c. 268, § 1.)

Part I
Insurance

Chapter 5A
Port-of-Entry for Foreign Insurance Companies

§ 560. Definitions.

As used in this part.

(1) "Non-U.S. insurer" means an insurer or reinsurer organized under the laws of a foreign country.

(2) "United States branch" or "U.S. branch" means the business unit through which business is transacted within the United States by a non-U.S. insurer and the assets and liabilities of the non-U.S. insurer within the United States pertaining to such business.

(80 Del. Laws, c. 159, § 1.)

§ 561. Scope.

This chapter applies to a U.S. branch using this State as a state of entry to transact insurance in the United States. The U.S. branch shall also be subject to all state laws applicable to an insurer domiciled in this State with the exception of Chapter 50 of this title, and unless otherwise provided.

(80 Del. Laws, c. 159, § 1.)

§ 562. Authorization of entry.

(a) A non-U.S. insurer may use this State as a state of entry to transact insurance in the United States through a U.S. branch by:

(1) Qualifying as an insurer licensed to do business in this State; and

(2) Establishing a trust account, pursuant to a trust agreement approved by the Commissioner with a U.S. bank approved by the Commissioner, in an amount at least equal to the minimum capital and surplus or authorized control level risk based capital, whichever is greater, required to be maintained by a domestic insurer licensed to do the same kind or kinds of insurance.

(b) Before authorizing the entry through this State of a U.S. branch of any non-U.S. insurer, the Commissioner shall require the non-U.S. insurer, in addition to any other requirement of the Insurance Law:

(1) To submit a copy of its charter and by-laws, if any, currently in force, and such other documents necessary to show the kinds of business which it is empowered to do in its domiciliary jurisdiction, attested to as accurate and complete by the insurance supervisory official in its home jurisdiction, and a full statement, subscribed and affirmed as true under the penalties of perjury by 2 officers or equivalent responsible representatives in such manner as the Commissioner shall prescribe, of its financial condition as of the close of its latest fiscal year, showing its assets, liabilities, income, disbursements, business transacted and other facts required to be shown in its annual statement, as reported to the insurance supervisory official in its home jurisdiction; such submission shall include an English language translation, as required by the Commissioner, of each of the documents required herein; and

(2) To submit to an examination of the insurer's affairs at its or its United States manager's principal office within the United States. However, the Commissioner may instead accept a report of the insurance supervisory official of the insurer's home jurisdiction.

(80 Del. Laws, c. 159, § 1.)

§ 563. Maintenance of trust account.

The assets in the trust account shall be known as "trusteed assets" and shall at all times be in an amount equal to the U.S. branch's reserves and other liabilities plus the minimum capital and surplus or authorized control level risk based capital, whichever is greater, required to be maintained by a domestic insurer licensed to do the same kind or kinds of insurance.

(80 Del. Laws, c. 159, § 1.)

§ 564. Requirements for trust agreement.

(a) The deed of trust and all amendments thereto shall be authenticated in such form and manner as the Commissioner may prescribe and shall not be effective unless approved by the Commissioner upon a finding that:

(1) A deed of trust and its amendments, if any, are sufficient in form and in conformity with law;

(2) The trustee or trustees are eligible as such; and

(3) The deed of trust is adequate to protect the interests of the beneficiaries of the trust.

(b) If at any time the Commissioner finds, after reasonable notice and hearing, that the requisites for the approval no longer exist, the Commissioner may withdraw approval.

(c) The Commissioner may from time to time approve amendments to the deed of trust, which in the Commissioner's judgment are not prejudicial to the interests of the people of this State or the United States policyholders, cedents and creditors of the U.S. branch.

(d) The deed of trust shall contain provisions which:

(1) Vest legal title to trusteed assets in the trustees, and their successors lawfully appointed;

(2) Require that all assets deposited in the trust shall be continuously kept within the United States;

(3) Require that all assets deposited in the trust shall be available to the Commissioner upon the issuance of a court order for all the uses set forth in Chapter 59 of this title.

(4) Provide for substitution of a new trustee or trustees in case of a vacancy by death, resignation or otherwise, subject to the approval of the Commissioner;

(5) Require that the trustee or trustees shall continuously maintain a record at all times sufficient to identify the assets of such fund;

(6) Require that the trusteed assets shall consist of cash or investments eligible for investment of the funds of domestic insurers and accrued interest thereon if collectable by the trustee;

(7) Require that the trust shall be for the exclusive benefit, security and protection of the policyholders and cedents, or policyholders, cedents and creditors, of the U.S. branch in the United States and that it shall be maintained as long as there is outstanding any liability of the non-U.S. insurer arising out of its insurance transactions in the United States; and

(8) Provide, in substance, that no withdrawals of assets, other than income as specified in subsection (e) of this section shall be made or permitted by the trustee or trustees without the approval of the Commissioner except to:

a. Make deposits required by law in any state for the security or benefit of all policyholders or cedents, or policyholders, cedents and creditors, of the U.S. branch in the United States;

b. Substitute other assets permitted by law and at least equal in value and quality to those withdrawn, upon the specific written direction of the United States manager of the U.S. branch when duly empowered and acting pursuant to either general or specific written authority previously given or delegated by the board of directors; or

c. Transfer such assets to an official liquidator or rehabilitator of the U.S. branch pursuant to an order of a court of competent jurisdiction.

(e) The deed of trust may provide that income, earnings, dividends or interest accumulations of the assets of the fund may be paid over to the United States manager of the U.S. branch upon request, provided that the total trusteed assets shall not thereby be less than the amount required to be maintained pursuant to § 563 of this title.

(f) Upon withdrawal of trusteed assets deposited in another state in which the insurer is authorized to do business, it shall be sufficient if the deed of trust requires similar written approval of the insurance supervising official of that state in lieu of approval of the Commissioner provided that the total trusteed assets shall not thereby be less than the amount required to be maintained pursuant to § 563 of this title. In all such cases the U.S. branch shall notify the Commissioner in writing of the nature and extent of the withdrawal.

(g) The Commissioner may from time to time:

(1) Make examinations of the trusteed assets of any authorized U.S. branch at the insurer's expense; and

(2) Require the trustee or trustees to file a statement, in such form as the Commissioner may prescribe, certifying the assets of the trust fund and the amounts thereof.

(h) Refusal or neglect of any trustee to comply with the foregoing requirements shall be grounds for the revocation of the insurer's license or the liquidation of its U.S. branch.

(80 Del. Laws, c. 159, § 1.)

§ 565. Reporting requirements for U.S. branches of non-U.S. insurers.

(a) In addition to other requirements of this chapter, every authorized U.S. branch shall, not later than the March 1 in each year and 45 days after the end of each of the first 3 calendar-year quarters, file with the Commissioner and with the National Association of Insurance Commissioners (NAIC):

(1) Annual and quarterly statements of the business transacted within the U.S. and the assets held by or for it within the U.S. for the protection of policyholders and creditors within the U.S., and of the liabilities incurred against such assets. The forms shall not contain any statement in regard to its assets and business elsewhere. The statements shall be in the same format required of an insurer domiciled in the U.S. branch's state of entry state and licensed to write the same kinds of insurance; and

(2) A statement of trusteed surplus, in such form as the Commissioner may prescribe, as of the end of the same period covered by the statement filed pursuant to paragraph (a)(1) of this section. The aggregate value of the insurer's general state deposits and trusteed assets deposited with a trustee in compliance with § 564 of this title, plus accrued investment income thereon where such interest is collected by the states for trustees, less the aggregate net amount of all of its reserves and other liabilities in the United States as determined in accordance with this section shall be known as its "trusteed surplus" in the United States. In determining the net amount of the U.S. branch's liabilities in the United States to be reported in the statement of trusteed surplus, the U.S. branch shall make adjustments to total liabilities reported on the accompanying annual or quarterly statement as follows:

a. Add back liabilities used to offset admitted assets reported in the accompanying quarterly or annual statement; and

b. Deduct:

1. Unearned premiums on agent's balances or uncollected premiums not more than 90 days past due;

2. Reinsurance on losses with authorized insurers, less unpaid reinsurance premiums;

3. Reinsurance recoverables on paid losses from unauthorized insurers that are included as an asset in the annual statement, but only to the extent a liability for such unauthorized recoverables is included in the liabilities report in the trusteed surplus statement;

4. Special state deposits held for the exclusive benefit of policyholders, or policyholders and creditors, of any particular state not exceeding net liabilities reports for that state;

5. Secured accrued retrospective premiums;

6. If a life insurer:

A. The amount of its policy loans to policyholders within the United States, not exceeding the amount of legal reserve required on each such policy; and

B. The net amount of uncollected and deferred premiums; and

7. Any other nontrusteed asset which the Commissioner determines secures liabilities in a substantially similar manner; and

(3) Any additional information that the Commissioner may require relating to the total business or assets, or any portion thereof, of the non-U.S. insurer.

(b) The annual statement and trusteed surplus statement shall be signed and verified by the United States manager, attorney-in-fact, or a duly empowered assistant United States manager, of the U.S. branch. The items of securities and other property held under trust deeds shall be certified in the trusteed surplus statement by the United States trustee or trustees.

(c) Every report on examination of a U.S. branch shall include a trusteed surplus statement as of the date of examination in addition to the general statement of the financial condition of the U.S. branch.

(80 Del. Laws, c. 159, § 1.)

§ 566. Additional requirements for U.S. branch license.

(a) Before issuing any new or renewal license to any U.S. branch, the Commissioner may require satisfactory proof, either in the non-U.S. insurer's charter or by an agreement evidenced by a duly certified resolution of its board of directors, or otherwise as the Commissioner may require, that the insurer will not engage in any insurance business in contravention of the provisions of the section or not authorized by its charter.

(b) The Commissioner shall issue a renewal license to any U.S. branch if satisfied, by such proof as required, that the insurer is not delinquent with respect to any requirement imposed by this chapter and that its continuance in business in this State will not be hazardous or prejudicial to the best interests of the people of this State.

(c) No U.S. branch shall be licensed to do in this State any kind of insurance business, or any combination of kinds of insurance business, which are not permitted to be done by domestic insurers licensed under the provisions of this chapter. No U.S. branch shall be authorized to do an insurance business in this State if it does anywhere within the United States any kind of business other than an insurance business and the business necessarily or properly incidental to the kinds of insurance business which it is authorized to do in this State.

(d) Except as otherwise specifically provided, no U.S. branch, entering through this State or another state, shall be or continue to be authorized to do an insurance business in this State if it fails to comply substantially with any requirement or limitation of this chapter, applicable to similar domestic insurers hereafter organized, which in the judgment of the Commissioner is reasonably necessary to protect the interest of the policyholders.

(e) No U.S. branch which does anywhere within the United States any kind or combination of kinds of insurance business not permitted to be done in this State by similar domestic insurers hereafter organized, shall be or continue to be authorized to do an insurance business in this State, unless in the judgment of the Commissioner the doing of such kind or combination of kinds of insurance business will not be prejudicial to the best interests of the people of this State.

(f) No U.S. branch shall be or continue to be authorized to do an insurance business in this State if it fails to keep full and correct entries of its transactions, which shall at all times be open to the inspection of persons invested by law with the rights of inspection and be maintained in its principal office within this State.

(80 Del. Laws, c. 159, § 1.)

§ 567. Authority of Commissioner.

Whenever it appears to the Commissioner from any annual or quarterly statement or trusteed surplus statement or any other report that a U.S. branch's trusteed surplus is reduced below minimum capital and surplus or the authorized control level risk based capital, whichever is greater, required to be maintained by a domestic insurer licensed to transact the same kinds of insurance, the Commissioner may proceed against the U.S. branch pursuant to the provisions of Chapter 59 of this title, as an insurer whose condition is such that its further transaction of business in the United States will be hazardous to its policyholders, its creditors or the public in the United States.

(80 Del. Laws, c. 159, § 1.)

Part I
Insurance
Chapter 7
Fees and Taxes

§ 701. Fee schedule.

Except as provided herein or otherwise by law, the Commissioner shall collect, in advance, fees, costs and miscellaneous charges as follows:

(1) Insurer's certificate of authority.	
a. For filing application for initial certificate of authority including all documents submitted as part of such application	$1,000
b. Issuance of certificate of authority	150
c. Annual continuation	150
d. Reinstatement (§ 518 of this title)	150
e. Amendment to include or delete lines of authority	150
The fee for a duplicate or replacement certificate issued under this title shall be the same as required for an original certificate.	
(2) Dental plan organization license (§ 3804 of this title).	
a. Original license	150
b. Annual continuation	150
(3) Managed care organizations license (§ 6404 of this title).	
a. Original license	750
b. Annual continuation	500
(4) Fraternal associations (§ 6227 of this title).	
a. Original license	100
b. Renewal	100
c. Annual statement	100
(5) Insurance premium finance company (§ 4802 of this title).	
a. Original license	500
b. Annual continuation	500
(6) Rating organization license.	
a. Application for original license and issuance of license, if issued	150
b. Annual continuation	150
(7) Risk retention group.	
a. Initial registration	150
b. Annual continuation	150
(8) Risk purchasing group.	
a. Initial registration	150
b. Annual continuation	150
(9) Accredited reinsurer.	
a. Initial registration	150
b. Annual continuation	150
(10) Surplus lines insurer.	
a. Initial registration	150
b. Annual continuation	150
(11) Captive insurer.	
a. Application fee	300
b. Annual continuation	400
c. Processing fee for examining, investigating, and processing initial application	3,200

d. Application fee for conditional certificate of authority	100
(12) Reinsurance intermediary.	
a. Initial license	250
b. Annual continuation	100
(13) Solicitation permit application, filing.	
a. For initial financing	250
b. For subsequent filing	100
(14) Charter documents (other than those filed with application for certificate of authority). Filing amendments to certificate of incorporation, or articles of incorporation, or charter, or bylaws, or power of attorney (as to reciprocal insurers) or to other constituent documents of the insurer	10
(15) Annual statement filing of insurer	150
(16) Registration statement of insurance holding company or member of insurance holding company system, filing.	
a. Annual registration statement filing	100
b. Each amendment thereof	100
(17) Form A filing	1,000
(18) Copies of documents on file in the Department, ($.50 per page) minimum	5
(19) Certifying and affixing official seals	10
(20) Certified copy of insurer certificate of authority or of any license issued under this title	10
(21) Rate changes or deviations	100
(22) Service of process, acceptance.	
a. Against unauthorized persons and insurers under Chapter 21 of this title	25
b. Others under § 525(a) of this title	25
(23) “Insurance producer,” “limited line credit insurance producer,” and “limited lines producer,” (all as defined in § 1702 of this title).	
a. Initial license (resident and nonresident)	125
b. Resident license renewal (due biennially February 28 in even years beginning February 28, 2004)	125
c. Resident insurance producers, limited line credit insurance producers, and limited lines producers initially licensed within 90 days prior to the renewal deadline of February 28 (December 1-February 28) are not subject to the renewal fee for that specific biennial renewal period referenced in paragraph (23)b of this section.	
d. Nonresident license renewal (due biennially February 28 in odd years beginning February 28, 2003)	125
e. Nonresident producers, nonresident limited line credit insurance producers, and nonresident limited lines producers initially licensed within 90 days prior to the renewal deadline of February 28 (December 1-February 28) are not subject to the renewal fee for that specific biennial renewal period referenced in paragraph (23)d. of this section.	
f. One-time appointment of insurance producer, limited line credit insurance producer, and limited lines producer (§ 1715 of this title), each insurer	50
(24) Amendments to license issued under Chapter 17 of this title	50
(25) Surplus lines broker (§ 1912 of this title):	
a. Initial license (resident and nonresident)	275

b. Resident license renewal (due biennially February 28 in even years beginning February 28, 2004)	225
c. Resident surplus lines brokers initially licensed within 90 days prior to the renewal deadline of February 28 (December 1-February 28) are not subject to the renewal fee for that specific biennial renewal period referenced in paragraph (25)b. of this section.	
d. Nonresident license renewal (due biennially February 28 in odd years beginning February 28, 2003)	225
e. Nonresident surplus lines brokers initially licensed within 90 days prior to the renewal deadline of February 28 (December 1-February 28) are not subject to the renewal fee for that specific biennial renewal period referenced in paragraph (25)d. of this section.	
(26) Fraternal representative (§ 1702(g) of this title):	
a. Initial license (resident and nonresident)	125
b. Resident license renewal (due biennially February 28 in even years beginning February 28, 2004)	125
c. Resident fraternal representatives initially licensed within 90 days prior to the renewal deadline of February 28 (December 1-February 28) are not subject to the renewal fee for that specific biennial renewal period referenced in paragraph (26)b. of this section.	
d. Nonresident license renewal (due biennially February 28 in odd years beginning February 28, 2003)	125
e. Nonresident fraternal representatives initially licensed within 90 days prior to the renewal deadline of February 28 (December 1-February 28) are not subject to the renewal fee for that specific biennial renewal period referenced in paragraph (26)d. of this section.	
f. One-time appointment of fraternal representative (§ 1715 of this title), each society or association	50
(27) Adjuster (§ 1702(a) of this title):	
a. Initial license (resident and nonresident)	125
b. Resident license renewal (due biennially February 28 in even years beginning February 28, 2004)	125
c. Resident adjusters initially licensed within 90 days prior to the renewal deadline of February 28 (December 1-February 28) are not subject to the renewal fee for that specific biennial renewal period referenced in paragraph (27)b. of this section.	
d. Nonresident license renewal (due biennially February 28 in odd years beginning February 28, 2003)	125
e. Nonresident adjusters initially licensed within 90 days prior to the renewal deadline of February 28 (December 1-February 28) are not subject to the renewal fee for that specific biennial renewal period referenced in paragraph (27)d. of this section.	
(28) Motor vehicle appraiser (§ 1702(c) of this title):	
a. Initial license (resident and nonresident)	125

b. Resident license renewal (due biennially February 28 in even years beginning February 28, 2004)	125

c. Resident motor vehicle appraisers initially licensed within 90 days prior to the renewal deadline of February 28 (December 1-February 28) are not subject to the renewal fee for that specific biennial renewal period referenced in paragraph (28)b. of this section.

d. Nonresident license renewal (due biennially February 28 in odd years beginning February 28, 2003)	125
e. Nonresident motor vehicle appraisers initially licensed within 90 days prior to the renewal deadline of February 28 (December 1-February 28) are not subject to the renewal fee for that specific biennial renewal period referenced in paragraph (28)d. of this section.	
(29) Apprentices (§ 1702(d) of this title) and temporary insurance producer (§ 1711 of this title):	
License (initial)	75
(30) “Viatical settlement provider” and “viatical settlement broker” (§ 7502 of this title):	
a. Initial license (resident and nonresident)	275
b. License renewal (due annually February 28)	275

c. Viatical settlement providers and brokers initially licensed within 90 days prior to the renewal deadline of February 28 (December 1-February 28) are not subject to the renewal fee for that specific renewal period referenced in paragraph (30)b. of this section.

d., e. [Repealed]	
(31) Business entity (insurance agency, § 1702(f) of this title):	
a. Initial license (resident and nonresident)	125
b. Resident license renewal (due biennially February 28 in even years beginning February 28, 2004)	125

c. Resident business entities initially licensed within 90 days prior to the renewal deadline of February 28 (December 1-February 28) are not subject to the renewal fee for that specific biennial renewal period referenced in paragraph (31)b. of this section.

d. Nonresident license renewal (due biennially February 28 in odd years beginning February 28, 2003)	125

e. Nonresident business entities initially licensed within 90 days prior to the renewal deadline of February 28 (December 1-February 28) are not subject to the renewal fee for that specific biennial renewal period referenced in paragraph (31)d. of this section.

(32) Vending machine, each year	100
(33) Examination of insurer, see § 322 of this title.	
(34) Form, advertising and/or rule filings for each insurance policy or annuity contract or application	150
(35) Bail agent, initial and renewal:	
Bail agent	225
(36)a. For initial licensing of a discount medical plan organization:	525
b. For renewal of discount medical plan organization license:	275
(37) Limited lines travel insurance producers (that are registering travel retailers under Chapter 17B of this title):	
a. For initial licensing of a limited lines travel insurance producer:	1,025
b. For renewal of a limited lines travel insurance producer license:	525

c. Licensing periods, renewal dates, and appointments for limited lines travel insurance producers are subject to paragraph (23) of this section.		
(38) Reciprocal jurisdiction reinsurer registration.		
a. Initial registration	1,000	
b. Annual continuation	1,000	
(39) Certified reinsurer registration.		
a. Initial registration	1,000	
b. Annual continuation	1,000	
(40) Third-party administrator certificate of authority.		
a. For filing application for initial certificate of authority including all documents submitted as part of an application	500	
b. Issuance of a certificate of authority	100	
c. Reinstatement of certificate of authority	100	
d. Amendment of certificate of authority	100	
(41) Vehicle rental company limited lines producer license (§ 2006 of this title), each year		325
(42) Portable electronic device vendor limited lines license (§ 2057 of this title).		
a. Initial license	1025	
b. License renewal	525	

The increase in fees collected in Fiscal Year 2018 pursuant to this section shall be used solely to make appropriations for certain grants-in-aid for the fiscal year ending June 30, 2018.

(18 Del. C. 1953, § 701; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 278, § 9; 59 Del. Laws, c. 197, § 2; 62 Del. Laws, c. 78, § 1; 65 Del. Laws, c. 142, §§ 1, 2; 65 Del. Laws, c. 143, §§ 1, 2; 67 Del. Laws, c. 260, § 1; 67 Del. Laws, c. 343, § 1; 71 Del. Laws, c. 423, §§ 1-27; 73 Del. Laws, c. 90, § 2; 73 Del. Laws, c. 325, §§ 1, 2; 75 Del. Laws, c. 156, § 2; 76 Del. Laws, c. 394, § 4; 77 Del. Laws, c. 470, § 2; 79 Del. Laws, c. 87, §§ 1, 2; 79 Del. Laws, c. 428, § 1; 80 Del. Laws, c. 215, § 1; 81 Del. Laws, c. 57, § 1; 81 Del. Laws, c. 172, § 1; 82 Del. Laws, c. 112, § 1; 84 Del. Laws, c. 336, § 2; 84 Del. Laws, c. 514, § 36; 85 Del. Laws, c. 12, § 2.)

§ 702. General premium tax; underwriting profits tax.

(a) Each authorized insurer and each formerly authorized insurer shall file with the Commissioner, on or before March 1 each year a report in form as prescribed by the Commissioner showing, except with respect to wet marine and transportation insurance, gross direct premium income, including policy, membership and other fees, assessments and all other considerations for insurance received by it during the next preceding calendar year on account of insurance contracts, other than as to workers' compensation and employer's liability, covering property, subjects or risks located, resident or to be performed in this State (with proper proportionate allocation of premiums as to such persons, property, subjects or risks in this State insured under policies covering persons, property, subjects or risks located or resident in more than 1 state), after deducting from such total direct premium income (1) the amount of returned premiums on cancelled policies (but not including the return of cash surrender values of life insurance policies) and (2) the unabsorbed portion of any deposit premium and the amount returned to policyholders as dividends and similar returns, whether paid in cash or credited or applied in reduction of premiums. The report shall be verified by the oath or affirmation of the president or secretary or other responsible officer of the insurer, duly administered by a person authorized to administer oaths. Considerations received for annuity contracts or funding agreements shall not be included in gross direct premium income or be subject to taxes imposed by this section or by § 707 of this title. Any premiums received for employer-owned life insurance policies, as defined in § 2704(e) of this title, and trust-owned life insurance policies, as defined in § 2704(c)(5) of this title, shall be itemized separately in the report, except that separate itemization for a trust-owned life insurance policy shall not be required if the insurer elects to pay tax on premiums received for such policy under paragraph (c)(1) of this section.

(b) For the purpose solely of the tax upon the premiums and at the rate provided under this section, a domestic insurer shall also include in the report provided for in subsection (a) of this section above, except with respect to wet marine and transportation insurance, the gross amount of premiums and other considerations for direct insurance received by it upon insurance business written pursuant to solicitation of business by mail directed to persons located in a state or province of Canada in which the insurer is not admitted to transact insurance with respect to persons, property and subjects or risks resident, located or to be performed in such state or province and on which a premium tax is not paid or surplus line tax is not payable to such state or province and shall deduct therefrom returned premiums, unabsorbed portion of deposit premiums, dividends, and similar returns paid or credited to policyholders as provided in such subsection.

(c) (1) There shall be paid a tax at the rate of 1.75% on net premiums as shown on reports required to be filed under subsection (a) of this section.

(2) In lieu of paragraph (c)(1) of this section, there shall be paid a tax on a graduated basis at the rates set forth in the following table on net premiums per case for employer-owned life insurance policies, as defined in § 2704(e)(3) of this title, and trust-owned

life insurance policies, as defined in § 2704(e)(4) of this title, not taxed pursuant to paragraph (c)(3) of this section. For purposes of this paragraph, a "case" is:

a. All contracts issued to an employer, or a trust established by an employer or an individual, as appropriate; or

b. All contracts issued to all employers or trusts that participate in a private placement under federal securities laws and/or purchase with respect to at least 25 lives policies covered by registrations under such laws.

Said tax shall be paid on net premiums and other considerations received on account of insurance contracts issued for delivery in this State, except that no premium tax shall be paid with respect to persons resident or located outside of this State upon whom premium tax is paid to the State of residency or location.

Net Premiums Per Case	Premium Tax Rate
First $10,000,000	2.0%
$10,000,001 to $24,999,999	1.5%
$25,000,000 to $99,999,999	1.25%
$100,000,000 and over	1.0%

The premium tax rate shall be calculated on the basis of net premiums (upon which taxes are payable to this State) received per case in each calendar year, except that in subsequent calendar years the premium tax rate shall not be higher than the rate established for the preceding year. A reduction in the premium tax rate for a subsequent calendar year shall not apply retrospectively to any previous calendar year. The following example illustrates calculation of the tax rates under this section:

Calendar Year	Premiums Per Case	Tax Rate
1995	$9,000,000	2%
1996	$20,000,000	2% x $10,000,000 + 1.5% x $10,000,000
1997	$30,000,000	1.5% x $25,000,000 + 1.25% x $5,000,000
1998	$9,000,000	1.25%

The tax imposed by this subsection shall be the only tax imposed by this chapter on employer-owned life insurance policies and trust-owned life insurance policies.

(3) In lieu of paragraphs (c)(1) and (2) of this section, the premium tax rate shall be 2% on the first $100,000 of net premiums and 0.0% for the net premium exceeding $100,000 for trust-owned life insurance policies covering the life of an individual that participate in private placement under federal securities laws. Said tax shall be paid on net premiums and other considerations received on account of insurance contracts issued for delivery in this State, except that no premium tax shall be paid with respect to persons resident or located outside of this State upon whom premium tax is paid to the State of residency or location. The premium tax rate shall be calculated on the basis of net premiums (upon which taxes are payable to this State) received per policy in each calendar year. The tax imposed by this paragraph shall be the only tax imposed by this chapter on trust-owned life insurance policies covering the life of an individual that participate in private placement under federal securities laws.

(d) The taxes imposed under this section and §§ 703, 704, and 707 of this title shall be payable as follows:

Fifty percent of the estimated tax liability for the current year shall be paid on April 15 of the current year, and the balance of the estimated tax shall be paid in installments as follows: 20% on June 15 of the current taxable year; 20% on September 15 of the current taxable year; 10% on December 15 of the current taxable year; and the remaining balance to be paid on March 1 of the following year.

(e) Tax on wet marine and transportation insurance underwriting profits:

(1) Each authorized insurer and formerly authorized insurer shall, with respect to all wet marine and transportation insurance written within this State, pay a tax of 5% upon its taxable underwriting profit, ascertained as, hereinafter provided, from such insurance written within this State;

(2) The underwriting profit on such insurance written within this State shall be that proportion of the total underwriting profit of such insurer from such insurance written within the United States which the amount of net premiums of such insurer from such insurance written within this State bears to the amount of net premiums of such insurer from such insurance written within the United States;

(3) The underwriting profit of such insurer on such insurance written within the United States shall be determined by deducting from the net earned premiums on such wet marine and transportation insurance written within the United States during the taxable year, meaning thereby the calendar year next preceding the date on which such tax is due, the following items:

a. Net losses incurred, meaning gross losses incurred during such calendar year under such wet marine and transportation insurance contracts written within the United States, less reinsurance claims collected or collectible and less net salvages or recoveries collected or collectible from any source applicable to the corresponding losses under such contracts;

b. Net expenses incurred in connection with such wet marine and transportation insurance contracts, including all state and federal taxes in connection therewith, but in no event shall the aggregate amount of such net expenses deducted exceed 40% of the net premiums on such wet marine and transportation insurance contracts, ascertained as hereinafter provided; and

c. Net dividends paid or credited to policyholders on such wet marine and transportation insurance contracts;

(4) In determining the amount of such tax, net earned premiums on such wet marine and transportation insurance contracts written within the United States during the taxable year shall be arrived at as follows:

From gross premiums written on such contracts during the taxable year deduct any and all return premiums, premiums on policies not taken, premiums paid for reinsurance of such contracts and net unearned premiums on all such outstanding contracts at the end of the taxable year and add to such amount net unearned premiums on such outstanding wet marine and transportation insurance contracts at the end of the calendar year next preceding the taxable calendar year;

(5) In determining the amount of such tax, net expenses incurred shall be determined as the sum of the following:

a. Specific expenses incurred on such wet marine and transportation insurance business, consisting of all commissions, agency expenses, taxes, licenses, fees, loss adjustment expenses and all other expenses incurred directly and specifically in connection with such business, less recoveries or reimbursements on account of or in connection with such commissions or other expenses collected or collectible because of reinsurance or from any other source;

b. General expenses incurred on such wet marine and transportation insurance business, consisting of that proportion of general or overhead expenses incurred in connection with such business which the net premiums on such wet marine and transportation insurance written during the taxable year bear to the total net premiums written by such insurer from all classes of insurance written by it during the taxable year. Within the meaning of this paragraph, general or overhead expenses shall include salaries of officers and employees, printing and stationery, all taxes of this State and of the United States, except as included in subparagraph a. above, and all other expenses of such insurer not included in paragraph (e)(5)a. of this section above, after deducting expenses specifically chargeable to any or all other classes of insurance business;

(6) In determining the amount of such tax, the taxable underwriting profit of such insurer on such wet marine and transportation insurance business written within this State shall be ascertained as follows:

a. In the case of every such insurer which has written any such business within this State during 3 calendar years immediately preceding the year in which such taxes were payable, the taxable underwriting profit shall be determined by adding or subtracting, as the case may be, the underwriting profit or loss on all such insurance written within the United States, ascertained as hereinbefore provided, for each of such 3 years, and dividing by 3;

b. In the case of every such insurer other than as specified in paragraph (e)(6)a. of this section, such taxable underwriting profit, if any, shall be the underwriting profit, if any, on such wet marine and transportation insurance business written within this State during the taxable year ascertained as hereinbefore provided; but after such insurer has written such wet marine and transportation insurance business within this State during 3 calendar years, an adjustment shall be made on the 3 year average basis by ascertaining the amount of tax payable in accordance with paragraph (e)(6)a. of this section above, but no refunds of all or any part of such payments shall be made, except as provided in § 707 of this title;

(7) The tax hereinbefore provided shall be paid annually, on or before June 1, by every insurer authorized to do in this State the business of wet marine and transportation insurance during any 1 or more of the next preceding 3 calendar years, and the calendar year next preceding such June 1 shall be deemed the taxable year within the meaning of this section;

(8) Every insurer liable to pay the tax hereinbefore provided under this subsection (e) shall, on or before June 1 of each year, file with the Commissioner a tax return in form prescribed by the Commissioner;

(9) The tax provided for in this subsection (e) shall apply to the business of the year ending December 31, 1968, and to subsequent years, and for such purpose the underwriting profits or losses of prior years shall be taken into account, as hereinbefore provided. Section 2702 of this title and in force immediately prior to November 1, 1968, shall continue to be effective with respect to all taxes due under such section, but this provision shall not be construed as imposing any duplication of taxes for any of such years.

(f) In case of any underpayment of estimated tax required by this section, there shall be added to the tax for the taxable year an amount determined at the rate of $1^1/_2$% per month, or fraction thereof, upon the amount of the underpayment for the period of the underpayment. The period of the underpayment shall run from the date the estimated tax or installment was required to be paid to the date on which actually paid. No penalty for underpayment shall be imposed if the quarterly estimated tax payments equal 100% of the total tax due and paid for the previous tax year.

(18 Del. C. 1953, § 702; 56 Del. Laws, c. 380, § 1; 66 Del. Laws, c. 17, §§ 1-3; 66 Del. Laws, c. 382, §§ 1-4; 69 Del. Laws, c. 462, §§ 6, 7; 70 Del. Laws, c. 186, § 1; 70 Del. Laws, c. 530, §§ 1, 2; 71 Del. Laws, c. 239, § 1; 76 Del. Laws, c. 275, § 1; 80 Del. Laws, c. 222, §§ 1, 2; 80 Del. Laws, c. 268, § 2; 85 Del. Laws, c. 7, § 1.)

§ 703. Privilege tax on certain domestic insurers.

(a) Except as provided in subsection (e) of this section, a domestic insurer, other than a mutual insurer doing business on the assessment premium plan, shall pay to the Commissioner for the use of the State an annual privilege tax in the amount determined in accordance with

subsections (b) and (c) of this section, due and payable at the same time as the premium tax and estimated payments as provided in § 702 of this title. The payment of such privilege tax shall accompany a form as designated and furnished by the Commissioner, together with such information required thereon relating to the provisions of this section.

(b) (1) For purposes of subsection (a) of this section, the privilege tax with respect to each year shall be an amount determined in accordance with the following table, less any credits provided in subsection (c) of this section:

If annual gross receipts are:	The annual privilege tax shall be:
Under $1,000,000	Exempt
$1,000,000 to $5,000,000	$10,000
$5,000,001 to $10,000,000	$25,000
$10,000,001 to $20,000,000	$45,000
$20,000,001 to $30,000,000	$65,000
$30,000,001 to $40,000,000	$85,000
over $40,000,000	$95,000

(2) For purposes of the foregoing table and subsection (e) of this section, the "annual gross receipts" of a domestic insurance company shall consist of its net premium income and its investment income. As the terms are used herein:

a. The term "net premium income" shall mean an amount determined by taking the domestic insurer's gross direct premium income and all other considerations for insurance received by the domestic insurer on account of insurance contracts, but excluding considerations received for annuity contracts and funding agreements, and subtracting therefrom the amount of any returned premiums on cancelled policies (but not including the return of cash surrender values of life insurance policies) and the unabsorbed portion of any deposit premium and the amount returned to policyholders as dividends and similar returns, whether paid in cash or credited or applied in reduction of premiums; and

b. The term "investment income" shall mean the amount shown on the line for investment income on the annual statement filed in accordance with § 526(a) of this title.

(c) In determining the annual privilege tax under subsection (a) of this section, the amount of tax determined in the table provided in subsection (b) of this section shall be reduced, but with respect to domestic insurers that do not maintain their principal offices in the State to an amount not less than $15,000, by the credits with respect to such year provided in this subsection. Except as limited by subsection (d) of this section, the domestic insurer subject to tax under this section is entitled to credits against annual privilege tax liability as follows:

For each $100,000 of gross salaries, wages and other compensation paid by the domestic insurer and its affiliates for employee services performed within Delaware, the domestic insurer shall be entitled to a credit of $1,500 for such year.

Notwithstanding the above, any insurer which writes 50 percent or more of its total premium on property or persons residing within this State shall be exempt from application and payment of the privilege tax.

(d) Domestic insurers shall not be entitled to carry-over or carry back or otherwise apply a credit to any year other than the year to which the credit originally applies.

(e) In the case of domestic insurers with 1, 2 or 3 domestic insurer affiliates, only the affiliate with the largest gross receipts as defined herein shall be subject to the annual privilege tax imposed pursuant to subsection (b) of this section. Any affiliates exceeding 3 in number shall each be subject to the annual privilege tax.

(f) For purposes of subsections (c) and (e) of this section, "affiliate" shall: (i) have the same meaning as provided in subchapter V of Chapter 7 of Title 5, and (ii) shall mean any corporation which is a member of a controlled group of corporations as defined in § 1563(a) of the Internal Revenue Code of 1986 ("IRC") [26 U.S.C. § 1563(a)], without regard to subsections (a)(4) and (b)(2)(D) of IRC § 1563 [26 U.S.C. § 1563(a)(4) and (b)(2)(D)], except that "more than 50 percent" shall be substituted for "at least 80 percent" each place it appears in IRC § 1563(a) [26 U.S.C. § 1563(a)]; provided further that "affiliate" shall also include the insurance division of a bank created pursuant to 5 Del. C. § 767(a).

(18 Del. C. 1953, § 703; 56 Del. Laws, c. 380, § 1; 66 Del. Laws, c. 382, § 7; 68 Del. Laws, c. 83, § 1; 69 Del. Laws, c. 153, § 1; 80 Del. Laws, c. 268, § 2.)

§ 704. Tax on workers' compensation; employer's liability premiums.

(a) Every insurance carrier shall pay a tax upon all workers' compensation or employer's liability premiums received in this State or on account of business done in this State at the rate of 2% of the amount of such premiums, which tax shall be in lieu of all other taxes on such premiums.

(b) The insurance carrier shall be credited with all canceled or returned premiums actually refunded during the year on such insurance and premiums on reinsurance received from other insurance carriers, except that mutual insurance companies shall be taxed upon the gross premiums charged and collected and shall not be credited with unabsorbed premiums or dividends.

(c) The taxes imposed by this section shall be collected as provided in § 702(d) and (f) of this title.

(18 Del. C. 1953, § 704; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; 73 Del. Laws, c. 266, § 5.)

§ 705. Reporting by insurers of gross premiums; payments to fire companies or departments and the State Insurance Coverage Office based on the Insurance Commissioner's reports.

(a) (1) Every insurance company receiving premiums for covering risks of loss on any real or personal property within the limits of this State from fire, other allied lines, homeowners multiple peril, commercial multiple peril (nonliability portion), multiple peril crop, farmowners multiple peril, federal flood, ocean marine, inland marine, earthquake, private passenger automobile physical damage, commercial automobile physical damage and aircraft (all perils) shall annually, at the same time that the insurance company files the insurance company's annual report as required by law, deliver to the Insurance Commissioner a full detailed statement of the amount of gross premiums of all such business done by the insurance company in the City of Wilmington, in the County of New Castle outside the City of Wilmington, in Kent County, and in Sussex County, less return and reinsurance premiums received from other companies or by any agent or agents of the insurance company, in cash or otherwise, for the year ending on the previous December 31.

(2) For purposes of this section, "City of Wilmington" means the area consisting of zip codes 19801, 19802, 19805, and 19806.

(3) The insurance company must include in its statement an allocation of the portion of the gross premiums coverage allocable to the City of Wilmington, the County of New Castle outside the City of Wilmington, Kent County, and Sussex County.

(4) The statement must be verified by the oath or affirmation of the insurance company's president or vice-president and secretary or other officer, and the statement must be on a form prepared and furnished by the Insurance Commissioner for that purpose.

(5) The Insurance Commissioner may request and receive additional information regarding any insurance company's business of covering the types of risks of loss stated in paragraph (a)(1) of this section. Failure to give the Insurance Commissioner the requested information is good cause, under § 520 of this title, for revocation of any certificate of authority of any insurance company so ignoring the request.

(b) The Insurance Commissioner shall ascertain and report to the State Treasurer, on or before May 15 of each year, the following information:

(1) The information contained in the statements under paragraph (a)(1) of this section and such other information as the Insurance Commissioner has obtained from the insurance companies under subsection (a) of this section.

(2) The proportions in which the sum described in subsection (c) of this section is to be allocated among, and the actual amounts due to, the Treasurer of the City of Wilmington and to the member fire companies or departments of this State. The allocations and amounts must be calculated as follows:

a. The sum of the premiums attributable to the City of Wilmington is to be allocated to the Treasurer of the City of Wilmington.

b. The sum of the premiums attributable to the County of New Castle, outside the City of Wilmington, is to be divided and allocated equally among the fire companies or departments in the County of New Castle outside of the City of Wilmington.

c. The sum of the premiums attributable to Kent County is to be divided and allocated equally among the fire companies or departments in Kent County.

d. The sum of the premiums attributable to Sussex County is to be divided and allocated equally among the fire companies or departments in Sussex County.

(c) (1) After receipt of the report under subsection (b) of this section, and not later than July 15 of each year, the State Treasurer shall pay, in the proportions stated in paragraph (b)(2) of this section, the total sum in the special fund established under paragraph (c)(2) of this section to the Treasurer of the City of Wilmington and to the fire companies or departments of this State.

(2) The special fund is to consist of a sum equivalent to 3¾% of all the premiums obtained for writing in Delaware during the preceding year the types of coverage stated in paragraph (a)(1) of this section. Payments to the special fund are to be made out of taxes deposited with the State Treasurer by the Insurance Commissioner, not including those funds received under § 707 of this title.

(d) Payments made from the special fund under paragraph (c)(1) of this section are to be used as follows:

(1) For the City of Wilmington, for assisting and maintaining the fire department.

(2) For the County of New Castle outside the City of Wilmington, Kent County, and Sussex County, for assisting and maintaining the fire companies or departments in each of these areas.

(e) The Delaware Volunteer Firefighter's Association shall annually submit to the Insurance Commissioner and the State Fire Prevention Commission a report giving their location, apparatus and equipment maintained for its member fire companies or departments.

(f) All future rate filings covering the types of coverage described in subsection (a) of this section within this State shall make allowance for no more than 2% premium tax, unless the premium tax shall be changed after January 1, 2025, in which case the insurance companies may make allowance in the rate filings for no more than the then effective premium tax.

(g) (1) On or before May 15 of each year, the Insurance Commissioner shall ascertain and report to the State Treasurer, based on information contained in statements filed under this section, the amount which equals 0.08% of the amount reflected in the statements as to the total premium obtained during the preceding calendar year for writing in Delaware the types of coverage stated in subsection (a) of this section.

(2) After receipt of the report under paragraph (g)(1) of this section, the State Treasurer shall pay the reported amount to the State Insurance Coverage Office for purposes of funding the premium payment required to be paid by the State Insurance Coverage Office under § 6707B of this title.

(3) Payments to the State Insurance Coverage Office under this section are to be paid out of taxes deposited with the State Treasurer by the Insurance Commissioner, not including those funds received under § 707 of this title.

(18 Del. C. 1953, § 705; 57 Del. Laws, c. 731; 66 Del. Laws, c. 382, §§ 10-14; 77 Del. Laws, c. 378, §§ 2, 3; 79 Del. Laws, c. 102, § 1; 83 Del. Laws, c. 123, § 2; 84 Del. Laws, c. 512, § 1; 85 Del. Laws, c. 347, § 33.)

§ 706. Definitions of terms used in §§ 707-709 of this title.

As used in §§ 707-709 of this title:

(1) "County police" means any police under the control and direction of the Levy Court or County Council of the 3 counties of this State which are separate and apart from any state or municipal police.

(2) "Municipal" means any incorporated city or town.

(3) "Municipal police" means police in any incorporated city or town.

(4) "Police pension fund" means any pension or retirement fund established by law for and on behalf of any state, county or municipal police.

(5) "State police" means that police agency of the State acting under the direction of the State Department of Safety and Homeland Security.

(18 Del. C. 1953, § 707; 56 Del. Laws, c. 380, § 1; 67 Del. Laws, c. 327, § 6; 74 Del. Laws, c. 110, § 138.)

§ 707. Special tax on gross premiums for benefit of police.

(a) Every insurer transacting insurance within this State, other than workers' compensation insurance and wet marine and transportation insurance, shall, in addition to other taxes, fees and charges required by law, at the same time as the premium tax and estimated payments as provided in § 702 of this title pay to the Commissioner, for the use of the State, $^1/_4$% upon the gross premiums received and assessments collected from insurance of every kind upon persons or on the lives of persons resident in or upon real and personal property located within this State, or upon any other risks insured within this State, by any such insurer or the authorized agent thereof for the calendar year immediately preceding the date herein provided for such payments.

(b) "Gross premiums" whenever used in this section in reference to premiums received by insurers on policies covering risks located in this State shall mean all moneys collected, together with all notes or credits allowed, as premiums on such policies including reinsurance premiums received. In computing taxable premiums there may be deducted from gross premiums dividends and similar returns paid or credited to policyholders, return premiums paid by reason of cancellation of policies, and reinsurance premiums received from other insurers.

(c) No insurer affected by provisions of this section shall increase the rate of insurance premiums upon any insurable risk affected by this section because of the tax provided for in this section, unless the Commissioner after a hearing on the matter is satisfied that an increase is necessary; and in the event the Commissioner is satisfied after such hearing that an increase in the premium rate is necessary, the Commissioner shall authorize such reasonable increase as he or she deems fair and equitable.

(18 Del. C. 1953, § 708; 56 Del. Laws, c. 380, § 1; 66 Del. Laws, c. 382, § 5; 70 Del. Laws, c. 186, § 1.)

§ 708. Distribution of proceeds of tax.

(a) Each insurance company, firm or corporation covered by the provisions of § 707 of this title shall, at the time of making tax payments, deliver to the Insurance Commissioner a full and detailed statement showing the gross amount of premiums received and assessments collected and dividends paid to policy holders by such insurance company, firm or corporation or the authorized agent thereof for the calendar year immediately preceding the date provided for in § 707 of this title for tax payments, and such statement shall be verified by the oath or affirmation of the president or secretary or other responsible officer of said company, duly administered by some person authorized to administer oaths. Said statement shall be on the blanks prepared and furnished by the Insurance Commissioner for the purpose of carrying out the provisions of this section and § 707 of this title.

(b) The money received by the Insurance Commissioner in accordance with the provisions of § 707 of this title shall be paid to the State Treasurer and shall be set aside as a special fund and shall be paid out by the State Treasurer, subject to the provisions of subsection (c) of this section, to the proper officers in charge of any state, county or municipal police department or bureau having a pension fund, or which shall hereafter by law have a police pension fund. The State Treasurer shall determine the total number of state, county and municipal police entitled to benefits under the provisions of this section and § 707 of this title from an annual registry in accordance with § 709(a) of this title, and shall make distribution proportionately and on a per capita basis, subject to the provisions of subsection (c) of this section, to the proper officers of any state, county or municipal police department or bureau complying with the provisions of this section and § 707 of this title. Distribution under this section shall take place twice annually, on or before June 30 and December 31.

(c) (1) The payments to the State referred to in this section for "state police," as defined in § 706 of this title, shall be deposited into a special fund, to be managed by the State Board of Pension Trustees, to provide post-retirement increases for retired county and municipal

police and firefighters. The State Board of Pension Trustees shall allocate the funds deposited in this special fund on a per capita basis to the account of each eligible county or municipality based upon the annual registry in accordance with § 709(b) of this title, provided that the eligible county or municipality has elected to participate in the State-administered County and Municipal Police/Firefighter Pension Plan for all new hires after the time a municipality or county elects into that plan in accordance with Chapter 88 of Title 11. No funds shall be disbursed from this special fund without the prior approval of the Board of Pension Trustees.

(2) Any county or municipality wishing to grant a post-retirement increase from this fund shall submit a proposal to the State Board of Pension Trustees outlining the proposal in such detail as the State Board of Pension Trustees may require. The State Board of Pension Trustees shall not approve any proposal for a post-retirement increase unless the county or municipality requesting such increase agrees to deposit into this special fund, prior to the implementation of such increase, sufficient funds to cover 25% of the total actuarial cost of such increase.

(3) Any funds on deposit in this special fund, including accumulated income, shall revert to the General Fund, if such funds are not utilized for a post-retirement increase by the eligible counties or municipalities within 10 years from the date of deposit into the special fund.

(4) If a county or municipality does not submit a proposal to the State Board of Pension Trustees, the State Board of Pension Trustees shall distribute funds from the account within this special fund to the county or municipality for the benefit of all eligible individuals who started receiving a normal retirement, disability, or survivor pension. The State Board of Pension Trustees shall distribute the funds consistent with the following:

a. For purposes of this section, “eligible retiree” means an individual who retired before June 30, 2025; a surviving beneficiary; or an individual receiving a disability pension. Eligible retirees must be alive on July 1 of each biennial payout year to receive payment.

b. Eligible retirees must be placed into 1 of the following 3 categories:

1. Category 1, consisting of individuals who are 1 of the following:

A. Retired for greater than or equal to 20 years.

B. A surviving beneficiary.

C. Receiving a disability pension.

2. Category 2, consisting of individuals who have been retired for greater than or equal to 10 years but less than 20 years.

3. Category 3, consisting of individuals who have been retired for less than 10 years.

c. On each biennial anniversary starting from July 1, 2025, and each biennial anniversary thereafter, the State Board of Pension Trustees shall make funds available for distribution from this special fund, as follows:

1. At least $500,000 must remain in this special fund after distributions are made to eligible retirees.

2. Payments to eligible retirees in Category 3 must not exceed $3,000 to each individual.

3. The amount of the payment to each individual in Category 1 shall be 3 times the amount of the payment to each individual in Category 3 and the amount of the payment to each individual in Category 2 shall be 2 times the amount of the payment to each individual in Category 3.

4. A payment may not be made to any individual who receives an annual pension of more than $55,000.

d. The State Board of Pension Trustees shall determine the total amount available for distribution in any given year by July 1 of such year based upon the category information received from the county or municipality before July 1 of such year.

e. A county or municipality must disperse payments to eligible retirees within 30 days of receiving the funds under paragraph (c)(4)c. of this section.

(18 Del. C. 1953, § 709; 56 Del. Laws, c. 380, § 1; 66 Del. Laws, c. 382, § 15; 67 Del. Laws, c. 327, §§ 7, 8; 68 Del. Laws, c. 120, § 1; 70 Del. Laws, c. 464, § 1; 80 Del. Laws, c. 419, § 1; 81 Del. Laws, c. 398, § 1; 83 Del. Laws, c. 159, § 1; 85 Del. Laws, c. 71, § 1.)

§ 709. Registering information.

(a) It shall be the duty of the officer in charge of any state, county or municipal police department or bureau participating in the provisions of §§ 707 and 708 of this title to register with the State Treasurer on or before the 1st day of April in each year, and to provide the State Treasurer with the following information: the location, jurisdiction and average number of paid, full-time, sworn police officers employed for the year ending on the previous December 31.

(b) It shall be the duty of the officer in charge of any county or municipal police/fire department or bureau participating in the provisions of §§ 707 and 708 of this title to register with the State Board of Pension Trustees on or before April 1 in each year, and to provide the State Board of Pension Trustees with a listing of the number of retired police officers or firefighters receiving benefits as of December 31 of the preceding year excluding those covered by the County and Municipal Police/Firefighter Pension Plan as contained in Chapter 88 of Title 11.

(18 Del. C. 1953, § 710; 56 Del. Laws, c. 380, § 1; 67 Del. Laws, c. 327, §§ 9, 10; 70 Del. Laws, c. 186, § 1.)

§ 710. Purpose, receipt, deposit of fees, fines and taxes.

(a) All fees, charges, administrative fines and taxes payable under this title shall be paid to and collected by the Commissioner.

(b) The Commissioner shall give to any person paying cash a prenumbered, itemized receipt for fees, charges, administrative fines and taxes paid under this title.

(c) Except as otherwise expressly provided, the Commissioner shall promptly deposit to the credit of the General Fund all fees, charges, administrative fines, taxes and other funds collected by him or her for the use of this State, and shall promptly report the same to the State Treasurer as provided in Chapter 61 of Title 29.

(18 Del. C. 1953, § 711; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 351; 70 Del. Laws, c. 186, § 1.)

§ 711. Refund of overpayments.

(a) Any person from whom fees, charges or taxes imposed by this title have been erroneously collected may apply to the Commissioner for refund at any time within 1 year from the date such fees, charges or taxes were originally required to be paid or within 30 days from the date of payment of any additional tax, charge or fee.

(b) If the amount of taxes, charges or fees found due are less than the amount paid, either by examination of the return by the Commissioner or by allowance of a claim for overpayment filed by the payer with the Commissioner, the State Treasurer shall refund the excess out of the General Fund of this State upon certification and approval by the Commissioner.

(c) No such refund shall be made unless the amount to be so refunded is $10 or more.

(18 Del. C. 1953, § 712; 56 Del. Laws, c. 380, § 1; 75 Del. Laws, c. 88, § 21(10); 83 Del. Laws, c. 319, § 1.)

§ 712. In lieu; preemption provision.

(a) The fees, charges and premium taxes imposed by the State shall be in lieu of all county and municipal license fees and taxes upon the business of insurance in this State, excepting property taxes.

(b) The State hereby preempts the field of regulating or of imposing excise, privilege, franchise, income, license, permit, registration and similar taxes, licenses and fees upon insurers and their general agents, agents and other representatives as such, and on the intangible property of insurers or such representatives, and all political subdivisions or agencies thereof in this State are prohibited from regulating insurers or their general agents, agents and other representatives as such, and from imposing upon them any such tax, license or fee. However, this provision shall not prohibit the imposition by political subdivisions of taxes upon real and tangible personal property.

(18 Del. C. 1953, § 713; 56 Del. Laws, c. 380, § 1.)

§ 713. Reporting gross premiums received by life and health insurers; special fund for payments to all volunteer ambulance companies or rescue services.

(a) The Insurance Commissioner each year shall ascertain the total amount of gross premiums received by insurance companies and agents thereof as payment for all types of life and/or health insurance coverage within this State. The Insurance Commissioner shall then notify the State Treasurer of the total amount of such gross premiums and also the names and addresses of each volunteer ambulance company or volunteer rescue service in this State. After the Insurance Commissioner so informs the State Treasurer, the State Treasurer shall:

(1) Establish a special fund each year. This special fund shall be created out of the existing annual premium taxes paid by insurance companies and agents thereof pursuant to this chapter on all types of life and/or health insurance coverage within this State. The special fund shall be created out of the aforesaid premium taxes, and shall be equal to $^{20}/_{100}$ of 1% of the gross premiums received by insurance companies and agents thereof for all types of life and/or health insurance coverage within this State.

(2) Distribute on a pro rata basis the proceeds of the special fund to the aforementioned nonprofit organizations within this State that are engaged in providing ambulance and/or rescue services.

(b) The Insurance Commissioner shall have the authority to request and receive any information regarding any insurance company's business relating to any type of life and/or health insurance coverage sold or offered for sale within this State for the purpose of determining the gross premiums received for such insurance coverage in order to determine the amount of the special fund.

(c) For the purpose of implementing this section, the Insurance Commissioner is authorized to promulgate rules and regulations that are consistent with this section.

(d) For the purpose of this section:

(1) "Basic life support (BLS)" shall have the same meaning as set forth in § 9702 of Title 16.

(2) "Volunteer ambulance company" shall mean a nonprofit ambulance company that is certified by the State Fire Prevention Commission and is providing basic life support (BLS) services.

(65 Del. Laws, c. 196, § 1; 66 Del. Laws, c. 302, § 1; 79 Del. Laws, c. 437, § 1.)

§ 714. Expenses and fees for form and rate filings.

(a) In addition to a filing fee as set forth in § 701 of this title, the expenses and fees of the Department of Insurance for the review and determination of a form and rate filing by an insurer shall be assessed to and paid by the insurer and shall include the reasonable and

proper expenses of the Commissioner and the Commissioner's examiners and assistants, including expert assistance contracted for by the Commissioner. Such insurer shall promptly pay the form and rate filing review expense upon presentation by the Commissioner or the Commissioner's examiners of a reasonably detailed written account thereof.

(b) No insurer shall be required to pay a form filing fee pursuant to § 701(34) of this title that exceeds $2,000 per filing. For form filings that are made on a group-wide basis, the $2,000 filing cap shall be applied to each insurer within the filing.

(73 Del. Laws, c. 325, § 3; 75 Del. Laws, c. 156, § 1; 81 Del. Laws, c. 57, § 2; 82 Del. Laws, c. 112, § 1.)

Part I
Insurance
Chapter 9
Kinds of Insurance; Limits of Risk; Reinsurance
Subchapter I
Kinds of Insurance

§ 901. Definitions not mutually exclusive.

It is intended that certain insurance coverages may come within the definitions of 2 or more kinds of insurance as defined in this chapter, and the inclusion of such coverage within 1 definition shall not exclude it as to any other kind of insurance within the definition of which such coverage is likewise reasonably includable.

(18 Del. C. 1953, § 901; 56 Del. Laws, c. 380, § 1.)

§ 902. "Life insurance" defined.

Life insurance is insurance on human lives. The transaction of life insurance includes also the granting of endowment benefits, additional benefits in event of death or dismemberment by accident or accidental means, additional benefits in event of the insured's disability, and optional modes of settlement of proceeds of life insurance.

(18 Del. C. 1953, § 902; 56 Del. Laws, c. 380, § 1.)

§ 903. "Health insurance" defined.

Health insurance is insurance of human beings against bodily injury, disablement or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance appertaining thereto.

(18 Del. C. 1953, § 903; 56 Del. Laws, c. 380, § 1.)

§ 904. "Property insurance" defined.

Property insurance is insurance on real or personal property of every kind and of every interest therein against loss or damage from any and all hazard or cause, and against loss consequential upon such loss or damage, other than noncontractual legal liability for any such loss or damage. Property insurance does not include title insurance, as defined in § 908 of this chapter.

(18 Del. C. 1953, § 904; 56 Del. Laws, c. 380, § 1.)

§ 905. "Surety insurance" defined.

(a) Surety insurance includes:

(1) Fidelity insurance, which is insurance guaranteeing the fidelity of persons holding positions of public or private trust;

(2) Insurance guaranteeing the performance of contracts, other than insurance policies, and guaranteeing and executing bonds, undertakings and contracts of suretyship;

(3) Insurance indemnifying banks, bankers, brokers, financial or moneyed corporations or associations against loss, resulting from any cause, of bills of exchange, notes, bonds, securities, evidences of debt, deeds, mortgages, warehouse receipts or other valuable papers, documents, money, precious metals and articles made therefrom, jewelry, watches, gems, precious and semiprecious stones, including any loss while the same are being transported in armored motor vehicles or by messenger, but not including any other risks of transportation or navigation; also insurance against loss or damage to such an insured's premises or to his or her furnishings, fixtures, equipment, safes and vaults therein caused by burglary, robbery, theft, vandalism or malicious mischief, or any attempt thereat.

(b) Transaction of surety insurance does not confer power on the insurer to guarantee titles to real estate.

(18 Del. C. 1953, § 905; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 906. "Casualty insurance" defined.

(a) Casualty insurance includes:

(1) *Vehicle insurance.* — Insurance against loss of or damage to any land vehicle or aircraft or any draft or riding animal or to property while contained therein or thereon or being loaded or unloaded therein or therefrom, from any hazard or cause, and against any loss, liability or expense resulting from or incidental to ownership, maintenance or use of any such vehicle, aircraft or animal; together with insurance against accidental injury to individuals, irrespective of legal liability of the insured, including the named insured while in, entering, alighting from, adjusting, repairing, cranking or caused by being struck by a vehicle, aircraft or draft or riding animal, if such insurance is issued as an incidental part of insurance on the vehicle, aircraft or draft or riding animal;

(2) *Liability insurance.* — Insurance against legal liability for the death, injury or disability of any human being, or for damage to property, and provision of medical, hospital, surgical, disability benefits to injured persons and funeral and death benefits to dependents,

beneficiaries or personal representatives of persons killed, irrespective of legal liability of the insured, when issued as an incidental coverage with or supplemental to liability insurance;

(3) *Workers' compensation and employer's liability.* — Insurance of the obligations accepted by, imposed upon, or assumed by employers under law for death, disablement or injury of employees;

(4) *Burglary and theft.* — Insurance against loss or damage by burglary, theft, larceny, robbery, forgery, fraud, vandalism, malicious mischief, confiscation or wrongful conversion, disposal or concealment, or from any attempt at any of the foregoing, including supplemental coverage for medical, hospital, surgical and funeral expense incurred by the named insured or any other person as a result of bodily injury during the commission of a burglary, robbery or theft by another; also insurance against loss of or damage to moneys, coins, bullion, securities, notes, drafts, acceptances or any other valuable papers and documents resulting from any cause;

(5) *Personal property floater.* — Insurance upon personal effects against loss or damage from any cause;

(6) *Glass.* — Insurance against loss or damage to glass, including its lettering, ornamentation and fittings;

(7) *Boiler and machinery.* — Insurance against any liability and loss or damage to property or interest resulting from accidents to or explosions of boilers, pipes, pressure containers, machinery or apparatus, and to make inspection of and issue certificates of inspection upon boilers, machinery and apparatus of any kind, whether or not insured;

(8) *Leakage and fire extinguishing equipment.* — Insurance against loss or damage to any property or interest caused by the breakage or leakage of sprinklers, hoses, pumps and other fire extinguishing equipment or apparatus, water pipes or containers, or by water entering through leaks or openings in buildings, and insurance against loss or damage to such sprinklers, hoses, pumps and other fire extinguishing equipment or apparatus;

(9) *Credit.* — Insurance against loss or damage resulting from failure of debtors to pay their obligations to the insured;

(10) *Medical negligence.* — Insurance against legal liability of the insured, and against loss, damage or expense incidental to a claim of such liability, and including medical, hospital, surgical and funeral benefits to injured persons, irrespective of legal liability of the insured, arising out of the death, injury or disablement of any person, or arising out of damage to the economic interest of any person, as the result of negligence in rendering expert, fiduciary or professional service;

(11) *Elevator.* — Insurance against loss of or damage to any property of the insured, resulting from the ownership, maintenance or use of elevators, except loss or damage by fire, and to make inspection of and issue certificates of inspection upon elevators;

(12) *Congenital defects.* — Insurance against congenital defects in human beings;

(13) *Livestock.* — Insurance against loss or damage to livestock, and services of a veterinary for such animals;

(14) *Entertainments.* — Insurance indemnifying the producer of any motion picture, television, radio, theatrical, sport, spectacle, entertainment, or similar production, event or exhibition against loss from interruption, postponement or cancellation thereof due to death, accidental injury or sickness of performers, participants, directors or other principals;

(15) *Miscellaneous.* — Insurance against any other kind of loss, damage or liability properly a subject of insurance and not within any other kind of insurance as defined in this subchapter, if such insurance is not disapproved by the Commissioner as being contrary to law or public policy.

(b) Provision of medical, hospital, surgical and funeral benefits, and of coverage against accidental death or injury, as incidental to and part of other insurance as stated under paragraphs (a)(1) (vehicle), (2) (liability), (4) (burglary), (7) (boiler and machinery), (10) (medical negligence), and (11) (elevator) of this section, shall for all purposes be deemed to be the same kind of insurance to which it is so incidental, and shall not be subject to provisions of this title applicable to life and health insurances.

(18 Del. C. 1953, § 906; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; 71 Del. Laws, c. 373, § 3.)

§ 907. Marine and transportation, "wet marine" insurance defined.

(a) "Marine and transportation insurance" includes:

(1) Insurance against any kinds of loss or damage to:

a. Vessels, craft, aircraft, cars, automobiles and vehicles of every kind, as well as all goods, freights, cargoes, merchandise, effects, disbursements, profits, moneys, bullion, precious stones, securities, choses in action, evidences of debt, valuable papers, bottomry and respondentia interests and all other kinds of property and interests therein, in respect to, appertaining to, or in connection with any and all risks or perils of navigation, transit or transportation, including war risks, on or under any seas or other waters, on land or in the air, or while being assembled, packed, crated, baled, compressed or similarly prepared for shipment or while awaiting the same or during any delays, storage, transshipment or reshipment incident thereto, including marine builder's risks and all personal property floater risks; and

b. Person or to property in connection with or appertaining to a marine, inland marine, transit or transportation insurance, including liability for loss of or damage to either, arising out of or in connection with the construction, repair, operation, maintenance or use of the subject matter of such insurance (but not including life insurance or surety bonds nor insurance against loss by reason of bodily injury to the person arising out of the ownership, maintenance or use of automobiles); and

c. Precious stones, jewels, jewelry, gold, silver and other precious metals, whether used in business or trade or otherwise and whether the same be in course of transportation or otherwise; and

d. Bridges, tunnels and other instrumentalities of transportation and communication (excluding buildings, their furniture and furnishings, fixed contents and supplies held in storage) unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot and/or civil commotion are the only hazards to be covered; piers, wharves, docks and slips, excluding the risks of fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot and/or civil commotion; other aids to navigation and transportation, including dry docks and marine railways, against all risks.

(2) "Marine protection and indemnity insurance," meaning insurance against, or against legal liability of the insured for, loss, damage or expense arising out of or incident to the ownership, operation, chartering, maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness or death or for loss of or damage to the property of another person.

(b) For the purposes of this title "wet marine and transportation" insurance is that part of "marine and transportation" insurance which includes only:

(1) Insurance upon vessels, crafts, hulls and of interests therein or with relation thereto;

(2) Insurance of marine builders' risks, marine war risks and contracts of marine protection and indemnity insurance;

(3) Insurance of freights and disbursements pertaining to a subject of insurance coming within this definition; and

(4) Insurance of personal property and interests therein, in course of exportation from or importation into any country, or in course of transportation coastwise or on inland waters, including transportation by land, water or air from point of origin to final destination in respect to, appertaining to or in connection with any and all risks or perils of navigation, transit or transportation, and while being prepared for and while awaiting shipment, and during any delays, storage, transshipment or reshipment incident thereto.

(18 Del. C. 1953, § 907; 56 Del. Laws, c. 380, § 1.)

§ 908. "Title insurance" defined.

Title insurance is insurance of owners of property or others having an interest therein, or liens or encumbrances thereon, against loss by encumbrance or defective titles or invalidity or adverse claim to title.

(18 Del. C. 1953, § 908; 56 Del. Laws, c. 380, § 1.)

§ 908A. "Automobile club" defined.

"Automobile club" means a legal entity which, in consideration of dues, assessments or periodic payments of money, promises its members or subscribers to assist them in matters relating to motor travel or the operation, use or maintenance of a motor vehicle, by supplying services which may include but are not limited to towing service, emergency road service, indemnification service, guaranteed arrest bond certificate service, discount service, financial service, theft service, map service or touring service. This definition does not include an entity that enters into a service contract with an automobile club licensed under this chapter for the provision of emergency road service and towing service to the entity's customers.

(75 Del. Laws, c. 49, § 1; 78 Del. Laws, c. 169, § 1.)

Subchapter II
Limits of Risk

§ 909. Limits of risk.

(a) No insurer shall retain any risk on any 1 subject of insurance, whether located or to be performed in this State or elsewhere, in an amount exceeding 10% of its surplus to policyholders.

(b) A "subject of insurance" for the purposes of this section, as to insurance against fire and hazards other than windstorm, earthquake and other catastrophic hazards, includes all properties insured by the same insurer which are customarily considered by underwriters to be subject to loss or damage from the same fire or the same occurrence of any other hazard insured against.

(c) Reinsurance ceded as authorized by § 910 of this title shall be deducted in determining risk retained. Except, that as to surety risks reinsurance shall be allowed as a deduction only if such reinsurance is with an insurer authorized to transact such insurance in this State, and is in such form as to enable the obligee or beneficiary to maintain an action thereon against the reinsured jointly with the reinsurer, and upon recovering judgment against the reinsured to have recovery against the reinsurer for payment to the extent in which it may be liable under such reinsurance and in discharge thereof. As to surety risks, deduction shall also be made of the amount assumed by any authorized cosurety and the value of any security deposited, pledged or held subject to the surety's consent and for the surety's protection.

(d) As to alien insurers, this section shall relate only to risks and surplus to policyholders of the insurer's United States branch.

(e) "Surplus to policyholders" for the purposes of this section, in addition to the insurer's capital and surplus, shall be deemed to include any voluntary reserves which are not required pursuant to law, and shall be determined from the last sworn statement of the insurer on file with the Commissioner or by the last report of examination of the insurer, whichever is the more recent at time of assumption of risk.

(f) This section shall not apply to life or health insurance, annuities, title insurance, insurance of wet marine and transportation risks, workers' compensation insurance, employers' liability coverages, nor to any policy or type of coverage as to which the maximum possible loss to the insurer is not readily ascertainable on issuance of the policy.

(g) Limits of risk as to newly formed domestic mutual insurers shall be as provided in § 4905 of this title.

(18 Del. C. 1953, § 910; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

Subchapter III
Reinsurance

§ 910. Reinsurance.

Any authorized insurer may reinsure all or any part of an individual risk or of a particular class of risks in any other insurer or accept such reinsurance from any other insurer. Domestic insurers will be subject to § 4944 of this title with regard to bulk reinsurance.

(18 Del. C. 1953, § 910; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 96, § 1; 68 Del. Laws, c. 58, § 1; 78 Del. Laws, c. 364, § 1.)

§ 911. Credit allowed a domestic ceding insurer.

Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of paragraph (1), (2), (3), (4), (5), (6) or (7) of this section; provided further, that pursuant to § 915(b) of this title, the Commissioner may adopt by regulation specific additional requirements relating to or setting forth the valuation of assets or reserve credits, the amount and forms of security supporting reinsurance arrangements described in § 915(b) of this title, and the circumstances pursuant to which credit will be reduced or eliminated. Credit shall be allowed under paragraph (1), (2) or (3) of this section only as respects cessions of those kinds or classes of business which the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a U.S. branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. Credit shall be allowed under paragraph (3) or (4) of this section only if the applicable requirements of paragraph (8) of this section have been satisfied.

(1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this State.

(2) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited by the Commissioner as a reinsurer in this State. In order to be eligible for accreditation, a reinsurer must:

a. File with the Commissioner evidence of its submission to this State's jurisdiction;

b. Submit to this State's authority to examine its books and records;

c. Be licensed to transact insurance or reinsurance in at least 1 state, or in the case of a U.S. branch of an alien assuming insurer, be entered through and licensed to transact insurance or reinsurance in at least 1 state;

d. File annually with the Commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and

e. Demonstrate to the satisfaction of the Commissioner that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. An assuming insurer is deemed to meet this requirement as of the time of its application if it maintains a surplus as regards policyholders in an amount not less than $20,000,000 and its accreditation has not been denied by the Commissioner within 90 days after submission of its application.

(3) a. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is domiciled in, or in the case of a U.S. branch of an alien assuming insurer is entered through, a state that employs standards regarding credit for reinsurance substantially similar to those applicable under this statute and the assuming insurer or U.S. branch of an alien assuming insurer:

1. Maintains a surplus as regards policyholders in an amount not less than $20,000,000; and

2. Submits to the authority of this State to examine its books and records.

b. The requirement of paragraph (3)a.1. of this section does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(4) a. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified U.S. financial institution, as defined in § 913(b) of this title, for the payment of the valid claims of its U.S. ceding insurers, their assigns and successors in interest. To enable the Commissioner to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the Commissioner information substantially the same as that required to be reported on the National Association of Insurance Commissioners (NAIC) Annual Statement form by licensed insurers. The assuming insurer shall submit to examination of its books and records by the Commissioner and bear the expense of examination.

b. 1. Credit for reinsurance shall not be granted under this subsection unless the form of the trust and any amendments to the trust have been approved by:

A. The Commissioner of the state where the trust is domiciled; or

B. The Commissioner of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

2. The form of the trust and any trust amendments also shall be filed with the Commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its

assets in its trustees for the benefit of the assuming insurer's U.S. ceding insurers, their assigns and successors in interest. The trust and the assuming insurer shall be subject to examination as determined by the Commissioner.

3. The trust shall remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. No later than February 28 of each year the trustee of the trust shall report to the Commissioner in writing the balance of the trust and listing the trust's investments at the preceding year-end and shall certify the date of termination of the trust, if so planned, or certify that the trust will not expire prior to the following December 31.

c. The following requirements apply to the following categories of assuming insurer:

1. The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers, and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20,000,000, except as provided in paragraph (4)c.2. of this section.

2. At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least 3 full years, the Commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of U.S. ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an amount less than 30% of the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers covered by the trust.

3. A. In the case of a group including incorporated and individual unincorporated underwriters:

I. For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after January 1, 1993, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by U.S. domiciled ceding insurers to any underwriter of the group;

II. For reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, not-withstanding the other provisions of 78 Del. Laws, c. 364, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States; and

III. In addition to these trusts, the group shall maintain in trust a trusteed surplus of which $100,000,000 shall be held jointly for the benefit of the U.S. domiciled ceding insurers of any member of the group for all years of account; and

B. The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.

C. Within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the Commissioner an annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group.

4. In the case of a group of incorporated underwriters under common administration, the group shall:

A. Have continuously transacted an insurance business outside the United States for at least 3 years immediately prior to making application for accreditation;

B. Maintain aggregate policyholders' surplus of at least $10,000,000,000;

C. Maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by U.S. domiciled ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group;

D. In addition, maintain a joint trusteed surplus of which $100,000,000 shall be held jointly for the benefit of U.S. domiciled ceding insurers of any member of the group as additional security for these liabilities; and

E. Within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, make available to the Commissioner an annual certification of each underwriter member's solvency by the member's domiciliary regulator and financial statements of each underwriter member of the group prepared by its independent public accountant.

(5) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that has been certified by the Commissioner as a reinsurer in this State and secures its obligations in accordance with the requirements of this paragraph.

a. In order to be eligible for certification, the assuming insurer shall meet the following requirements:

1. The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the Commissioner pursuant to paragraph (5)c. of this section;

2. The assuming insurer must maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the Commissioner pursuant to regulation;

3. The assuming insurer must maintain financial strength ratings from 2 or more rating agencies deemed acceptable by the Commissioner pursuant to regulation;

4. The assuming insurer must agree to submit to the jurisdiction of this State, appoint the Commissioner as its agent for service of process in this State, and agree to provide security for 100% of the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers if it resists enforcement of a final U.S. judgment;

5. The assuming insurer must agree to meet applicable information filing requirements as determined by the Commissioner, both with respect to an initial application for certification and on an ongoing basis; and

6. The assuming insurer must satisfy any other requirements for certification deemed relevant by the Commissioner.

b. An association including incorporated and individual unincorporated underwriters may be a certified reinsurer. In order to be eligible for certification, in addition to satisfying requirements of paragraph (5)a. of this section:

1. The association shall satisfy its minimum capital and surplus requirements through the capital and surplus equivalents (net of liabilities) of the association and its members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members, in an amount determined by the Commissioner to provide adequate protection;

2. The incorporated members of the association shall not be engaged in any business other than underwriting as a member of the association and shall be subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members; and

3. Within 90 days after its financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the Commissioner an annual certification by the association's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the association.

c. The Commissioner shall create and publish a list of qualified jurisdictions, under which an assuming insurer licensed and domiciled in such jurisdiction is eligible to be considered for certification by the Commissioner as a certified reinsurer.

1. In order to determine whether the domiciliary jurisdiction of a non-U.S. assuming insurer is eligible to be recognized as a qualified jurisdiction, the Commissioner shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the non-U.S. jurisdiction to reinsurers licensed and domiciled in the U.S. A qualified jurisdiction must agree to share information and cooperate with the Commissioner with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction may not be recognized as a qualified jurisdiction if the Commissioner has determined that the jurisdiction does not adequately and promptly enforce final U.S. judgments and arbitration awards. Additional factors may be considered in the discretion of the Commissioner.

2. A list of qualified jurisdictions shall be published through the NAIC committee process. The Commissioner shall consider this list in determining qualified jurisdictions. If the Commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the Commissioner shall provide thoroughly documented justification in accordance with criteria to be developed under regulations.

3. U.S. jurisdictions that meet the requirement for accreditation under the NAIC financial standards and accreditation program shall be recognized as qualified jurisdictions.

4. If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the Commissioner has the discretion to suspend the reinsurer's certification indefinitely, in lieu of revocation.

d. The Commissioner shall assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies deemed acceptable to the Commissioner pursuant to regulation. The Commissioner shall publish a list of all certified reinsurers and their ratings.

e. A certified reinsurer shall secure obligations assumed from U.S. ceding insurers under this paragraph at a level consistent with its rating, as specified in regulations promulgated by the Commissioner.

1. In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the Commissioner and consistent with the provisions of § 912 of this title, or in a multibeneficiary trust in accordance with paragraph (4) of this section, except as otherwise provided in this paragraph.

2. If a certified reinsurer maintains a trust to fully secure its obligations subject to paragraph (4) of this section, and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this subsection or comparable laws of other U.S. jurisdictions and for its obligations subject to paragraph (4) of this section. It shall be a condition to the grant of certification under this paragraph (5) that the certified reinsurer shall have bound itself, by the language of the trust and agreement with the Commissioner with principal regulatory oversight of each such trust account, to fund, upon termination of any such trust account, out of the remaining surplus of such trust any deficiency of any other such trust account.

3. The minimum trusteed surplus requirements provided in paragraph (4) of this section are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this paragraph, except that such trust shall maintain a minimum trusteed surplus of $10,000,000.

4. With respect to obligations incurred by a certified reinsurer under this paragraph (5), if the security is insufficient, the Commissioner shall reduce the allowable credit by an amount proportionate to the deficiency, and has the discretion to impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

5. For purposes of this paragraph (5), a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure 100% of its obligations.

A. As used in this paragraph (5), the term "terminated" refers to revocation, suspension, voluntary surrender and inactive status.

B. If the Commissioner continues to assign a higher rating as permitted by other provisions of this section, this requirement does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

f. If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the Commissioner has the discretion to defer to that jurisdiction's certification, and has the discretion to defer to the rating assigned by that jurisdiction, and such assuming insurer shall be considered to be a certified reinsurer in this State.

g. A certified reinsurer that ceases to assume new business in this State may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of this paragraph (5), and the Commissioner shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

(6) a. Credit shall be allowed when the reinsurance is ceded to an assuming insurer meeting each of the conditions set forth below.

1. The assuming insurer must have its head office or be domiciled in, as applicable, and be licensed in a reciprocal jurisdiction. A "reciprocal jurisdiction" is a jurisdiction that meets 1 of the following:

A. A non-U.S. jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and European Union, is a member state of the European Union. For purposes of this subsection, a "covered agreement" is an agreement entered into pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. §§ 313 and 314, that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this State or for allowing the ceding insurer to recognize credit for reinsurance;

B. A U.S. jurisdiction that meets the requirements for accreditation under the National Association of Insurance Commissioners financial standards and accreditation program; or

C. A qualified jurisdiction, as determined by the Commissioner pursuant to § 911(5)e. of this title, which is not otherwise described in paragraph (6)a.1.A. or B. of this section above and which meets certain additional requirements, consistent with terms and conditions of in-force covered agreements, as specified by the Commissioner in regulation.

2. The assuming insurer must have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, calculated according to the methodology of its domiciliary jurisdiction, in an amount to be set forth in regulation. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain, on an ongoing basis, minimum capital and surplus equivalents (net of liabilities), calculated according to the methodology applicable in its domiciliary jurisdiction, and a central fund containing a balance in amounts to be set forth in regulation.

3. The assuming insurer must have and maintain, on an ongoing basis, a minimum solvency or capital ratio, as applicable, which will be set forth in regulation. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has its head office or is domiciled, as applicable, and is also licensed.

4. The assuming insurer must agree and provide adequate assurance to the Commissioner, in a form specified by the Commissioner pursuant to regulation, as follows:

A. The assuming insurer must provide prompt written notice and explanation to the Commissioner if it falls below the minimum requirements set forth in paragraphs (6)a.2. and 3. of this section, or if any regulatory action is taken against it for serious noncompliance with applicable law;

B. The assuming insurer must consent in writing to the jurisdiction of the courts of this State and to the appointment of the Commissioner as agent for service of process. The Commissioner may require that consent for service of process be provided to the Commissioner and included in each reinsurance agreement. Nothing in this provision shall limit, or in any way alter, the capacity of the parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws;

C. The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained;

D. Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to 100% of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate; and

E. The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement which involves this State's ceding insurers, and agree to notify the ceding insurer and the Commissioner and to provide security in an amount equal to 100% of the assuming insurer's liabilities to the ceding insurer, should the assuming insurer enter into such a solvent scheme of arrangement. Such security shall be in a form consistent with the provisions of paragraph (5) of this section and § 912 of this title and as specified by the Commissioner in regulation.

5. The assuming insurer or its legal successor must provide, if requested by the Commissioner, on behalf of itself and any legal predecessors, certain documentation to the Commissioner, as specified by the Commissioner in regulation.

6. The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements, pursuant to the criteria set forth in regulation.

7. The assuming insurer's supervisory authority must confirm to the Commissioner on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements set forth in paragraphs (6)a.2. and 3. of this section.

8. Nothing in this provision precludes an assuming insurer from providing the Commissioner with information on a voluntary basis.

b. The Commissioner shall timely create and publish a list of reciprocal jurisdictions.

1. A list of reciprocal jurisdictions is published through the National Association of Insurance Commissioners Committee Process. The Commissioner's list shall include any reciprocal jurisdiction as defined under paragraphs (6)a.1 and 2. of this section, and shall consider any other reciprocal jurisdiction included on the National Association of Insurance Commissioners list. The Commissioner may approve a jurisdiction that does not appear on the National Association of Insurance Commissioners list of reciprocal jurisdictions in accordance with criteria to be developed under regulations issued by the Commissioner.

2. The Commissioner may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction, in accordance with a process set forth in regulations issued by the Commissioner, except that the Commissioner shall not remove from the list a reciprocal jurisdiction as defined under paragraphs (6)a.1. and 2. of this section. Upon removal of a reciprocal jurisdiction from this list credit for reinsurance ceded to an assuming insurer which has its home office or is domiciled in that jurisdiction shall be allowed, if otherwise allowed pursuant to this section.

c. The Commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this subsection and to which cessions shall be granted credit in accordance with this subsection. The Commissioner may add an assuming insurer to such list if a National Association of Insurance Commissioners accredited jurisdiction has added such assuming insurer to a list of such assuming insurers or if, upon initial eligibility, the assuming insurer submits the information to the Commissioner as required under paragraph (6)a.4. of this section and complies with any additional requirements that the Commissioner may impose by regulation, except to the extent that they conflict with an applicable covered agreement.

d. If the Commissioner determines that an assuming insurer no longer meets 1 or more of the requirements under this subsection, the Commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this subsection in accordance with procedures set forth in regulation.

1. While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with § 912 of this title.

2. If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the Commissioner and consistent with the provisions of § 912 of this title.

e. If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

f. Nothing in this subsection shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by this chapter or other applicable law or regulation.

g. Credit may be taken under this subsection only for reinsurance agreements entered into, amended, or renewed on or after the effective date of the statute adding this subsection, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements pursuant to paragraph (6)a. of this section, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal.

1. This paragraph does not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under this paragraph, as long as the reinsurance qualifies for credit under any other applicable provision of this section.

2. Nothing in this subsection shall authorize an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of the agreement.

3. Nothing in this subsection shall limit, or in any way alter, the capacity of parties to any reinsurance agreement to renegotiate the agreement.

(7) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of paragraph (1), (2), (3), (4), (5) or (6) of this section, but only as to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.

(8) If the assuming insurer is not licensed, accredited or certified to transact insurance or reinsurance in this State, the credit permitted by paragraphs (3) and (4) of this section shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

a. 1. That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction, and will abide by the final decision of the court or of any appellate court in the event of an appeal; and

2. To designate the Commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding insurer.

b. This paragraph (8) is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement.

(9) If the assuming insurer does not meet the requirements of paragraph (1), (2), (3) or (6) of this section, the credit permitted by paragraph (4) or (5) of this section shall not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

a. Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by paragraph (4)c. of this section, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the Commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the Commissioner with regulatory oversight all of the assets of the trust fund.

b. The assets shall be distributed by and claims shall be filed with and valued by the Commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies.

c. If the Commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the U.S. ceding insurers of the grantor of the trust, the assets or part thereof shall be returned by the Commissioner with regulatory oversight to the trustee for distribution in accordance with the trust agreement.

d. The grantor shall waive any right otherwise available to it under U.S. law that is inconsistent with this provision.

(10) If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the Commissioner may suspend or revoke the reinsurer's accreditation or certification.

a. The Commissioner must give the reinsurer notice and opportunity for hearing. The suspension or revocation may not take effect until after the Commissioner's order on hearing, unless:

1. The reinsurer waives its right to hearing;

2. The Commissioner's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under paragraph (5)f. of this section; or

3. The Commissioner finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the Commissioner's action.

b. While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with § 912 of this title. If a reinsurer's accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with paragraph (5)e. of this section or § 912 of this title.

(11) *Concentration risk.* — a. A ceding insurer shall take steps to manage its reinsurance recoverables proportionate to its own book of business. A domestic ceding insurer shall notify the Commissioner within 30 days after reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, exceeds 50% of the domestic ceding insurer's last reported surplus to policyholders, or after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

b. A ceding insurer shall take steps to diversify its reinsurance program. A domestic ceding insurer shall notify the Commissioner within 30 days after ceding to any single assuming insurer, or group of affiliated assuming insurers, more than 20% of the ceding insurer's gross written premium in the prior calendar year, or after it has determined that the reinsurance ceded to any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(68 Del. Laws, c. 58, § 2; 69 Del. Laws, c. 399, § 1; 78 Del. Laws, c. 364, § 2; 83 Del. Laws, c. 104, § 1; 84 Del. Laws, c. 33, § 1.)

§ 912. Asset or reduction from liability for reinsurance ceded by domestic insurer to assuming insurer not meeting requirements of § 911 of this title.

An asset or reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of § 911 of this title shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified U.S. financial institution, as defined in § 913(b) of this title. This security may be in the form of any of the following:

(1) Cash;

(2) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets;

(3) a. Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified U.S. financial institution, as defined in § 913(a) of this title, effective no later than December 31 of the year for which the filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement.

b. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing (or confirming) institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs;

(4) Any other form of security acceptable to the Commissioner.

(68 Del. Laws, c. 58, § 3; 78 Del. Laws, c. 364, § 3; 83 Del. Laws, c. 104, § 1.)

§ 913. Qualified U.S. financial institutions.

(a) For purposes of § 912(3) of this title, a "qualified U.S. financial institution" means an institution that:

(1) Is organized or (in the case of a U.S. office of a foreign banking organization) licensed under the laws of the United States or any state thereof;

(2) Is regulated, supervised and examined by U.S. federal or state authorities having regulatory authority over banks and trust companies; and

(3) Has been determined by either the Commissioner or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the Commissioner.

(b) A "qualified U.S. financial institution" means, for purposes of those provisions of this law specifying those institutions that are eligible to act as a fiduciary of a trust, an institution that:

(1) Is organized, or, in the case of a U.S. branch or agency office of a foreign banking organization, licensed, under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

(2) Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies.

(68 Del. Laws, c. 58, § 4; 78 Del. Laws, c. 364, § 4.)

§ 914. Additional requirements.

(a) Notwithstanding any other provision of § 911 or § 912 of this title, no credit shall be allowed as an admitted asset or deduction from liability unless the reinsurance agreement provides that in the event of insolvency of the ceding insurer, reinsurance proceeds shall be paid under a contract or contracts reinsured by the assuming insurer on the basis of the amount of the claim allowed in the insolvency proceeding without diminution by reason of the inability of the ceding insurer to pay all or any part of the claim. For all ceding insurers which are subject to liquidation proceedings pursuant to Chapter 59 of this title on or before December 31, 1999, such payments shall be made directly to the domiciliary liquidator. For all other ceding insurers, including ceding insurers under supervision or rehabilitation proceedings under Chapter 59 of this title as of December 31, 1999, subject to the provisions of subchapter II (Summary Proceedings) of Chapter 59 of this title, such payments shall be made directly to the ceding insurer or to its domiciliary liquidator, except:

(1) Where the contract or other written agreement between the ceding insurer and the assuming insurer specifically provides another payee of such reinsurance in the event of the insolvency of the ceding insurer; provided, however, that the exception set forth in this paragraph shall only apply to the extent that the re-insurance proceeds due such payee are actually paid by the assuming insurer; or

(2) Where the assuming insurer, with the consent of the direct insured or insureds, has assumed such policy obligations of the ceding insurer as direct obligations of the assuming insurer to the payees under such policies and in full and complete substitution for the obligations of the ceding insurer to such payees.

(b) Upon request of the Commissioner an insurer shall promptly inform the Commissioner in writing of the cancellation or any other material change of any of its reinsurance treaties or arrangements.

(68 Del. Laws, c. 58, § 5; 72 Del. Laws, c. 405, § 1.)

§ 915. Rules and regulations.

(a) The Commissioner may adopt rules and regulations implementing the provisions of this law.

(b) The Commissioner is further authorized to adopt rules and regulations applicable to reinsurance arrangements described in paragraph (b)(1) of this section.

(1) A regulation adopted pursuant to this subsection may only apply to reinsurance relating to any of the following:

a. Life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits.

b. Universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period.

c. Variable annuities with guaranteed death or living benefits.

d. Long-term care insurance policies.

e. Such other life and health insurance and annuity products as to which the National Association of Insurance Commissioners (NAIC) adopts model regulatory requirements with respect to credit for reinsurance.

(2) A regulation adopted pursuant to paragraphs (b)(1)a. and (b)(1)b. of this section may apply to any treaty containing:

a. Policies issued on or after January 1, 2024; or

b. Policies issued prior to January 1, 2024, if risk pertaining to such pre-2024 policies is ceded in connection with the treaty, in whole or in part, on or after January 1, 2024.

(3) A regulation adopted pursuant to this subsection may require the ceding insurer, in calculating the amounts or forms of security required to be held under regulations promulgated under this authority, to use the Valuation Manual adopted by the NAIC under § 1121 of this title, including all amendments adopted by the NAIC and in effect on the date as of which the calculation is made, to the extent applicable.

(4) A regulation adopted pursuant to this subsection shall not apply to cessions to an assuming insurer that does any of the following:

a. Meets the conditions set forth in § 911(6) of this title.

b. Is certified in this State as set forth in § 911(5) of this title.

c. Maintains at least $250 million in capital and surplus when determined in accordance with the NAIC Accounting Practices and Procedures Manual, including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices; and is

1. Licensed in at least 26 states; or

2. Licensed in at least 10 states, and licensed or accredited in a total of at least 35 states.

(5) The authority to adopt regulations pursuant to this subsection does not limit the Commissioner's general authority to adopt regulations pursuant to subsection (a) of this section.

(68 Del. Laws, c. 58, § 6; 78 Del. Laws, c. 364, § 5; 84 Del. Laws, c. 33, § 1.)

§ 916. Reinsurance agreements affected.

78 Del. Laws, c. 364 shall apply to all cessions after July 27, 2012, under reinsurance agreements that have an inception, anniversary or renewal date after January 27, 2013. 83 Del. Laws, c. 104 shall apply to all cessions after July 30, 2021, under reinsurance agreements that have an inception, anniversary or renewal date after January 30, 2022.

(78 Del. Laws, c. 364, § 6; 83 Del. Laws, c. 104, § 1.)

Subchapter IV

Exemptions

(82 Del. Laws, c. 71, § 1.)

§ 917. Definitions.

For purposes of this subchapter, the following terms shall have the following meaning:

(1) "Consumer product" means any tangible personal property that is distributed in commerce and is normally used for personal, family, or household purposes, including a motor vehicle and any tangible personal property intended to be attached to or installed in any real property without regard to whether it is so attached or installed.

(2) “Guaranteed asset protection waiver” means a contractual agreement wherein a creditor agrees, with or without a separate charge, to cancel or waive all or part of the following:

a. Amounts due on a borrower’s motor vehicle finance agreement in the event of a total physical damage loss or unrecovered theft of the motor vehicle, which agreement must be part of, or a separate addendum to, the finance agreement.

b. The excess wear and use charges owed by the borrower to the creditor under a motor vehicle lease contract when the borrower returns a leased vehicle to the creditor at termination of the lease, which agreement must be part of, or a separate addendum to, the lease contract.

(3) “Incidental costs” means expenses specified in a vehicle theft protection program warranty that are incurred by the warranty holder due to the failure of a vehicle theft protection program to perform as provided in the contract. Incidental costs may be reimbursed in either a fixed amount specified in the vehicle theft protection program warranty or by use of a formula itemizing specific incidental costs incurred by the warranty holder.

(4) “Maintenance agreement” means a contract of limited duration that provides for scheduled maintenance only.

(5) “Road hazard” means a hazard that is encountered while driving a motor vehicle and which may include potholes, rocks, wood debris, metal parts, glass, plastic, curbs, or composite scraps.

(6) “Service contract” means a contract or agreement for a separately stated consideration for any duration to perform the repair, replacement, or maintenance of a consumer product or indemnification for the same, for the operational or structural failure of a consumer product due to a defect in materials, workmanship, accidental damage from handling, or normal wear and tear, with or without additional provisions for incidental payment of indemnity under limited circumstances, including towing, rental, and emergency road service and road hazard protection. Service contracts may provide for the repair, replacement, or maintenance of a consumer product for damage resulting from power surges or interruption. Service contract also includes a contract or agreement sold for a separately stated consideration for a specific duration that provides for any of the following:

a. The repair or replacement or indemnification for the repair or replacement of a motor vehicle for the operational or structural failure of 1 or more parts or systems of the motor vehicle brought about by the failure of an additive product to perform as represented.

b. The repair or replacement of tires or wheels on a motor vehicle damaged as a result of coming into contact with road hazards.

c. The removal of dents, dings, or creases on a motor vehicle that can be repaired using the process of paintless dent removal without affecting the existing paint finish and without replacing vehicle body panels, sanding, bonding, or painting.

d. The repair of chips or cracks in or the replacement of motor vehicle windshields as a result of damage caused by road hazards.

e. The replacement of a motor vehicle key or key-fob in the event that the key or key-fob becomes inoperable or is lost or stolen.

f. The reduction of some or all of the amounts due on a consumer’s finance agreement in the event of a total physical damage loss or unrecovered theft of a motor vehicle.

g. Other services or products which may be approved by the Commissioner.

(7) “Vehicle theft protection product” means a device or system that:

a. Is installed on or applied to a motor vehicle;

b. Is designed to prevent loss or damage to a motor vehicle from theft; and

c. Includes a vehicle theft protection program warranty.

Vehicle theft protection product does not include fuel additives, oil additives, or other chemical products applied to the engine, transmission, or fuel system, or interior or exterior surfaces of a motor vehicle.

(8) “Vehicle theft protection product warranty” means a written agreement by a warrantor that provides if the vehicle theft protection product fails to prevent loss or damage to a motor vehicle from theft, that the warrantor will pay to or on behalf of the warranty holder specified incidental costs as a result of the failure of the vehicle theft protection product to perform pursuant to the terms of the vehicle theft protection product warranty.

(82 Del. Laws, c. 71, § 1; 70 Del. Laws, c. 186, § 1; 83 Del. Laws, c. 465, § 1.)

§ 918. Exemption from insurance regulation.

The offering, sale, or issuance of a guaranteed asset protection waiver, service contract, vehicle theft protection product warranty, or maintenance agreement shall not be considered insurance or subject to the insurance laws of this State unless made expressly applicable thereto.

(82 Del. Laws, c. 71, § 1; 83 Del. Laws, c. 465, § 2.)

Part I
Insurance
Chapter 11
Assets and Liabilities
Subchapter I
Assets

§ 1101. “Assets” defined.

In any determination of the financial condition of an insurer, there shall be allowed as assets only such assets as are owned by the insurer and which consist of:

(1) Cash in the possession of the insurer or in transit under its control, and including the true balance of any deposit in a solvent bank or trust company;

(2) Investments, securities, properties and loans acquired or held in accordance with this title, and in connection therewith the following items:

a. Interest due or accrued on any bond or evidence of indebtedness which is not in default and which is not valued on a basis including accrued interest;

b. Declared and unpaid dividends on stock and shares, unless such amount has otherwise been allowed as an asset;

c. Interest due or accrued upon a collateral loan in an amount not to exceed 1 year’s interest thereon;

d. Interest due or accrued on deposits in solvent banks and trust companies, and interest due or accrued on other assets, if such interest is in the judgment of the Commissioner a collectible asset;

e. Interest due or accrued on a mortgage loan in an amount not exceeding in any event the amount, if any, of the excess of the value of the property less delinquent taxes thereon over the unpaid principal;

f. Rent due or accrued on real property if such rent is not in arrears for more than 3 months, and rent more than 3 months in arrears if the payment of such rent be adequately secured by property held in the name of the tenant and conveyed to the insurer as collateral;

g. The unaccrued portion of taxes paid prior to the due date on real property;

(3) Premium notes, policy loans, and other policy assets and liens on policies and certificates of life insurance and annuity contracts and accrued interest thereon in an amount not exceeding the legal reserve and other policy liabilities carried on each individual policy;

(4) The net amount of uncollected and deferred premiums and annuity considerations in the case of a life insurer;

(5) Premiums in the course of collection, other than for life insurance, not more than 3 months past due, less commissions payable thereon. The foregoing limitation shall not apply to premiums payable directly or indirectly by the United States government or by any of its instrumentalities;

(6) Installment premiums other than life insurance premiums to the extent of the unearned premium reserve carried on the policy to which premiums apply;

(7) Notes and like written obligations not past due, taken for premiums other than life insurance premiums, on policies permitted to be issued on such basis, to the extent of the unearned premium reserves carried thereon;

(8) The full amount of reinsurance recoverable by a ceding insurer from a solvent reinsurer and which reinsurance is authorized under § 910 of this title;

(9) Amounts receivable by an assuming insurer representing funds withheld by a solvent ceding insurer under a reinsurance treaty;

(10) Deposits or equities recoverable from underwriting associations, syndicates and reinsurance funds, or from any suspended banking institution, to the extent deemed by the Commissioner available for the payment of losses and claims and at values to be determined by him or her;

(11) All assets, whether or not consistent with the provisions of this section, as may be allowed pursuant to the annual statement form approved by the Commissioner for the kinds of insurance to be reported upon therein;

(12) As to a title insurer, its title plant and equipment reasonably necessary for conduct of its abstract or title insurance business;

(13) Electronic and mechanical data processing machines and related equipment are allowed as prescribed in the NAIC Accounting Practices and Procedures Manual;

(14) Other assets, not inconsistent with this section, deemed by the Commissioner to be available for the payment of losses and claims at values to be determined by him or her.

(18 Del. C. 1953, § 1101; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; 74 Del. Laws, c. 214, §§ 1-3.)

§ 1102. Assets not allowed.

In addition to assets impliedly excluded by § 1101 of this title, the following expressly shall not be allowed as assets in any determination of the financial condition of an insurer:

(1) Trade names and other like intangible assets;

(2) Advances to officers (other than policy loans) whether secured or not, and advances to employees, agents and other persons on personal security only;

(3) Stock of such insurer, owned by it, or any equity therein or loans secured thereby, or any proportionate interest in such stock acquired or held through the ownership by such insurer of an interest in another firm, corporation or business unit;

(4) Furniture, fixtures, furnishings, safes, vehicles, libraries, stationery, literature and supplies (other than data processing, recordkeeping and accounting systems authorized under § 1101(13) of this title) and except in the case of title insurers such materials and plants as the insurer is expressly authorized to invest in under § 1322 of this title [repealed]; and except, in the case of any insurer, such personal property as the insurer is permitted to hold pursuant to Chapter 13 of this title, or which is reasonably necessary for the maintenance and operation of real estate lawfully acquired and held by the insurer other than real estate used by it for home office, branch office and similar purposes;

(5) The amount, if any, by which the aggregate book value of investments as carried in the ledger assets of the insurer exceeds the aggregate value thereof as determined under this title;

(6) With respect to an insurance division of a bank or trust company established pursuant to § 767(a) of Title 5, any assets of the bank or trust company other than those entered on the separate and distinct financial records of such division.

(18 Del. C. 1953, § 1102; 56 Del. Laws, c. 380, § 1; 67 Del. Laws, c. 223, § 21; 74 Del. Laws, c. 214, § 4.)

§ 1102A. Bank insurance department or division distinct from bank.

The assets of any insurance department or division of a bank or trust company established pursuant to § 767(a) of Title 5 shall be liable for and applicable to the payment and satisfaction of the liabilities, obligations and expenses of such insurance department or division only. The liabilities, obligations and expenses of any such insurance department or division shall be applied against and paid and satisfied solely out of the assets of such insurance department or division.

(67 Del. Laws, c. 223, § 22.)

Subchapter II
Liabilities and Reserves

§ 1103. Liabilities, in general.

In any determination of the financial condition of an insurer, capital stock and liabilities to be charged against its assets shall include:

(1) The amount of its capital stock outstanding, if any, or capital account required by § 511(a) of this title;

(2) The amount, estimated consistent with the provisions of this title, necessary to pay all of its unpaid losses and claims incurred on or prior to the date of statement, whether reported or unreported, together with the expenses of adjustment or settlement thereof;

(3) With reference to life insurance policies and annuity contracts, and disability and accidental death benefits in or supplemental thereto:

a. The amount of reserves on life insurance policies and annuity contracts in force, valued according to the tables of mortality, rates of interest, and methods adopted pursuant to this title which are applicable thereto;

b. Reserves for disability benefits, for both active and disabled lives;

c. Reserves for accidental death benefits;

d. Any additional reserves which may be required by the Commissioner consistent with applicable customary and general practice in insurance accounting;

(4) As to health insurance policies, the reserves required under § 1108 of this title;

(5) With reference to insurance other than specified in paragraphs (3) and (4) of this section above, and other than title insurance, the amount of the unearned premium reserves computed in accordance with this subchapter;

(6) Taxes, expenses and other obligations due or accrued at the date of the statement;

(7) With respect to an insurance division of a bank or trust company established pursuant to § 767(a) of Title 5, only those liabilities enumerated in this section which are entered on the separate and distinct financial records of such department or division.

(18 Del. C. 1953, § 1103; 56 Del. Laws, c. 380, § 1; 67 Del. Laws, c. 223, §§ 23, 24.)

§ 1104. Reserves of domestic insurers transacting business in foreign countries only.

A domestic insurer transacting insurance in foreign countries only, and not transacting insurance in any state as defined in § 103 of this title, may calculate its reserves on insurance written in each foreign jurisdiction in accordance with the reserve standards required by such jurisdiction; and negotiation and issuance of insurance on subjects of insurance resident, located or to be performed in such foreign jurisdiction, and changes in, communications concerning, and collection of premiums on insurance so issued shall not be deemed to constitute the transaction of insurance in any such state.

(18 Del. C. 1953, § 1104; 56 Del. Laws, c. 380, § 1.)

§ 1105. Disallowance of “wash” transactions.

(a) The Commissioner shall disallow as an asset or as a credit against liabilities any reinsurance found by him or her after a hearing thereon to have been arranged for the purpose principally of deception as to the ceding insurer’s financial condition as at the date of any

financial statement of the insurer. Without limiting the general purport of the foregoing provision, reinsurance of any substantial part of the insurer's outstanding risks contracted for in fact within 4 months prior to the date of any such financial statement and cancelled in fact within 4 months after the date of such statement, or reinsurance under which the reinsurer bears no substantial insurance risk or chance of net loss to itself, shall prima facie be deemed to have been arranged principally for the purpose of deception.

(b) The Commissioner shall disallow as an asset any deposit, funds or other assets of the insurer found by him or her after a hearing thereon:

(1) Not to be in good faith the property of the insurer; and

(2) Not freely subject to withdrawal or liquidation by the insurer at any time for the payment or discharge of claims or other obligations arising under its policies; and

(3) To be resulting from arrangements made principally for the purpose of deception as to the insurer's financial condition as at the date of any financial statement of the insurer.

(c) The Commissioner may suspend or revoke the certificate of authority of any insurer which has knowingly been a party to any such deception or attempt thereat.

(18 Del. C. 1953, § 1105; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 1106. Unearned premium reserve.

(a) As to property, casualty and surety insurance the insurer shall maintain an unearned premium reserve on all policies in force.

(b) Except as provided in § 1107 of this title as to marine and transportation risks, the unearned premium shall be equal to the unearned portion of gross premiums in force (after deduction of applicable reinsurance in solvent insurers) computed on an annual, monthly or more frequently pro rata basis.

(18 Del. C. 1953, § 1106; 56 Del. Laws, c. 380, § 1.)

§ 1107. Unearned premium reserve for marine and transportation insurance.

As to marine and transportation insurance, the entire amount of premiums on trip risks not terminated shall be deemed unearned, and the Commissioner may require the insurer to carry a reserve equal to 100% of premiums on trip risks written during the month ended as of the date of statement.

(18 Del. C. 1953, § 1107; 56 Del. Laws, c. 380, § 1.)

§ 1108. Health insurance policy reserves.

For all health insurance policies the insurer shall maintain an active life reserve which shall place a sound value on its liabilities under such policies and be not less than the reserve according to appropriate standards set forth in regulations issued by the Commissioner and, in no event, less in the aggregate than the pro rata gross unearned premiums for such policies.

(18 Del. C. 1953, § 1108; 56 Del. Laws, c. 380, § 1.)

§ 1109. Title insurance reserves.

In addition to an adequate reserve as to outstanding losses as required under § 1103 of this title, a title insurer shall maintain a guaranty fund or unearned premium reserve of not less than an amount computed as follows:

(1) Ten percent of the total amount of the risk portion of premiums written in the calendar year for title insurance contracts shall be assigned originally to the reserve;

(2) During each of the 20 years next following the year in which the title insurance contract was issued, the reserve applicable to the contract may be reduced by 5% of the original amount of such reserve.

(18 Del. C. 1953, § 1109; 56 Del. Laws, c. 380, § 1.)

§ 1110. Mortgage guaranty contingency reserve.

Casualty or surety insurers insuring real property mortgage lenders against loss by reason of nonpayment of the mortgage indebtedness by the borrower shall maintain a contingency reserve for the protection of policyholders against the effects of adverse economic cycles.

(18 Del. C. 1953, § 1110; 56 Del. Laws, c. 380, § 1; 74 Del. Laws, c. 214, § 5.)

Subchapter III

Life Insurance Reserves

§ 1111. Title and definitions.

(a) This subchapter III shall be known as the "Standard Valuation Law" (the "Act").

(b) For purposes of the Act, the following definitions shall apply on or after the operative date of the valuation manual:

(1) "Accident and health insurance" means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

(2) "Appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in § 1113(b) of this title.

(3) "Company" means an entity, which (A) has written, issued, or reinsured life insurance contracts, accident and health insurance contracts or deposit-type contracts in this State and has at least 1 such policy in force or on claim or (B) has written, issued or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance or deposit-type contracts in this State.

(4) "Deposit-type contract" means contracts that do not incorporate mortality or morbidity risks and as may be specified in the valuation manual.

(5) "Life insurance" means contracts that incorporate mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.

(6) "NAIC" means the National Association of Insurance Commissioners.

(7) "Policyholder behavior" means any action a policyholder, contract holder or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this Act including, but not limited to, lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

(8) "Principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and is required to comply with § 1122 of this title as specified in the valuation manual.

(9) "Qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements and who meets the requirements specified in the valuation manual.

(10) "Tail risk" means a risk that occurs either where the frequency of low probability events is higher than expected under a normal probability distribution or where there are observed events of very significant size or magnitude.

(11) "Valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in this Act or as subsequently amended.

(80 Del. Laws, c. 117, § 1.)

§ 1112. Reserve valuation.

(a) *Policies and contracts issued prior to the operative date of the valuation manual.* — (1) The Commissioner shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurance company doing business in this state issued on or after 1968 and prior to the operative date of the valuation manual, except that in the case of an alien insurer such valuation shall be limited to its insurance transactions in the United States. In calculating reserves, the Commissioner may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves required of a foreign or alien company, the Commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this Act.

(2) The provisions set forth in §§ 1114, 1114A, 1114B, 1115, 1115A, 1116, 1117, 1118, 1119, and 1120 of this title shall apply to all policies and contracts, as appropriate, subject to this Act issued on or after 1968 and prior to the operative date of the valuation manual and the provisions set forth in §§ 1121 and 1122 of this title shall not apply to any such policies and contracts.

(3) The minimum standard for the valuation of policies and contracts issued prior to 1968 shall be that provided by the laws in effect immediately prior to that date.

(b) *Policies and contracts issued on or after the operative date of the valuation manual.* — (1) The Commissioner shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life insurance contracts, annuity and pure endowment contracts, accident and health contracts, and deposit-type contracts of every company issued on or after the operative date of the valuation manual. In lieu of the valuation of the reserves required of a foreign or alien company, the Commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this Act.

(2) The provisions set forth in §§ 1121 and 1122 of this title shall apply to all policies and contracts issued on or after the operative date of the valuation manual.

(80 Del. Laws, c. 117, § 1.)

§ 1113. Actuarial opinions of reserves.

(a) *Actuarial opinion prior to the operative date of the valuation manual.* — (1) *General.* — Every life insurance company doing business in this State shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the Commissioner by regulation are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this State. The Commissioner shall define by regulation the specifics of this opinion and add any other items deemed to be necessary to its scope.

(2) *Actuarial analysis of reserves and assets supporting reserves.* — (A) Every life insurance company, except as exempted by regulation, shall also annually include in the opinion required by paragraph (a)(1) of this section, an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the Commissioner

by regulation, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

(B) The Commissioner may provide by regulation for a transition period for establishing any higher reserves that the qualified actuary may deem necessary in order to render the opinion required by this section.

(3) *Requirement for opinion under paragraph (a)(2) of this section.* — Each opinion required by paragraph (a)(2) of this section shall be governed by the following provisions:

(A) A memorandum, in form and substance acceptable to the Commissioner as specified by regulation, shall be prepared to support each actuarial opinion.

(B) If the insurance company fails to provide a supporting memorandum at the request of the Commissioner within a period specified by regulation or the Commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the regulations or is otherwise unacceptable to the Commissioner, the Commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the Commissioner.

(4) *Requirement for all opinions subject to subsection (a) of this section.* — Every opinion required by subsection (a) of this section shall be governed by the following provisions:

(A) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, 2014.

(B) The opinion shall apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the Commissioner as specified by regulation.

(C) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on such additional standards as the Commissioner may by regulation prescribe.

(D) In the case of an opinion required to be submitted by a foreign or alien company, the Commissioner may accept the opinion filed by that company with the insurance supervisory official of another State if the Commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this State.

(E) For the purposes of this section, "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirements set forth in the regulation.

(F) Except in cases of fraud or wilful misconduct, the qualified actuary shall not be liable for damages to any person (other than the insurance company and the Commissioner) for any act, error, omission, decision or conduct with respect to the actuary's opinion.

(G) Disciplinary action by the Commissioner against the company or the qualified actuary shall be defined in regulations by the Commissioner.

(H) Except as provided in paragraphs (a)(4)(L), (M) and (N) of this section, documents, materials or other information in the possession or control of the Department of Insurance that are a memorandum in support of the opinion, and any other material provided by the company to the Commissioner in connection with the memorandum, shall be confidential by law and privileged, shall not be subject to this State's Freedom of Information Act (Chapter 100 of Title 29), shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties.

(I) Neither the Commissioner nor any person who received documents, materials or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to paragraph (a)(4)(H) of this section.

(J) In order to assist in the performance of the Commissioner's duties, the Commissioner:

(i) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to paragraph (a)(4)(H) of this section with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal and international law-enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(ii) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law-enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(iii) May enter into agreements governing sharing and use of information consistent with paragraphs (a)(4)(H) to (J) of this section.

(K) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in paragraph (a)(4)(J) of this section.

(L) A memorandum in support of the opinion, and any other material provided by the company to the Commissioner in connection with the memorandum, may be subject to subpoena for the purpose of defending an action seeking damages from the actuary submitting the memorandum by reason of an action required by this section or by regulations promulgated hereunder.

(M) The memorandum or other material may otherwise be released by the Commissioner with the written consent of the company or to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the Commissioner for preserving the confidentiality of the memorandum or other material.

(N) Once any portion of the confidential memorandum is cited by the company in its marketing or is cited before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of the confidential memorandum shall be no longer confidential.

(b) *Actuarial opinion of reserves after the operative date of the valuation manual.* — (1) *General.* — Every company with outstanding life insurance contracts, accident and health insurance contracts or deposit-type contracts in this State and subject to regulation by the Commissioner shall annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this State. The valuation manual will prescribe the specifics of this opinion including any items deemed to be necessary to its scope.

(2) *Actuarial analysis of reserves and assets supporting reserves.* — Every company with outstanding life insurance contracts, accident and health insurance contracts or deposit-type contracts in this State and subject to regulation by the Commissioner, except as exempted in the valuation manual, shall also annually include in the opinion required by paragraph (b)(1) of this section, an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

(3) *Requirements for opinions subject to paragraph (b)(2) of this section.* — Each opinion required by paragraph (b)(2) of this section shall be governed by the following provisions:

(A) A memorandum, in form and substance as specified in the valuation manual, and acceptable to the Commissioner, shall be prepared to support each actuarial opinion.

(B) If the insurance company fails to provide a supporting memorandum at the request of the Commissioner within a period specified in the valuation manual or the Commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the Commissioner, the Commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the Commissioner.

(4) *Requirement for all opinions subject to this subsection (b).* — Every opinion shall be governed by the following provisions:

(A) The opinion shall be in form and substance as specified in the valuation manual and acceptable to the Commissioner.

(B) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after the operative date of the valuation manual.

(C) The opinion shall apply to all policies and contracts subject to paragraph (b)(2) of this section, plus other actuarial liabilities as may be specified in the valuation manual.

(D) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board or its successor, and on such additional standards as may be prescribed in the valuation manual.

(E) In the case of an opinion required to be submitted by a foreign or alien company, the Commissioner may accept the opinion filed by that company with the insurance supervisory official of another State if the Commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this State.

(F) Except in cases of fraud or wilful misconduct, the appointed actuary shall not be liable for damages to any person (other than the insurance company and the Commissioner) for any act, error, omission, decision or conduct with respect to the appointed actuary's opinion.

(G) Disciplinary action by the Commissioner against the company or the appointed actuary shall be defined in regulations by the Commissioner.

(80 Del. Laws, c. 117, § 1.)

§ 1114. Computation of minimum standard.

Except as provided in §§ 1114A, 1114B and 1120 of this title, the minimum standard for the valuation of policies and contracts issued prior to 1968, shall be that provided by the laws in effect immediately prior to 1968. Except as otherwise provided in §§ 1114A, 1114B and

1120 of this title, the minimum standard for the valuation of all policies and contracts issued on or after 1968 shall be the Commissioners reserve valuation methods defined in §§ 1115, 1115A, 1118 and 1120 of this title, $3^1/_2$% interest, or in the case of life insurance policies and contracts, other than annuity and pure endowment contracts, issued on or after June 21, 1973, 4% interest for policies issued prior to July 8, 1980, and $4^1/_2$% interest for all other policies issued on and after July 8, 1980, and the following tables:

(a) For ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in the policies: the Commissioners 1941 Standard Ordinary Mortality Table for policies issued prior to the operative date of § 2929(e) of this title, the Commissioners 1958 Standard Ordinary Mortality Table for policies issued on or after the operative date of § 2929(e) of this title and prior to the operative date of § 2929(g) of this title, provided that for any category of policies issued on female risks, all modified net premiums and present values referred to in this Act may be calculated according to an age not more than 6 years younger than the actual age of the insured; and for policies issued on or after the operative date of § 2929(g) of this title:

(1) The Commissioners 1980 Standard Ordinary Mortality Table;

(2) At the election of the company for any 1 or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; or

(3) Any ordinary mortality table, adopted after 1980 by the NAIC, which is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for such policies;

(b) For industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in the policies: the 1941 Standard Industrial Mortality Table for policies issued prior to the operative date of § 2929(f) of this title, and for policies issued on or after the operative date of § 2929(f) of this title, the Commissioners 1961 Standard Industrial Mortality Table or any industrial mortality table adopted after 1980 by the NAIC that is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for the policies;

(c) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in the policies: the 1937 Standard Annuity Mortality Table, or at the option of the company, the Annuity Mortality Table for 1949, Ultimate, or any modification of either of these tables approved by the Commissioner;

(d) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in the policies: (i) the Group Annuity Mortality Table for 1951 or any modification of the table approved by the Commissioner, (ii) at the option of the company, the 1971 Group Annuity Mortality Table or any modification of such table approved by the Commissioner in which event 5% interest shall be used in determining the minimum standard for the valuation of such contracts, or (iii) at the option of the company, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts;

(e) For total and permanent disability benefits in or supplementary to ordinary policies or contracts: for policies or contracts issued on or after January 1, 1966, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates adopted after 1980 by the NAIC, that are approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for those policies; for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either those tables or, at the option of the company, the Class (3) Disability Table (1926); and for policies issued prior to January 1, 1961, the Class (3) Disability Table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies;

(f) For accidental death benefits in or supplementary to policies issued on or after January 1, 1966: the 1959 Accidental Death Benefits Table or any accidental death benefits table adopted after 1980 by the NAIC that is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for those policies, for policies issued on or after January 1, 1961, and prior to January 1, 1966, either that table or, at the option of the company, the Inter-Company Double Indemnity Mortality Table; and for policies issued prior to January 1, 1961, the Inter-Company Double Indemnity Mortality Table. Either table shall be combined with a mortality table for calculating the reserves for life insurance policies; and

(g) For group life insurance, life insurance issued on the substandard basis and other special benefits: tables approved by the Commissioner.

(80 Del. Laws, c. 117, § 1.)

§ 1114A. Computation of minimum standards for annuities.

(a) Except as provided in § 1114B of this title, the minimum standard of valuation for individual annuity and pure endowment contracts issued on or after the operative date of this section and for annuities and pure endowments purchased on or after the operative date under group annuity and pure endowment contracts, shall be the Commissioners reserve valuation methods defined in §§ 1115 and 1115A of this title and the following tables and interest rates:

(1) For individual annuity and pure endowment contracts issued prior to July 8, 1980, excluding any disability and accidental death benefits in those contracts: the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the Commissioner, and 6% interest for single premium immediate annuity contracts and 4% interest for all other individual annuity and pure endowment contracts;

(2) For individual single premium immediate annuity contracts issued on or after July 8, 1980, excluding any disability and accidental death benefits in those contracts: the 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980 by the NAIC that is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for these contracts, or any modification of these tables approved by the Commissioner, and $7^1/_2$% interest;

(3) For individual annuity and pure endowment contracts issued on or after July 8, 1980, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in those contracts: the 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980 by the NAIC, that is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for those contracts, or any modification of these tables approved by the Commissioner, and $5^1/_2$% interest for single premium deferred annuity and pure endowment contracts and $4^1/_2$% interest for all other individual annuity and pure endowment contracts;

(4) For annuities and pure endowments purchased prior to July 8, 1980, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under those contracts: the 1971 Group Annuity Mortality Table or any modification of this table approved by the Commissioner, and 6% interest; and

(5) For annuities and pure endowments purchased on or after July 8, 1980, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under those contracts: the 1971 Group Annuity Mortality Table, or any group annuity mortality table adopted after 1980 by the NAIC that is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for annuities and pure endowments, or any modification of these tables approved by the Commissioner, and $7^1/_2$% interest;

(b) After June 21, 1973, any company may file with the Commissioner a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1979, which shall be the operative date of this section for that company, provided that a company may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If a company makes no election, the operative date of this section for that company shall be January 1, 1979.

(80 Del. Laws, c. 117, § 1.)

§ 1114B. Computation of minimum standard by calendar year of issue.

(a) The interest rates used in determining the minimum standard for the valuation of the following shall be the calendar year statutory valuation interest rates as defined in this section:

(1) Life insurance policies issued in a particular calendar year, on or after the operative date of § 2929(g) of this title;

(2) Individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1984;

(3) Annuities and pure endowments purchased in a particular calendar year on or after January 1, 1984, under group annuity and pure endowment contracts; and

(4) The net increase, if any, in a particular calendar year after January 1, 1984, in amounts held under guaranteed interest contracts.

(b) *Calendar year statutory valuation interest rates.* — (1) The calendar year statutory valuation interest rates, *I*, shall be determined as follows and the results rounded to the nearer ¼ of 1%

(A) For life insurance:

$I = .03 + W (R 1 - .03) + W / 2 (R 2 - .09)$

(B) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options:

$I = .03 + W (R - .03)$

Where R_1 is the lesser of *R* and .09, R_2 is the greater of *R* and .09, *R* is the reference interest rate defined in this section, and is the weighting factor defined in this section;

(C) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in paragraph (b)(1)(B) of this section, the formula for life insurance stated in paragraph (b)(1)(A) of this section shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of 10 years and the formula for single premium immediate annuities stated in paragraph (b)(1)(B) of this section shall apply to annuities and guaranteed interest contracts with guarantee duration of 10 years or less;

(D) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in paragraph (b)(1)(B) of this section shall apply.

(E) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in paragraph (b)(1)(B) of this section shall apply.

(2) However, if the calendar year statutory valuation interest rate for a life insurance policy issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than $^1/_2$ of 1%, the calendar year statutory valuation interest rate for the life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding

sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980 (using the reference interest rate defined in 1979) and shall be determined for each subsequent calendar year regardless of when § 2929(g) of this title becomes operative.

(c) *Weighting factors.* — (1) The weighting factors referred to in the formulas stated above are given in the following tables:

(A) Weighting factors for life insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy;

(B) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options: .80.

(C) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in paragraph (c)(1)(B) of this section, shall be as specified in paragraphs (c)(1)(C)(i), (ii) and (iii) of this section below, according to the rules and definitions in paragraphs (c)(1)(C)(iv), (v) and (vi) of this section below:

(i) For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration	Weighting for Plan Type		
(Years)	A	B	C
5 or less:	.80	.60	.50
More than 5, but not more than 10:	.75	.60	.50
More than 10, but not more than 20:	.65	.50	.45
More than 20:	.45	.35	.35

(ii) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in paragraph (c)(1)(C)(i) of this section above increased by:

Plan Type	A	B	C
	.15	.25	.05

(iii) For annuities and guaranteed interest contracts valued on an issue year basis (other than those with no cash settlement options) that do not guarantee interest on considerations received more than 1 year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis that do not guarantee interest rates on considerations received more than 12 months beyond the valuation date, the factors shown in paragraph (c)(1)(C)(i) of this section or derived in paragraph (c)(1)(C)(ii) of this section increased by:

Plan Type	A	B	C
	.05	.05	.05

(iv) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of 20 years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guaranteed duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(v) "Plan type" as used in the above tables is defined as follows:

Plan type A: — At any time policyholder may withdraw funds only (1) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) without an adjustment but installments over 5 years or more, or (3) as an immediate life annuity, or (4) no withdrawal permitted.

Plan type B: — Before expiration of the interest rate guarantee, policyholder may withdraw funds only (1) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) without an adjustment but in installments over 5 years or more, or (3) no withdrawal permitted. At the end of interest rate guarantee, funds may be withdrawn without an adjustment in a single sum or installments over less than 5 years.

Plan type C: — Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than 5 years either (1) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(vi) A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. As used in this section, an "issue year basis of valuation" refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and the change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

(d) *Reference interest rate.* — (1) The reference interest rate referred to in subsection (b) of this section shall be defined as follows:

(A) For life insurance, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year preceding the year of issue, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(B) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or year of purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(C) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in paragraph (d)(1)(B) of this section, with guarantee duration in excess of 10 years, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(D) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in paragraph (d)(1)(B) of this section, with guarantee duration of 10 years or less, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(E) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(F) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in paragraph (d)(1)(B) of this section, the average over a period of 12 months, ending on June 30 of the calendar year of the change in the fund, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(e) *Alternative method for determining reference interest rates.* — In the event that the monthly average of the composite yield on seasoned corporate bonds is no longer published by Moody's Investors Service, Inc. or in the event that the NAIC determines that the monthly average of the composite yield on seasoned corporate bonds as published by Moody's Investors Service, Inc. is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate adopted by the NAIC and approved by regulation promulgated by the Commissioner may be substituted.

(80 Del. Laws, c. 117, § 1.)

§ 1115. Reserve valuation method—Life insurance and endowment benefits.

(a) Except as otherwise provided in §§ 1115A, 1118 and 1120 of this title, reserves according to the Commissioners reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums shall be the excess, if any, of the present value, at the date of valuation, of the future guaranteed benefits provided for by those policies, over the then present value of any future modified net premiums therefor. The modified net premiums for a policy shall be the uniform percentage of the respective contract premiums for the benefits such that the present value, at the date of issue of the policy, of all modified net premiums shall be equal to the sum of the then present value of the benefits provided for by the policy and the excess of (1) over (2), as follows:

(1) A net level annual premium equal to the present value, at the date of issue, of the benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of 1 per annum payable on the first and each subsequent anniversary of

the policy on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the 19-year premium whole life plan for insurance of the same amount at an age 1 year higher than the age at issue of the policy.

(2) A net 1-year term premium for the benefits provided for in the first policy year.

(b) For a life insurance policy issued on or after January 1, 1987, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for the excess and which provides an endowment benefit or a cash surrender value or a combination in an amount greater than the excess premium, the reserve according to the Commissioners reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than the excess premium shall, except as otherwise provided in § 1118 of this title, be the greater of the reserve as of the policy anniversary calculated as described in the preceding paragraph and the reserve as of the policy anniversary calculated as described in that paragraph, but with (i) the value defined in subsection (a) of this section being reduced by 15% of the amount of such excess first year premium, (ii) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date, (iii) the policy being assumed to mature on that date as an endowment, and (iv) the cash surrender value provided on that date being considered as an endowment benefit. In making the above comparison the mortality and interest bases stated in §§ 1114 and 1114B of this title shall be used.

(c) Reserves according to the Commissioners reserve valuation method shall be calculated by a method consistent with the principles of the preceding paragraphs of this section for:

(1) Life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums;

(2) Group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under § 408 of the Internal Revenue Code [26 U.S.C. § 408], as now or hereafter amended;

(3) Disability and accidental death benefits in all policies and contracts; and

(4) All other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, shall be calculated by a method consistent with the principles of the preceding paragraphs of the subsection,

(5) Notwithstanding the paragraphs in this subsection, any extra premiums charged because of impairments or special hazards shall be disregarded in the determination of modified net premiums.

(80 Del. Laws, c. 117, § 1.)

§ 1115A. Reserve valuation method—Annuity and pure endowment benefits.

(a) This section shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under § 408 of the Internal Revenue Code [26 U.S.C. § 408], as now or hereafter amended.

(b) Reserves according to the Commissioners annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in the contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by the contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of the contract, that become payable prior to the end of the respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate, or rates, specified in the contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of the contracts to determine nonforfeiture values.

(80 Del. Laws, c. 117, § 1.)

§ 1116. Minimum reserves.

(a) In no event shall a company's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued on or after 1968, be less than the aggregate reserves calculated in accordance with the methods set forth in §§ 1115, 1115A, 1118 and 1119 of this title and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for the policies.

(b) In no event shall the aggregate reserves for all policies, contracts, and benefits be less than the aggregate reserves determined by the appointed actuary to be necessary to render the opinion required by § 1113 of this title.

(80 Del. Laws, c. 117, § 1.)

§ 1117. Optional reserve calculation.

(a) Reserves for any category of policies, contracts, or benefits as established by the Commissioner, issued prior to 1968, may be calculated, at the option of the company, according to any standards that produce greater aggregate reserves for all such policies and contracts than the minimum reserves required by the laws in effect immediately prior to that date.

(b) Reserves for any category of policies, contracts or benefits established by the commissioner, issued on or after 1968, may be calculated, at the option of the company, according to any standards that produce greater aggregate reserves for the category than those calculated according to the minimum standard provided herein, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be greater than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided in the policies or contracts.

(c) A company, which adopts at any time a standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided under this Act, may adopt a lower standard of valuation with the approval of the Commissioner, but not lower than the minimum provided herein; provided that, for the purposes of this section, the holding of additional reserves previously determined by the appointed actuary to be necessary to render the opinion required by § 1113 of this title shall not be deemed to be the adoption of a higher standard of valuation.

(80 Del. Laws, c. 117, § 1.)

§ 1118. Reserve calculation—Valuation net premium exceeding the gross premium charged.

(a) If in any contract year the gross premium charged by a company on a policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for the policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for the policy or contract, or the reserve calculated by the method actually used for the policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in §§ 1114 and 1114B of this title.

(b) Provided, that for a life insurance policy issued on or after January 1, 1987, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for the excess and which provides an endowment benefit or a cash surrender value or a combination in an amount greater than the excess premium, the provisions of this section shall be applied as if the method actually used in calculating the reserve for the policy were the method described in § 1115 of this title, ignoring the second paragraph of § 1115 of this title. The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with § 1115 of this title, including the second paragraph of that section, and the minimum reserve calculated in accordance with this section.

(80 Del. Laws, c. 117, § 1.)

§ 1119. Reserve calculation—Indeterminate premium plans.

(a) In the case of a plan of life insurance that provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of a plan of life insurance or annuity that is of such a nature that the minimum reserves cannot be determined by the methods described in §§ 1115, 1115A and 1118 of this title, the reserves that are held under the plan shall:

(1) Be appropriate in relation to the benefits and the pattern of premiums for that plan; and

(2) Be computed by a method that is consistent with the principles of this Standard Valuation Law, as determined by regulations promulgated by the Commissioner.

(b) Notwithstanding any other provision in the laws of this State, a policy, contract, or certificate providing life insurance under such a plan shall be affirmatively approved by the Commissioner before it can be marketed, issued, delivered, or used in this State.

(80 Del. Laws, c. 117, § 1.)

§ 1120. Minimum standard for accident and health insurance contracts.

For accident and health insurance contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under § 1112(b) of this title. For disability, accident and sickness, accident and health insurance contracts issued on or after 1968 and prior to the operative date of the valuation manual the minimum standard of valuation is the standard adopted by the Commissioner by regulation.

(80 Del. Laws, c. 117, § 1.)

§ 1121. Valuation manual for policies issued on or after the operative date of the valuation manual.

(a) For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under § 1112(b) of this title, except as provided under subsection (e) or (g) of this section.

(b) The operative date of the valuation manual is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

(1) The valuation manual has been adopted by the NAIC by an affirmative vote of at least 42 members, or $^{3}/_{4}$ of the members voting, whichever is greater.

(2) The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by States representing greater than 75% of the direct premiums written as reported in the following annual statements submitted for 2008: life, accident and health annual statements; health annual statements; or fraternal annual statements.

(3) The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least 42 of the following 55 jurisdictions: The 50 States of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam, and Puerto Rico.

(c) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual shall be effective on January 1 following the date when all of the following have occurred:

(1) The change to the valuation manual has been adopted by the NAIC by an affirmative vote representing:

(A) At least $^{3}/_{4}$ of the members of the NAIC voting, but not less than a majority of the total membership; and

(B) Members of the NAIC representing jurisdictions totaling greater than 75% of the direct premiums written as reported in the following annual statements most recently available prior to the vote in paragraph (c)(1)(A) of this section: life, accident and health annual statements, health annual statements, or fraternal annual statements.

(2) The valuation manual becomes effective pursuant to a regulation adopted by the Commissioner.

(d) The valuation manual must specify all of the following:

(1) Minimum valuation standards for and definitions of the policies or contracts subject to § 1112(b) of this title. Such minimum valuation standards shall be:

(A) The Commissioners reserve valuation method for life insurance contracts, other than annuity contracts, subject to § 1112(b) of this title;

(B) The Commissioners annuity reserve valuation method for annuity contracts subject to § 1112(b) of this title; and

(C) Minimum reserves for all other policies or contracts subject to § 1112(b) of this title.

(2) Which policies or contracts or types of policies or contracts that are subject to the requirements of a principle-based valuation in § 1122(a) of this title and the minimum valuation standards consistent with those requirements;

(3) For policies and contracts subject to a principle-based valuation under § 1122 of this title:

(A) Requirements for the format of reports to the Commissioner under § 1122(b)(3) of this title and which shall include information necessary to determine if the valuation is appropriate and in compliance with this Act;

(B) Assumptions shall be prescribed for risks over which the company does not have significant control or influence.

(C) Procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of such procedures.

(4) For policies not subject to a principle-based valuation under § 1122 of this title the minimum valuation standard shall either:

(A) Be consistent with the minimum standard of valuation prior to the operative date of the valuation manual; or

(B) Develop reserves that quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring.

(5) Other requirements, including, but not limited to, those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules and internal controls; and

(6) The data and form of the data required under § 1123 of this title, with whom the data must be submitted, and may specify other requirements including data analyses and reporting of analyses.

(e) In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is not, in the opinion of the Commissioner, in compliance with this Act, then the company shall, with respect to such requirements, comply with minimum valuation standards prescribed by the Commissioner by regulation.

(f) The Commissioner may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in this Act. The Commissioner may rely upon the opinion, regarding provisions contained within this Act, of a qualified actuary engaged by the Commissioner of another State, district or territory of the United States. As used in this paragraph, the term "engage" includes employment and contracting.

(g) The Commissioner may require a company to change any assumption or method that in the opinion of the Commissioner is necessary in order to comply with the requirements of the valuation manual or this Act; and the company shall adjust the reserves as required by the Commissioner. The Commissioner may take other disciplinary action as permitted pursuant to this title.

(80 Del. Laws, c. 117, § 1.)

§ 1122. Requirements of a principle-based valuation.

(a) A company must establish reserves using a principle-based valuation that meets the following conditions for policies or contracts as specified in the valuation manual:

(1) Quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. For polices or contracts with significant tail risk, reflects conditions appropriately adverse to quantify the tail risk.

(2) Incorporate assumptions, risk analysis methods and financial models and management techniques that are consistent with, but not necessarily identical to, those utilized within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods.

(3) Incorporate assumptions that are derived in 1 of the following manners:

(A) The assumption is prescribed in the valuation manual.

(B) For assumptions that are not prescribed, the assumptions shall:

(i) Be established utilizing the company's available experience, to the extent it is relevant and statistically credible; or

(ii) To the extent that company data is not available, relevant, or statistically credible, be established utilizing other relevant, statistically credible experience.

(4) Provide margins for uncertainty including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve.

(b) A company using a principle-based valuation for 1 or more policies or contracts subject to this section as specified in the valuation manual shall complete all of the following:

(1) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual.

(2) Provide to the Commissioner and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. Such controls shall be designed to assure that all material risks inherent in the liabilities and associated assets subject to such valuation are included in the valuation, and that valuations are made in accordance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year.

(3) Develop, and file with the Commissioner upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual.

(c) A principle-based valuation may include a prescribed formulaic reserve component.

(80 Del. Laws, c. 117, § 1.)

§ 1123. Experience reporting for policies in force on or after the operative date of the valuation manual.

A company shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual.

(80 Del. Laws, c. 117, § 1.)

§ 1124. Confidentiality.

(a) For purposes of this section, "confidential information" means all of the following:

(1) A memorandum in support of an opinion submitted under § 1113 of this this title and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the Commissioner or any other person in connection with such memorandum;

(2) All documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the Commissioner or any other person in the course of an examination made under § 1121(f) of this title; provided, however, that if an examination report or other material prepared in connection with an examination made under Chapter 3 of this title is not held as private and confidential information under Chapter 3 of this title, an examination report or other material prepared in connection with an examination made under § 1121(f) of this title shall not be confidential information to the same extent as if such examination report or other material had been prepared under Chapter 3 of this title;

(3) Any reports, documents, materials and other information developed by a company in support of, or in connection with, an annual certification by the company under § 1122(b)(2) of this title evaluating the effectiveness of the company's internal controls with respect to a principle-based valuation and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the Commissioner or any other person in connection with such reports, documents, materials and other information;

(4) Any principle-based valuation report developed under § 1122(b)(3) of this title and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the Commissioner or any other person in connection with such report; and

(5) Any documents, materials, data and other information submitted by a company under § 1123 of this title (collectively "experience data") and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies thereof, created or produced in connection with such experience data, in each case that include any potentially company-identifying

or personally identifiable information, that is provided to or obtained by the Commissioner (together with any experience data, the "experience materials") and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the Commissioner or any other person in connection with such experience materials.

(b) *Privilege for, and confidentiality of, confidential information.* — (1) Except as provided in this section, a company's confidential information is confidential by law and privileged, and shall not be subject to this State's Freedom of Information Act (Chapter 100 of Title 29), shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action; provided, however, that the Commissioner is authorized to use the confidential information in the furtherance of any regulatory or legal action brought against the company as a part of the Commissioner's official duties.

(2) Neither the Commissioner nor any person who received confidential information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential information.

(3) In order to assist in the performance of the Commissioner's duties, the Commissioner may share confidential information:

(A) With other state, federal and international regulatory agencies and with the NAIC and its affiliates and subsidiaries; and

(B) In the case of confidential information specified in paragraphs (a)(1) and (a)(4) of this section only, with the Actuarial Board for Counseling and Discipline or its successor upon request stating that the confidential information is required for the purpose of professional disciplinary proceedings and with state, federal and international law enforcement officials; in the case of paragraph (b)(3)(A) of this section and this paragraph (b)(3)(B), provided that such recipient agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of such documents, materials, data and other information in the same manner and to the same extent as required for the Commissioner.

(4) The Commissioner may receive documents, materials, data and other information, including otherwise confidential and privileged documents, materials, data or information, from the NAIC and its affiliates and subsidiaries, from regulatory or law-enforcement officials of other foreign or domestic jurisdictions and from the Actuarial Board for Counseling and Discipline or its successor and shall maintain as confidential or privileged any document, material, data or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or other information.

(5) The Commissioner may enter into agreements governing sharing and use of information consistent with this subsection (b) of this section.

(6) No waiver of any applicable privilege or claim of confidentiality in the Confidential Information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in paragraph (b)(3) of this section.

(7) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection (b) shall be available and enforced in any proceeding in, and in any court of, this State.

(8) For purposes of this section, "regulatory agency," "law-enforcement agency" and the "NAIC" include, but are not limited to, their employees, agents, consultants and contractors.

(c) Notwithstanding subsection (b) of this section, any confidential information specified in paragraphs (a)(1) and (a)(4) of this section:

(1) May be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under § 1113 of this title or principle-based valuation report developed under § 1122(b)(3) of this title by reason of an action required by this Act or by regulations promulgated hereunder;

(2) May otherwise be released by the Commissioner with the written consent of the company; and

(3) Once any portion of a memorandum in support of an opinion submitted under § 1113 of this title or a principle-based valuation report developed under § 1122(b)(3) of this title is cited by the company in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of such memorandum or report shall no longer be confidential.

(80 Del. Laws, c. 117, § 1.)

§ 1125. Single state exemption.

(a) The Commissioner may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in the State of Delaware from the requirements of § 1121 of this title, provided:

(1) The Commissioner has issued an exemption in writing to the company and has not subsequently revoked the exemption in writing; and

(2) The company computes reserves using assumptions and methods used prior to the operative date of the valuation manual in addition to any requirements established by the Commissioner and promulgated by regulation.

(b) For any company granted an exemption under this section, §§ 1113, 1114, 1114A, 1114B, 1115, 1115A, 1116, 1117, 1118, 1119 and 1120 of this title shall be applicable. With respect to any company applying this exemption, any reference to § 1121 of this title found in §§ 1113, 1114, 1114A, 1114B, 1115, 1115A, 1116, 1117, 1118, 1119 and 1120 of this title shall not be applicable.

(80 Del. Laws, c. 117, § 1.)

§ 1126. Effective date.

All acts and parts of acts inconsistent with the provisions of this Act are hereby repealed as of 1968. This Act shall take effect as of 1968.

(80 Del. Laws, c. 117, § 1.)

Subchapter IV

Valuation of Assets

§ 1127. Valuation of bonds.

(a) All bonds or other evidences of debt having a fixed term and rate of interest held by an insurer may, if amply secured and not in default as to principal or interest, be valued as follows:

(1) If purchased at par, at the par value;

(2) If purchased above or below par, on the basis of the purchase price adjusted so as to bring the value to par at maturity and so as to yield in the meantime the effective rate of interest at which the purchase was made, or in lieu of such method, according to such accepted method of valuation as is approved by the Commissioner;

(3) Purchase price shall in no case be taken at a higher figure than the actual market value at the time of purchase, plus actual brokerage, transfer, postage or express charges paid in the acquisition of such securities;

(4) Unless otherwise provided by valuation established or approved by the Commissioner, no such security shall be carried at above the call price for the entire issue during any period within which the security may be so called.

(b) Notwithstanding any other provision of this section, no bond or other evidence of debt shall be valued in excess of the value established by the National Association of Insurance Commissioners' Capital Markets and Investment Analysis Office.

(18 Del. C. 1953, § 1114; 56 Del. Laws, c. 380, § 1; 69 Del. Laws, c. 92, § 4; 80 Del. Laws, c. 117, § 2; 83 Del. Laws, c. 184, § 3.)

§ 1128. Valuation of other securities.

(a) Securities, other than those referred to in § 1127 of this title, held by an insurer shall be valued, in the discretion of the Commissioner, at their market value, or at their appraised value, or at prices determined by the Commissioner as representing their fair market value.

(b) Preferred or guaranteed stocks or shares while paying full dividends may be carried at a fixed value in lieu of market value, at the discretion of the Commissioner and in accordance with such method of computation as he or she may approve.

(c) Notwithstanding any other provision of this section, securities shall be valued at prices established by the National Association of Insurance Commissioners' Capital Markets and Investment Analysis Office and in accordance with procedures established by the National Association of Insurance Commissioners.

(18 Del. C. 1953, § 1115; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, § 39; 68 Del. Laws, c. 48, § 1; 70 Del. Laws, c. 186, § 1; 80 Del. Laws, c. 117, § 2; 83 Del. Laws, c. 184, § 4.)

§ 1129. Valuation of property.

(a) Real property acquired pursuant to a mortgage loan or contract for sale, in the absence of a recent appraisal deemed by the Commissioner to be reliable, shall not be valued at an amount greater than the unpaid principal of the defaulted loan or contract plus interest due and accrued at the date of such acquisition, together with any taxes and expenses paid or incurred in connection with such acquisition, and the cost of improvements thereafter made by the insurer and any amounts thereafter paid by the insurer on assessments levied for improvements in connection with the property.

(b) Real property owned by an insurer shall be valued at cost plus capital improvements less depreciation. Such a value shall not be in excess of the NAIC accounting practices and procedures manual valuation nor in excess of fair market value as determined by a recent appraisal acceptable to the Commissioner. If the valuation is based on an appraisal more than 3 years old, the Commissioner may require a new appraisal to determine fair market value.

(18 Del. C. 1953, § 1116; 56 Del. Laws, c. 380, § 1; 69 Del. Laws, c. 92, § 5; 80 Del. Laws, c. 117, § 2.)

§ 1130. Valuation of purchase money mortgages.

Purchase money mortgages on real property referred to in § 1129(a) of this title shall be valued in an amount not exceeding the acquisition cost of the real property covered thereby or 90% of the fair value of such real property, whichever is less.

(18 Del. C. 1953, § 1117; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 117, § 2.)

Subchapter V

Property and Casualty Actuarial Opinion Law

§ 1131. Title.

This subchapter shall be known as the "Property and Casualty Actuarial Opinion Law of 2011."

(78 Del. Laws, c. 57, § 1; 80 Del. Laws, c. 117, § 2.)

§ 1132. Actuarial opinion of reserves and supporting documentation.

(a) This section shall become operative January 1, 2013.

(b) Every property and casualty insurance company doing business in Delaware, unless otherwise exempted by the Commissioner, shall annually submit to the Department of Insurance the opinion of an appointed actuary entitled "Statement of Actuarial Opinion." This opinion shall be filed in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions.

(c) Every property and casualty insurance company domiciled in Delaware that is required to submit a Statement of Actuarial Opinion shall annually submit an actuarial opinion summary, written by the company's appointed actuary. This actuarial opinion summary shall be filed in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions and shall be considered as a document supporting the actuarial opinion required in subsection (b) of this section.

(d) A company licensed but not domiciled in Delaware shall provide the actuarial opinion summary upon request.

(e) An actuarial report and underlying workpapers as required by the appropriate NAIC Property and Casualty Annual Statement Instructions shall be prepared to support each actuarial opinion.

(f) If the insurance company fails to provide a supporting actuarial report and/or workpapers at the request of the Commissioner or the Commissioner determines that the supporting actuarial report or workpapers provided by the insurance company are otherwise unacceptable to the Commissioner, the Commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting actuarial report or workpapers.

(g) The appointed actuary shall not be liable for damages to any person (other than the insurance company and the Commissioner) for any act, error, omission, decision or conduct with respect to the actuary's opinion, except in cases of fraud or wilful misconduct on the part of the appointed actuary.

(78 Del. Laws, c. 57, § 1; 80 Del. Laws, c. 117, § 2.)

§ 1133. Confidentiality.

(a) The Statement of Actuarial Opinion shall be provided with the annual statement in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions and shall be treated as a public document.

(b) (1) Documents, materials or other information in the possession or control of the Department of Insurance that are considered an actuarial report, workpapers or actuarial opinion summary provided in support of the opinion, and any other material provided by the company to the Commissioner in connection with the actuarial report, workpapers or actuarial opinion summary, shall be confidential by law and privileged, and, in accordance with § 10002(o)(2) of Title 29 shall be deemed to not be public records for purposes of the Delaware Freedom of Information Act [Chapter 100 of Title 29], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

(2) This provision shall not be construed to limit the Commissioner's authority to release the documents to the Actuarial Board for Counseling and Discipline (ABCD) so long as the material is required for the purpose of professional disciplinary proceedings and that the ABCD establishes procedures satisfactory to the Commissioner for preserving the confidentiality of the documents, nor shall this section be construed to limit the Commissioner's authority to use the documents, materials or other information in furtherance of any regulatory or legal action brought as part of the Commissioner's official duties.

(c) Neither the Commissioner nor any person who received documents, materials or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection (b) of this section.

(d) In order to assist in the performance of the Commissioner's duties, the Commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection (b) of this section with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal and international law-enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the documents, material or other information and has the legal authority to maintain confidentiality;

(2) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law-enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any documents, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the documents, material or information; and

(3) May enter into agreements governing sharing and use of information consistent with subsections (b) to (d) of this section.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (d) of this section.

(78 Del. Laws, c. 57, § 1; 78 Del. Laws, c. 382, § 1; 80 Del. Laws, c. 117, § 2; 83 Del. Laws, c. 65, § 1.)

Part I
Insurance
Chapter 13
Investments

§ 1301. Scope of chapter.

Except as to § 1329 of this title, this chapter applies to domestic insurers only.

(18 Del. C. 1953, § 1301; 56 Del. Laws, c. 380, § 1.)

§ 1302. Eligible investments.

(a) Insurers shall invest in or lend their funds on the security of, and shall hold as invested assets, only eligible investments as prescribed in this chapter.

(b) Any particular investment held by an insurer on November 1, 1968, which was a legal investment at the time it was made, and which the insurer was legally entitled to possess immediately prior to such date, shall be deemed to be an eligible investment.

(c) An investment qualified, in whole or in part, for acquisition or holding as an eligible investment may be qualified or requalified at the time of acquisition or at a later date, in whole or in part, under any section of this chapter, if the relevant conditions contained in the section are satisfied at the time of qualification or requalification. In order for an investment, subsequent to the time of its acquisition, to be qualified or requalified, prior written approval of the Commissioner must be obtained.

(d) Unless otherwise specified, an investment limitation computed on the basis of an insurer's admitted assets or capital and surplus shall relate to the amount required to be shown on the statutory balance sheet of the insurer most recently required to be filed with the Commissioner or as shown by a current financial statement resulting from merger of another insurer, bulk reinsurance, or change in capitalization. For purposes of computing any limitation based upon admitted assets, the insurer shall deduct from the amount of its admitted assets the amount of the liability recorded on its statutory balance sheet for:

(1) The return of acceptable collateral received in a reverse repurchase transaction or a securities lending transaction;

(2) Cash received in a dollar roll transaction; and

(3) The amount reported as borrowed money in the most recently filed financial statement, to the extent not included in paragraphs (d)(1) and (2) of this section.

(e) An insurer shall not invest in:

(1) Corporate obligations under § 1308 (c)(5) of this title;

(2) Bonds, notes or other evidences of indebtedness secured by second mortgages or deeds of trust under § 1323(a) of this title;

(3) Participations under § 1323(e) of this title;

(4) Secured obligations of institutions under § 1331 of this title; or

(5) Production payments under § 1332 of this title;

Unless such insurer possesses unimpaired capital and surplus (contributed and assigned) of not less than $7,500,000 (as shown by the insurer's annual statement as of December 31 next preceding the date of acquisition), which amount shall be invested in investments permitted under this chapter other than those specified in this subsection or § 1320 (miscellaneous investments) of this title.

(18 Del. C. 1953, § 1302; 56 Del. Laws, c. 380, § 1; 63 Del. Laws, c. 363, § 19; 70 Del. Laws, c. 108, §§ 1, 2; 71 Del. Laws, c. 202, §§ 1, 2.)

§ 1303. General qualifications.

(a) No security or investment, other than real and personal property acquired under § 1324 (real estate) of this title, shall be eligible for acquisition, unless it is interest bearing or interest accruing or entitled to dividends or is otherwise income earning, is not then in default in any respect, and the insurer is entitled to receive for its exclusive account and benefit the interest or income accruing thereon. A debt security will be considered to be income earning where, although bearing no fixed or contingent interest, it is issued at a discount and contains a specific maturity date on which redemption is to be made at a stated value. Stocks will be considered income earning although dividends are currently not being paid. Nothing in this section shall prohibit an insurer from giving or receiving a participating interest in a bond, note or other evidence of indebtedness acquired by such insurer under § 1323 of this title, or the acquisition by an insurer of warrants, options or similar rights to acquire securities if:

(1) The acquisition of such securities would then be permitted by this chapter (other than § 1320 of this title); or

(2) Such warrants, options or similar rights are acquired in connection with an investment otherwise permitted by this chapter.

(b) No security or investment shall be eligible for purchase at a price above its fair value or market value.

(c) Nothing in this chapter shall prohibit the acquisition by an insurer of other or additional securities or property if received as a dividend or as a lawful distribution of assets, or upon a debt or judgment, or under a lawful and bona fide agreement of bulk reinsurance, merger or consolidation, or if acquired by it through the exercise of warrants, options or similar rights to acquire securities received by it in accordance with this chapter. Nothing in this chapter shall prevent any insurer from entering into an agreement for the purpose

of protecting the interests of the insurer in securities lawfully held by it, or for the purpose of reorganization of a corporation which issued securities so held, and from depositing such securities with a committee or depositaries appointed under such agreement, nor from accepting stock, bonds or other securities or other property which may be distributed pursuant to any such agreement, or to any plan of reorganization or arrangement; and no provision of this chapter shall prevent any insurer from acquiring or holding any property acquired in satisfaction of any debt previously contracted, or that shall be obtained by sale or foreclosure of any security held by it. Any security or property so acquired which is not otherwise an eligible investment under this chapter shall be disposed of pursuant to § 1325 of this title if real estate, or pursuant to § 1326 of this title if personal property or securities.

(d) Except as provided in § 1305(5) of this title, the limitations of this chapter shall apply to all investments described in § 77r-1 of Title 15 of the United States Code [15 U.S.C. § 77r-1].

(e) For purposes of the investment limitations of this chapter, investments made by an insurer shall include investments made by that insurer's investment subsidiary.

(18 Del. C. 1953, § 1303; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, §§ 1, 2; 63 Del. Laws, c. 363, § 12; 68 Del. Laws, c. 177, § 1; 71 Del. Laws, c. 202, § 3.)

§ 1304. Authorization; record of investments.

An insurer shall not make any investment or loan (other than policy loans or annuity contract loans of a life insurer) unless the same is authorized or approved by the insurer's board of directors or by a committee thereof charged with supervision of investments and loans. The insurer shall maintain a full record of each investment.

(18 Del. C. 1953, § 1304; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, § 3.)

§ 1305. Diversification.

An insurer shall invest in or hold as admitted assets categories of investments within applicable limits as follows only:

(1) *One person.* — An insurer shall not at any 1 time have any combination of investments in or loans upon the security of obligations, property or securities of any 1 person (other than its lawful subsidiary) aggregating over 10% of the insurer's assets. This shall not apply as to general obligations of the United States or of any state, or of Canada or any province thereof, or include policy loans made under § 1317 of this title.

(2) *Voting stock.* — An insurer may invest in and hold at any time not more than 50% of the outstanding voting stock of any corporation, except as to voting rights of preferred stock during periods of defaults of dividends. This restriction shall not apply to stock of a subsidiary of the insurer acquired under § 1313 of this title, or to controlling stock of an insurer acquired under § 1312(b) of this title. The cost of such investments in any 1 corporation shall not exceed 3% of the insurer's assets. The aggregate value of all stock acquired and held under this section shall not exceed 40% of the insurer's assets.

(3) *Stocks.* — a. A life insurer shall not:

1. Invest in any stocks under §§ 1311 (common stocks), 1312(a) (insurance stocks), and 1314 (common trust funds; mutual funds) of this title if the cost thereof, when added to the aggregate cost of all such investments then held by such insurer, would exceed 125% of its policyholders' surplus (as defined in § 511(a)(2) of this title), or hold at any 1 time investments under such sections having an aggregate market value exceeding 250% of such policyholders' surplus; and

2. Invest in any stocks under § 1310 (preferred and guaranteed stocks) of this title if the cost thereof, when added to the aggregate cost of all such stocks then held by such insurer, would exceed 20% of its assets, or hold at any 1 time stocks under such section having an aggregate market value exceeding 40% of its assets.

b. This provision shall not apply to stock of any controlled or subsidiary corporation under §§ 1312(b) and 1313 of this title.

c. The cost of such investments in any 1 corporation shall not exceed 3% of the insurer's assets.

(4) *Mortgages.* — An insurer shall not at any 1 time have more than 50% of its assets invested in obligations under § 1323 of this title, exclusive of that portion of such obligations guaranteed or insured by an agency of the United States government. The investment by an insurer in any 1 property shall not exceed 3% of the insurer's assets.

(5) *Certain mortgage pools.* — An insurer may invest in and hold at any time up to 50% of its assets in certificates or other instruments evidencing participating interests in mortgage loans or pools thereof issued by the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation. The cost of such investment in any 1 mortgage pool shall not exceed 7% of the insurer's assets.

(6) *Other specific limits.* — Limits as to investments in the category of real estate shall be as provided in § 1324 of this title, and other specific limits, if any, shall apply as stated in sections dealing with other respective kinds of investments. Upon a request in writing the Commissioner may permit an insurer to invest an amount up to 5% in excess of any specific investment limitation if determined by the Commissioner to be a sound and prudent investment. Notwithstanding any other limitations contained herein, no investment in a single person other than an investment deemed eligible under § 1302(b) of this title or as provided in § 1313 of this title, shall exceed 50% of policyholders' surplus without the written approval of the Commissioner.

(18 Del. C. 1953, § 1305; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, §§ 4-6; 60 Del. Laws, c. 347, § 1; 61 Del. Laws, c. 150, § 1; 63 Del. Laws, c. 363, §§ 1, 13; 68 Del. Laws, c. 261, §§ 1-5; 69 Del. Laws, c. 373, § 1; 70 Del. Laws, c. 186, § 1; 70 Del. Laws, c. 494, § 1.)

§ 1306. Public obligations.

An insurer may invest in bonds or other evidences of indebtedness, not in default as to principal or interest, which are valid and legally authorized obligations issued, assumed or guaranteed by the United States or by any state thereof, or by Canada or any of the provinces thereof, or by any county, city town, village, municipality or district therein or by any political subdivision thereof or by a public instrumentality of 1 or more of the foregoing, and in any such obligations issued, assumed or guaranteed by the federal government of Mexico, if, by statutory or other legal requirements applicable thereto, such obligations are payable, as to both principal and interest, from (1) taxes levied or required to be levied upon all taxable property or all taxable income within the jurisdiction of such governmental unit, or from (2) adequate special revenues pledged or otherwise appropriated or by law required to be provided for the purpose of such payment; but not including any obligation payable solely out of special assessments on properties benefited by local improvements, unless adequate security is evidenced by the ratio of assessment to the value of the property or the obligation is additionally secured by an adequate guaranty fund required by law.

(18 Del. C. 1953, § 1306; 56 Del. Laws, c. 380, § 1; 63 Del. Laws, c. 363, § 17.)

§ 1307. Obligations and stock of certain federal and international agencies.

An insurer may invest in the obligations and/or stock where stated, issued, assumed or guaranteed by the following agencies of the government of the United States of America, or in which such government is a participant, whether or not such obligations are guaranteed by such government:

(1) Farm Loan Bank.

(2) Commodity Credit Corporation.

(3) Federal intermediate credit banks.

(4) Federal land banks.

(5) Central Bank for Cooperatives.

(6) Federal home loan banks, and stock thereof.

(7) Federal National Mortgage Association, and stock thereof.

(8) International Bank for Reconstruction and Development.

(9) Inter-American Development Bank.

(10) Asian Development Bank.

(11) African Development Bank.

(12) Any other similar agency of, or participated in by, the government of the United States of America and of similar financial quality.

(18 Del. C. 1953, § 1307; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 158; 59 Del. Laws, c. 79, § 7; 66 Del. Laws, c. 20, § 1.)

§ 1308. Corporate obligations.

(a) An insurer may invest any of its funds in obligations rated 1 or 2 by the SVO if they are issued, assumed or guaranteed by any solvent institution created or existing under the laws of the United States or Canada or of any state, district, province or territory thereof.

(b) An insurer may also invest any of its funds in any medium or lower grade obligations of any institution created or existing under the laws of the United States or Canada or of any state, district, province or territory thereof, provided, however, that:

(1) Without prior approval of the Commissioner, no insurer shall invest any of its funds in any medium grade or lower grade obligation of any institution if, after giving effect to any such acquisition, the aggregate amount of all medium grade and lower grade obligations then held by the insurer would exceed 20 percent of its admitted assets.

(2) Without the prior approval of the Commissioner, no insurer shall invest any of its funds in any lower grade obligation of any institution if, after giving effect to any such acquisition, the aggregate amount of all lower grade obligations then held by the insurer would exceed 10 percent of its admitted assets; provided, that no more than 3 percent of its admitted assets consists of obligations rated 5 or 6 by the Securities Valuation Office. In addition, without the Commissioner's prior approval, no insurers shall acquire any obligation rated 6 by the Securities Valuation Office and no more than 1 percent of its admitted assets may consist of obligations rated 6 by the Securities Valuation Office.

(3) Attaining the limit of any 1 category referred to in paragraph (b)(2) of this section shall not preclude an insurer from investing any of its funds in obligations in other categories subject to the specific and multicategory limits. Nothing contained in this section shall prohibit an insurer from investing any of its funds in any obligation which it has committed to acquire if the insurer would have been permitted to invest any of its funds in that obligation pursuant to this section on that date on which such insurer committed to make such investment. For the purposes of determining limitations contained in this chapter, an insurer shall give appropriate recognition to any commitments to acquire investments. Notwithstanding the foregoing, an insurer may invest any of its funds in an obligation of an institution in which such insurer already has 1 or more investments, if such investment is made in order to protect an investment previously made in the obligations of such institution; provided, that such investment shall not exceed $^{1}/_{2}$ of 1 percent of the insurer's admitted assets.

(c) An insurer may also invest any of its funds in obligations other than those permitted in subsection (a) or (b) of this section or those eligible for investment under § 1323 (real estate mortgages) of this title if they are issued, assumed or guaranteed by any solvent institution created or existing under the laws of the United States or Canada or of any state, district, province or territory thereof and are qualified under any of the following:

(1) Obligations which are secured by adequate collateral security and bear fixed interest, if during each of any 3, including either of the last 2, fiscal years of a period of not less than 3 nor more than 5 fiscal years next preceding the date of acquisition by such insurer, the net earnings of the issuing, assuming or guaranteeing institution available for its fixed charges, as defined in § 1309 of this title, shall have been not less than $1^1/_4$ times the total of its fixed charges for such year, or obligations which, at the date of acquisition by such insurer, are adequately secured and have investment qualities and characteristics wherein the speculative elements are not predominant. In determining the adequacy of collateral security not more than $^1/_3$ of the total value of such required collateral shall consist of stock other than stock meeting the requirements of § 1310 (preferred or guaranteed stocks) of this title.

(2) Fixed interest-bearing obligations, other than those described in paragraph (c)(1) of this section, or noninterest-bearing obligations issued at a discount and repayable at a stated value on a specific maturity date, if the net earnings of the issuing, assuming or guaranteeing institution available for its fixed charges for a period of 5 fiscal years next preceding the date of acquisition by such insurer shall have averaged per year not less than $1^1/_2$ times its average annual fixed charges applicable to such period and if during either of the last 2 years of such period such net earnings shall have been not less than $1^1/_2$ times its fixed charges for such year.

(3) Adjustment, income or other contingent interest obligations including, without limitation, variable or adjustable rate interest obligations if the net earnings of the issuing, assuming or guaranteeing institution available for its fixed charges for a period of 5 fiscal years next preceding the date of acquisition by the insurer have averaged per year not less than $1^1/_2$ times the sum of its average annual fixed charges and its average annual maximum contingent interest applicable to such period and if during either of the last 2 years of such period such net earnings have not been less than $1^1/_2$ times the sum of its fixed charges and maximum contingent interest for such year.

(4) Fixed interest-bearing obligations, other than those described in paragraphs (c)(1) and (2) of this section, or noninterest-bearing obligations issued at a discount and repayable at a stated value on a specific maturity date, if:

a. The net earnings of the issuing, assuming or guaranteeing institution available for its fixed charges for a period of 5 fiscal years next preceding the date of acquisition by such insurer shall have averaged per year not less than $1^1/_4$ times its average annual fixed charges applicable to such period and if during each of any 4 fiscal years of such period such net earnings shall have been not less than $1^1/_4$ times its fixed charges for such year;

b. The net earnings of such institution available for its fixed charges during a period of not less than 7 nor more than 10 fiscal years next preceding the date of acquisition by such insurer shall have been such that for each of any 7 fiscal years of such period such net earnings shall have been not less than $1^1/_4$ times its fixed charges for such year; and

c. The liquid assets of such institution shall have been not less than 105 percent of its liabilities (other than deferred income taxes, deferred investment tax credits, capital stock and surplus).

(5) Fixed interest-bearing obligations, other than those described in paragraphs (c)(1), (2) and (4) of this section, or noninterest-bearing obligations issued at a discount and repayable at a stated value on a specific maturity date, if either: (i) The net earnings of the issuing, assuming or guaranteeing institution available for its fixed charges during each of the 5 fiscal years next preceding the date of acquisition by such insurer shall have been not less than 125 percent of its fixed charges for such year, and (ii) the liquid assets of such institution as of the end of the fiscal year next preceding the date as of which determination thereof shall be made and as of the end of each of the 4 fiscal years next preceding such fiscal year shall have been not less than 95 percent of its liabilities (other than deferred income taxes, deferred investment tax credits, capital stock and surplus); or (i) the net earnings of the issuing, assuming or guaranteeing institution available for its fixed charges for a period of 5 fiscal years next preceding the date of acquisition by such insurer shall have averaged per year not less than 115 percent of its average annual fixed charges applicable to such period and during each of any 4 fiscal years of such period such net earnings shall have been not less than 115 percent of its fixed charges for such year and during any fiscal year of such 5-year period such net earnings shall have been not less than 105 percent of its fixed charges for such year, and (ii) the liquid assets of such institution as of the end of the fiscal year next preceding the date as of which determination thereof shall be made and as of the end of each of the 4 fiscal years next preceding such fiscal year shall have been not less than 105 percent of its liabilities (other than deferred income taxes, deferred investment tax credits, capital stock and surplus).

(18 Del. C. 1953, § 1308; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, §§ 8-10; 63 Del. Laws, c. 363, §§ 2, 3; 70 Del. Laws, c. 108, § 3; 71 Del. Laws, c. 202, §§ 4-6.)

§ 1309. Corporate obligations; terms defined.

(a) Certain terms used are defined for the purposes of this chapter as follows:

(1) “Fixed charges” includes interest on funded and unfunded debt, amortization of debt discount and rentals for leased properties, except that interest paid by a bank or trust company upon any deposit shall not be deemed a fixed charge of such institution.

(2) “Institution” includes corporations, joint-stock associations, investment partnerships, business joint ventures and business trusts, statutory trusts or similar entities.

(3) “Liquid assets” and “liabilities”, as to the most recent fiscal year of an issuing, assuming or guaranteeing institution, shall be determined in reliance upon the latest regular financial statement of such institution prepared as of a date not more than 15 months prior to the date of acquisition of the obligations in question by an insurer and, as to any prior fiscal year of such institution, shall be determined in reliance upon the regular financial statement of such institution as of the close of the applicable fiscal year. If net earnings are determined in reliance upon consolidated earnings statements of parent and subsidiary institutions, “liquid assets” and “liabilities” shall be determined in reliance upon consolidated financial statements of parent and subsidiary institutions after treating any minority stock interest in such subsidiary institutions as a liability.

(4) “Liquid assets” means the sum of cash, receivables or portions thereof, as the case may be, payable on demand or not more than 12 years after the date as of which determination thereof shall be made for purposes of § 1308 of this title, and readily marketable securities, in each case less applicable reserves and unearned income.

(5) “Lower grade obligations” means obligations rated 4, 5 or 6 by the Securities Valuation Office of the National Association of Insurance Commissioners.

(6) “Medium grade obligations” means obligations rated 3 by the Securities Valuation Office of the National Association of Insurance Commissioners.

(7) “Net earnings available for fixed charges” means net income after deducting operating and maintenance expenses, taxes (other than federal, state and other income taxes), depreciation and depletion, but excluding extraordinary nonrecurring items of income or expense appearing in the regular financial statements of such institutions.

(8) “Obligations” includes bonds, debentures, notes and other evidences of indebtedness (whether or not liability for payment extends beyond the security therefor) as well as participation interests in any of the foregoing.

(9) “SVO” means the Securities Valuation Office of the NAIC or any successor office established by the NAIC.”

(b) If net earnings are determined in reliance upon consolidated earnings statements of parent and subsidiary institutions, such net earnings shall be determined after provision for income taxes of subsidiaries in which the parent institution owns directly or indirectly less than 80% of all classes of voting stock, and after proper allowance for minority stock interest if any; and the required coverage of fixed charges shall be computed on a basis including fixed charges and preferred dividends of subsidiaries other than those payable by such subsidiaries to the parent corporation or to any other of such subsidiaries, except that if the minority common stock interest in the subsidiary corporation is substantial, the fixed charges and preferred dividends may be apportioned in accordance with regulations prescribed by the Commissioner.

(c) If the issuing, assuming or guaranteeing institution has not been in legal existence for the whole of the period for which earnings tests are being applied for purposes of § 1308, § 1310 or § 1311 of this title, but was formed as a consolidation or merger of 2 or more businesses of which at least 1 was in operation at the commencement of such period or such institution has acquired all or substantially all of the assets of a business or any divisional, branch or other unitary portion thereof which was in operation at the commencement of such period, the tests of eligibility under § 1308, § 1310 or § 1311 of this title, as the case may be, shall be based upon pro forma statements incorporating statements of the predecessor or constituent institutions or businesses or portions thereof.

(18 Del. C. 1953, § 1309; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, §§ 11-13; 63 Del. Laws, c. 363, §§ 4-7; 70 Del. Laws, c. 108, § 4; 71 Del. Laws, c. 202, § 7; 73 Del. Laws, c. 329, § 61.)

§ 1310. Preferred or guaranteed stocks.

An insurer may invest in preferred or guaranteed stocks or shares of any solvent institution existing under the laws of the United States or of Canada, or of any state or province thereof, if all of the prior obligations and prior preferred stocks, if any, of such institution at the date of acquisition of the investment by the insurer are eligible as investments under this chapter and are rated 1 or 2 by the SVO or if the net earnings of such institution available for its fixed charges during either of the last 2 years have been, and during each of the last 5 years have averaged, not less than $1^1/_2$ times the sum of its average annual fixed charges, if any, its average annual maximum contingent interest, if any, and its average annual preferred dividend requirements. For the purposes of this section such computation shall refer to the fiscal years immediately preceding the date of acquisition of the investment by the insurer, and the term “preferred dividend requirement” shall be deemed to mean cumulative or noncumulative dividends, whether paid or not.

(18 Del. C. 1953, § 1310; 56 Del. Laws, c. 380, § 1; 71 Del. Laws, c. 202, § 8.)

§ 1311. Common stocks; limited partnerships.

An insurer may invest in common stocks, other than insurance stocks, of any solvent institution organized and existing under the laws of the United States or Canada, or of any state or province thereof, if during a period of 7 fiscal years next preceding the date of acquisition by such insurer the institution had aggregate net earnings available for the payment of dividends upon its common stock of no less than the aggregate sum which would have been sufficient to pay dividends of 4% per annum upon the par value (or in the case of common stocks without par value, upon the stated capital) of all of its shares of common stock outstanding during such period. As used in this

section the term “common stock” includes transferable certificates of participation in business trusts and statutory trusts. An insurer may invest in or otherwise acquire and hold a limited partnership interest in any limited partnership formed pursuant to the laws of any state or the United States of America. No limited partnership interest shall be acquired under this section if the cost thereof would exceed 2% of the assets of such insurer nor if such cost, plus the book value on the date of such acquisition of all limited partnership interest then held by such insurer and acquired under this section, would exceed 10% of such assets.

(18 Del. C. 1953, § 1311; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, § 14; 63 Del. Laws, c. 363, § 8; 73 Del. Laws, c. 329, § 62.)

§ 1312. Insurance stocks.

(a) An insurer may invest in the stocks of other solvent insurers formed under the laws of this or another state, which stocks meet the applicable requirements of §§ 1310 (preferred or guaranteed stock) and 1311 (common stocks) of this title.

(b) With the Commissioner’s advance written consent an insurer may acquire and hold the controlling interest in the outstanding voting stock of another stock insurer formed under the laws of this or another state. All stocks under this subsection shall be subject to the limitation as to amount as provided in § 1313 of this title. The Commissioner shall not give his or her consent to any such acquisition if the Commissioner finds that it would not be in the best interests of the insurers involved, or of their respective policyholders or stockholders, or that such acquisition would materially tend to lessen competition or to result in any monopoly in the insurance business.

(18 Del. C. 1953, § 1312; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 1313. Stock of subsidiaries.

(a) An insurer may invest in:

(1) The stock of subsidiary insurance corporations formed or acquired by it; or,

(2) in addition to the right to own stock in other corporations given insurers in § 1305(2) of this title, it may also invest in not less than a majority of the voting stock of a business corporation formed under the laws of this or another state or a foreign nation, the activities of which corporation are primarily supplementary and complementary to the convenient operation of the insurer’s business or to the administration of its affairs, and corporations engaged or organized to engage in the marketing of financial, insurance or service products, the products to be subject to the approval of the Insurance Commissioner.

As used in this title, “subsidiaries” shall include, in addition to those such corporations where the insurer owns a majority of their stock, those corporations formed or acquired by an insurer where it owns less than a majority of such corporation’s voting stock due to the laws of a foreign national which require the insurer to own less than a majority of the voting stock of such subsidiary insurance corporation if it is to operate in that nation.

(b) Limitations on investments in subsidiaries shall be as follows:

(1) Domestic insurers transacting insurance in any state of the United States of America and not establishing reserves and operating in accordance with § 1104 of this title.

a. All of the insurer’s investments pursuant to paragraph (a)(1) of this section shall not at any time exceed the amount of the investing insurer’s surplus, if a life insurer, or its policyholders’ surplus (as defined in § 511(a)(2) of this title) if other than a life insurer.

b. All of the insurer’s investments pursuant to paragraph (a)(2) of this section shall not at any time exceed the lesser of 10 percent of the insurer’s admitted assets or 50 percent of the insurer’s surplus, if a life insurer, or its policyholders’ surplus (as defined in § 511(a)(2) of this title) if other than a life insurer. With prior approval of the Commissioner, an insurer may invest a greater amount in the securities of subsidiaries than permitted by paragraph (a)(2) of this section if after such investment the investing insurer’s surplus, if a life insurer, or its policyholders’ surplus (as defined in § 511(a)(2) of this title) if other than a life insurer, will be reasonable in relation to the insurer’s outstanding liabilities and adequate to meet its financial needs.

(2) Domestic insurers transacting insurance in foreign countries only, and not transacting insurance in any state of the United States of America and establishing reserves and operating in accordance with § 1104 of this title: All of the insurer’s investments in subsidiaries shall not at any time exceed 100 percent of the insurer’s surplus, if a life insurer, or its policyholders’ surplus (as defined in § 511(a)(2) of this title) if other than a life insurer.

(c) All of the insurer’s investments under this section, together with its investments in insurance stocks under § 1312(b) of this title, shall not at any time exceed the amount of the investing insurer’s surplus, if a life insurer, or its policyholders’ surplus (as defined in § 511(a)(2) of this title) if other than a life insurer.”

(18 Del. C. 1953, § 1313; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, § 15; 60 Del. Laws, c. 347, § 2; 66 Del. Laws, c. 179, § 1; 73 Del. Laws, c. 336, § 1; 74 Del. Laws, c. 188, § 1.)

§ 1314. Common trust funds; mutual funds.

An insurer may invest in:

(1) A bank’s common trust fund as defined in § 584 of the United States Internal Revenue Code of 1954 [26 U.S.C. § 584]; and

(2) The securities of any open-end or closed-end management type investment company or investment trust registered with the Federal Securities and Exchange Commission under the Investment Company Act of 1940 [15 U.S.C. § 80a-1 et seq.] as from time to time amended, if such investment company or trust has assets of not less than $25,000,000 as at date of investment by the insurer.

(18 Del. C. 1953, § 1314; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, § 16.)

§ 1315. Bankers' acceptances; bills of exchange.

An insurer may invest in bankers' acceptances and bills of exchange of the kinds and maturities made eligible by law for rediscount with Federal Reserve Banks, and generally accepted by banks or trust companies which are members of the Federal Reserve System.

(18 Del. C. 1953, § 1315; 56 Del. Laws, c. 380, § 1.)

§ 1316. Equipment trust certificates.

An insurer may invest in equipment trust obligations or certificates adequately secured and evidencing an interest in transportation equipment used wholly or in part within the United States of America or Canada, which obligations or certificates carry the right to receive determined portions of rental, purchase or other fixed obligatory payments to be made for the use or purchase of such transportation equipment.

(18 Del. C. 1953, § 1316; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, § 17.)

§ 1317. Policy loans.

A life insurer may lend to its policyholder upon pledge of the policy as collateral security any sum not exceeding the cash surrender value of the policy, or may lend against pledge or assignment of any of its supplementary contracts or other contracts or obligations, so long as the loan is adequately secured by such pledge or assignment. Loans so made are eligible investments of the insurer.

(18 Del. C. 1953, § 1317; 56 Del. Laws, c. 380, § 1.)

§ 1318. Collateral loans.

An insurer may lend and thereby invest its funds upon the pledge of securities eligible for investment under this chapter. As at date made, no such loan shall exceed in amount 100% of the market value of such collateral pledged. The amount so loaned shall be included pro rata in determining the maximum percentage of funds permitted under this chapter to be invested in the respective categories of securities so pledged.

(18 Del. C. 1953, § 1318; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, § 18.)

§ 1319. Savings and share accounts.

An insurer may invest in share or savings accounts of savings and loan or building and loan associations, or in savings accounts of banks; and in any 1 such institution only to the extent that the investment is insured by the federal savings and loan insurance corporation or the federal deposit insurance corporation.

(18 Del. C. 1953, § 1319; 56 Del. Laws, c. 380, § 1.)

§ 1320. Miscellaneous investments.

(a) An insurer may make loans or investments not otherwise expressly permitted under this chapter, in an aggregate amount not over 10% of the insurer's assets, if such loan or investment fulfills the requirements of § 1303 of this title and otherwise qualifies as a sound investment. No such loan or investment shall be represented by:

(1) Any item described in § 1102 (assets not allowed) of this title, or any loan or investment otherwise expressly prohibited;

(2) Agents' balances or amounts advanced to or owing by agents, except as to policy loans, mortgage loans and collateral loans otherwise authorized under this chapter;

(3) Loans or investments expressly eligible under any other provision of this chapter;

(4) Any asset theretofore acquired or held by the insurer under any other category of loans or investments eligible under this chapter.

(b) The insurer shall keep a separate record of all loans and investments made under this section.

(18 Del. C. 1953, § 1320; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, §§ 19, 20.)

§ 1321. Investments in foreign countries.

(a) An insurer transacting insurance in a foreign country may invest funds required to meet its obligations in such country and in conformity with the laws thereof in the same kinds of securities and investments of or in such country as the insurer is authorized to invest in or acquire under other provisions of this chapter. Except as provided in the foregoing sentence and in subsection (b) of this section, an insurer may not invest more than 15% of its assets in securities or investments of or in foreign countries other than Canada nor invest more than an aggregate of 5% of its assets in securities or investments of or in a single foreign jurisdiction which has a sovereign debt rating of SVO 1 or 3% of its assets as to any other foreign jurisdiction. The Commissioner may promulgate regulations which permit, after thorough and appropriate review on a case-by-case basis, a life insurer domiciled in Delaware to increase its aggregate limit on foreign investments to 20%.

(b) If such an insurer is not doing business in any state of the United States of America, it may invest its funds as permitted by the laws of any jurisdiction where it does business. Negotiation and issuance of insurance on risks situated outside every such state, and changes in, communications concerning, and collection of premiums on insurance so issued shall not be deemed hereunder to be doing business in any such state.

(c) If such an insurer is not transacting insurance in the United States of America, it may establish 1 or more separate accounts and subaccounts thereto in respect to 1 or more jurisdictions outside the United States relating to insurance business conducted in such jurisdiction outside the United States. The insurer may allocate assets and make deposits thereto in respect of the whole or any part of the insurance business transacted by it in such jurisdiction for the purpose of segregating the insurer's assets for the benefit of policyholders of that jurisdiction, subject to the following:

(1) All amounts received by an insurer in respect of a class of insurance business written in that jurisdiction, after the establishment of a separate account in respect of that class or classes of business, shall be carried to and become assets of the separate account. The assets of each separate account shall be kept separate and distinct from other assets of the insurer.

(2) Subaccounts may be established within a separate account for classes of insurance business written in that jurisdiction. All amounts received by the insurer with respect to the class of insurance in a subaccount shall be carried to and become assets of such subaccount.

(3) The income, gains and losses, realized or unrealized, from assets allocated to a separate account or subaccount thereof shall be credited to or charged against such separate account or subaccount, without regard to other income, gains or losses of the insurer. To the extent that the value of the assets in such separate account or subaccount are in excess of the reserves, other contract liabilities, solvency and other requirements of the jurisdiction in which the separate account or subaccount is established, such excess may be withdrawn by the insurer.

(4) Amounts allocated to a separate account or subaccount thereof in the exercise of the power granted by this subsection shall be owned by the insurer and the insurer shall not be, nor hold itself out to be, a trustee with respect to such amounts.

(5) The assets of a separate account or subaccount shall not be available to meet any liabilities of the insurer other than policyholder liabilities, expenses, taxes and levies, directly related to such separate account or subaccounts. The assets of any separate account or subaccount equal to the reserves and other contract liabilities with respect to those accounts are excluded from the insurer's general assets and as such shall not be charged with other liabilities of the insurer which may arise out of any other business which the insurer may conduct other than the separate account or subaccount. In any dissolution or liquidation of an insurer which has established a separate account or subaccount under this subsection, the assets of the account shall be available only for meeting the policyholder liabilities of the company attributable to the business in respect of which such separate account or subaccount was established. Any assets which remain in any such account after the satisfaction of all policyholder liabilities of the account shall be made available to the appointed receiver.

(6) An insurer shall not mortgage or charge any of the assets of any separate account or subaccount thereof, except for the benefit of such separate account or subaccount.

(7) Assets of a readily determinable market value maintained in the separate account or subaccount shall be freely exchangeable in the discretion of the insurer at any time for assets of like value.

(8) Where an insurer wishes to establish a separate account in respect of a part of the insurance business of the insurer, the insurer shall apply to the Commissioner in writing for approval to establish the separate account, and shall indicate the proposed date and the part of the insurance business of the insurer in respect of which the separate account is to be established. The separate account shall take effect upon the approval of the Commissioner.

(9) A separate account or subaccount established under this subsection in respect of any part of the insurance business of an insurer shall continue to be maintained in accordance with this subsection for as long as the insurer has any outstanding obligations or liabilities in respect of that part of its business.

(10) Negotiation and issuance of insurance on risks situated outside the United States of America, and changes in, and communications concerning, and collection of premiums on insurance so issued shall not be deemed hereunder to be doing business or transacting insurance in the United States of America.

(18 Del. C. 1953, § 1321; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, § 21; 63 Del. Laws, c. 363, § 18; 68 Del. Laws, c. 343, § 1; 71 Del. Laws, c. 202, § 9; 76 Del. Laws, c. 39, § 1.)

§ 1322. Special investments of title insurers.

Repealed by 74 Del. Laws, c. 214, § 6, effective March 30, 2004.

§ 1323. Real estate mortgages.

(a) An insurer may invest in bonds, notes or other evidences of indebtedness secured by first or second mortgages or deeds of trust representing first or second liens upon real estate, perpetual leases thereon or leasehold estates when the remaining term of such leasehold and enforceable renewals is not less than the term of such first or second lien, as the case may be, in the United States or Canada, subject to the following conditions:

(1) The amount loaned or the aggregate amount of bonds or other evidences of indebtedness issued upon the security of a mortgage or deed of trust (when added to the amount unpaid upon any prior first mortgage or deed of trust) shall not at the time of the investment exceed 75% of the fair market value of the real estate, as such value has been determined by a qualified appraiser for the purposes of the investment or at the time of issuance of the bonds or other evidences of indebtedness.

(2) In applying the limitation under paragraph (a)(1) of this section above, there may be excluded from the amount invested that portion of the investment which is guaranteed by the Administrator of Veterans' Affairs pursuant to the Servicemen's Readjustment Act of 1944 [38 U.S.C. § 1802 et seq.], as amended, or insured by the Federal Housing Administrator or other United States or Canadian government agency.

(3) Insurance not less comprehensive than fire and extended coverage must be carried on the improvements, if any, on the real estate, in an amount not less than 75% of the insurable value of the improvements or the unpaid balance of the investment, whichever is the lesser amount, and the policy or policies evidencing such insurance shall be endorsed to show the interest of the lender.

(4) No mortgage loan upon a leasehold shall be made or acquired by an insurer pursuant to this section unless the terms thereof shall provide for such payments of principal, whatever the period of the loan, so that at no time during the period of the loan shall the aggregate payments of principal theretofore required to be made under the terms of the loan be less than would have been necessary for a loan payable completely by the end of the lesser of a period of $^4/_5$ of the period of the leasehold, inclusive of the period or periods which may be provided by enforceable options of renewal, which is unexpired at the time the loan is made or 40 years, through payments of interest only for 5 years and equal payments applicable first to interest and then to principal at the end of each year thereafter.

(5) The total investments of any insurer permitted under this subsection in bonds, notes or other evidences of indebtedness secured by second mortgages or deeds of trust, under subsection (e) of this section regarding participations evidencing participating interests in bonds, notes or other evidences of indebtedness which are so secured and under subsection (f) of this section, shall not exceed 5% of its assets, and no such investment shall be made or acquired by an insurer if the mortgagor, without the approval of the insurer, may increase the principal amount of the indebtedness secured by the prior first mortgage except to the extent that the amount of such increase is applied in reduction of the investment held by the insurer.

(b) For the purposes of this section real estate shall not be deemed to be encumbered by reason of the existence of taxes or assessments which are not delinquent, instruments creating or reserving mineral, oil or timber rights, rights-of-way, joint driveways, sewer rights, rights in walls, or by reason of building restrictions or other restrictive covenants, or when such real estate is subject to lease in whole or in part whereby rents or profits are reserved to the owner.

(c) An insurer may invest in purchase money mortgages or like securities received by it upon the sale or exchange of real property acquired pursuant to § 1324 of this title.

(d) In addition to the foregoing and supplemental to § 1320 of this title, any such insurer may, to an aggregate amount not in excess of 5% of the assets of such insurer, make and hold loans upon real property, including leasehold estates therein, in any state of the United States, or in the District of Columbia or Puerto Rico, or in any province of the Dominion of Canada, notwithstanding the fact that such loans and the mortgages securing the same do not comply with the provisions of this section.

(e) A permissible investment under this section shall include a participation (meaning an instrument evidencing a participating interest in a bond, note or other evidence of indebtedness secured by first or second mortgage or deed of trust) if the entire indebtedness would qualify for investment under subsection (a) of this section and:

(1) The entire indebtedness secured by the same mortgage or deed of trust is held by such insurer; or

(2) The insurer holds a senior participation giving it substantially the rights of a first or second mortgagee and a position of priority over the other holders of participations in such indebtedness; or

(3) If each participation is of equal rank, the aggregate amount of the insurer's investment under this paragraph in all such participations does not exceed 20% of its assets.

(f) An insurer may invest in bonds, notes or other evidences of indebtedness secured by first or second mortgages or deeds of trust representing first or second liens upon perpetual leases on real estate or leasehold estates in the jurisdictions approved by the Commissioner, provided that the maturity date of the loan occurs on a date that is no later than 40 years prior to the leasehold termination date (inclusive of the period or periods which may be provided by enforceable options of renewal) and the loan to value ratio of the leasehold as of the date of acquisition of such loan does not exceed 70%. Bonds, notes or other evidences of indebtedness acquired pursuant to this subsection shall be subject to the applicable limitations of § 1321 of this title. After a thorough and appropriate review on a case-by-case basis, the Commissioner may grant authority to invest in bonds, notes or other evidences of indebtedness secured by first or second mortgages or deeds of trust representing first or second liens upon leasehold estates in any jurisdiction that otherwise meets the requirements of this subsection.

(18 Del. C. 1953, § 1324; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, §§ 22-24; 63 Del. Laws, c. 363, §§ 9-11; 83 Del. Laws, c. 317, § 1.)

§ 1324. Real estate.

(a) A domestic insurer may invest in real estate only if used for the purposes or acquired in the manners, and within the limits, as follows:

(1) The building in which it has its principal office, the land upon which the building stands, and such other real estate as may be requisite for the insurer's convenient accommodation in the transaction of its business. The amount so invested and apportioned as to space actually so occupied or used shall not aggregate more than 10% of the insurer's assets;

(2) Real estate acquired in satisfaction of loans, mortgages, liens, judgments, decrees or debts previously owing to the insurer in the due course of its business;

(3) Real estate acquired in part payment of the consideration on the sale of other real estate owned by it, if such transaction shall have effected a net reduction in the insurer's investments in real estate;

(4) Real estate acquired by gift or devise, or through merger, consolidation or bulk reinsurance of another insurer under this title;

(5) The seller's interest in real estate subject to an agreement of purchase or sale, but the sum invested in any such interest shall not exceed $^{2}/_{3}$ of the fair value of such parcel;

(6) Additional real estate and equipment incident thereto, if necessary or convenient for the purpose of enhancing the sale or other value of real estate previously acquired or held under this section. Such real estate and equipment, together with the real estate for the enhancement of which it was acquired, shall be included, for the purpose of applicable investment limits, and shall be subject to disposal under § 1325 of this title at the same time and under the same conditions as apply to such enhanced real estate;

(7) Real estate, or any interest therein, acquired or held by purchase, lease or otherwise, acquired as an investment for production of income, or acquired to be improved or developed for such investment purposes pursuant to an existing program therefor. The insurer may hold, mortgage, improve, develop, maintain, manage, lease, sell, convey and otherwise dispose of real estate acquired by it under this provision. An insurer shall not have at any 1 time invested in real estate under this paragraph more than 15% of its assets. Real estate to be used primarily for agricultural, ranch, mining, development of oil and mineral resources, recreational, amusement, hotel, motel or club purposes shall in total not exceed 10% of an insurer's assets.

(b) All real estate owned by a domestic insurer under this section, other than as to seller's interest specified in paragraph (a)(5) of this section, shall not at any 1 time exceed 25% of the insurer's assets.

(18 Del. C. 1953, § 1325; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, §§ 25, 26; 63 Del. Laws, c. 363, § 14.)

§ 1325. Time limit for disposal of real estate.

(a) Except as stated in subsection (b) of this section, or unless the insurer elects to hold the real estate as an investment under § 1324(a)(7) of this title:

(1) An insurer shall dispose of real estate acquired under § 1324(a)(1) of this title within 5 years after it has ceased to be necessary for the convenient accommodation of the insurer in the transaction of its business;

(2) An insurer shall dispose of real estate acquired under § 1324(a)(2), (3) and (4) of this title within 5 years after the date of acquisition, unless used or to be used for the insurer's accommodation under § 1324 (a)(1) of this title.

(b) The Commissioner may by order grant, from time to time, reasonable extensions of the period, as specified in any such order, within which an insurer shall dispose of any particular parcel of such real estate.

(18 Del. C. 1953, § 1326; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, § 27.)

§ 1326. Time limit for disposal of other ineligible property and securities.

Any personal property or securities lawfully acquired by an insurer, which it could not otherwise have invested in or loaned its funds upon at the time of such acquisition, shall be disposed of within 5 years from date of acquisition, unless within such period the security has attained to the standard of eligibility; except, that any security or personal property acquired under any agreement of bulk reinsurance, merger or consolidation may be retained for a longer period if so provided in the plan for such reinsurance, merger or consolidation as approved by the Commissioner under Chapter 49 of this title. The Commissioner may by order grant, from time to time, reasonable extensions of the period, as specified in any such order, within which an insurer shall dispose of any such property or security.

(18 Del. C. 1953, § 1327; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, §§ 28, 29.)

§ 1327. Failure to dispose of real estate or securities; effect; penalty.

(a) Any real estate, personal property, or securities lawfully acquired and held by an insurer after expiration of the period for disposal thereof or any extension of such period granted by the Commissioner as provided in §§ 1325 and 1326 of this title, shall not be allowed as an asset of the insurer.

(b) The insurer shall forthwith dispose of any ineligible investment unlawfully acquired by it, and the Commissioner shall suspend or revoke the insurer's certificate of authority if the insurer fails to dispose of the investment within such reasonable time as the Commissioner may, by his or her order, specify.

(18 Del. C. 1953, § 1328; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 1328. Prohibited investments and investment underwriting.

(a) In addition to investments excluded pursuant to other provisions of this title, an insurer shall not invest in or lend its funds upon the security of:

(1) Issued shares of its own capital stock, except:

a. For the purpose of mutualization under § 4928 of this title; and

b. Where the insurer has first submitted a plan for such investment or loan to the commissioner and the Commissioner has not, within 20 days after such submission or within such additional reasonable period as the Commissioner may request, disapproved such plan as unfair or inequitable to the insurer's policyholders or stockholders;

(2) Securities issued by any corporation or enterprise the controlling interest of which is, or will after such acquisition by the insurer be, held directly or indirectly by the insurer or any combination of the insurer and the insurer's directors, officers, subsidiaries or controlling stockholders (other than a parent corporation), and the spouses and children of any of the foregoing individuals. Investments in controlled insurance corporations or subsidiaries under §§ 1312(b) and 1313 of this title are not subject to this provision;

(3) Any note or other evidence of indebtedness of any director, officer, employee or controlling stockholder of the insurer or of the spouse, or child of any of the foregoing individuals, except as to policy loans authorized under § 1317 of this title.

(b) No insurer shall underwrite or participate in the underwriting of an offering of securities or property of any other person.

(c) No insurer shall enter into any agreement to withhold from sale any of its securities or property, and the disposition of its assets shall at all times be within the control of the insurer.

(18 Del. C. 1953, § 1329; 56 Del. Laws, c. 380, § 1.)

§ 1329. Investments of foreign insurers.

The investment portfolio of a foreign or alien insurer shall be as permitted by the laws of its domicile if of a quality substantially equal to that required under this chapter for similar funds of like domestic insurers.

(18 Del. C. 1953, § 1330; 56 Del. Laws, c. 380, § 1.)

§ 1330. Personal property.

An insurer may invest in tangible personal property, or interests therein evidenced by trust certificates or other instruments, and a right to receive rental, charter hire, purchase or other payments for the use or purchase of such personal property adequate to return the investment and payable or guaranteed by 1 or more governmental units or instrumentalities whose obligations would qualify for investment under § 1306 of this title (public obligations) or 1 or more institutions whose obligations would qualify for investment under § 1308(a) or under § 1308(c)(2) or (4) of this title (corporate obligations). No insurer shall make an investment pursuant to this section if the aggregate amount so invested will exceed 5% of its assets or if the aggregate amount so invested as to which such rental, charter hire, purchase or other payments are payable or guaranteed by any 1 governmental unit or instrumentality other than the United States or Canada or any 1 institution will exceed 1% of such sets.

(18 Del. C. 1953, § 1331; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, § 30; 71 Del. Laws, c. 202, § 10.)

§ 1331. Secured obligations.

(a) An insurer may invest in obligations which are secured by:

(1) An assignment of a right to receive rental, charter hire, purchase or other payments for the use or purchase of real or personal property adequate to return the investment and payable or guaranteed by 1 or more governmental units or instrumentalities whose obligations would qualify for investment under § 1306 of this title (public obligations) or 1 or more institutions whose obligations would qualify for investment under § 1308(a) or under § 1308(c)(2), (4) or (5) of this title (corporate obligations); and

(2) A mortgage on or secured interest in such real or personal property.

(b) No insurer shall make an investment pursuant to this section in obligations, other than those of institutions, if the aggregate amount so invested will exceed 10% of its assets or if the aggregate amount so invested as to which such rental, charter hire, purchase or other payments are payable or guaranteed by any 1 governmental unit or instrumentality or any 1 institution will exceed 5% of such assets. No insurer shall make any investment pursuant to this section in obligations of or in any affiliate (as defined in § 5001 of this title).

(18 Del. C. 1953, § 1332; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, § 31; 63 Del. Laws, c. 363, § 15; 71 Del. Laws, c. 202, § 11.)

§ 1332. Production payments.

Production payments, or interests therein evidenced by trust certificates or other instruments, payable from oil, gas or other hydrocarbons in producing properties located in the United States or Canada or the adjacent continental shelf if an obligation secured by and payable from such production payment or interest therein would qualify for investment under § 1308(a) or under § 1308(c)(1) of this title as an obligation which is adequately secured and has investment qualities and characteristics wherein the speculative elements are not predominant. The term "production payments" shall be deemed to mean rights to oil, gas or other hydrocarbons in place or as produced which entitle the owner thereof to a specified fraction or percentage of production until a specified sum of money has been received. No insurer shall make an investment pursuant to this section if the aggregate amount so invested will exceed 15% of its assets.

(63 Del. Laws, c. 363, § 16; 71 Del. Laws, c. 202, § 12.)

§ 1333. Rules and regulations [For application of this section, see 79 Del. Laws, c. 207, § 3].

The Commissioner may issue such reasonable rules, regulations and orders as the Commissioner may deem necessary or desirable to effectuate the purposes of this chapter, including setting standards for the prudent use by domestic insurers of derivative instruments and other qualified financial contracts (as defined in § 5901 of this title), and setting standards (including without limitation any limits or conditions) for domestic insurers qualifying for, entering into advance agreements and reporting borrowings from any federal home loan bank, as defined in 12 U.S.C. § 1422(1)(A).

(78 Del. Laws, c. 29, § 1; 79 Del. Laws, c. 207, § 1.)

§ 1334. Additional investments.

An insurer may make additional loans or investments in excess of any aggregate investment limitation contained in this chapter in accordance with paragraph (1) of this section except for the aggregate limitations contained in §§ 1305(1) and 1313 of this title.

(1) An insurer may make additional loans or investments in accordance with the following:

a. A property and casualty insurer may invest an amount that is the lesser of:

1. Policyholder surplus less any surplus write-ins less 400% of the authorized control level risk-based capital; or

2. Ten percent of the insurer's cash and invested assets;

b. A life and health insurer may invest an amount that is the lesser of:

1. Policyholder surplus less surplus from separate accounts less any surplus write-ins less 450% of the authorized control level risk-based capital; or

2. Ten percent of the insurer's cash and invested assets.

No insurer shall make an investment pursuant to this section if the aggregate amount so invested will exceed 200% of the existing aggregate limitation stipulated in any section of this title.

(2) No such loan or investment shall be represented by:

a. Any item described in § 1102 (assets not allowed) of this title, or any loan or investment otherwise expressly prohibited in any section of this title;

b. Investments in derivatives.

(3) The insurer shall keep a separate record of all loans and investments made under this section.

(4) Unless otherwise specified, an investment limitation computed on the basis of an insurer's cash and invested assets shall relate to the amount required to be shown on the statutory balance sheet of the insurer most recently required to be filed with the Commissioner or as shown by a current financial statement resulting from merger of another insurer, bulk reinsurance, or change in capitalization. For purposes of computing any limitation based upon cash and invested assets, the insurer shall deduct from the amount of its cash and invested assets the amount of the liability recorded on its statutory balance sheet for:

a. The return of acceptable collateral received in a reverse repurchase transaction or a securities lending transaction;

b. Cash received in a dollar roll transaction; and

c. The amount reported as borrowed money in the most recently filed financial statement, to the extent not included in paragraphs (4)a. and b. of this section.

(78 Del. Laws, c. 56, § 1.)

Part I
Insurance
Chapter 15
Administration of Deposits

§ 1501. Authorized deposits of insurers.

The following deposits of insurers, when made through the Commissioner, shall be accepted and held by the Commissioner in trust, subject to the provisions of this chapter:

(1) Deposits required under this title for authority to transact insurance in this State;

(2) Deposits of domestic insurers when made pursuant to the laws of other states, provinces and countries as requirement for authority to transact insurance in such state, province or country;

(3) Deposits in such additional amounts as are permitted to be made under § 1508 of this title.

(18 Del. C. 1953, § 1501; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 1502. Purpose of deposit.

(a) Deposits made in this State under § 513 (deposit requirements, in general) of this title shall be held in trust for the respective purposes stated in that section.

(b) A deposit made in this State by a domestic insurer transacting insurance in another state, province or country, and as required by the laws of such other state, province or country, shall be held for the protection of all the insurer's policyholders or all its policyholders and creditors or for such other purpose or purposes as may be specified pursuant to such laws.

(c) Deposits made by domestic life insurers in connection with registered policies and bonds shall be made and held for the special protection of the holders of such policies and bonds.

(d) Deposits required under the retaliatory law, § 532 of this title, shall be held for such purposes as is required by such law, and as specified by the Commissioner's order requiring such deposit to be made.

(18 Del. C. 1953, § 1502; 56 Del. Laws, c. 380, § 1.)

§ 1503. Securities eligible for deposit.

(a) All such deposits required under § 513 of this title for authority to transact insurance in this State shall consist of good interest-bearing or dividend-paying securities of kinds eligible for investment of the funds of domestic insurers under Chapter 13 of this title.

(b) All other deposits of a domestic insurer held in this State pursuant to the laws of another state, province or country shall be comprised of securities of the kinds described in subsection (a) of this section above, and of such additional kind or kinds of securities required or permitted by the laws of such state, province or country.

(c) Deposits of foreign insurers made in this State under the retaliatory law, § 532 of this title, shall consist of such assets as are required by the Commissioner pursuant to such law.

(d) All securities placed on deposit on and after July 1, 1973, shall be of such a nature that the interest or dividends are payable without the necessity of access to the depository.

(18 Del. C. 1953, § 1503; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, § 35.)

§ 1504. Depository; access; costs.

(a) Deposits made in this State under this title shall be made through the Commissioner and kept in safe deposit with an established bank or trust company located in this State and selected by the Commissioner.

(b) Wherever reasonably possible all deposited securities shall be registered in the name of the Insurance Commissioner, State of Delaware, in trust for the depositing insurer, or registered in the insurer's name and be accompanied by a duly executed power of attorney in favor of the Commissioner. The State shall be responsible for the safekeeping of all securities deposited under this subsection and shall charge the costs of maintaining these deposits to the insurer.

(c) If securities for deposit are submitted in form other than as provided in subsection (b) of this section above or in connection with "registered" policies or bonds, the Commissioner or his or her representative shall forthwith deposit the same in the presence of the president, vice-president or authorized agent of the insurer, in a strong metal box, which shall require 2 distinct and different keys to unlock the same, 1 key to be kept by the Commissioner and the other by the insurer. The box shall not be opened except in the presence of the Commissioner or duly authorized representative, and the president, vice-president or authorized agent of the insurer. The insurer shall bear the costs of the depository.

(d) In addition to the manner of making deposits under this title provided for above, any such deposits may also be made by sufficient securities or cash being deposited directly with any established bank or trust company located in this State pursuant to an escrow agreement entered into between the person making such deposits and the bank receiving them which agreement has first been approved in writing

by the Commissioner. If deposits are made in this manner, the provisions of subsections (a), (b) and (c) of this section above shall not apply to such deposits, except as required by the Commissioner in granting approval of such escrow agreement and the arrangements made pursuant thereto.

(18 Del. C. 1953, § 1504; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, § 40; 65 Del. Laws, c. 419, § 1; 70 Del. Laws, c. 186, § 1.)

§ 1505. Record of deposits.

(a) The Commissioner shall give to the depositing insurer vouchers as to all assets and securities so deposited with the Commissioner.

(b) The Commissioner shall keep a record of the assets and securities comprising each deposit, showing as far as practical the amount and market value of each item, and all the Commissioner's transactions relative thereto.

(18 Del. C. 1953, § 1505; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 1506. Assignment, transfer of securities.

All securities deposited by an insurer and not negotiable by delivery shall be duly registered in the name of the Commissioner and his or her successors in office, or with power of attorney as provided in § 1504 of this title. Upon release of any such security to the insurer, the Commissioner shall reassign or surrender the power of attorney to the insurer.

(18 Del. C. 1953, § 1507; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 1507. Appraisal.

The Commissioner may, in his or her discretion, prior to acceptance for deposit of any particular asset or security, or at any time thereafter while so deposited, have the same appraised or valued by competent appraisers. The reasonable costs of any such appraisal or valuation shall be borne by the insurer.

(18 Del. C. 1953, § 1508; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 1508. Excess deposits.

(a) If assets deposited by an insurer under this chapter are subject to material fluctuations in market value, the Commissioner may, in his or her discretion, require the insurer to deposit and maintain on deposit additional assets in an amount reasonably necessary to assure that the deposit at all times has a market value of not less than the amount specified under the law by which the deposit is required.

(b) An insurer may otherwise at its option deposit assets in an amount exceeding its deposit required or otherwise permitted under this title by not more than 20% of such required or permitted deposit, or $20,000, whichever is the larger amount, for the purpose of absorbing fluctuations in the value of assets deposited and to facilitate exchange and substitution of such assets. During the solvency of the insurer any such excess shall be released to the insurer upon its request. During the insolvency of the insurer, such excess deposit shall be released only as provided in § 1512(e) of this title.

(18 Del. C. 1953, § 1509; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 1509. Rights of insurer during solvency.

So long as the insurer remains solvent and is in compliance with this title it may:

(1) Demand, receive, sue for and recover the income from the assets deposited;

(2) Exchange and substitute for the deposited assets, assets of equivalent or greater fair market value; and

(3) At any reasonable time inspect any such deposit.

(18 Del. C. 1953, § 1510; 56 Del. Laws, c. 380, § 1.)

§ 1510. Levy upon deposit.

(a) Except as provided in subsection (b) of this section below, no judgment creditor or other claimant of an insurer shall have the right to levy upon any of the assets held in this State as a deposit for the protection of the insurer's policyholders or policyholders and creditors. As to deposits made pursuant to the retaliatory provision, § 532 of this title, levy thereupon shall be permitted if so provided in the Commissioner's order under which the deposit is required.

(b) Securities comprising the special deposit of a surety insurer required under § 513(b) of this title shall not be subject to levy under any writ of attachment, but shall be subject to process against the insurer, by final judgment and execution issued against the insurer on account of its default upon any surety contract issued by it in this State, upon 30 days written notice to the insurer specifying the time, place and manner of sale and the process under which and purposes for which the securities are to be sold and accompanied by a copy of such process.

(18 Del. C. 1953, § 1511; 56 Del. Laws, c. 380, § 1.)

§ 1511. Deficiency of deposit.

If for any reason the market value of assets of an insurer held on deposit in this State as required under this title falls below the required amount, the insurer shall promptly deposit other or additional assets eligible for deposit sufficient to cure the deficiency. If the insurer has

failed to cure the deficiency within 20 days after receipt of notice thereof by registered mail from the Commissioner, the Commissioner shall forthwith revoke the insurer's certificate of authority.

(18 Del. C. 1953, § 1512; 56 Del. Laws, c. 380, § 1.)

§ 1512. Duration and release of deposit, in general.

(a) Every deposit made in this State by an insurer pursuant to the retaliatory law, § 532 of this title, shall be held for so long as the basis of such retaliation exists.

(b) When an insurer determines to discontinue business in this State, whether through merger, bulk reinsurance, or otherwise, and desires to withdraw its deposit, upon the insurer's application and at its expense the Commissioner shall publish notice of such intention in a newspaper of general circulation in the State once a week for 4 weeks. After such publication the Commissioner shall deliver the securities remaining on deposit to the insurer or its assigns when the Commissioner is satisfied, upon examination and the oaths of the president and secretary or other chief officers of the insurer, that all debts and liabilities of every kind due or to become due which the deposit was made to secure are paid or extinguished or otherwise adequately provided for.

(c) If the insurer has reinsured all its outstanding risks in another insurer or insurers, the Commissioner shall deliver such assets and securities to such insurer or insurers so assuming such risks, after publication of the notice required under subsection (b) of this section above, and upon proof to the Commissioner's satisfaction that:

(1) The assuming insurer has assumed and agreed to discharge all liabilities of every kind due and to become due which the deposit was to secure;

(2) The assuming insurer has on deposit in this State or with a state official in the United States, securities of a quality and in an amount and value not less than the deposit required of the reinsured insurer under this title and which will subsist for the security of the obligations of the reinsured insurer so assumed; and

(3) Such assets and securities have been duly assigned, transferred and set over to such assuming insurer or insurers.

(d) If such a withdrawal of deposit is desired by a foreign insurer, in addition to other requirements therefor the insurer shall notify its domiciliary state or province of the intended withdrawal and furnish to the Commissioner written acknowledgment by such state of such notification, in form satisfactory to the Commissioner.

(e) If the insurer is subject to delinquency proceedings as defined in § 5901 of this title, upon the order of a court of competent jurisdiction, the Commissioner shall yield the insurer's assets held on deposit to the receiver, conservator, rehabilitator or liquidator of the insurer, or to any other properly designated official or officials who succeed to the management and control of the insurer's assets.

(f) No release of deposited assets shall be made except upon application to and the written order of the Commissioner. The Commissioner shall have no personal liability for any release of any such deposit or part thereof so made by him or her in good faith.

(18 Del. C. 1953, § 1513; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 1513. Deposit for "registered" life insurance policies and bonds.

(a) Deposits made with the Commissioner in connection with "registered" policies and bonds heretofore issued in this State by a life insurer shall be held as long as the policy or contract with respect to which such deposit was made continues in force.

(b) Deposits held with respect to policies and bonds still in force shall not be released, whether or not such policies and bonds have been reinsured or the entire liability thereunder assumed by another insurer, or the issuing insurer has become insolvent, subject to delinquency proceedings, or dissolved.

(c) Upon proof satisfactory to the Commissioner that certain of such policies or bonds have lapsed, been surrendered for cash value, matured, or otherwise terminated, and that all liabilities of the insurer to policyholders and beneficiaries or bondholders with respect thereto have been fully paid and discharged, the Commissioner may release any applicable portion of the deposit if the deposit is then in excess of the amount otherwise required. The Commissioner may accept and rely upon the records of the insurer, as kept, summarized, and reported to him or her in regular course of its business, as to any such payment and discharge.

(18 Del. C. 1953, § 1514; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 1514. Commissioner's liability.

If the Commissioner wilfully fails faithfully to require, deposit, keep, account, and receipt for, or surrender in the manner by law authorized or required any assets as provided in this title, the Commissioner shall be responsible upon his or her official bond therefor and suit may be brought upon his or her bond by any person injured by such failure; and the Commissioner so offending shall be guilty of a felony, and fined not more than $10,000 and imprisoned not less than 2 years or more than 10 years.

(18 Del. C. 1953, § 1515; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

Part I
Insurance
Chapter 16
Reinsurance Intermediary Act

§ 1601. Short title.

This chapter may be cited as the “Reinsurance Intermediary Act.”

(68 Del. Laws, c. 69, § 1.)

§ 1602. Definitions.

(a) “Actuary” means a person who is a member in good standing of the American Academy of Actuaries.

(b) “Controlling person” means any person, firm, association or corporation who directly or indirectly has the power to direct or cause to be directed, the management, control or activities of the reinsurance intermediary.

(c) “Insurer” means any person, firm, association or corporation duly licensed in this State pursuant to the applicable provisions of the Insurance Law as an insurer.

(d) “Licensed producer” means an agent, broker or reinsurance intermediary licensed pursuant to the applicable provisions of the Insurance Law.

(e) *Qualified United States financial institutions.* — For purposes of this chapter, a “qualified United States financial institution” means an institution that:

(1) Is organized or (in the case of a United States office of a foreign banking organization) licensed, under the laws of the United States or any state thereof;

(2) Is regulated, supervised and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(3) Has been determined by either the Commissioner, or the Securities Valuation Office of the National Association of Insurance Commissioners, to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the Commissioner.

(f) “Reinsurance intermediary” means a reinsurance intermediary-broker or a reinsurance intermediary-manager as these terms are defined in subsections (f) and (g) of this section.

(g) “Reinsurance intermediary-broker” (“RB”) means any person, other than an officer or employee of the ceding insurer, “firm,” association or corporation who solicits, negotiates or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of such insurer.

(h) “Reinsurance intermediary-manager” (“RM”) means any person, firm, association or corporation who has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer (including the manager of a separate division, department or underwriting office) and acts as an agent for such reinsurer whether known as an RM, manager or other similar term. Notwithstanding the above, the following persons shall not be considered an RM, with respect to such reinsurer, for the purposes of this chapter:

(1) An employee of the reinsurer;

(2) A United States manager of the United States branch of an alien reinsurer;

(3) An underwriting manager which, pursuant to contract, manages all the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to the Holding Company Act, and whose compensation is not based on the volume of premiums written;

(4) The manager of a group, association, pool or organization of insurers which engage in joint underwriting or joint reinsurance and who are subject to examination by the insurance commissioner of the state in which the manager’s principal business office is located.

(i) “Reinsurer” means any person, firm, association or corporation duly licensed in this State pursuant to the applicable provisions of the Insurance Law as an insurer which assumes reinsurance.

(j) “To be in violation” means that the reinsurance intermediary, insurer or reinsurer for whom the reinsurance intermediary was acting failed to substantially comply with this chapter.

(68 Del. Laws, c. 69, § 1.)

§ 1603. Licensure.

(a) No person, firm, association or corporation shall act as an RB in this State if the RB maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation:

(1) In this State, unless such RB is a licensed producer in this State; or

(2) In another state, unless such RB is a licensed producer in this State or another state having a law substantially similar to this law or such RB is licensed in this State as a nonresident reinsurance intermediary.

(b) No person, firm, association or corporation shall act as an RM:

(1) For a reinsurer domiciled in this State, unless such RM is a licensed producer in this State;

(2) In this State, if the RM maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation in this State, unless such RM is a licensed producer in this State;

(3) In another state for a nondomestic insurer, unless such RM is a licensed producer in this State or another state having a law substantially similar to this law or such person is licensed in this State as a nonresident reinsurance intermediary.

(c) The Commissioner may require an RM subject to subsection (b) of this section to:

(1) File a bond in an amount from an insurer acceptable to the Commissioner for the protection of the reinsurer; and

(2) Maintain an errors and omissions policy in an amount acceptable to the Commissioner.

(d) (1) The Commissioner may issue a reinsurance intermediary license to any person, firm, association or corporation who has complied with the requirements of this chapter. Any such license issued to a firm or association will authorize all the members of such firm or association and any designated employees to act as reinsurance intermediaries under the license, and all such persons shall be named in the application and any supplements thereto. Any such license issued to a corporation shall authorize all of the officers, and any designated employees and directors thereof to act as reinsurance intermediaries on behalf of such corporation, and all such persons shall be named in the application and any supplements thereto.

(2) If the applicant for a reinsurance intermediary license is a nonresident, such applicant, as a condition precedent to receiving or holding a license, shall designate the Commissioner as agent for service of process in the manner, and with the same legal effect, provided for by this chapter, for designation of service of process upon unauthorized insurers; and also shall furnish the Commissioner with the name and address of a resident of this State upon whom notices or orders of the Commissioner or process affecting such nonresident reinsurance intermediary may be served. Such licensee shall promptly notify the Commissioner in writing of every change in its designated agent for service of process, and such change shall not become effective until acknowledged by the Commissioner.

(e) The Commissioner may refuse to issue a reinsurance intermediary license if, in the Commissioner's judgment, the applicant, anyone named on the application, or any member, principal, officer or director of the applicant, is not trustworthy, or that any controlling person of such applicant is not trustworthy to act as a reinsurance intermediary, or that any of the foregoing has given cause for revocation or suspension of such license, or has failed to comply with any prerequisite for the insurance of such license. Upon written request therefor, the Commissioner will furnish a summary of the basis for refusal to issue a license, which document shall be privileged and not subject to disclosure under the Freedom of Information Act [Chapter 100 of Title 29].

(f) Licensed attorneys-at-law of this State, when acting in their professional capacity as such, shall be exempt from this section.

(68 Del. Laws, c. 69, § 1; 70 Del. Laws, c. 186, § 1.)

§ 1604. Required contract provisions; reinsurance intermediary-brokers.

Transactions between an RB and the insurer it represents in such capacity shall only be entered into pursuant to a written authorization, specifying the responsibilities of each party. The authorization shall, at a minimum, contain provisions that:

(1) The insurer may terminate the RB's authority at any time.

(2) The RB will render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to, the RB, and remit all funds due to the insurer within 30 days of receipt.

(3) All funds collected for the insurer's account will be held by the RB in a fiduciary capacity in a bank which is a qualified United States financial institution as defined herein.

(4) The RB will comply with § 1605 of this title.

(5) The RB will comply with the written standards established by the insurer for the cession or retrocession of all risks.

(6) The RB will disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

(68 Del. Laws, c. 69, § 1.)

§ 1605. Books and records; reinsurance intermediary-brokers.

(a) For at least 10 years after expiration of each contract of reinsurance transacted by the RB, the RB will keep a complete record for each transaction showing:

(1) The type of contract, limits, underwriting restrictions, classes or risks and territory;

(2) Period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation;

(3) Reporting and settlement requirements of balances;

(4) Rate used to compute the reinsurance premium;

(5) Names and addresses of assuming reinsurers;

(6) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the RB;

(7) Related correspondence and memoranda;

(8) Proof of placement;

(9) Details regarding retrocessions handled by the RB including the identity of retrocessionaires and percentage of each contract assumed or ceded;

(10) Financial records, including but not limited to, premium and loss accounts; and

(11) When the RB procures a reinsurance contract on behalf of a licensed ceding insurer:

a. Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

b. If placed through a representative of the assuming reinsurer, other than an employee, written evidence that such reinsurer has delegated binding authority to the representative.

(b) The insurer will have access and the right to copy and audit all accounts and records maintained by the RB related to its business in a form usable by the insurer.

(68 Del. Laws, c. 69, § 1.)

§ 1606. Duties of insurers utilizing services of reinsurance intermediary-broker.

(a) An insurer shall not engage the services of any person, firm, association or corporation to act as an RB on its behalf unless such person is licensed as required by § 1603(a) of this title.

(b) An insurer may not employ an individual who is employed by an RB with which it transacts business, unless such RB is under common control with the insurer and subject to the Holding Company Act.

(c) The insurer shall annually obtain a copy of statements of the financial condition of each RB with which it transacts business.

(68 Del. Laws, c. 69, § 1.)

§ 1607. Required contract provisions; reinsurance intermediary-managers.

Transactions between an RM and the reinsurer it represents in such capacity shall only be entered into pursuant to a written contract, specifying the responsibilities of each party, which shall be approved by the reinsurer's board of directors. At least 30 days before such reinsurer assumes or cedes business through such producer, a true copy of the approved contract shall be filed with the Commissioner for approval. The contract shall, at a minimum, contain provisions that:

(1) The reinsurer may terminate the contract for cause upon written notice to the RM. The reinsurer may suspend the authority of the RM to assume or cede business during the pendency of any dispute regarding the cause for termination.

(2) The RM will render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to the RM, and remit all funds due under the contract to the reinsurer on not less than a monthly basis.

(3) All funds collected for the reinsurer's account will be held by the RM in a fiduciary capacity in a bank which is a qualified United States financial institution as defined herein. The RM may retain no more than 3 months' estimated claims payments and allocated loss adjustment expenses. The RM shall maintain a separate bank account for each reinsurer that it represents.

(4) For at least 10 years after expiration of each contract of reinsurance transacted by the RM, the RM will keep a complete record for each transaction showing:

a. The type of contract, limits, underwriting restrictions, classes or risks and territory;

b. Period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation, and disposition of outstanding reserves on covered risks;

c. Reporting and settlement requirements of balances;

d. Rate used to compute the reinsurance premium;

e. Names and addresses of reinsurers;

f. Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the RM;

g. Related correspondence and memoranda;

h. Proof of placement;

i. Details regarding retrocessions handled by the RM, as permitted by § 1609(d) of this title, including the identity of retrocessionaires and percentage of each contract assumed or ceded;

j. Financial records, including but not limited to, premium and loss accounts; and

k. When the RM places a reinsurance contract on behalf of a ceding insurer:

1. Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

2. If placed through a representative of the assuming reinsurer, other than an employee, written evidence that such reinsurer has delegated binding authority to the representative.

(5) The reinsurer will have access and the right to copy all accounts and records maintained by the RM related to its business in a form usable by the reinsurer.

(6) The contract cannot be assigned in whole or in part by the RM.

(7) The RM will comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection or cession of all risks.

(8) Sets forth the rates, terms and purposes of commissions, charges and other fees which the RM may levy against the reinsurer.

(9) If the contract permits the RM to settle claims on behalf of the reinsurer:

a. All claims will be reported to the reinsurer in a timely manner.

b. A copy of the claim file will be sent to the reinsurer at its request or as soon as it becomes known that the claim:

1. Has the potential to exceed the lesser of an amount determined by the Commissioner or the limit set by the reinsurer;

2. Involves a coverage dispute;

3. May exceed the RM's claims settlement authority;

4. Is open for more than 6 months; or

5. Is closed by payment of the lesser of an amount set by the Commissioner or any amount set by the reinsurer.

c. All claim files will be the joint property of the reinsurer and RM. However, upon an order of liquidation of the reinsurer such files shall become the sole property of the reinsurer or its estate; the RM shall have reasonable access to and the right to copy the files on a timely basis.

d. Any settlement authority granted to the RM may be terminated for cause upon the reinsurer's written notice to the RM or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination.

(10) If the contract provides for a sharing of interim profits by the RM, that such interim profits will not be paid until 1 year after the end of each underwriting period for property business and 5 years after the end of each underwriting period for casualty business (or a later period set by the Commissioner for specified lines of insurance) and not until the adequacy of reserves on remaining claims has been verified pursuant to § 1609(c) of this title.

(11) The RM will annually provide the reinsurer with a statement of its financial condition prepared by an independent certified accountant.

(12) The reinsurer shall periodically (at least semiannually) conduct an on-site review of the underwriting and claims processing operations of the RM.

(13) The RM will disclose to the reinsurer any relationship it has with any insurer prior to ceding or assuming any business with such insurer pursuant to this contract.

(14) The acts of the RM shall be deemed to be the acts of the reinsurer on whose behalf it is acting.

(68 Del. Laws, c. 69, § 1.)

§ 1608. Prohibited acts.

The RM shall not:

(1) Bind retrocessions on behalf of the reinsurer, except that the RM may bind facultative retrocessions pursuant to obligatory facultative agreements if the contract with the reinsurer contains reinsurance underwriting guidelines for such retrocessions. Such guidelines shall include a list of reinsurers with which such automatic agreements are in effect, and for each such reinsurer, the coverages and amounts or percentages that may be reinsured, and commission schedules.

(2) Commit the reinsurer to participate in reinsurance syndicates.

(3) Appoint any producer without assuring that the producer is lawfully licensed to transact the type of reinsurance for which the producer is appointed.

(4) Without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or 1 percent of the reinsurer's policyholder's surplus as of December 31 of the last complete calendar year.

(5) Collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire, without prior approval of the reinsurer. If prior approval is given, a report must be promptly forwarded to the reinsurer.

(6) Jointly employ an individual who is employed by the reinsurer.

(7) Appoint a sub-RM.

(68 Del. Laws, c. 69, § 1; 70 Del. Laws, c. 186, § 1.)

§ 1609. Duties of reinsurers utilizing services of reinsurance intermediary-manager.

(a) A reinsurer shall not engage the services of any person, firm, association or corporation to act as an RM on its behalf unless such person is licensed as required by § 1603(b) of this title.

(b) The reinsurer shall annually obtain a copy of statements of the financial condition of each RM which such reinsurer has engaged prepared by an independent certified accountant in a form acceptable to the Commissioner.

(c) If an RM establishes loss reserves, the reinsurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the RM. This opinion shall be in addition to any other required loss reserve certification.

(d) Binding authority for all retrocessional contracts or participation in reinsurance syndicates shall rest with an officer of the reinsurer who shall not be affiliated with the RM.

(e) Within 30 days of termination of a contract with an RM, the reinsurer shall provide written notification of such termination to the Commissioner.

(f) A reinsurer shall not appoint to its board of directors any officer, director, employee, controlling shareholder or subproducer of its RM. This subsection shall not apply to relationships governed by the Holding Company Act or, if applicable, the Broker Controlled Insurer Act.

(68 Del. Laws, c. 69, § 1.)

§ 1610. Examination authority.

(a) A reinsurance intermediary shall be subject to examination by the Commissioner. The Commissioner shall have access to all books, bank accounts and records of the reinsurance intermediary in a form usable to the Commissioner.

(b) An RM may be examined as if it were the reinsurer.

(68 Del. Laws, c. 69, § 1.)

§ 1611. Penalties and liabilities.

(a) A reinsurance intermediary, insurer or reinsurer found by the Commissioner after a hearing conducted in accordance with the Administrative Procedures Act [Chapter 101 of Title 29] to be in violation of any provision(s) of this chapter shall:

(1) For each separate violation, pay a penalty in an amount not exceeding $15,000;

(2) Be subject to revocation or suspension of its license; and

(3) If a violation was committed by the reinsurance intermediary, such reinsurance intermediary shall make restitution to the insurer, reinsurer, rehabilitator or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer attributable to such violation.

(b) The decision, determination or order of the Commissioner pursuant to subsection (a) of this section shall be subject to judicial review pursuant to the Administrative Procedures Act [Chapter 101 of Title 29].

(c) Nothing contained in this section shall affect the right of the Commissioner to impose any other penalties provided in the Insurance Law.

(d) Nothing contained in this chapter is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, creditors or other third parties or confer any rights to such persons.

(68 Del. Laws, c. 69, § 1.)

§ 1612. Rules and regulations.

The Commissioner may adopt reasonable rules and regulations for the implementation and administration of this chapter.

(68 Del. Laws, c. 69, § 1.)

§ 1613. Effective date.

This chapter shall take effect on January 1, 1992. No insurer or reinsurer may continue to utilize the services of a reinsurance intermediary on and after January 1, 1992, unless utilization is in compliance with this chapter.

(68 Del. Laws, c. 69, § 1.)

Part I
Insurance
Chapter 16A
Business Transacted With Producer Controlled Insurer Act

§ 1650. Definitions.

(a) "Accredited state" means a state in which the insurance department or regulatory agency has qualified as meeting the minimum financial regulatory standards promulgated and established from time to time by the National Association of Insurance Commissioners (NAIC).

(b) "Control" or "controlled" has the meaning ascribed in Chapter 50 of this title.

(c) "Controlled insurer" means a licensed insurer which is controlled, directly or indirectly, by a producer.

(d) "Controlling producer" means a producer who, directly or indirectly, controls an insurer.

(e) "Licensed insurer" or "insurer" means any person, firm, association or corporation duly licensed to transact a property/casualty insurance business in this State. The following, inter alia, are not licensed insurers for the purposes of this chapter:

(1) All risk retention groups as defined in the Superfund Amendments [and] Reauthorization Act of 1986, Pub. L. No. 99-499, 100 Stat. 1613 (1986) [29 U.S.C. § 655; 42 U.S.C. §§ 9601 note, 9611, 9671-9675], the Risk Retention Act, 15 U.S.C. § 3901 et seq. (1982 & Supp. 1986) and Chapter 80 of this title;

(2) All residual market pools and joint underwriting authorities or associations; and

(3) All captive insurers (for the purposes of this chapter, captive insurers are insurance companies owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, insurance organizations owned by the insureds whose exclusive purpose is to insure risks to member organizations and/or group members and their affiliates).

(f) "Producer" means an insurance broker or brokers or any other person, firm, association or corporation, when, for any compensation, commission or other thing of value, such person, firm, association or corporation acts or aids in any manner in soliciting, negotiating or procuring the making of any insurance contract on behalf of an insured other than the person, firm, association or corporation.

(68 Del. Laws, c. 334, § 1.)

§ 1651. Applicability.

This chapter shall apply to licensed insurers as defined in § 1650 of this title, whether domiciled in this State or domiciled in a state that is not an accredited state having in effect a substantially similar law. All provisions of the Insurance Holding Company Act, to the extent they are not superseded by this chapter, shall continue to apply to all parties within holding company systems subject to this chapter.

(68 Del. Laws, c. 334, § 1.)

§ 1652. Minimum standards.

(a) *Applicability of section.* — (1) The provisions of this section shall apply if, in any calendar year, the aggregate amount of gross written premium on business placed with a controlled insurer by a controlling producer is equal to or greater than 5 percent of the admitted assets of the controlled insurer, as reported in the controlled insurer's quarterly statement filed as of September 30 of the prior year.

(2) Notwithstanding paragraph (a)(1) of this section, the provisions of this section shall not apply if the controlling producer:

a. Places insurance only with the controlled insurer, or only with the controlled insurer and a member or members of the controlled insurer's holding company system, or the controlled insurer's parent, affiliate or subsidiary and receives no compensation based upon the amount of premiums written in connection with such insurance; and

b. Accepts insurance placements only from nonaffiliated subproducers, and not directly from insureds; and

c. The controlled insurer, except for insurance business written through a residual market facility such as Assigned Risk Plan, accepts insurance business only from a controlling producer, a producer controlled by the controlled insurer, or a producer that is a subsidiary of the controlled insurer.

(b) *Required contract provisions.* — A controlled insurer shall not accept business from a controlling producer and a controlling producer shall not place business with a controlled insurer unless there is a written contract between the controlling producer and the insurer specifying the responsibilities of each party, which contract has been approved by the board of directors of the insurer and contains the following minimum provisions:

(1) The controlled insurer may terminate the contract for cause, upon written notice to the controlling producer. The controlled insurer shall suspend the authority of the controlling producer to write business during the pendency of any dispute regarding the cause for the termination;

(2) The controlling producer shall render accounts to the controlled insurer detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to, the controlling producer;

(3) The controlling producer shall remit all funds due under the terms of the contract to the controlled insurer on at least a monthly basis. The due date shall be fixed so that premiums or installments thereof collected shall be remitted no later than 90 days after the effective date of any policy placed with the controlled insurer under this contract;

(4) All funds collected for the controlled insurer's account shall be held by the controlling producer in a fiduciary capacity, in 1 or more appropriately identified bank accounts in banks that are members of the Federal Reserve System, in accordance with the provisions of the insurance law as applicable. (Funds of a controlling producer not required to be licensed in this State shall be maintained in compliance with the requirements of the controlling producer's domiciliary jurisdiction);

(5) The controlling producer shall maintain separately identifiable records of business written for the controlled insurer;

(6) The contract shall not be assigned in whole or in part by the controlling producer;

(7) The controlled insurer shall provide the controlling producer with its underwriting standards, rules and procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks. The controlling producer shall adhere to the standards, rules, procedures, rates and conditions. The standards, rules, procedures, rates and conditions shall be the same as those applicable to comparable business placed with the controlled insurer by a producer other than the controlling producer;

(8) The rates and terms of the controlling producer's commissions, charges or other fees and the purposes for those charges or fees.

The rates of the commissions, charges and other fees shall be no greater than those applicable to comparable business placed with the controlled insurer by producers other than controlling producers. For purposes of this paragraph and paragraph (b)(7) of this section, examples of "comparable business" include the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits, and similar quality of business;

(9) If the contract provides that the controlling producer, on insurance business placed with the insurer, is to be compensated contingent upon the insurer's profits on that business, then such compensation shall not be determined and paid until at least 5 years after the premiums on liability insurance are earned and at least 1 year after the premiums are earned on any other insurance. In no event shall the commissions be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified pursuant to paragraph (d)(1) of this section;

(10) A limit on the controlling producer's writings in relation to the controlled insurer's surplus and total writings. The insurer may establish a different limit for each line or sub-line of business. The controlled insurer shall notify the controlling producer when the applicable limit is approached and shall not accept business from the controlling producer if the limit is reached. The controlling producer shall not place business with the controlled insurer if it has been notified by the controlled insurer that the limit has been reached; and

(11) The controlling producer may negotiate but shall not bind reinsurance on behalf of the controlled insurer on business the controlling producer places with the controlled insurer, except that the controlling producer may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and commission schedules.

(c) *Audit committee.* — Every controlled insurer shall have an audit committee of the board of directors composed of independent directors. The audit committee shall annually meet with management, the insurer's independent certified public accountants, and an independent casualty actuary or other independent loss reserve specialist acceptable to the Commissioner to review the adequacy of the insurer's loss reserves.

(d) *Reporting requirements.* — (1) In addition to any other required loss reserve certification, the controlled insurer shall annually, on April 1 of each year, file with the Commissioner an opinion of an independent casualty actuary or such other independent loss reserve specialist acceptable to the Commissioner reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year-end (including incurred but not reported) on business placed by the producer; and

(2) The controlled insurer shall annually report to the Commissioner the amount of commissions paid to the producer, the percentage such amount represents of the net premiums written and comparable amounts and percentage paid to noncontrolling producers for placements of the same kinds of insurance.

(68 Del. Laws, c. 334, § 1.)

§ 1653. Disclosure.

The producer, prior to the effective date of the policy, shall deliver written notice to the prospective insured disclosing the relationship between the producer and the controlled insurer; except that, if the business is placed through a subproducer who is not a controlling producer, the controlling producer shall retain in the producer's records a signed commitment from the subproducer that the subproducer is aware of the relationship between the insurer and the producer and that the subproducer has or will notify the insured.

(68 Del. Laws, c. 334, § 1; 70 Del. Laws, c. 186, § 1.)

§ 1654. Penalties.

(a) (1) If the Commissioner believes that the controlling producer or any other person has not materially complied with this chapter, or any regulation or order promulgated hereunder, after notice and opportunity to be heard, the Commissioner may order the controlling producer to cease placing business with the controlled insurer; and

(2) If it is found that because of such material noncompliance that the controlled insurer or any policyholder thereof has suffered any loss or damage, the Commissioner may maintain a civil action or intervene in an action brought by or on behalf of the insurer or policyholder for recovery of compensatory damages for the benefit of the insurer or policyholder or other appropriate relief.

(b) If an order for liquidation or rehabilitation of the controlled insurer has been entered pursuant to Chapter 59 of this title, and the receiver appointed under that order believes that the controlling producer or any other person has not materially complied with this chapter, or any regulation or order promulgated hereunder, and the insurer suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

(c) Nothing contained in this section shall affect the right of the Commissioner to impose any other penalties provided for in the Insurance Law.

(d) Nothing contained in this section is intended to or shall in any manner alter or affect the rights of policyholders, claimants, creditors or other 3rd parties.

(68 Del. Laws, c. 334, § 1.)

Part I
Insurance
Chapter 17
Licensing of Professional Insurance Personnel

§ 1701. Purpose and scope.

(a) This chapter governs the qualifications and procedures for the licensing of insurance producers, surplus lines brokers, fraternal representatives, adjusters, apprentice adjusters, property damage appraisers, apprentice property damage appraisers and temporary licensees. This chapter shall apply to all lines of insurance, including, but not limited to, life, health, variable annuity and variable life, property, casualty, surety, title, credit, personal lines, travel, transportation and marine, and to all types of insurers, whether operating on a mutual, stock, reciprocal, fraternal, group or other plan. It simplifies and organizes some statutory language to improve efficiency, permits the use of new technology, and reduces costs associated with issuing and renewing insurance licenses.

(b) This chapter shall establish the qualifications for granting licenses to professional insurance personnel; establish the procedures to be followed in determining the initial and continuing qualifications for such personnel; and provide definitions of such personnel's authorities, duties, responsibilities and prohibitions in a manner that will provide guidance to such personnel and control over such personnel by the Commissioner of Insurance for the benefit and protection of the citizens of the State.

(c) All transactions entered into by a surplus lines broker shall also be subject to Chapter 19 of this title.

(18 Del. C. 1953, § 1701; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 577, § 1; 65 Del. Laws, c. 142, § 3; 70 Del. Laws, c. 424, § 1; 73 Del. Laws, c. 80, § 1.)

§ 1702. Definitions.

For purposes of this chapter:

(1) "Adjuster" means a licensee of the Department who, as an independent contractor or on behalf of an independent contractor, insurer, self-insurer, producer or managing general agent, investigates and/or negotiates settlement of claims arising under insurance contracts.

(2) "Agent of the insurer" means a licensed producer of the Department appointed by an insurer to sell, solicit or negotiate applications for policies of insurance on its behalf and, if authorized to do so by the insurer, to issue conditional receipts.

(3) "Appraiser" means a licensee of the Department who assesses property damage to motor vehicles.

(4) "Apprentice" means a licensee of the Department who is qualified in all respects as an adjuster or appraiser, except as to experience, education and/or training.

(5) "Broker of insured" means a licensed producer of the Department who for compensation negotiates on behalf of others contracts for insurance from companies to whom such licensed producer is not appointed.

(6) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

(7) "Fraternal representative" means a licensee of the Department who is appointed or authorized to act for a society or fraternal organization to sell, solicit or negotiate, or make a life insurance, accident, or health insurance or annuity contract for no compensation except as specifically exempted from this requirement by § 6233 of this title.

(8) "Home state" means the District of Columbia or any state or territory of the United States in which an insurance producer, adjuster or appraiser maintains a principal place of residence or principal place of business and is licensed to act as an insurance producer, adjuster or appraiser.

(9) "Insurance producer" means a person required to be licensed under the laws of this State to sell, solicit or negotiate contracts of insurance or annuity or the lines of authority authorized within the scope of such license. For the purposes of this title the terms "insurance agent," "insurance broker," and "insurance consultant" shall be used interchangeably with the term "insurance producer."

(10) "License" means a document issued by this State's Insurance Commissioner authorizing a person to act as an insurance producer, adjuster or appraiser for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent or inherent, in the holder to represent or commit an insurance carrier.

(11) "Licensee" means any person issued a license pursuant to this chapter.

(12) "Limited line credit insurance" includes credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection (gap) insurance and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation that the Insurance Commissioner determines should be designated a form of limited line credit insurance.

(13) "Limited line credit insurance producer" means a person who sells, solicits or negotiates 1 or more forms of limited line credit insurance coverage to individuals through a master, corporate, group or individual policy.

(14) "Limited lines insurance" means those lines of insurance defined in § 1707(b) of this title or any other line of insurance that the Insurance Commissioner deems necessary to recognize for the purposes of complying with § 1708(e) of this title.

(15) “Limited lines producer” means a person authorized by the Insurance Commissioner to sell, solicit or negotiate limited lines insurance.

(16) “Negotiate” means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

(17) “Person” means an individual or a business entity.

(18) “Portable electronics insurance” has the meaning set forth in § 2051 of this title.

(19) “Revocation” means recalling or taking back an insurance license or licenses for a minimum period of 12 months. Any insurer appointments of such license shall likewise be revoked. No individual whose license is revoked shall be issued another license without first complying with all requirements of § 1706 of this title.

(20) “Self-service storage insurance” means insurance offered in connection with and incidental to the rental of space at a self-service storage facility.

(21) “Sell” means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

(22) “Solicit” means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

(23) “Suspension” means to bar temporarily the privileges of an insurance license or licenses granted under Chapter 17 of this title, for a maximum of 12 months. A suspension shall also include a suspension of the appointment of such licensee. Upon the expiration of the suspension period and upon satisfactory completion of such terms and conditions as the Commissioner has imposed pursuant to the suspension, all licenses and appointments shall be reinstated.

(24) “Termination” means the cancellation of the relationship between a licensee and the insurer or the termination of a licensee’s authority to transact insurance.

(25) “Transact” shall have the meaning set forth in § 103 of this title and, for purposes of this chapter shall include negotiating, selling and soliciting insurance and settling and/or adjusting claims under policies.

(26) “Travel insurance” means insurance coverage for personal risks incident to planned travel, including any of the following:

a. Interruption or cancellation of trip or event.

b. Loss of baggage or personal effects.

c. Damages to accommodations or rental vehicles.

d. Sickness, accident, disability or death occurring during travel.

e. Emergency evacuation.

f. Repatriation of remains.

g. Any other contractual obligations to indemnify or pay a specified amount to the traveler upon determinable contingencies related to travel as approved by the Commissioner.

“Travel insurance” does not include major medical plans, which provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including for example, those working or residing overseas as an expatriate or military personnel being deployed, or any other product that requires a specific insurance producer license.

(27) “Uniform Business Entity Application” means the current version of the National Association of Insurance Commissioners (NAIC) Uniform Business Entity Application for resident and nonresident business entities.

(28) “Uniform Application” means the current version of the NAIC Uniform Application for resident and nonresident producer licensing.

(70 Del. Laws, c. 424, § 1; 70 Del. Laws, c. 186, § 1; 71 Del. Laws, c. 381, § 1; 73 Del. Laws, c. 80, § 1; 78 Del. Laws, c. 359, § 1; 79 Del. Laws, c. 428, § 2; 80 Del. Laws, c. 215, § 1; 81 Del. Laws, c. 437, § 1; 84 Del. Laws, c. 40, § 1; 84 Del. Laws, c. 42, § 1; 84 Del. Laws, c. 514, § 37.)

§ 1703. License required.

A person shall not transact insurance in this State for any class or classes of insurance unless the person is licensed as an insurance producer, adjuster or appraiser for that line of authority in accordance with this chapter.

(59 Del. Laws, c. 577, § 1; 61 Del. Laws, c. 64, § 1; 65 Del. Laws, c. 142, §§ 5, 6; 70 Del. Laws, c. 186, § 1; 70 Del. Laws, c. 424, § 1; 73 Del. Laws, c. 80, § 1; 80 Del. Laws, c. 215, § 2.)

§ 1704. Exceptions to licensing.

(a) Nothing in this chapter shall be construed to require an insurer to obtain a license pursuant to this chapter. In this section, the term “insurer” does not include an insurer’s officers, directors, employees, subsidiaries or affiliates.

(b) A license as an insurance producer shall not be required of the following:

(1) An officer, director or employee of an insurer or of an insurance producer, provided that the officer, director or employee does not receive any commission on policies written or sold to insure risks residing, located or to be performed in this State and:

a. The officer, director or employee's activities are executive, administrative, managerial, or clerical, or a combination of these, and are only indirectly related to the sale, solicitation or negotiation of insurance;

b. The officer, director or employee's function relates to underwriting; or

c. The officer, director or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation or negotiation of insurance;

(2) A person who secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, or group or blanket accident and health insurance or for the purpose of enrolling individuals under plans; a person issuing certificates under plans or otherwise assisting in administering plans; or a person who performs administrative services related to mass marketed property and casualty insurance, where no commission is paid to the person for the service;

(3) An employer or association or its officers, directors or employees, or the trustees of an employee trust plan, to the extent that the employers, officers, employees, director or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, as long as the employers, associations, officers, directors, employees or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts;

(4) Employees of insurers or organizations employed by insurers who are engaging in the rating or classification of risks or in the supervision of the training of insurance producers and who are not individually engaged in the sale, solicitation or negotiation of insurance;

(5) A person whose activities in this State are limited to advertising without the intent to solicit insurance in this State through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the State, provided that the person does not sell, solicit or negotiate insurance that would insure risks residing, located or to be performed in this State;

(6) A person who is not a resident of this State who sells, solicits or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than 1 state insured under that contract, provided that that person is otherwise licensed as an insurance producer to sell, solicit or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state; or

(7) A salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer provided that the employee does not sell or solicit insurance or receive a commission.

(18 Del. C. 1953, § 1709; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 577, § 1; 65 Del. Laws, c. 142, §§ 10, 11; 70 Del. Laws, c. 186, § 1; 70 Del. Laws, c. 424, § 1; 73 Del. Laws, c. 80, § 1; 80 Del. Laws, c. 215, § 3.)

§ 1705. Application for examination.

(a) A resident individual applying for a license shall pass a written examination unless exempt pursuant to § 1709 of this title. The examination shall test the knowledge of the individual concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer, adjuster or appraiser, as applicable, general insurance knowledge, insurance ethics as established by the Commissioner, and the insurance laws and regulations of this State.

(b) The Insurance Commissioner may make arrangements for administration and grading by an independent testing service as specified by contract.

(c) An individual who fails to appear for the examination as scheduled or fails to pass the examination shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination.

(d) *Reexamination.* — The failure of an applicant to pass an examination or the failure to appear for the examination or to take or complete the examination does not preclude the applicant from taking subsequent examinations.

(e) All examination score reports are valid for a period of 12 months from the date of examination.

(18 Del. C. 1953, §§ 1714, 1716, 1717; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 279, § 10; 59 Del. Laws, c. 577, § 1; 64 Del. Laws, c. 230, § 1; 70 Del. Laws, c. 424, § 1; 71 Del. Laws, c. 381, § 3; 73 Del. Laws, c. 80, § 1; 80 Del. Laws, c. 215, § 4.)

§ 1706. Application for license [For application of this section, see 83 Del. Laws, c. 297, § 2].

(a) A person applying for a resident license shall make application to the Insurance Commissioner on the Uniform Application or on forms prescribed by the Commissioner for license types and lines of authority not available on the Uniform Application and declare under penalty of refusal, suspension or revocation of the license that the statements made in the application are true, correct and complete to the best of the individual's knowledge and belief. Before approving the application, the Insurance Commissioner shall find that the individual:

(1) Is at least 18 years of age;

(2) Has not committed any act that is a ground for denial, suspension, or revocation set forth in § 1712 of this title;

(3) Has paid the fees set forth in Chapter 7 of this title;

(4) Has successfully passed the examinations for the lines of authority for which the person has applied, unless specifically exempted from such examination by this chapter; and

(5) If applying for a resident producer license, is a resident of Delaware or works for a business entity that is licensed to conduct the business of insurance in Delaware and maintains a physical location in Delaware that is open to the public and from which such business is conducted. An applicant may not use registered agent services or a Delaware postal box in order to establish the residency requirements set forth in this paragraph.

(b) (1) Any person applying for a resident license, whether a resident applicant or a nonresident applicant that has declared Delaware to be the person's home state, shall submit fingerprints and other necessary information to the State Bureau of Identification in order to obtain all of the following:

a. A report of the person's entire criminal history record from the State Bureau of Identification or a statement from the State Bureau of Identification that the State Bureau of Identification Central Repository contains no such information relating to that person.

b. A report of the person's entire federal criminal history from the Federal Bureau of Investigation pursuant to the Federal Bureau of Investigation appropriation of Title II of Public Law 92-544(28 U.S.C. § 534, note) or a statement that the Federal Bureau of Investigation's records contain no such information relating to that person.

(2) The State Bureau of Identification shall be the intermediary for purposes of this section and the Department shall be the screening point for the receipt of federal criminal history reports required by paragraph (b)(1)b. of this section.

(3) The State Bureau of Identification shall forward all information obtained under this subsection to the Department.

(4) A person required to obtain criminal history reports under this subsection is responsible for any costs associated with obtaining the criminal history reports.

(c) Every applicant for a license as an apprentice adjuster or apprentice property damage appraiser must file with the Commissioner a certification from one holding a license as an adjuster or property damage appraiser in which said holder of the license assumes responsibility for the applicant's training and for all actions undertaken by the applicant pursuant to the requested license.

(d) Every applicant for a license as an insurance producer for the line of variable annuity must hold a license as a life insurance agent and must be registered with the National Association of Security Dealers.

(e) All premiums, return premiums or other funds received in any manner by a licensee or a surplus lines broker shall be held in a fiduciary capacity and shall be accounted for by such licensee or surplus lines broker. The licensee or surplus lines broker shall, in the ordinary course of business, pay the funds to the insured or the insured's assignee, insurer, insurance premium finance company or agent entitled to the payment.

(f) A business entity acting as an insurance producer, adjuster or appraiser is required to obtain a license pursuant to this chapter. Application shall be made using the Uniform Business Entity Application or on forms prescribed by the Commissioner for license types and lines of authority not available on the Uniform Business Entity Application. Before approving the application, the Insurance Commissioner shall find that:

(1) The business entity has paid the fees set forth in Chapter 7 of this title; and

(2) The business entity has designated a licensed producer, adjuster or appraiser, as applicable, responsible for the business entity's compliance with the insurance laws, rules and regulations of this State. If the license of a business entity's designated responsible licensee is no longer active (whether due to expiration, suspension, revocation or otherwise), the license of such business entity shall be immediately suspended until such time as a designated responsible licensee in good standing is designated as such business entity's responsible producer, adjuster or appraiser, as applicable.

(g) The Insurance Commissioner may require any documents reasonably necessary to verify the information contained in an application.

(h) Each insurer that sells, solicits or negotiates any form of limited line credit insurance shall provide to each individual whose duties will include selling, soliciting or negotiating limited line credit insurance a program of instruction that may be approved by the Insurance Commissioner.

(i) No resident of Canada may be licensed as an adjuster pursuant to this section or may designate Delaware as the adjuster's home state, unless such person has successfully passed the adjuster examination and has complied with other applicable portions of this section.

(j) A business entity applying for a license as an adjuster for portable electronic insurance claims shall submit such application on a form as prescribed by the Commissioner. The Commissioner is authorized, at all times, to require the applicant to disclose the names and addresses of all executive officers and directors of the applicant and of all executive officers and directors of entities owning and any individuals owning, directly or indirectly, 51% or more of the outstanding voting securities of the applicant. The Commissioner is further authorized, at all times, to require the applicant to obtain their criminal histories from their state of residence. The Commissioner may, in the exercise of the Commissioner's discretion, refuse to issue a license to the applicant if not satisfied that their conduct meets the standards of this chapter. Any nonresident business entity applicant whose home-state requirements comply with all of these provisions of this subsection shall not be required to submit this material.

(59 Del. Laws, c. 577, § 1; 64 Del. Laws, c. 228, § 1; 65 Del. Laws, c. 142, §§ 12, 13; 70 Del. Laws, c. 186, § 1; 70 Del. Laws, c. 424, § 1; 71 Del. Laws, c. 434, § 1; 73 Del. Laws, c. 80, § 1; 78 Del. Laws, c. 359, § 2; 79 Del. Laws, c. 102, § 5; 80 Del. Laws, c. 116, § 1; 80 Del. Laws, c. 203, § 1; 80 Del. Laws, c. 215, § 5; 83 Del. Laws, c. 297, § 1; 84 Del. Laws, c. 42, § 1.)

§ 1707. License.

(a) Unless denied licensure pursuant to § 1712 of this title, persons who have met the requirements of §§ 1705 and 1706 of this title shall be issued a license. An insurance producer may receive qualification for a license in 1 or more of the following lines of authority:

(1) Life insurance coverage on human lives, including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income as defined in § 902 of this title.

(2) Accident and health or sickness insurance coverage for sickness, bodily injury or accidental death, and may include benefits for disability income as defined in § 903 of this title.

(3) Property insurance coverage for the direct or consequential loss or damage to property of every kind as defined in § 904 of this title.

(4) Casualty insurance coverage against legal liability, including that for death, injury or disability or damage to real or personal property as defined in § 906 of this title.

(5) Variable life and variable annuity products insurance coverage provided under variable life insurance contracts and variable annuities.

(6) Personal lines property and casualty insurance coverage sold to individuals and families for noncommercial purposes.

(7) Fidelity and surety, as defined in § 905 of this title.

(8) Marine and transportation insurance, as defined in § 907 of this title.

(9) Title insurance, as defined in § 908 of this title.

(10) Any other line of insurance permitted under state laws or regulations.

(b) Limited lines producer may be qualified and licensed and a qualified producer may hold 1 or more of the following limited lines of authority:

(1) Credit insurance lines.

(2) Life insurance or annuity products used solely to fund a pre-arranged funeral program.

(3) Travel insurance.

(4) Bail agent as provided for in Chapter 43 of this title.

(5) Automobile club where its activities are limited to those specified in § 908A of this title.

(6) Self-service storage insurance.

(7) Any other limited line of insurance permitted under state laws or regulations.

(c) A property damage appraiser’s license shall convey authority for the appraisal of damage to motor vehicles as defined in § 101 of Title 21.

(d) An adjuster’s license shall convey authority to investigate and negotiate settlement of claims on behalf of licensed agents, brokers, self-insurers, or insurers in 1 or more of the following lines of insurance:

(1) Property insurance.

(2) Casualty insurance.

(3) Fidelity and surety insurance.

(4) Automobile insurance.

(5) Marine and transportation insurance.

(6) Crop insurance.

(7) Workers compensation insurance.

(e) No license shall be required for any of the following:

(1) An adjuster or appraiser sent into this State on behalf of an insurer for the investigation of a particularly unusual or extraordinary loss, or series of losses, resulting from a catastrophe common to all such losses; provided that such adjuster or appraiser shall furnish to the Commissioner written notice within 10 calendar days of any such catastrophic insurance adjustment or appraisal work.

(2) An individual who, in regards to portable electronics insurance claims, collects claim information from, or furnishes claim information to, insureds or claimants, and who conducts data entry including entering data into an automated claims adjudication system, provided that the individual is an employee of a licensed independent adjuster or its affiliate where no more than 25 such persons are under the supervision of 1 licensed independent adjuster or licensed producer. A producer who is acting as a supervisor and adjusting claims pursuant to this paragraph is not required to be licensed as an adjuster. For purposes of this section, “automated claims adjudication system” means a preprogrammed computer system designed for the collection, data entry, calculation and final resolution of portable electronics insurance claims which:

a. Is only utilized by a licensed independent adjuster, licensed producer, or supervised individuals operating pursuant to this paragraph;

b. Complies with all claims payment requirements of the insurance code; and

c. Is certified as compliant with this section by a licensed independent adjuster that is an officer of a licensed business entity under this chapter.

(3) An individual who is a licensed agent or broker and who adjusts or assists in the adjustment of losses arising under policies of insurance issued through or serviced by such agent or broker; provided, however, that the Commissioner may promulgate regulations addressing the parameters pursuant to which a licensed agent or broker may adjust claims on behalf of an insurer without obtaining an adjuster's license.

(f) A license issued pursuant to this chapter shall remain in effect unless revoked or suspended as long as the fee set forth in Chapter 7 of this title is paid and education requirements for resident licensees are met by the due date. Notwithstanding anything to the contrary in this chapter, a licensee's failure to pay the fees set forth in Chapter 7 of this title or meet the education requirements established by the Commissioner shall result in the lapse by operation of law of the license issued to such licensee, without any notice required to be sent by the Department of Insurance to the licensee.

(g) An individual licensee who fails to timely renew and, as a result, allows said individual licensee's license to lapse may, within 12 months from the due date of the renewal fee or due date for the completion of the education requirements, as applicable, reapply for the same license without the necessity of passing a written examination. However, a penalty in the amount of double the unpaid renewal fee shall be required for any renewal fee received after the due date and within the first grace period of 6 months from the due date of the renewal fee; and may be subject to a civil fine of not less than $200 and not more than $1,000 within the second grace period of 6 months after the due date of the first grace period. Prior to any such license being reissued, the licensee shall provide evidence of compliance with all continuing education requirements for the relevant renewal period. Licensees who do not intend to renew their licenses must, on or prior to the due date of the renewal fee or due date for the completion of the education requirements, as applicable, submit to the Department a notice of voluntary surrender of their license in a form approved by the Department. Licensees who fail to timely renew within the grace period set forth in this subsection and do not otherwise submit a timely notice of voluntary surrender shall be subject to the same civil fine imposed on those licensees who renew within the second grace period referenced above, with such fine to be payable prior to being able to reapply for a Delaware license.

(h) A licensee who is unable to comply with license renewal procedures due to military service or some other extenuating circumstance (e.g., a long-term medical disability) may request a waiver of those procedures. The licensee may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with renewal procedures.

(i) The license shall contain the licensee's name, address, and personal identification number, and the date of issuance, the lines of authority, the expiration date and any other information the Insurance Commissioner deems necessary.

(j) Licensees shall inform the Insurance Commissioner by any means acceptable to the Insurance Commissioner of a legal name change or a change of physical mailing address or electronic mail address within 30 days of the change. Failure to timely inform the Insurance Commissioner of a change in legal name or address as required by this subsection shall result in a penalty pursuant to § 1712(a) and/or (d) of this title.

(k) The Commissioner may issue a new license for any lost, stolen or destroyed license issued pursuant to this chapter upon written request from the licensee and payment of appropriate fees for such duplicate license. In order to assist in the performance of the Insurance Commissioner's duties, the Insurance Commissioner may contract with nongovernmental entities, including the National Association of Insurance Commissioners (NAIC) or any affiliates or subsidiaries that the NAIC oversees, to perform any ministerial functions, including the collection of fees, related to producer, adjuster and appraiser licensing that the Insurance Commissioner and the nongovernmental entity may deem appropriate.

(*l*) The Commissioner may participate, in whole or in part, with the NAIC, or any affiliates or subsidiaries the NAIC oversees, in a centralized license registry where insurance producer licenses, adjuster licenses, appraiser licenses and appointments may be centrally or simultaneously effected for all states that require an insurance producer license, adjuster license or appraiser license and participate in such centralized license registry. If the Commissioner finds that participation in such a centralized license registry is in the public interest, the Commissioner may adopt by rule any uniform standards and procedures as necessary to participate in the registry. This includes the central collection of all fees for licenses or appointments that are processed through the registry.

(m) *Records.* — (1) The licensee shall maintain at such licensee's principal place of business the license issued by the Commissioner, together with such records as may be reasonably required by the Commissioner. Such records shall show all of the following:

a. With respect to insurance producers, for each policy or contract placed or countersigned by or through the licensee, names of the insurers, insureds, policy number, expiration date thereof, premium payable under the terms of the policy or contract, and such other information as the Commissioner may, from time to time, require.

b With respect to adjusters, for each claim settled or adjusted, names of the insurers, insureds, policy number, the amount for which the claim was adjusted or settled, and such other information as the Commissioner may, from time to time, require.

c. With respect to appraisers, for each appraisal submitted, the names of the insured and the person for whom the appraisal was completed, a copy of the written appraisal, and such other information as the Commissioner may, from time to time, require.

(2) Records shall be retained and available for inspection by the Commissioner for a period of 5 years.

(59 Del. Laws, c. 577, § 1; 62 Del. Laws, c. 284, § 2; 65 Del. Laws, c. 142, § 9; 66 Del. Laws, c. 4, § 2; 68 Del. Laws, c. 208, § 1; 70 Del. Laws, c. 186, § 1; 70 Del. Laws, c. 424, § 1; 73 Del. Laws, c. 80, § 1; 75 Del. Laws, c. 49, § 2; 76 Del. Laws, c. 394, § 3;

78 Del. Laws, c. 359, § 3; 79 Del. Laws, c. 428, § 3; 80 Del. Laws, c. 215, § 6; 81 Del. Laws, c. 437, § 2; 83 Del. Laws, c. 201, § 1; 84 Del. Laws, c. 35, § 1; 84 Del. Laws, c. 42, § 1; 84 Del. Laws, c. 293, § 1.)

§ 1708. Nonresident licensing.

(a) Unless denied licensure pursuant to § 1712 of this title, a nonresident person shall receive a nonresident license if:

(1) The person is currently licensed as a resident and in good standing in that person's home state; and

(2) The person has submitted the proper request for licensure and has paid the fees required by Chapter 7 of this title; and

(3) The person has submitted or transmitted to the Insurance Commissioner the application for licensure that the person submitted to his or her home state, or in lieu of the same, a completed Uniform Application or forms prescribed by the Commissioner for license types and lines of authority not available on the Uniform Application; and

(4) The person's home state awards nonresident licenses to residents of this State on the same basis.

Nonresident adjusters whose home states (including designated home states) do not have examination requirements for adjusters shall be required to satisfy this State's examination requirements prior to licensure.

Except where prohibited by state or federal law, by submitting an application for license, the applicant shall be deemed to have appointed the Commissioner as the agent for service of process on the applicant in any action or proceeding arising in this State out of or in connection with the exercise of the license. Such appointment of the Commissioner as agent for service of process shall be irrevocable during the period within which a cause of action against the applicant may arise out of transactions with respect to subjects of insurance in this State. Process shall be served upon the Commissioner or any Deputy Insurance Commissioner or such other person or persons as the Commissioner shall designate by rule or regulation.

(b) The Insurance Commissioner may verify the licensee's licensing status through the Producer Database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries. If a nonresident licensee's license in his or her home state is no longer in good standing (whether as a result of suspension, revocation or other action by the home state regulator), such licensee's nonresident license shall, 30 days after the final action taken with respect to the home state license, lapse by operation of law, without any notice required to be sent by the Department of Insurance to the licensee.

(c) A nonresident licensee who moves from 1 state to another state or a resident licensee who moves from this State to another state shall file a change of address and provide certification from the new resident state within 30 days of the change of legal residence. No license fee or license application is required.

(d) Notwithstanding any other provision of this chapter, a person licensed as a surplus lines producer in his or her home state shall receive a nonresident surplus lines producer license pursuant to subsection (a) of this section. Except as to subsection (a) of this section, nothing in this section otherwise amends or supersedes any provision of Chapter 19 of this title.

(e) Notwithstanding any other provision of this chapter, a person licensed as a limited line credit insurance or other type of limited lines producer in that person's home state shall receive a nonresident limited lines producer license, pursuant to subsection (a) of this section, granting the same scope of authority as granted under the license issued by the producer's home state. For the purposes of this subsection, limited line insurance is any authority granted by the home state which restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to § 1707(a)(1) through (6) of this title.

(f) Insurance for an insurer authorized to do business in Delaware which is permitted as a limited line of insurance in a Delaware nonresident producer's home state and is not described in this section shall have the same scope of authority as granted under the limited license issued by the producer's resident state, which shall be briefly described on the license issued.

(59 Del. Laws, c. 577, § 1; 65 Del. Laws, c. 142, § 15; 70 Del. Laws, c. 186, § 1; 70 Del. Laws, c. 424, § 1; 73 Del. Laws, c. 80, § 1; 73 Del. Laws, c. 324, § 1; 80 Del. Laws, c. 215, § 7.)

§ 1709. Exemption from examination.

(a) An individual who applies for a license in this State who was previously licensed for the same lines of authority in another state shall not be required to complete any prelicensing education or examination. This exemption is only available if the person is currently licensed in that state or if the application is received within 90 days of the cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state or the state's Producer Database records maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries indicate that the individual is or was licensed in good standing for the line of authority requested.

(b) A person licensed as an insurance producer, adjuster or appraiser in another state who moves to this State shall make application within 90 days of establishing legal residence to become a resident licensee pursuant to § 1706 of this title. No prelicensing education or examination shall be required of that person to obtain any line of authority previously held in the prior state except where the Insurance Commissioner determines otherwise by regulation.

(c) An applicant for a license as a producer for title insurance who is an attorney licensed to practice law in this State shall not be required to complete any prelicensing education or examination.

(d) An applicant for a license as a travel insurance licensee shall not be required to complete any prelicensing education or examination.

(e) An applicant for a license as an automobile club licensee shall not be required to complete any prelicensing education or examination.

(f) An applicant for a license as a self-service storage producer shall not be required to complete any prelicensing education or examination.

(18 Del. C. 1953, § 1715; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 279, § 9; 59 Del. Laws, c. 577, § 1; 64 Del. Laws, c. 230, § 3; 65 Del. Laws, c. 142, § 16; 70 Del. Laws, c. 424, § 1; 70 Del. Laws, c. 533, § 3; 73 Del. Laws, c. 80, § 1; 75 Del. Laws, c. 49, § 3; 79 Del. Laws, c. 428, § 4; 80 Del. Laws, c. 215, § 8; 81 Del. Laws, c. 437, § 3.)

§ 1710. Assumed names.

A licensee doing business under any name other than the licensee's legal name is required to notify and receive the approval of the Insurance Commissioner prior to using the assumed name. Such notification shall include proof that the licensee has registered the assumed name with the appropriate state authority.

(73 Del. Laws, c. 80, § 1; 80 Del. Laws, c. 215, § 9.)

§ 1711. Temporary licensing.

(a) The Insurance Commissioner may issue a temporary license for a period not to exceed 180 days without requiring an examination if the Insurance Commissioner deems that the temporary license is necessary for the servicing of an insurance business in the following cases:

(1) To the surviving spouse or court-appointed personal representative of a licensee who dies or becomes mentally or physically disabled to allow adequate time for the sale of the insurance business owned by the licensee or for the recovery or return of the licensee to the business or to provide for the training and licensing of new personnel to operate the licensee's business;

(2) To a member or employee of a business entity licensed as an insurance producer, adjuster or appraiser, upon the death or disability of an individual designated in the business entity application or the license;

(3) To the designee of a licensee entering active service in the armed forces of the United States of America; or

(4) In any other circumstance where the Insurance Commissioner deems that the public interest will best be served by the issuance of this license.

(b) The Insurance Commissioner may by order limit the authority of any temporary licensee in any way deemed necessary to protect insureds and the public. The Insurance Commissioner may require the temporary licensee to have a suitable sponsor who is a licensed producer, adjuster, appraiser or insurer, as applicable, and who assumes responsibility for all acts of the temporary licensee and may impose other similar requirements designed to protect insureds and the public. The Insurance Commissioner may by order revoke a temporary license if the interest of insureds or the public are endangered. A temporary license may not continue after the owner or the personal representative disposes of the business.

(59 Del. Laws, c. 577, § 1; 64 Del. Laws, c. 121, § 1; 70 Del. Laws, c. 424, § 1; 73 Del. Laws, c. 80, § 1; 80 Del. Laws, c. 215, § 10.)

§ 1712. License denial, nonrenewal or revocation.

(a) The Insurance Commissioner may place on probation, suspend, revoke or refuse to issue or renew a license or may levy a penalty in accordance with subsection (d) of this section or any combination of actions, for any 1 or more of the following causes:

(1) Providing incorrect, misleading, incomplete or materially untrue information in the license application or presenting, causing to be presented, preparing, assisting, abetting, soliciting or conspiring with another to prepare any document in the conduct of the licensee's business that contains false, incomplete or misleading information concerning any fact material to such document;

(2) Violating any insurance laws, or violating any regulation, subpoena or order of the Insurance Commissioner or of another state's Insurance Commissioner;

(3) Obtaining or attempting to obtain a license through misrepresentation or fraud;

(4) Improperly withholding, misappropriating or converting any moneys or properties received in the course of doing insurance business;

(5) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

(6) Having been convicted of a felony;

(7) Having admitted or been found to have committed any insurance unfair trade practice or fraud;

(8) Using fraudulent, coercive or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this State or elsewhere;

(9) Having an insurance producer, adjuster or appraiser license or its equivalent, denied, suspended or revoked in any other state, province, district or territory;

(10) Forging another's name to an application for insurance or to any document related to an insurance transaction;

(11) Improperly using notes or any other reference material to complete an examination for an insurance license;

(12) Knowingly accepting insurance business from an individual who is not licensed;

(13) Failing to comply with an administrative or court order imposing a child support obligation;

(14) Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax; or

(15) Failing to provide preliminary substantive responses to inquiries from the Department regarding violations of this title within 21 calendar days of such inquiry.

(b) In the event that the action by the Insurance Commissioner is to nonrenew or to deny an application for a license, the Insurance Commissioner shall notify the applicant or licensee and advise, in writing, the applicant or licensee of the reason for the denial or nonrenewal of the applicant's or licensee's license. The applicant or licensee may make written demand upon the Insurance Commissioner within 10 days for a hearing before the Insurance Commissioner to determine the reasonableness of the Insurance Commissioner's action. The hearing shall be held pursuant to the Administrative Procedures Act, Chapter 101 of Title 29, and such additional implemented regulations as may be published by the Commissioner.

(c) The license of a business entity may be suspended, revoked or refused if the Insurance Commissioner finds, after hearing, that an individual licensee's violation was known or should have been known by 1 or more of the partners, officers or managers acting on behalf of the business entity and the violation was neither reported to the Insurance Commissioner nor was corrective action taken.

(d) In addition to or in lieu of any applicable denial, suspension or revocation of a license, a person may, after hearing, be subject to a fine of not less than $200 and not more than $20,000 for each such violation. The Commissioner's order shall specify the date upon which such fine shall be paid and shall revoke the license of any licensee failing to comply with such order. The date on which payment shall be due shall be not less than 30 days following the date of the Commissioner's order unless otherwise specified in the order. The Commissioner may institute a civil action to recover fines so levied and shall pay over all fines paid and recovered to the State Treasurer.

(e) The Insurance Commissioner shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this chapter and this title against any person who is under investigation for or charged with a violation of this chapter or this title even if the person's license or registration has been surrendered or has lapsed by operation of law. The Commissioner may, upon the Commissioner's discretion, reinstate a suspended license at any time, and may impose as conditions upon the reinstatement such terms and conditions as the Commissioner determines appropriate.

(f) The Commissioner may place any individual or business entity on probation for a period of 1 year for violation of any insurance laws, rules, regulations and orders. The probationary period will not exceed 1 year.

(g) A person whose license has been revoked or suspended on 2 occasions shall not again be licensed under this title.

(h) An applicant whose license application was denied for 1 or more of the causes set forth in subsection (a) of this section shall be ineligible to reapply for a license under this chapter for a period of 1 year following the date of the denial of the application.

(59 Del. Laws, c. 577, § 1; 70 Del. Laws, c. 186, § 1; 70 Del. Laws, c. 424, § 1; 73 Del. Laws, c. 80, § 1; 80 Del. Laws, c. 215, § 11.)

§ 1713. Conservation of insurance business.

(a) If the Commissioner finds that the business of any licensee in this State has become financially impaired or insolvent, or has been abandoned by the licensee, or has been conducted in such a manner as to require or justify revocation of the licenses of that licensee, and if the Commissioner further finds that the conservation and administration of the business of the licensee would be in the public interest, he or she shall file in the Court of Chancery in the county in which the insurance business is located a petition for the appointment of the Commissioner as conservator or receiver of such licensee's business except by leave of the Court.

(b) The petition shall be verified by the Commissioner and shall set forth the facts and circumstances from which the existence of 1 or more of the grounds required under subsection (a) of this section may be determined; such petition may request that the licensee be required to show cause why the petition should not be granted.

(c) A copy of the petition and of the order to show cause, if they are issued, shall be served upon the licensee in the same manner as provided by law of this State for service of other legal process.

(d) Upon the filing of a petition and pending a hearing upon the order to show cause, the Court may, upon good cause shown and without notice to the other party, appoint the Commissioner as temporary conservator or receiver of the licensee's business.

(e) The Commissioner shall, as conservator or receiver, be authorized and empowered to conduct and administer the affairs of the licensee's business in order to expeditiously terminate such business and, to the extent reasonably possible, to provide services and an accounting for funds to all persons previously insured and to insurers who have previously been doing business through such licensee. Subject to the Court's order, the Commissioner shall have the power to collect funds owed to the licensee on account of insurance business transacted by him or her, and to account for and make payment of those funds to such persons as are entitled to them.

(f) The Commissioner may delegate the actual conduct and administration of the business of the licensee and no charges for services so rendered shall be made against the funds or assets of the licensee business except by leave of the Court.

(g) Except as expressly herein provided, receivership or conservatorship shall be subject to the applicable laws of this State and to the order of any court of competent jurisdiction.

(18 Del. C. 1953, § 1746; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 577, § 1; 70 Del. Laws, c. 186, § 1; 70 Del. Laws, c. 424, § 1; 73 Del. Laws, c. 80, § 1; 80 Del. Laws, c. 215, § 12.)

§ 1714. Commissions.

(a) An insurance company or insurance producer shall not pay a commission, service fee, brokerage or other valuable consideration to a person for selling, soliciting or negotiating insurance in this State if that person is required to be licensed under this chapter and is not so licensed.

(b) A person shall not accept a commission, service fee, brokerage or other valuable consideration for selling, soliciting or negotiating insurance in this State if that person is required to be licensed under this chapter and is not so licensed.

(c) Renewal or other deferred commissions may be paid to a person for selling, soliciting or negotiating insurance in this State if the person was required to be licensed under this chapter at the time of the sale, solicitation or negotiation and was so licensed at that time.

(d) An insurer or insurance producer may pay or assign commissions, service fees, brokerages or other valuable consideration to an insurance agency or to persons who do not sell, solicit or negotiate insurance in this State, unless the payment would violate §§ 2303 and 2304 of this title.

(e) No producer acting as a consultant may accept any fee, commission or other consideration from an insurer for any activity for which the producer acting as a consultant has received or will receive a fee from the producer's client.

(f) An insurer or insurance producer shall not pay a commission, service fee, brokerage or other valuable consideration to a person for selling, soliciting or negotiating insurance in this State if that person is required to be licensed under this chapter and is not so licensed. Nothing in this section allows an insurer to pay commissions to a nonappointed insurance producer when an appointment is otherwise required.

(g) An unlicensed person who refers a customer or potential customer to an insurer or insurance producer and who does not discuss specific terms and conditions of a policy or give opinions or advice regarding insurance may be compensated for the referral, if the compensation:

(1) For each referral is:

a. Nominal;

b. On a 1-time basis; and

c. Fixed in amount by referral;

(2) Does not depend on whether the customer or potential customer purchases the insurance; and

(3) Is not contingent on the volume of insurance transacted.

The restrictions set forth in this provision shall not apply to commercial lines. Referral fees for commercial lines shall still be subject to subsection (d) of this section.

(18 Del. C. 1953, § 1737; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 577, § 1; 65 Del. Laws, c. 142, §§ 22, 23; 70 Del. Laws, c. 186, § 1; 70 Del. Laws, c. 424, § 1; 73 Del. Laws, c. 80, § 1; 80 Del. Laws, c. 215, § 13.)

§ 1715. Appointments.

(a) An insurance producer shall not act as an agent of an insurer unless the insurance producer becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.

(b) To appoint a producer as its agent, the appointing insurer shall file, in a format approved by the Insurance Commissioner, a notice of appointment within 15 days from the date the agency contract is executed or the first insurance application is submitted. An insurer may also elect to appoint a producer to all or some insurers within the insurer's holding company system or group by the filing of a single appointment request. The group appointment provision of this section is only applicable upon implementation by this Department of an electronic appointment process.

(c) Upon receipt of the notice of appointment, the Insurance Commissioner shall verify within a reasonable time not to exceed 30 days that the insurance producer is eligible for appointment. If the insurance producer is determined to be ineligible for appointment, the Insurance Commissioner shall notify the insurer within 5 days of its determination.

(d) An insurer shall pay an appointment fee, in the amount and method of payment set forth in Chapter 7 of this title, for each insurance producer appointed by the insurer.

(59 Del. Laws, c. 577, § 1; 65 Del. Laws, c. 142, §§ 7, 8; 70 Del. Laws, c. 424, § 1; 73 Del. Laws, c. 80, § 1.)

§ 1716. Notification to Insurance Commissioner of termination.

(a) *Termination for cause.* — An insurer or authorized representative of the insurer that terminates the appointment, employment, contract or other insurance business relationship with a producer shall notify the Insurance Commissioner within 30 days following the effective date of the termination, using a format prescribed by the Insurance Commissioner, if the reason for termination is 1 of the reasons set forth in § 1712 of this title or the insurer has knowledge the producer was found by a court, government body or self-regulatory organization authorized by law to have engaged in any of the activities in § 1712 of this title. Upon the written request of the Insurance Commissioner, the insurer shall provide additional information, documents, records or other data pertaining to the termination or activity of the producer.

(b) *Termination without cause.* — An insurer or authorized representative of the insurer that terminates the appointment, employment or contract with a producer for any reason not set forth in § 1712 of this title shall notify the Insurance Commissioner within 30 days following the effective date of the termination, using a format prescribed by the Insurance Commissioner. Upon written request of the Insurance Commissioner, the insurer shall provide additional information, documents, records or other data pertaining to the termination.

(c) *Ongoing notification requirement.* — The insurer or the authorized representative of the insurer shall promptly notify the Insurance Commissioner in a format acceptable to the Insurance Commissioner if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the Insurance Commissioner in accordance with subsection (a) of this section had the insurer then known of its existence.

(d) *Copy of notification to be provided to producer.* — (1) Within 15 days after making the notification required by subsections (a), (b) and (c) of this section, the insurer shall mail a copy of the notification to the producer at his or her last known address. If the producer is terminated for cause for any of the reasons listed in § 1712 of this title, the insurer shall provide a copy of the notification to the producer at that producer's last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

(2) Within 30 days after the producer has received the original or additional notification, the producer may file written comments concerning the substance of the notification with the Insurance Commissioner. The producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer, and the comments shall become a part of the Insurance Commissioner's file and accompany every copy of a report distributed or disclosed for any reason about the producer as permitted under subsection (f) of this section.

(e) *Immunities.* — (1) In the absence of actual malice, an insurer, the authorized representative of the insurer, a producer, the Insurance Commissioner, or an organization of which the Insurance Commissioner is a member and that compiles the information and makes it available to other Insurance Commissioners or regulatory or law-enforcement agencies shall not be subject to civil liability, and a civil cause of action of any nature shall not arise against these entities or their respective agents or employees as a result of any statement or information required by or provided pursuant to this section or any information relating to any statement that may be requested in writing by the Insurance Commissioner from an insurer or producer or a statement by a terminating insurer or producer to an insurer or producer limited solely and exclusively to whether a termination for cause under subsection (a) of this section was reported to the Insurance Commissioner, provided that the propriety of any termination for cause under subsection (a) of this section is certified in writing by an officer or authorized representative of the insurer or producer terminating the relationship.

(2) In any action brought against a person that may have immunity under paragraph (e)(1) of this section for making any statement required by this section or providing any information relating to any statement that may be requested by the Insurance Commissioner, the party bringing the action shall plead specifically in any allegation that paragraph (e)(1) of this section does not apply because the person making the statement or providing the information did so with actual malice.

(3) Paragraph (e)(1) or (2) of this section shall not abrogate or modify any existing statutory or common law privileges or immunities.

(f) *Confidentiality.* — (1) Any documents, materials or other information in the control or possession of the Department of Insurance that is furnished by an insurer or producer or an employee or agent thereof acting on behalf of the insurer or producer or obtained by the Insurance Commissioner in an investigation pursuant to this section shall be confidential by law and privileged, shall not be subject to Chapter 100 of Title 29, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Insurance Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the Insurance Commissioner's duties.

(2) Neither the Insurance Commissioner nor any person who received documents, materials or other information while acting under the authority of the Insurance Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to paragraph (f)(1) of this section.

(3) In order to assist in the performance of the Insurance Commissioner's duties under this chapter, the Insurance Commissioner:

a. May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to paragraph (f)(1) of this section, with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries, and with state, federal and international law-enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

b. May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners, its affiliates or subsidiaries and from regulatory and law-enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

c. May enter into agreements governing sharing and use of information consistent with this subsection.

(4) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in paragraph (f)(3) of this section.

(5) Nothing in this chapter shall prohibit the Insurance Commissioner from releasing final, adjudicated actions including for cause terminations that are open to public inspection pursuant to Chapter 100 of Title 29 to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners or its affiliates or subsidiaries.

(g) *Penalties for failing to report.* — An insurer, the authorized representative of the insurer, or a producer that fails to report as required under the provisions of this section or that is found to have reported with actual malice by a court of competent jurisdiction may, after notice and hearing, have its license or certificate of authority suspended or revoked and may be fined in accordance with this title.

(59 Del. Laws, c. 577, § 1; 67 Del. Laws, c. 260, § 1; 70 Del. Laws, c. 186, § 1; 70 Del. Laws, c. 424, § 1; 71 Del. Laws, c. 381, § 5; 73 Del. Laws, c. 80, § 1.)

§ 1717. Reciprocity.

(a) The Insurance Commissioner shall waive any requirements for a nonresident license applicant with a valid license from the applicant's home state, except the requirements imposed by § 1708 of this title, if the applicant's home state awards nonresident licenses to residents of this State on the same basis.

(b) A nonresident licensee's satisfaction of that licensee's home state's continuing education requirements for licensed insurance producers, adjusters or appraisers, as applicable, shall constitute satisfaction of this State's continuing education requirements if the nonresident licensee's home state recognizes the satisfaction of its continuing education requirements imposed upon licensees from this State on the same basis. Nonresident adjusters whose home states (including designated home states) do not have continuing education requirements for adjusters shall be required to satisfy this State's continuing education requirements.

(c) No resident of Canada shall be granted reciprocity for purposes of obtaining a nonresident's adjuster license unless that individual has designated another state as his or her home state or obtained a resident adjuster's license in another state.

(73 Del. Laws, c. 80, § 1; 70 Del. Laws, c. 186, § 1; 78 Del. Laws, c. 359, § 4; 80 Del. Laws, c. 215, § 14.)

§ 1718. Additional or continuing education.

In addition to meeting the standards prescribed in other sections of this chapter for the issuance of a license, the Commissioner may promulgate regulations and/or prerequisites which will establish reasonable standards and criteria for requiring additional or continuing education of licensees, in order to ensure the maintenance or improvement of a licensee's insurance skills and knowledge. Failure to provide proof of meeting continuing education requirements shall result in the automatic lapse of such licensee's license in accordance with § 1707(f) of this title and may result in the imposition of monetary penalties in accordance with §§ 1707(g) and 1712(d) of this title.

(59 Del. Laws, c. 577, § 1; 64 Del. Laws, c. 230, § 2; 66 Del. Laws, c. 4, § 3; 70 Del. Laws, c. 424, § 1; 73 Del. Laws, c. 80, § 1; 80 Del. Laws, c. 215, § 15.)

§ 1719. Reporting of actions.

(a) A licensee shall report to the Insurance Commissioner any administrative action taken against the licensee in another jurisdiction or by another governmental agency in this State within 30 days of the final disposition of the matter. This report shall include a copy of the order, consent to order or other relevant legal documents.

(b) Within 30 days of the initial pretrial hearing date, a licensee shall report to the Insurance Commissioner any criminal prosecution of the licensee taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

(66 Del. Laws, c. 16, § 1; 70 Del. Laws, c. 424, § 1; 73 Del. Laws, c. 80, § 1; 80 Del. Laws, c. 215, § 16.)

§ 1720. Regulations.

The Insurance Commissioner may promulgate reasonable regulations as are necessary or proper to carry out the purposes of this chapter.

(59 Del. Laws, c. 577, § 1; 70 Del. Laws, c. 424, § 1; 73 Del. Laws, c. 80, § 1.)

§ 1721. Enforcement after license lapses or is surrendered.

The Commissioner shall retain authority to enforce the provisions of, and impose any penalty or remedy authorized by, this chapter and title against any person who is under investigation for, or charged with, a violation of this chapter and title even if, while the investigation or charges are pending, such person's license or registration is surrendered or lapses by operation of law.

(70 Del. Laws, c. 424, § 1; 73 Del. Laws, c. 80, § 1.)

§ 1722. Regulation of adjusters and appraisers [Repealed].

(79 Del. Laws, c. 102, § 5; repealed by 80 Del. Laws, c. 215, § 17, effective Apr. 20, 2016.)

§ 1723. Severability.

If any provisions of this chapter, or the application of a provision to any person or circumstances, shall be held invalid, the remainder of the chapter, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

(73 Del. Laws, c. 80, § 1; 79 Del. Laws, c. 102, § 6; 80 Del. Laws, c. 215, § 17.)

§ 1724. Effective date.

This chapter shall take effect March 1, 2002.

(73 Del. Laws, c. 80, § 1; 79 Del. Laws, c. 102, § 6; 80 Del. Laws, c. 215, § 17.)

Part I
Insurance

Chapter 17A
Licensing of Public Adjusters

§ 1750. Definitions.

For the purposes of § § 1750 through 1761 of this title, the following terms have the meanings indicated.

(1) “Adjuster” means an adjuster as defined in § 1702 of this title.

(2) “License” means a license issued by the Commissioner to act as a public insurance adjuster.

(3) “Licensee” means any person licensed in the State to do business as a public insurance adjuster.

(4) “Public adjuster” shall include any person who, for compensation or any other thing of value:

a. Acts or aids, solely in relation to first party claims arising under insurance contracts that insure the real or personal property of the insured, on behalf of an insured individual in negotiating for, or effecting the settlement of, a claim for loss or damage covered by an insurance contract;

b. Advertises for employment as an adjuster of insurance claims or solicits business or represents oneself to the public as an adjuster of first party insurance claims for losses or damages arising out of policies of insurance that insure real or personal property; or

c. Directly or indirectly solicits business, investigates or adjusts losses or advises an insured about first-party claims for losses or damages arising out of policies of insurance that insure real or personal property for another person engaged in the business of adjusting losses or damages covered by an insurance policy.

(74 Del. Laws, c. 178, § 1; 70 Del. Laws, c. 186, § 1; 84 Del. Laws, c. 514, § 38.)

§ 1751. License requirement.

(a) No person shall, directly or indirectly, act as a public adjuster without first procuring a license from the Commissioner to act as a public insurance adjuster.

(b) The Commissioner shall issue a license to an applicant for a public adjuster’s license who:

(1) Has paid the applicable fee, which shall be the same as that for an adjuster’s license;

(2) Passes a written examination for which a fee may be charged, in accordance with regulations issued pursuant to this chapter; and

(3) Has sufficient experience, training, and instruction concerning the adjusting of first party claims for damages or losses under insurance contracts that insure the real or personal property of the insured, as determined by the Commissioner in accordance with regulations issued pursuant to this chapter.

(c) The Commissioner may issue a license to any applicant without an examination if:

(1) The applicant holds a like license in good standing from another state and the public official having supervision of public insurance adjusters in the other state certifies that the applicant has passed a written examination; and

(2) The other state recognizes public insurance adjusters with public insurance adjuster licenses issued by the State of Delaware for the purpose of licensing the applicant without the requirement of an examination.

(d) A license issued pursuant to this section shall continue in force provided the licensee has completed continuing education requirements as established for adjusters and paid renewal fees as established for adjusters under this title, unless suspended, revoked or otherwise terminated prior thereto. Requests for renewal of the license shall be made to the Commissioner and accompanied by the license fee as established under Title 18.

(74 Del. Laws, c. 178, § 1.)

§ 1752. Bond requirement.

(a) At the time of the application for license as a public adjuster, the applicant shall file with the Commissioner a bond executed and issued by a surety insurer authorized to transact business in the State in the amount of $20,000, which bond shall serve the faithful performance of his or her duties as a public insurance adjuster. A public adjuster license shall automatically terminate when the bond is not in force.

(b) The bond shall have the following characteristics:

(1) The bond shall be in favor of the State and shall specifically authorize recovery by the Commissioner of the damages sustained if the licensee is convicted of fraud or unfair practices in connection with the licensee’s business as a public adjuster.

(2) The aggregate liability of the surety for all damages shall not exceed the amount of the bond.

(3) The bond shall not be terminated unless at least 30 days written notice is given to the licensee and filed with the Commissioner.

(74 Del. Laws, c. 178, § 1; 70 Del. Laws, c. 186, § 1.)

§ 1753. Ownership of other entities.

(a) An applicant for a public adjuster's license shall disclose to the Commissioner the full name and residence of each person who directly or indirectly owns or controls the licensee, or holds with power to vote or holds proxies with the power to vote, 10 percent or more of the voting securities of the licensee.

(b) The Commissioner may deny an application or suspend or revoke the license of a public adjuster if any person who directly or indirectly owns or controls the licensee, or holds with power to vote or holds proxies with the power to vote, 10 percent or more of the voting securities of the licensee does not meet the qualifications for licensure under this chapter.

(c) Every applicant for an initial or renewal public adjuster's license shall file with the Commissioner a list of the full names of all employees who are authorized to negotiate claims settlements.

(74 Del. Laws, c. 178, § 1.)

§ 1754. Maintenance of records.

(a) A public adjuster shall maintain a complete record of each transaction as a public insurance adjuster. The records required by this section shall include at least the:

(1) Name of the insured;

(2) Date, location and amount of the loss;

(3) Copy of the contract between the public insurance adjuster and insured;

(4) Name of the insurer, amount, expiration date and number of each policy carried with respect to the loss;

(5) Itemized statement of the insured's recoveries; and

(6) Itemized statement of all compensation received by the public insurance adjuster, from any source whatsoever, in connection with a particular claim.

(b) Records shall be maintained for at least 5 years after the termination of the transaction with an insured and shall be open to examination by the Commissioner at all times.

(c) Records submitted in accordance with this section that contain proprietary information, identified in writing as such by the public insurance adjuster shall be treated as confidential by the Commissioner.

(74 Del. Laws, c. 178, § 1.)

§ 1755. License denial, suspension, revocation and refusal to renew; civil penalties.

(a) The Commissioner may deny a license to an applicant or suspend, revoke or refuse to renew a license if the applicant or licensee:

(1) Violates the provisions of this chapter and any provision of the Delaware Unfair Trade Practices Law [Chapter 25 of Title 6] or the Delaware Unfair Claims Settlement Practices Law [Chapter 23 of this title] or any standard of conduct prescribed by the Commissioner in regulations;

(2) Makes a material misstatement in the application for the license;

(3) Engages in fraudulent or dishonest practices;

(4) Demonstrates incompetence or untrustworthiness to act as a public insurance adjuster; or

(5) Fails to complete continuing education requirements.

(b) Upon a finding by the Commissioner of a violation of subsection (a) of this section, the Commissioner may impose a civil penalty not to exceed $1,000 for each violation.

(c) This chapter shall not be applied or interpreted to bar a borrower from bringing an action pursuant to any Delaware or federal law for damages, injunctive relief or any other relief.

(74 Del. Laws, c. 178, § 1.)

§ 1756. Contracts and solicitation of contracts.

(a) No licensee shall, directly or indirectly, act within the State as a public adjuster without having first entered into a contract, in writing, on a form approved by the Commissioner and executed in duplicate by the public insurance adjuster and the insured or a duly authorized representative. One copy of the contract shall be kept on file by the licensee and be available at all times for inspection without notice by the Commissioner.

(b) (1) An insured who contracts for the services of a public adjuster shall have the right to cancel the contract until midnight on the third business day after the day on which the insured signs the contract. Contracts that do not substantially conform to the requirements contained in this section shall be void. Cancellation of the contract shall be effective when mailed if the following conditions are met:

a. The cancellation shall be in writing, but need not take a particular form, and shall be sufficient if it indicates the intent of the person not to go forward with the representation.

b. The right to cancel shall be contained in the approved contract in a format designated by the Commissioner.

(2) The right of rescission contained in this subsection shall be in addition to, and not in limitation of, any other rights of the insured.

(3) In a commercial loss, if a contract is cancelled in accordance with this subsection, the public adjuster shall be entitled to reasonable compensation for actual services rendered and costs incurred between the time the contract was entered into and the time it was cancelled.

(c) A licensee shall not solicit, or attempt to solicit, a client for employment during the progress of a loss-producing occurrence, as defined in the client's insurance contract.

(d) A licensee shall not permit an unlicensed employee or agent in the unlicensed employee's or agent's own name to advertise, engage clients, furnish reports or present bills to clients, or in any manner whatsoever to conduct business for which a license is required under this chapter.

(e) A licensee shall not charge the client a fee that exceeds 2.5% of the first $25,000 of the total insurance recovery of the client. A licensee may charge the client a fee of up to 12% of the amount of the total insurance recovery of the client that exceeds $25,000.

(f) A licensed public adjuster may not prevent or attempt to dissuade an insured from communicating with an insurer, the insurer's adjuster, an independent adjuster representing the insurer, an attorney, or any other person regarding the settlement of the insured's claim.

(g) A public adjuster shall be subject to the Delaware Unfair Claims Settlement Act [Chapter 23 of this title].

(74 Del. Laws, c. 178, § 1; 70 Del. Laws, c. 186, § 1.)

§ 1757. Adjustments to comply with insurance contract and law.

A public insurance adjuster shall adjust or investigate every claim, damage or loss made or occurring under an insurance contract for which the public insurance adjuster has been employed in accordance with the terms and conditions of the public insurance adjuster's contract with the insured and the applicable laws and regulations of the State.

(74 Del. Laws, c. 178, § 1; 70 Del. Laws, c. 186, § 1.)

§ 1758. Prohibited acts.

(a) Notwithstanding any other grounds for disciplinary action provided for under this chapter, the Commissioner may deny, revoke, suspend, refuse to renew, or impose a penalty on an applicant or licensee for violation of acts prohibited under this section.

(b) A licensed public adjuster is prohibited from doing any of the following:

(1) Paying any money or giving anything of value to any person in consideration of a direct or indirect referral of a client or potential client.

(2) Paying any money or giving anything of value to any person in consideration as an inducement to refer business or clients.

(3) Charging, collecting, or receiving any money or anything of value from any person providing services to an insured, either directly or on behalf of the public adjuster, in connection with the business of adjusting insurance claims, without the prior written disclosure of the fee or benefit to the insured.

(4) Rebating to any client any part of a fee specified in the employment contract.

(5) Splitting the licensed public adjuster's fees or paying any money to any person for services rendered to a client unless such other person is also licensed as a public adjuster.

(6) Having any interest directly or indirectly in any home improvement, restoration, construction, salvage, appraisal, loss mitigation, cleaning, or environmental restoration business that conducts business in this State.

(7) In connection with the licensee's conduct of business as public adjuster, making any misrepresentation of facts or advising any person on any question of law.

(8) Making false statements about any insurance company or its employees, agents, or representatives.

(9) Soliciting the employment by a client in connection with any loss which is the subject of an employment contract involving the client and another public adjuster.

(10) Representing both the insurer and the insured.

(11) Advancing any money to a client pending the settlement of a loss where such amount would be included in the final settlement.

(c) (1) A violation of this section is all of the following:

a. A prohibited trade practice under Chapter 25 of Title 6.

b. A violation of the Unfair Trade Practices Act under Chapter 23 of this title.

(2) A violation of this section may constitute insurance fraud under § 2407 of this title.

(d) A public adjuster is also subject to the penalties applicable to licensees under Chapter 17 of this title.

(74 Del. Laws, c. 178, § 1; 70 Del. Laws, c. 186, § 1; 83 Del. Laws, c. 283, § 24.)

§ 1759. Regulations and scope.

(a) The Commissioner shall promulgate rules and regulations as are necessary to carry out this chapter.

(b) This chapter shall not apply to:

(1) An adjuster for or an agent or employee of an insurer or group of insurers under common control or ownership that, as a representative of the insurer or group, adjusts losses or damages under policies issued by the insurer or group of insurers;

(2) An agent or broker that acts as an adjuster without compensation for an insured for whom the agent or broker is acting as an agent or broker;

(3) An attorney at law who does not:

a. Regularly act as a public insurance adjuster; or

b. Represent to the public by sign, advertisement or other written or oral communication indicating that the attorney at law acts as a public insurance adjuster; or

(4) A licensed health-care provider, or employee of a licensed health-care provider, who prepares or files a health insurance claim form on behalf of a patient;

(5) Persons employed only for the purpose of obtaining facts surrounding a loss or furnishing technical assistance to a licensed adjuster, including but not limited to photographers, private investigators, engineers and handwriting experts;

(6) Any agent or other person who negotiates and/or settles claims arising under life and health insurance policies;

(7) A person who performs clerical duties for or as an employee of an insurance company, but who does not participate in negotiations with parties on disputed and/or contested claims; or

(8) Any person who settles subrogation claims between authorized insurers.

(74 Del. Laws, c. 178, § 1.)

§ 1760. Immunity.

There shall be no liability on the part of and no cause of action shall arise against, the Commissioner or the Insurance Department or its employees for any action taken by them in the performance of their powers and duties under this chapter.

(74 Del. Laws, c. 178, § 1.)

§ 1761. Severability clause.

If any provision of this chapter, or its application to any person or circumstance, is held invalid, that determination shall not affect the provisions or applications of this chapter that can be given effect without the invalid provision or application, and to that end the provisions of this chapter are severable.

(74 Del. Laws, c. 178, § 1.)

Part I
Insurance

Chapter 17B
Licensing of Limited Lines Travel Insurance Producers

§ 1770. Short title.

This chapter shall be known as the “Limited Lines Travel Insurance Act.”

(79 Del. Laws, c. 428, § 5.)

§ 1771. Definitions.

For purposes of this chapter, the following terms have the meanings indicated.

(1) “Limited lines travel insurance producer” means a licensed managing general agent or third-party administrator, or licensed insurance producer, including a limited lines producer, or a “travel administrator” as defined in § 5603 of this title.

(2) “Offer and disseminate” means providing general information, including a description of the coverage and price, as well as processing the application, collecting premiums, and performing other nonlicensable activities permitted by the State.

(3) “Travel insurance” shall have the meaning stated in § 1702 of this title.

(4) “Travel retailer” means a business entity that makes, arranges or offers travel services and may offer and disseminate travel insurance as a service to its customers on behalf of and under the direction of a limited lines travel insurance producer.

(79 Del. Laws, c. 428, § 5; 80 Del. Laws, c. 215, § 1; 84 Del. Laws, c. 40, § 2.)

§ 1772. Requirements.

Notwithstanding any other provision of law:

(1) The Commissioner may issue a limited lines travel insurance producer license to an individual or business entity that has filed with the Commissioner an application for such limited license in a form and manner prescribed by the Commissioner. Such limited lines travel insurance producer shall be licensed to sell, solicit or negotiate travel insurance through a licensed insurer. No person may act as a limited lines travel insurance producer or travel insurance retailer unless properly licensed or registered, respectively.

(2) A travel retailer may offer and disseminate travel insurance on behalf of a limited lines travel insurance producer business entity only if the following conditions are met:

a. The limited lines travel insurance producer provides, or causes the travel retailer to provide, to purchasers of travel insurance, brochures or written materials that contain all of the following:

1. A description of the material terms or the actual terms of the insurance coverage.

2. A description of the process for filing a claim.

3. A description of the review or cancellation process for the travel insurance policy.

4. The identity and contact information of the insurer and limited lines travel insurance producer.

5. An explanation that the purchase of travel insurance is not required in order to purchase any other product or service from the travel retailer.

6. An explanation that an unlicensed travel retailer is permitted to provide general information about the insurance offered by the travel retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the travel retailer or to evaluate the adequacy of the customer’s existing insurance coverage.

7. A disclosure that the coverage offered may duplicate existing coverage maintained by the consumer and indicate that the consumer may wish to compare the terms with existing life, health, home, and automobile policies, and other sources of protection.

b. At the time of licensure, the limited lines travel insurance producer shall establish and maintain a register, on a form prescribed by the Commissioner, of each travel retailer that offers travel insurance on the limited lines travel insurance producer’s behalf. The register shall be maintained and updated annually by the limited lines travel insurance producer and shall include the name, address, and contact information of the travel retailer and an officer or person who directs or controls the travel retailer’s operations, and the travel retailer’s Federal Tax Identification Number. The limited lines travel insurance producer shall submit such register to the Commissioner upon reasonable request. The limited lines travel insurance producer shall also certify that all travel retailers registered comply with 18 U.S.C. § 1033. The grounds for the suspension, revocation and the penalties applicable to insurance producers under § 1712 of this title shall be applicable to the limited lines travel insurance producers and travel retailers.

c. The limited lines travel insurance producer has designated 1 of its employees who is a licensed individual producer as the person responsible (a “designated responsible producer” or “DRP”) for the limited lines travel insurance producer’s compliance with the travel insurance laws, rules and regulations of this State applicable to the limited lines travel insurance producer and its registrants.

d. The DRP, president, secretary, treasurer, and any other officer or person who directs or controls the limited lines travel insurance producer's insurance operations comply with the fingerprinting requirements applicable to insurance producers in the resident state of the limited lines travel insurance producer.

e. The limited lines travel insurance producer has paid all applicable insurance producer licensing fees as set forth in Chapter 7 of this title.

f. The limited lines travel insurance producer requires each employee and authorized representative of the travel retailer whose duties include offering and disseminating travel insurance to receive a program of instruction or training, which may be subject to review by the Commissioner. The training material shall, at a minimum, contain adequate instructions on the types of insurance offered, ethical sales practices, and required disclosures to prospective customers.

g. Limited lines travel insurance producers are exempt from the examination and continuing education requirements under Chapter 17 of this title.

(3) If any of the above-listed conditions is not satisfied, the sale of travel insurance (whether by a limited lines travel insurance producer or travel retailer) shall be pursuant to the terms of Chapter 17 of this title.

(4) A travel retailer and any of its employees or authorized representatives, who are not licensed as an insurance producer may not:

a. Evaluate or interpret the technical terms, benefits, and conditions of the offered travel insurance coverage;

b. Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

c. Hold that travel retailer or its employees or authorized representatives out as a licensed insurer, licensed producer, or insurance expert.

(79 Del. Laws, c. 428, § 5; 70 Del. Laws, c. 186, § 1; 84 Del. Laws, c. 40, § 3; 84 Del. Laws, c. 42, § 1.)

§ 1773. Registration.

Notwithstanding any other provision in law, a travel retailer whose insurance-related activities, and those of its employees and authorized representatives, are limited to offering and disseminating travel insurance on behalf of and under the direction of a limited lines travel insurance producer meeting the conditions stated in this chapter, is authorized to do so and receive related compensation, upon registration by the limited lines travel insurance producer as described in § 1772(2)b. of this title.

(79 Del. Laws, c. 428, § 5.)

§ 1774. Policy.

Travel insurance may be provided to a "primary policyholder," as "group travel insurance," or as "blanket travel insurance," as those terms are defined in § 5603 of this title.

(79 Del. Laws, c. 428, § 5; 84 Del. Laws, c. 40, § 4; 84 Del. Laws, c. 514, § 39.)

§ 1775. Responsibility.

As the insurer's designee, the limited lines travel insurance producer is responsible for the acts of the travel retailers and shall use reasonable means to ensure compliance by the travel retailers with this chapter.

(79 Del. Laws, c. 428, § 5; 84 Del. Laws, c. 40, § 5.)

§ 1776. Enforcement.

The limited lines travel insurance producer and any travel retailer offering and disseminating travel insurance on behalf of the limited lines travel insurance producer shall be subject to Chapter 17 (to the extent not inconsistent with this chapter) and Chapter 23 of this title.

(79 Del. Laws, c. 428, § 5.)

Part I
Insurance
Chapter 18
Managing General Agents Act

§ 1801. Short title.

This chapter may be cited as the “Managing General Agents Act.”

(68 Del. Laws, c. 68, § 1.)

§ 1802. Definitions.

As used in this chapter:

(1) “Actuary” means a person who is a member in good standing of the American Academy of Actuaries.

(2) “Insurer” means any person, firm, association or corporation duly licensed in this State as an insurance company pursuant to Chapter 5 of this title.

(3) “Managing general agent” (“MGA”) means any person, firm, association or corporation who negotiates and binds ceding reinsurance contracts on behalf of an insurer or manages all or part of the insurance business of an insurer (including the management of a separate division, department or underwriting office) and acts as an agent for such insurer whether known as a managing general agent, manager or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than 5 percent of the policyholder surplus as reported in the last annual statement of the insurer in any 1 quarter or year together with 1 or more of the following:

a. Adjusts or pays claims in excess of an amount determined by the Commissioner; or

b. Negotiates reinsurance on behalf of the insurer.

Notwithstanding the above, the following persons shall not be considered as MGAs for the purposes of this chapter:

a. An employee of the insurer;

b. A United States manager of the United States branch of an alien insurer;

c. An underwriting manager which, pursuant to contract, manages all or part of the insurance operations of the insurer, is under common control with the insurer, subject to the holding company regulatory act and whose compensation is not based on the volume of premiums written without regard for the profitability of the business written;

d. The attorney-in-fact authorized by, and acting for, the subscribers of a reciprocal insurer of interinsurance exchange under powers of attorney.

(4) “Underwrite” means the authority to accept or reject risk on behalf of the insurer.

(68 Del. Laws, c. 68, § 1; 84 Del. Laws, c. 233, § 37.)

§ 1803. Licensure.

(a) No person, firm, association or corporation shall act in the capacity of an MGA with respect to risks located in this State for an insurer licensed in this State unless such person is a licensed producer in this State.

(b) No person, firm, association or corporation shall act in the capacity of an MGA representing an insurer domiciled in this State with respect to risks located outside this State unless such person is licensed as a producer in this State (such license may be a nonresident license) pursuant to this chapter.

(c) The Commissioner may require a bond in an amount acceptable to the Commissioner for the protection of the insurer.

(d) The Commissioner may require the MGA to maintain an errors and omissions policy.

(68 Del. Laws, c. 68, § 1; 70 Del. Laws, c. 186, § 1.)

§ 1804. Required contract provisions.

No person, firm, association or corporation acting in the capacity of an MGA shall place business with an insurer unless there is in force a written contract between both parties which sets forth the responsibilities of each party and where both parties share responsibility for a particular function, specifies the division of such responsibilities and which contains the following minimum provisions:

(1) The insurer may terminate the contract for cause upon written notice to the MGA. The insurer may suspend the underwriting authority of the MGA during the pendency of any dispute regarding the cause for termination.

(2) The MGA will render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis.

(3) All funds collected for the account of an insurer will be held by the MGA in a fiduciary capacity in a bank which is a member of the Federal Reserve System. This account shall be used for all payments on behalf of the insurer. The MGA may retain no more than 3 months estimated claims payments and allocated loss adjustment expenses.

(4) Separate records of business written by the MGA will be maintained. The insurer shall have access and right to copy all accounts and records related to its business in a form usable by the insurer and the Commissioner shall have access to all books, bank accounts and such records of the MGA in a form usable to the Commissioner. Such records shall be retained until completion of the insurer's triennial financial examination.

(5) The contract may not be assigned in whole or part by the MGA.

(6) Appropriate underwriting guidelines including:

a. The maximum annual premium volume;

b. The basis of the rates to be charged;

c. The types of risks which may be written;

d. Maximum limits of liability;

e. Applicable exclusions;

f. Territorial limitations;

g. Policy cancellation provisions; and

h. The maximum policy period.

The insurer shall have the right to cancel or nonrenew any policy of insurance subject to the applicable laws and regulations.

(7) If the contract permits the MGA to settle claims on behalf of the insurer:

a. All claims must be reported to the company in a timely manner.

b. A copy of the claim file shall be sent to the insurer at its request or as it becomes known that the claim:

1. Has the potential to exceed an amount determined by the Commissioner or exceeds the limit set by the company, whichever is less;

2. Involves a coverage dispute;

3. May exceed the MGA's claims settlement authority;

4. Is open for more than 6 months; or

5. Is closed by payment of an amount set by the Commissioner or an amount set by the company, whichever is less.

c. All claim files will be the joint property of the insurer and MGA. However, upon an order of liquidation of the insurer, such files shall become the sole property of the insurer or its estate; the MGA shall have reasonable access to and the right to copy the files on a timely basis.

d. Any settlement authority granted to the MGA may be terminated for cause upon the insurer's written notice to the MGA or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination.

(8) Where electronic claims files are in existence, the contract must address the timely transmission of the data.

(9) If the contract provides for a sharing of interim profits by the MGA, and the MGA has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments, or in any other manner, interim profits will not be paid to the MGA until 1 year after they are earned for property insurance business and 5 years after they are earned on casualty business and not until the profits have been verified pursuant to § 1805 of this title.

(10) The MGA shall not:

a. Bind reinsurance or retrocessions on behalf of the insurer, except that the MGA may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and commission schedules;

b. Commit the insurer to participate in insurance or reinsurance syndicates;

c. Appoint any producer without assuring that the producer is lawfully licensed to transact the type of insurance for which the producer is appointed;

d. Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed 1 percent of the insurer's policyholder's surplus as of December 31 of the last completed calendar year;

e. Collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer, without prior approval of the insurer. If prior approval is given, a report must be promptly forwarded to the insurer;

f. Permit its subproducer to serve on the insurer's board of directors;

g. Jointly employ an individual who is employed with the insurer; or

h. Appoint a sub-MGA.

(68 Del. Laws, c. 68, § 1; 70 Del. Laws, c. 186, § 1.)

§ 1805. Duties of insurers.

(a) The insurer shall have on file an independent financial examination, in a form acceptable to the Commissioner, of each MGA with which it has done business.

(b) If an MGA establishes loss reserves, the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the MGA. This is in addition to any other required loss reserve certification.

(c) The insurer shall periodically (at least semiannually) conduct an on-site review of the underwriting and claims processing operations of the MGA.

(d) Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer, who shall not be affiliated with the MGA.

(e) Within 30 days of entering into or termination of a contract with an MGA, the insurer shall provide written notification of such appointment or termination to the Commissioner. Notices of appointment of an MGA shall include a statement of duties which the applicant is expected to perform on behalf of the insurer, the lines of insurance for which the applicant is to be authorized to act, and any other information the Commissioner may request.

(f) An insurer shall review its books and records each quarter to determine if any producer, as defined by § 1802(3) of this title, has become, by operation of § 1802(3) of this title, an MGA as defined in that section. If the insurer determines that a producer has become an MGA pursuant to the above, the insurer shall promptly notify the producer and the Commissioner of such determination and the insurer and producer must fully comply with this chapter within 30 days.

(g) An insurer shall not appoint to its board of directors an officer, director, employee, subproducer or controlling shareholder of its MGAs. This subsection shall not apply to relationships governed by the Insurance Holding Company Act or, if applicable, the Broker Controlled Insurer Act.

(68 Del. Laws, c. 68, § 1.)

§ 1806. Examination authority.

The acts of the MGA are considered to be the acts of the insurer on whose behalf it is acting. An MGA may be examined as if it were the insurer. An MGA shall retain all records pertaining to a specific insurer until the conclusion of the regular financial examination on that insurer by the domestic regulator.

(68 Del. Laws, c. 68, § 1; 69 Del. Laws, c. 92, § 6.)

§ 1807. Penalties and liabilities.

(a) If the Commissioner finds after a hearing conducted in accordance with the Administrative Procedures Act [Chapter 100 of Title 29] that any person has violated any provision or provisions of this chapter, the Commissioner may order:

(1) For each separate violation, a penalty in an amount of $15,000;

(2) Revocation or suspension of the producer's license; and

(3) The MGA to reimburse the insurer, the rehabilitator or liquidator of the insurer for any losses incurred by the insurer caused by a violation of this chapter committed by the MGA.

(b) The decision, determination or order of the Commissioner pursuant to subsection (a) of this section shall be subject to judicial review pursuant to the Administrative Procedures Act [Chapter 100 of Title 29].

(c) Nothing contained in this section shall affect the right of the Commissioner to impose any other penalties provided for in the Insurance Law.

(d) Nothing contained in this chapter is intended to or shall in any manner limit or restrict the rights of policyholders, claimants and auditors.

(68 Del. Laws, c. 68, § 1.)

§ 1808. Rules and regulations.

The Commissioner of Insurance may adopt reasonable rules and regulations for the implementation and administration of this chapter.

(68 Del. Laws, c. 68, § 1.)

§ 1809. Effective date.

This chapter shall take effect on September 30, 1991. No insurer may continue to utilize the services of an MGA on and after September 30, 1991, unless such utilization is in compliance with this chapter.

(68 Del. Laws, c. 68, § 1.)

Part I
Insurance

Chapter 19
Delaware Nonadmitted Insurance Act

Subchapter I
Compliance with Federal Statutes

§ 1901. Finding and purpose.

(a) It is determined and declared as a matter of legislative finding that it is in the public interest to cooperate on a reciprocal basis with other states in considering procedures which implement the provisions of the Nonadmitted and Reinsurance Reform Act of 2010 [15 U.S.C. § 8201 et seq.].

(b) It is further determined and declared that the purpose and policy of this chapter shall be to:

(1) Carry out the requirements of the Nonadmitted and Reinsurance Reform Act of 2010 [15 U.S.C. § 8201 et seq.] as such act existed on January 1, 2011;

(2) Provide authority for the Insurance Commissioner to enter into an interstate cooperative agreement, reciprocal agreement, or compact if doing so is in the best interests of this State; and

(3) Regulate the placement of insurance coverage with nonadmitted insurers when this State is the home state of the insured.

(78 Del. Laws, c. 176, § 1.)

§ 1902. Home state regulation of nonadmitted insurance.

(a) The placement of nonadmitted insurance business shall be subject to the statutory and regulatory requirements solely of the insured's home state as defined in this chapter.

(b) This section may not be construed to preempt any law, rule, or regulation that restricts the placement of workers' compensation insurance or excess insurance for self-funded workers' compensation plans with a nonadmitted insurer.

(78 Del. Laws, c. 176, § 1.)

§ 1903. Interstate insurance regulatory cooperation.

(a) The Commissioner is authorized to enter into an interstate cooperative agreement, reciprocal agreement, or compact, hereafter "Agreement," for the purpose of carrying out the Nonadmitted and Reinsurance Reform Act of 2010 [15 U.S.C. § 8201 et seq.] (NRRA) and to facilitate the collection, allocation, and disbursement of premium taxes attributable to the placement of nonadmitted insurance, to provide for uniform methods of allocation and reporting among nonadmitted insurance risk classifications, and share information among states relating to nonadmitted insurance premium taxes.

(b) The Commissioner may also enter into other cooperative agreements with surplus lines stamping offices located in this state or other states for the reporting and capturing of related tax information. In addition, the Commissioner may enter into cooperative agreements with processing entities located in this State or other states related to the capturing and processing of insurance premium and tax data.

(c) The Commissioner may participate in a clearinghouse operation established for the purpose of collecting and disbursing to reciprocal states any premium tax funds collected applicable to properties, risks, or exposures located or to be performed outside of this State. The Commissioner may also participate in such clearinghouse for purposes of surplus lines policies applicable to risks located solely within this State.

(d) In order to assist in the performance of the Commissioner's duties, under the NRRA, the Commissioner may contract with nongovernmental entities, including the NAIC or any affiliates or subsidiaries that the NAIC oversees, to perform any ministerial functions that the Commissioner and the nongovernmental entity may deem to be appropriate, including:

(1) The collection of fees related to producer licensing; and

(2) The collection of the premium tax under § 1925 of this title.

The NAIC or other entity with whom the Commissioner contracts may charge a reasonable fee to the insurer, insured, or other appropriate person for the functions performed.

(e) An Agreement entered into under this section prevails over an inconsistent rule of the Commissioner. Except as otherwise provided by this section, a statute of this State prevails over an inconsistent provision of an Agreement entered into under this section.

(f) The Commissioner may adopt rules as necessary to implement this chapter or the terms of an Agreement entered into under this section. In adopting rules under this chapter, the Commissioner may not adopt a rule that does not specifically implement this chapter or the Agreement.

(78 Del. Laws, c. 176, § 1.)

§ 1903A. Nonadmitted Reinsurance and Reform Act of 2010 Implementation Revenue Study.

(a) The Insurance Commissioner shall establish a Nonadmitted and Reinsurance Reform Act of 2010 [15 U.S.C. § 8201 et seq.] (NRRA) Implementation Revenue Study Committee to study the potential impact that would result from the State's entrance into an Agreement pursuant to § 1903 of this title in order to prevent the State from losing revenue after July 21, 2011, the effective date of the NRRA. The Committee shall determine if entering into an Agreement would result in retention of out-of-state surplus lines tax revenue for the State and, if so, which Agreement would result in the most retention of surplus lines tax revenue for the State and the most cost-efficient method of administering the collection and distribution of tax revenues. Notwithstanding subsection (b) of this section, the Committee shall report its findings and recommendations, including any proposed legislation, to the chairs of the respective Senate and House committees, the Senate Pro-Tempore, the Speaker of the House and to the Controller General no later than January 2012.

(b) In the event that an interstate surplus lines tax allocation, reporting and payment system becomes operational and the Insurance Commissioner determines that the State of Delaware is likely to lose significant revenue by delaying the decision to enter into an Agreement pursuant to § 1903 of this title until after completion of the report by the NRRA Implementation Revenue Study Committee, then the Commissioner may enter into an Agreement after notice and hearing, which shall involve testimony regarding the Commissioner's determination, and the burden the tax allocation, reporting and payment system selected would impose on brokers.

(78 Del. Laws, c. 176, § 1.)

§ 1904. Definitions.

(a) For the purposes of this chapter the following definitions shall apply:

(1) *Admitted insurer.* — The term "admitted insurer" means an insurer authorized to engage in the business of insurance in this State.

(2) *Affiliate.* — The term "affiliate" means, with respect to an insured, any entity that controls, is controlled by, or is under common control with the insured.

(3) *Affiliated group.* — The term "affiliated group" means any group of entities that are all affiliated.

(4) *Broker.* — The term "broker," as used in this chapter and unless context otherwise requires, means a surplus lines broker duly licensed as such under this chapter.

(5) *Clearinghouse.* — The term "clearinghouse" means a mechanism or entity established for the receipt and distribution of premium taxes and transaction data related to the sale of nonadmitted insurance.

(6) *Control.* — An entity has "control" over another entity if:

a. The entity directly or indirectly or acting through 1 or more other persons owns, controls, or has the power to vote 25 percent or more of any class of voting securities of the other entity; or

b. The entity controls in any manner the election of a majority of the directors or trustees of the other entity.

(7) *Export.* — The term "export" means to place insurance in a nonadmitted insurer under this surplus lines law.

(8) *Gross premium.* — The term "gross premium" means the amount charged by an insurer for consideration for insurance. Any assessment, or any membership, policy, survey, inspection, service or similar fee or other charge in consideration for an insurance contract is deemed part of the premium.

(9) *Home state.* — a. *In general.* — Except as provided in paragraph (a)(9)b. of this section, the term "home state" means, with respect to an insured

1. The state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence; or

2. If 100 percent of the insured risk is located out of the state referred to in paragraph (a)(9)a.1. of this section, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

b. *Affiliated groups.* — If more than 1 insured from an affiliated group are named insureds on a single nonadmitted insurance contract, the term "home state" means the home state, as determined pursuant to paragraph (a)(9)a. of this section, of the member of the affiliated group that has the largest percentage of premium attributed to it under such insurance contract.

(10) *Home state insured.* — The term "home state insured" means, unless the context indicates otherwise, an insured whose home state is Delaware.

(11) *Independently procured insurance.* — The term "independently procured insurance" means insurance procured directly by an insured from a nonadmitted insurer.

(12) *Multi-state risk.* — The term "multi-state risk" means a risk with exposures in more than 1 state.

(13) *NAIC.* — The term "NAIC" means the National Association of Insurance Commissioners or any successor entity.

(14) *Net premium.* — The term "net premium" means, for the purposes of this chapter, gross premium as defined herein, less any returned premiums.

(15) *Nonadmitted insurance.* — The term "nonadmitted insurance" means any property and casualty insurance permitted to be placed directly or through a surplus lines broker with a nonadmitted insurer eligible to accept such insurance. For purposes of this chapter, nonadmitted insurance includes independently procured insurance placed directly and surplus lines insurance.

(16) *Nonadmitted insurer.* — The term "nonadmitted insurer"

a. Means an insurer not authorized to engage in the business of insurance in this state; but

b. Does not include a risk retention group, as that term is defined in § 2(a)(4) of the Liability Risk Retention Act of 1986 (15 U.S.C. § 3901(a)(4)).

(17) *Premium tax.* — The term "premium tax" means, with respect to surplus lines or independently procured insurance coverage, any tax, fee, assessment, or other charge imposed by a government entity directly or indirectly based on any payment made as consideration for an insurance contract for such insurance, including premium deposits, assessments, registration fees, and any other compensation given in consideration for a contract of insurance.

(18) *Qualified risk manager.* — The term "qualified risk manager" means, with respect to a policyholder of commercial insurance, a person who meets all of the following requirements:

a. The person is an employee of, or third-party consultant retained by, the commercial policyholder.

b. The person provides skilled services in loss prevention, loss reduction, or risk and insurance coverage analysis, and purchase of insurance.

c. The person:

1. A. Has a bachelor's degree or higher from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by a state insurance commissioner or other state regulatory official or entity to demonstrate minimum competence in risk management; and

B. I. Has 3 years of experience in risk financing, claims administration, loss prevention, risk and insurance analysis, or purchasing commercial lines of insurance; or

II. Has:

(A) A designation as a "chartered property and casualty underwriter" (in this subparagraph referred to as "CPCU") issued by the American Institute for CPCU/Insurance Institute of America;

(B) A designation as an "associate in risk management" ("ARM") issued by the American Institute for CPCU/Insurance Institute of America;

(C) A designation as "certified risk manager" ("CRM") issued by the National Alliance for Insurance Education & Research;

(D) A designation as a "RIMS Fellow" ("RF") issued by the Global Risk Management Institute; or

(E) Any other designation, certification, or license determined by a state insurance commissioner or other state insurance regulatory official or entity to demonstrate minimum competency in risk management;

2. A. Has at least 7 years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; and

B. Has any 1 of the designations specified in paragraphs (18)c.1.B.(II)(A) through (E) of this section;

3. Has at least 10 years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; or

4. Has a graduate degree from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by a State insurance commissioner or other state regulatory official or entity to demonstrate minimum competence in risk management.

(19) *Reciprocal state.* — The term "reciprocal state" means a state that has:

a. Entered into a nonadmitted insurance compact or agreement; or

b. Otherwise adopted the allocation schedule and reporting forms prescribed by a multi-state agreement for nonadmitted insurance

(20) *Single-state risk.* — The term "single-state risk" means a risk with exposure in only 1 state.

(21) *State.* — The term "state" includes any state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Northern Mariana Islands, the Virgin Islands, and American Samoa.

(22) *Surplus lines broker.* — The term "surplus lines broker" means an individual, firm, or corporation which is licensed in this State to sell, solicit, negotiate, or procure insurance in this state with nonadmitted insurers.

(23) *Surplus lines insurance.* — The term "surplus lines insurance" means insurance procured by a surplus lines licensee from a surplus lines insurer or other nonadmitted insurer as permitted under the law of the home state; for purposes of this chapter "surplus lines insurance" shall also mean excess lines insurance as may be defined by applicable state law.

(24) *Surplus lines insurer.* — The term "surplus lines insurer" means a nonadmitted insurer eligible under the law of the home state to accept business from a surplus lines licensee; for purposes of this chapter "surplus lines insurer" shall also mean an insurer that is permitted to write surplus lines insurance under the laws of the state where such insurer is domiciled.

(b) In this chapter, unless otherwise specified, words and expressions used have the same meaning as in the NRRA [Nonadmitted and Reinsurance Reform Act of 2010, 15 U.S.C. § 8201 et seq.].

(78 Del. Laws, c. 176, § 1; 80 Del. Laws, c. 386, § 1.)

§ 1905. Exclusions.

(a) Unless the Commissioner rules otherwise pursuant to § 1915 of this title, life insurance and health insurance shall not be considered surplus lines insurance and shall be placed with admitted insurers licensed to write those types of insurance.

(b) The provisions of this chapter shall not apply to reinsurance or to the following insurances when so placed by licensed producers or surplus lines brokers of this State:

(1) Wet marine and transportation insurance;

(2) Insurance on subjects located, resident or to be performed wholly outside this State or on vehicles or aircraft owned and principally garaged outside this State;

(3) Insurance on operations of railroads engaged in transportation in interstate commerce and their property used in such operations;

(4) Insurance of aircraft owned or operated by manufacturers of aircraft or of aircraft operated in commercial interstate flight or cargo of such aircraft or against liability, other than workers' compensation and employer's liability, arising out of the ownership, maintenance or use of such aircraft;

(5) Transactions for which a certificate of authority to do business is not required of an insurer under the insurance laws of this State.

(78 Del. Laws, c. 176, § 1; 80 Del. Laws, c. 47, § 1.)

Subchapter II

Surplus Lines Insurance

§ 1911. Placement of insurance business.

(a) An insurer shall not engage in the transaction of insurance in this State unless authorized by a certificate of authority in force pursuant to the laws of this State, or exempted by this chapter or otherwise exempted by the insurance laws of this State.

(b) A person shall not engage in a transaction of insurance or in this State directly or indirectly act as agent for, or otherwise represent or aid on behalf of another, a nonadmitted insurer in the solicitation, negotiation, procurement or effectuation of insurance, or renewals thereof, or forwarding of applications, or delivery of policies or contracts or inspection of risks, or fixing of rates, or investigation or adjustment of claims or losses, or collection or forwarding of premiums, or in any other manner represent or assist the insurer in the transaction of insurance.

(c) A person who represents or aids a nonadmitted insurer in violation of this section shall be subject to the penalties set forth in § 106 of this title. No insurance contract entered into in violation of this section shall preclude the insured from enforcing his or her rights under the contract in accordance with the terms and provisions of the contract of insurance and the laws of this State, to the same degree those rights would have been enforceable had the contract been lawfully procured.

(d) If the nonadmitted insurer fails to pay a claim or loss within the provisions of the insurance contract and the laws of this State, a person who assisted or in any manner aided directly or indirectly in the procurement of the insurance contract, shall be liable to the insured for the full amount under the provisions of the insurance contract.

(e) Subsection (b) or (d) of this section shall not apply to an insured who independently procures insurance.

(f) This section shall not apply to a person, properly licensed as a producer in this State who, for a fee and pursuant to a written agreement, is engaged solely to offer to the insured advice, counsel or opinion, or service with respect to the benefits, advantages or disadvantages promised under any proposed or in-force policy of insurance if the person does not, directly or indirectly, participate in the solicitation, negotiation or procurement of insurance on behalf of the insured.

(g) This section shall not apply to a surplus lines broker duly licensed in this State who is acting in material compliance with the insurance laws of this State in the placement of surplus lines insurance as provided in this chapter.

(78 Del. Laws, c. 176, § 2; 70 Del. Laws, c. 186, § 1.)

§ 1912. Conditions for export.

(a) If certain insurance coverage cannot be procured from authorized insurers, such coverage, hereinafter designated "surplus lines," may be procured from nonadmitted insurers, subject to the following conditions:

(1) Each insurer is an eligible surplus lines insurer; and

(2) Each insurer is authorized to write the type of insurance in its domiciliary jurisdiction; and

(3) The full amount of insurance required must not be procurable, after diligent effort has been made to do so, from among the insurers authorized to transact and actually writing that kind and class of insurance in this State, and the amount of insurance exported shall be only the excess over or other than the amount procurable from authorized insurers; and

(4) The insurance must not be so exported for the purpose of securing advantages either as to:

a. A lower premium rate than would be accepted by an authorized insurer; or

b. Terms of the insurance contract.

(5) All other requirements of this chapter are met.

(b) For purposes of this section, "type of insurance" means the hazard or combination of hazards covered by a contract of insurance.

(c) Each surplus line broker shall be responsible to ensure that a diligent effort is made among insurers that are admitted to transact and are actually writing the particular type of insurance in this State before procuring the insurance for a home state insured from a nonadmitted insurer.

(1) A diligent search shall only be performed by a surplus lines broker or a producer licensed in this State that holds an active property and casualty insurance producer license.

(2) An insurance producer or surplus lines broker is exempt from the diligent effort requirements of this section if the producer or surplus lines broker is procuring insurance for a risk purchasing group as provided in Chapter 80 of this title.

(d) Except as provided in paragraph (c)(2) of this section and § 1914 of this title, the Commissioner shall by regulation establish the degree of effort required to comply with paragraphs (a)(3) and (4) of this section and the means to certify to the accuracy of the facts supporting the surplus line broker's diligent search effort.

(18 Del. C. 1953, § 1904; 56 Del. Laws, c. 380, § 1; 78 Del. Laws, c. 176, § 2.)

§ 1913. Duty of inquiry by surplus lines broker.

(a) The surplus lines broker shall be responsible for determining whether an applicant for nonadmitted insurance is a Delaware home state insured. A surplus lines broker who reasonably relies on information provided in good faith by the applicant, whether directly or through the producer, shall be deemed to be in compliance with this requirement.

(b) A broker shall not knowingly place surplus lines insurance with an insurer that is unsound financially or that does not meet the eligibility requirements under subchapter III of this chapter.

(c) Before placing insurance with a nonadmitted insurer, all surplus lines brokers shall make a thorough inquiry into the financial condition and operating history of such insurer in order that the interests of the citizens of Delaware may be protected.

(d) During the course of placing business with a nonadmitted insurer, either foreign or alien, each surplus lines broker shall be under a continuous duty to apprise himself or herself that such insurer maintains a condition of solvency and general financial health, and that the company processes claims and pays losses expeditiously.

(e) Whenever any reasonable doubt arises as to the capacity, competence, stability or good faith of a nonadmitted insurer with which a surplus lines broker places insurance on behalf of the public of Delaware, the broker is under a further duty to inform the Insurance Commissioner of the basis of such doubt. Any broker in a position of doubt shall immediately cease and desist placing further business with such insurer.

(78 Del. Laws, c. 176, § 2; 70 Del. Laws, c. 186, § 1.)

§ 1914. Streamlined application for commercial purchasers.

(a) A surplus lines broker seeking to procure or place nonadmitted insurance in this State for an exempt commercial purchaser whose home state is this State shall not be required to satisfy any requirement to make a diligent effort to determine whether the full amount or type of insurance sought by such exempt commercial purchaser can be obtained from admitted insurers if:

(1) The broker procuring or placing the surplus lines insurance has disclosed to the exempt commercial purchaser that such insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight; and

(2) The exempt commercial purchaser has subsequently requested in writing the broker to procure or place such insurance from a nonadmitted insurer.

(b) For purposes of this section, the term "exempt commercial purchaser" means any person purchasing commercial insurance that, at the time of placement, meets the following requirements:

(1) The person employs or retains a qualified risk manager to negotiate insurance coverage.

(2) The person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of $100,000 in the immediately preceding 12 months.

(3) The person meets at least 1 of the following criteria:

a. The person possesses a net worth in excess of $20,000,000; as such amount is adjusted pursuant to subsection (c) of this section.

b. The person generates annual revenues in excess of $50,000,000; as such amount is adjusted pursuant to subsection (c) of this section.

c. The person employs more than 500 full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than 1,000 employees in the aggregate.

d. The person is a not-for-profit organization or public entity generating annual budgeted expenditures of at least $30,000,000; as such amount is adjusted pursuant to subsection (c) of this section.

e. The person is a municipality with a population in excess of 50,000 persons.

(c) Effective January 1, 2016, and each fifth January 1 occurring thereafter, the amounts in paragraphs (b)(3)a., b. and d. of this section shall be adjusted to reflect the percentage change for such 5-year period in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the Department of Labor.

(78 Del. Laws, c. 176, § 2.)

§ 1915. Open lines for export.

(a) The Commissioner may by order declare eligible for export for a home state insured, generally and without compliance with the provisions of § 1912 of this title, any class or classes of insurance coverage or risk for which the Commissioner finds, after a hearing of which notice was given to each insurer authorized to transact such class or classes in this State, that there is not a reasonable or adequate market among authorized insurers either as to acceptance of the risk, contract terms, or premium rate. Any such order shall continue in effect during the existence of the conditions upon which predicated, but subject to earlier termination by the Commissioner.

(b) The broker shall file as directed by the Commissioner a memorandum as to each such coverage placed by him or her in a nonadmitted insurer for a home state insured, in such form and context as the Commissioner may reasonably require for the identification of the coverage and determination of the tax payable to the state relative thereto.

(c) The broker or a licensed Delaware producer of the authorized insurer may also place with authorized insurers any insurance coverage made eligible for export generally under subsection (a) of this section above, and without regard to rate or form filings which may otherwise be applicable as to the authorized insurer. As to coverage so placed in an authorized insurer, the premium tax thereon shall be reported and paid by the insurer as required generally under Chapter 7 of this title.

(18 Del. C. 1953, § 1906; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; 78 Del. Laws, c. 176, § 2.)

§ 1916. Evidence of the insurance; changes; penalty.

(a) Upon placing a surplus lines coverage for a home state insured, the broker shall promptly issue and deliver to the insured evidence of the insurance consisting either of the policy as issued by the insurer or, if such policy is not then available, the surplus line broker's certificate. Such a certificate shall be executed by the broker and shall show the name and license number of the individual surplus lines broker, the description and location of the subject of the insurance, coverage, conditions and term of the insurance, the premium and rate charged, taxes collected from the insured, and the name and address of the insured and insurer. If the risk is assumed by more than 1 insurer, the certificate shall state the name and address and proportion of the entire risk assumed by each such insurer.

(b) No broker shall issue any such certificate or any cover note, or purport to insure or represent that insurance will be or has been granted by any nonadmitted insurer, unless he or she has prior written authority from the insurer for the insurance, or has received information from the insurer in the regular course of business that such insurance has been granted, or an insurance policy providing the insurance actually has been issued by the insurer and delivered to the insured.

(c) If after the issuance and delivery of any such certificate there is any change as to the identity of the insurers, or the proportion of the direct risk assumed by an insurer as stated in the broker's original certificate, or in any other material respect as to the insurance evidenced by the certificate, the broker shall promptly issue and deliver to the insured or the original producing agent a substitute for, or endorsement of, the original document, accurately showing the current status of the coverage and the insurers responsible for the coverage.

(d) As soon as reasonably possible after the placement of the insurance, the surplus lines broker shall deliver a copy of the policy or, if not available, a certificate of insurance to the insured or producing agent to replace any evidence of insurance previously issued. Each certificate or policy of insurance shall contain or have attached a complete record of all policy insuring agreements, conditions, exclusions, clauses, endorsements or any other material facts that would regularly be included in the policy.

(e) Any surplus lines broker, who knowingly or negligently issues a false certificate of insurance or who fails promptly to notify the insured of any material change with respect to such insurance by delivery to the insured of a substitute certificate as provided in subsection (c) of this section, shall, upon conviction, be subject to the penalty provided by § 106 of this title or to any greater applicable penalty otherwise provided by law.

(18 Del. C. 1953, § 1908; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; 78 Del. Laws, c. 176, § 2.)

§ 1917. Endorsement of contract.

(a) *Licensee's duty to notify insured.* — (1) No contract of insurance placed by a surplus lines broker under this chapter for a home state insured shall be binding upon the insured and no premium charged shall be due and payable until the surplus lines broker shall have notified the insured in writing, in a form acceptable to the Commissioner, a copy of which shall be maintained by the surplus lines broker with the records of the contract and available for possible examination, that:

a. The insurer with which the broker places the insurance is not licensed by this State and is not subject to its supervision; and

b. In the event of the insolvency of the surplus lines insurer, losses will not be paid by the state insurance guaranty fund.

(2) Nothing herein contained shall nullify any agreement by any insurer to provide insurance.

(3) This subsection shall not apply to an insured in this State who independently procures insurance.

(b) Every insurance contract procured and delivered as surplus lines coverage pursuant to this law shall have stamped or printed upon it, initialed by and bearing the name of the individual surplus lines broker who procured it, the following disclosure statement:

"This insurance contract is issued pursuant to the Delaware Insurance Laws by an insurer neither licensed by nor under the jurisdiction of the Delaware Insurance Department. This insurer does not participate in insurance guaranty funds created by state law. In the event of the insolvency of the surplus lines insurer, losses will not be paid by the state insurance guaranty fund."

(c) When a contract is issued to an exempt commercial purchaser as described in § 1914 of this title, neither the nonadmitted insurer nor the surplus line broker is required to provide the notice required in this section except on the confirmation of insurance, the certificate

of placement, or the policy, whichever is first provided to the insured, nor is the insurer or surplus line broker required to obtain the insured's signature. The producer shall ensure that the notice affixed to the confirmation of insurance, certificate of placement, or the policy is provided to the insured.

(d) Paragraph (a)(1)a. and subsection (b) of this section shall not apply when the surplus lines coverage is procured from a domestic surplus lines insurer pursuant to § 1932 of this title.

(18 Del. C. 1953, § 1909; 56 Del. Laws, c. 380, § 1; 78 Del. Laws, c. 176, § 2; 80 Del. Laws, c. 30, § 1.)

§ 1918. Surplus line insurance valid.

Insurance contracts procured as surplus lines coverage from nonadmitted insurers in accordance with this law, whether so procured by a surplus lines broker or directly by the insured by means of independent procurement, shall be fully valid and enforceable as to all parties, and shall be given recognition in all matters and respects to the same effect as like contracts issued by authorized insurers.

(18 Del. C. 1953, § 1910; 56 Del. Laws, c. 380, § 1; 78 Del. Laws, c. 176, § 2.)

§ 1919. Liability of insurer.

(a) A payment of premium to a surplus lines broker acting for a person other than himself or herself in procuring, continuing or renewing any policy of insurance procured under this law shall be deemed to be payment to the insurer, whatever conditions or stipulations may be inserted in the policy or contract notwithstanding.

(b) As to a surplus lines risk which has been assumed by a nonadmitted insurer pursuant to this surplus lines insurance law, and if the premium thereon has been received by the surplus line broker who placed such insurance, in all questions thereafter arising under the coverage as between the insurer and the insured the insurer shall be deemed to have received the premium due to it for such coverage, and the insurer shall be liable to the insured as to losses covered by such insurance and for unearned premiums which may become payable to the insured upon cancellation of such insurance, whether or not in fact the broker is indebted to the insurer with respect to such insurance or for any other cause.

(c) Each nonadmitted insurer assuming a surplus lines risk under this surplus lines insurance law shall be deemed thereby to have subjected itself to the terms of this section.

(18 Del. C. 1953, § 1911; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; 78 Del. Laws, c. 176, § 2.)

§ 1920. Surplus line brokers; licensing.

(a) No individual is required to be licensed pursuant to this chapter as a surplus lines broker if the home state of the insured is a state other than Delaware.

(b) The penalty in Chapter 17 of this title for selling, soliciting, negotiating, or procuring surplus lines insurance in this State without a surplus lines license shall be waived if the Insurance Commissioner receives an application for licensure as a surplus lines broker within 45 days from the effective date of a multi-state policy for which this State is the insured's home state.

(c) Any individual, while licensed in this State as a resident or nonresident producer, who is deemed by the Commissioner to be competent and trustworthy with respect to the handling of surplus lines may be licensed as a surplus lines broker.

(d) Application for the license shall be made to the Commissioner on forms as designated by the Commissioner.

(e) The license fee shall be as specified in § 701 of this title.

(f) The license and licensee shall be subject to the applicable provisions of Chapter 17 of this title.

(g) For the purposes of implementing the NRRA [Nonadmitted and Reinsurance Reform Act of 2010, 15 U.S.C. § 8201 et seq.], the Commissioner shall participate in the National Insurance Producer Database of the NAIC or any other equivalent national database for the licensure and license renewal of surplus lines brokers on and after July 21, 2012.

(18 Del. C. 1953, § 1912; 56 Del. Laws, c. 380, § 1; 73 Del. Laws, c. 69, § 1; 78 Del. Laws, c. 176, § 2.)

§ 1921. Suspension, revocation, of broker's license.

(a) Subject to § 1712 of this title, the Commissioner may also suspend or revoke any surplus line broker's license:

(1) If the broker fails to file the annual statement as required by § 1924 of this title, or to remit the tax as required by § 1925 of this title; or

(2) If the broker fails to keep the records, or to allow the Commissioner to examine his or her records as required by this law; or

(3) If the broker places a surplus line coverage in an insurer other than as authorized under subchapter III of this chapter; or

(4) For violation of any provision of this chapter; or

(5) For any cause for which an insurance license could be denied, revoked, suspended or renewal refused under Chapter 17 of this title.

(b) The procedures provided by Chapter 17 of this title for suspension or revocation of licenses shall apply to suspension or revocation of a surplus lines broker's license.

(c) Upon suspending or revoking the broker's surplus lines license the Commissioner shall also suspend or revoke all other licenses of or as to the same individual under this title.

(18 Del. C. 1953, § 1913; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; 78 Del. Laws, c. 176, § 2.)

§ 1922. Broker may compensate agents and other licensed producers.

A licensed surplus lines broker may accept and place surplus lines business for any insurance producer licensed in this State for the kind of insurance involved, and may compensate the producer for the business.

(18 Del. C. 1953, § 1914; 56 Del. Laws, c. 380, § 1; 78 Del. Laws, c. 176, § 2.)

§ 1923. Records of broker.

(a) Each broker shall keep in his or her office a full and true record of each surplus lines coverage procured by him or her for a home state insured, including a copy of each daily report, if any, a copy of each certificate of insurance issued by him or her, and such of the following items as may be applicable:

(1) Verification that the insured is a Delaware home state insured;

(2) Whether or not a policy is a single-state policy or a multi-state policy;

(3) Verification that a commercial insured qualifies under the provisions of § 1914 of this title;

(4) Amount of the insurance;

(5) Gross premium charged;

(6) Return premium paid, if any;

(7) Rate of premium charged upon the several items of property;

(8) Effective date of the contract and the terms thereof;

(9) Name and address of each insurer on the direct risk and the proportion of the entire risk assumed by such insurer if less than the entire risk;

(10) Name and address of the insured;

(11) Brief general description of the property or risk insured and where located or to be performed;

(12) A tax allocation spreadsheet detailing the portion of premium attributable to properties, risks, or exposures located in each state;

(13) Other information as may be required by the Commissioner; and

(14) A written statement on a form prescribed by the Commissioner as to the diligent effort to place the coverage with admitted insurers as set forth in § 1912 of this title and the results of that effort, except where the transaction is pursuant to § 1912(c)(2) or § 1914 of this title. The written statement must be open to public inspection. The written statement must affirm that the insured was expressly advised in writing prior to placement of the insurance that:

a. The surplus lines insurer with whom the insurance was to be placed is not licensed in this State and is not subject to the State's supervision; and

b. In the event of the insolvency of the surplus lines insurer, losses will not be paid by the State Insurance Guaranty Fund.

(b) The broker's record shall be open to examination by the Commissioner at all times within 5 years after issuance of the coverage to which it relates.

(c) After notice and hearing, the Commissioner may promulgate reasonable rules and regulations specifying the manner and type of records to be maintained by surplus lines brokers and the location or locations where those records shall be kept.

(18 Del. C. 1953, § 1915; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; 73 Del. Laws, c. 69, § 2; 78 Del. Laws, c. 176, § 2; 80 Del. Laws, c. 30, § 2.)

§ 1924. Annual statement of broker.

(a) Unless the Commissioner determines that more frequent reporting is necessary, each broker shall on or before March 1 of each year file with the Commissioner a statement verified by the broker of all surplus lines insurance transacted by him or her during the preceding calendar year.

(b) The statement shall be on forms as prescribed by the Commissioner and shall contain an account of the business done by the surplus lines broker placing business for a home state insured, showing:

(1) Gross amount of each kind of insurance transacted;

(2) Total amount of gross premiums charged for business conducted;

(3) Total amount of gross premiums charged for single state risks where 100% of the premium is attributable to risks in Delaware;

(4) Total amount of gross premiums charged for multi-state risks and the percentage of premium allocated to Delaware and each other state;

(5) Aggregate of returned premiums paid to insureds;

(6) Aggregate of net premiums;

(7) The amount of gross premiums of all business procured by him or her covering risks as described in § 705 of this title in the City of Wilmington, in the County of New Castle outside the City of Wilmington, in Kent County and in Sussex County, including allocation of the portion of the gross premiums for coverage types listed in § 705 of this title and allocable to each of the above geographic areas.

(8) Additional information as required by the Commissioner.

(c) For purposes of this section, "business done" or "business transacted" means all surplus lines insurance business conducted by the surplus lines broker for a home state insured. If 2 or more persons licensed as surplus lines brokers are involved in placing a policy, only the one who is responsible for negotiating, effecting the placement, and remitting the premium to the nonadmitted insurer or its representatives, shall be considered transacting business.

(18 Del. C. 1953, § 1916; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; 78 Del. Laws, c. 176, § 2.)

§ 1925. Tax on surplus lines.

(a) The Commissioner shall ensure that reasonable measures are developed to recover insurance taxes and other amounts due this State during each year.

(b) Every surplus lines broker shall collect and pay to the State Treasurer through the Commissioner a 3 percent tax on the gross premiums charged, less any returned premiums and exclusive of sums collected to cover federal and state taxes and examination fees, for insurance placed or procured under his or her surplus lines license in which this State is the home state of the insured.

(c) For the purposes of this section, if a surplus lines policy procured through a surplus lines broker covers properties, risks, or exposures only partially located or to be performed in this State, but this State is the home state of the insured, all premium for the policy shall be considered written on properties, risks, or exposures located or to be performed in this State.

(d) The tax on any portion of the premium unearned at termination of insurance having been credited by the State to the surplus lines producer must be returned to the policyholder directly by the surplus lines producer. The surplus lines producer is prohibited from rebating, for any reason, any part of the tax.

(e) Annually, on or before March 1, unless more frequent reporting and payment is ordered by the Commissioner, each surplus lines broker shall pay the premium tax due according to subsection (b) of this section for the policies written during the preceding calendar year as shown by his or her annual statement filed with the Commissioner pursuant to § 1924 of this title. Payment shall accompany such forms and shall be made in such manner as is prescribed by the Commissioner.

(f) One-third of the funds received by the Insurance Commissioner in accordance with the provisions of subsection (b) of this section shall be paid to the State Treasurer and shall be set aside as a special fund to provide funding for health insurance premiums for retired county and municipal police and firefighters as authorized in § 1928(a)(1) of this title. These funds shall be paid out by the State Treasurer to the Board of Pension Trustees. The State Treasurer shall determine the total number of state, county and municipal police from an annual registry in accordance with § 709(a) of this title, and shall make distribution proportionately and on a per capita basis, to the Board of Pension Trustees.

(18 Del. C. 1953, § 1917; 56 Del. Laws, c. 380, § 1; 66 Del. Laws, c. 382, § 6; 70 Del. Laws, c. 186, § 1; 78 Del. Laws, c. 176, § 3; 79 Del. Laws, c. 373, § 1.)

§ 1926. Independently procured insurance.

(a) Any person whose home state is this State may directly procure or directly renew insurance with a nonadmitted insurer, as defined in § 1904 of this title, without the involvement of a surplus lines licensee, on a risk located or to be performed, in whole or in part, in this State.

(b) Each insured whose home state is this State that independently procures or continues or renews insurance with a nonadmitted insurer on properties, risks, or exposures located or to be performed in whole or in part in this State, other than insurance procured through a surplus lines broker, is subject to the same tax reporting requirements under this chapter as apply to a surplus lines broker.

(c) On or before March 1 each year, the insured that independently procures insurance must file a written report with the Commissioner, upon forms prescribed by the Commissioner, showing the name and address of the insured or insureds, name and address of the insurer, the subject of the insurance, a general description of the coverage, the amount of premium currently charged, and additional pertinent information reasonably requested by the Commissioner.

(d) At the time of filing the report required in subsection (b) of this section, the insured shall pay to the State Treasurer through the Commissioner a tax at the same rate and in the same manner as surplus lines brokers, as required in § 1925(e) of this title.

(78 Del. Laws, c. 176, § 3.)

§ 1927. Failure to file statement or remit tax; penalty.

(a) If any broker fails to file his or her annual statement or fails to remit the tax as required in §§ 1924 and 1925 of this title, or if any insured who independently procured insurance fails to file the report and remit the tax provided by § 1926 of this title prior to or on the date the tax is due, and, if in the Commissioner's opinion such failure is without just cause, he or she shall be liable for a fine of $25 for each day of delinquency commencing with the first day after the tax is due.

(b) The tax may be collected by distraint, or the tax and fine may be recovered by an action instituted by the Commissioner in any court of competent jurisdiction.

(c) Any fine collected by the Commissioner shall be paid to the State Treasurer and credited to the General Fund.

(18 Del. C. 1953, § 1918; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; 78 Del. Laws, c. 176, § 3.)

§ 1928. Distribution of proceeds of special revenue for benefit of police retiree health insurance [For application of this section, see 79 Del. Laws, c. 373, § 3].

(a) (1) The payments to the Board of Pension Trustees referred to in § 1925(f) of this title for a county or municipality that has elected to participate in the state-administered County and Municipal Police/Firefighter Pension Plan in accordance with Chapter 88 of Title 11, shall be deposited into a special fund, to be managed by the State Board of Pension Trustees, to provide health insurance premiums for retired county and municipal police and firefighters. The State Board of Pension Trustees shall allocate the funds deposited in this special fund on an annual basis to provide up to 80% of the cost of retiree health insurance contingent on the availability of funds. The retiree's premium would be the difference between the total cost and what is available from the special fund.

(2) The payments to the Board of Pension Trustees referenced in § 1925(f) of this title for the State Police shall be deposited into the Other Post-Employment Benefits Fund (OEPB) established by § 5281 of Title 29, to provide for the State's health insurance premiums for retired State Police.

(b) Any funds on deposit in this special fund, including accumulated income, shall revert to the General Fund, if such funds are not utilized for retiree health insurance within 5 years from the date of deposit into the special fund.

(79 Del. Laws, c. 373, § 2.)

Subchapter III

Nonadmitted Insurers

§ 1931. Minimum financial eligibility standards for surplus line insurers.

(a) The Commissioner may consider a surplus lines insurer to be eligible if the nonadmitted insurer:

(1) If a United States domestic insurer has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction which equals the greater of:

a. 1. The minimum capital and surplus requirements under the law of this State; or

2. Fifteen million dollars.

b. The requirements of this paragraph (a)(1) may be satisfied by an insurer possessing less than the minimum capital and surplus upon an affirmative finding of acceptability by the Commissioner. The finding must be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability, and company record and reputation within the industry. The Commissioner may not make an affirmative finding of acceptability when the nonadmitted insurer's capital and surplus is less than $4,500,000; or

(2) The insurer is listed on the Quarterly Listing of Alien Insurers maintained by the International Insurers Department of the NAIC if the insurer is not domiciled in the United States or its territories.

(b) This section shall not be deemed to require the Commissioner to determine the actual financial condition or claims practices of any nonadmitted insurer; and the status of eligibility shall indicate only that the insurer appears to be sound financially and to have satisfactory claims practices, and that the Commissioner has no credible evidence to the contrary.

(78 Del. Laws, c. 176, § 4.)

§ 1932. Domestic surplus lines insurers.

(a) A Delaware domestic insurer possessing policyholder surplus of at least $15,000,000 may, pursuant to a resolution by its board of directors, and with the written approval of the Insurance Commissioner, be designated as a domestic surplus lines insurer. Such insurers may write surplus lines insurance in any jurisdiction, including this State.

(b) In this State, a Delaware domestic surplus lines insurer may only insure a Delaware risk when such coverage is procured pursuant to this chapter governing surplus lines insurance, and the premium shall be subject to surplus lines premium tax pursuant to § 1925 of this title.

(c) A domestic surplus lines insurer may not issue a policy designed to satisfy the motor vehicle financial responsibility requirements of this State (§ 2118(c) of Title 21), the Workers' Compensation Act (§ 2372(a) of Title 19), or any other law of this State mandating insurance coverage by a licensed insurance company.

(d) A domestic surplus lines insurer must agree to abide by all the requirements of this chapter, and all other requirements of the Delaware Code applicable to Delaware domestic insurers, unless otherwise exempted. The provisions of Chapters 42 and 44 of this title will not apply to a domestic surplus lines insurer.

(78 Del. Laws, c. 176, § 4.)

§ 1933. Withdrawal of eligibility as a surplus lines insurer.

(a) If at any time the Commissioner has reason to believe that a nonadmitted insurer currently eligible as a surplus lines insurer:

(1) Is in unsound financial condition or has acted in an untrustworthy manner; or

(2) No longer meets the requirements for eligibility set forth in § 1931 of this title; or

(3) Has wilfully violated the laws of this State; or

(4) Does not conduct a proper claims practice;

the Commissioner may declare such insurer no longer an eligible surplus lines insurer, upon notice and hearing.

(b) The Commissioner shall promptly mail notice of any such declaration to the regulatory authority of the domiciliary jurisdiction of the insurer. The Commissioner shall also publish notice of all such declarations electronically.

(78 Del. Laws, c. 176, § 4.)

§ 1934. Legal process against surplus line insurer.

(a) A nonadmitted insurer shall be sued, upon any cause of action arising in this State under any contract issued by it as a surplus line contract pursuant to this law, in the Superior Court of this State.

(b) Service of legal process against the insurer may be made in any such action by service of 2 copies thereof upon the Commissioner and payment of the service of process fee specified in § 701 of this title. The Commissioner shall forthwith mail a copy of the process served to the person designated by the insurer in the policy for the purpose by prepaid registered or certified mail with return receipt requested. If no such person is so designated in the policy, the Commissioner shall in like manner mail a copy of the process to the broker through whom such insurance was procured, or to the insurer at its principal place of business, addressed to the address of the broker or insurer, as the case may be, last of record with the Commissioner. Upon service of process upon the Commissioner and mailing of the same in accordance with this provision, the Court shall be deemed to have jurisdiction in personam of the insurer.

(c) A nonadmitted insurer issuing such policy shall be deemed thereby to have authorized service of process against it in the manner and to the effect as provided in this section. Any such policy shall contain a provision stating the substance of this section and designating the person to whom the Commissioner shall mail process as provided in subsection (b) of this section.

(18 Del. C. 1953, § 1919; 56 Del. Laws, c. 380, § 1; 78 Del. Laws, c. 176, § 4.)

§ 1935. Requirements for eligible surplus lines insurers.

(a) An eligible surplus lines insurer shall furnish at least annually to the Commissioner an annual financial statement in a form acceptable to the Commissioner.

(b) An eligible surplus lines insurer shall pay annual fees pursuant to § 701 of this title.

(c) The requirements for rate and form filing contained in this title shall not apply to surplus lines insurance.

(18 Del. C. 1953, § 1907; 56 Del. Laws, c. 380, § 1; 57 Del. Laws, c. 351; 70 Del. Laws, c. 186, § 1; 78 Del. Laws, c. 176, § 4.)

§ 1936. Application and qualifications for approval.

(a) The Commissioner shall from time to time publish a list of surplus lines insurers deemed by him or her eligible to place business on Delaware risks currently.

(b) No foreign or alien insurer shall become listed as a surplus lines insurer eligible in Delaware unless a completed application as prescribed by the Commissioner is received and the insurer has paid the application fee pursuant to § 701 of this title.

(78 Del. Laws, c. 176, § 4; 70 Del. Laws, c. 186, § 1.)

Subchapter IV

Miscellaneous

§ 1941. Applicability.

This chapter shall apply to all nonadmitted insurance business in which this State is the home state of the insured as defined in this chapter.

(78 Del. Laws, c. 176, § 5.)

§ 1942. Reserved power of this State to alter or repeal chapter.

All provisions of this chapter may be altered from time to time or repealed.

(78 Del. Laws, c. 176, § 5.)

§ 1943. Short title.

This chapter constitutes and may be cited as the “Delaware Nonadmitted Insurance Act.”

(78 Del. Laws, c. 176, § 5.)

§ 1944. Penalties and violations.

(a) Penalties cited in this chapter are not exclusive remedies. In addition to any penalty provided herein, including any suspension, revocation or refusal to renew a license, any person, firm, association or corporation violating any provision of this chapter may also be assessed penalties under § 2308 or § 2411 of this title.

(b) Whenever the Commissioner believes, from evidence satisfactory to him or her, that a person is violating or about to violate the provisions of this chapter, the Commissioner may cause a complaint to be filed in a court of competent jurisdiction for restitution and to enjoin and restrain the person from continuing the violation or engaging in or doing any act in furtherance thereof. The court shall have jurisdiction of the proceeding and shall have the power to make and enter an order of judgment awarding such preliminary or final injunctive relief and restitution as in its judgment is proper.

(78 Del. Laws, c. 176, § 5; 70 Del. Laws, c. 186, § 1.)

§ 1945. Urgency.

This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety, and support of the state government and its existing institutions, and shall go into immediate effect. The facts constituting the necessity are: In order to forestall preemption on June 16, 2011, of state statutes pertaining to surplus line insurance taxation, eligibility, and broker licensure by the Nonadmitted and Reinsurance Reform Act of 2010 [15 U.S.C. § 8201 et seq.], a part of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 [12 U.S.C. § 5301], it is necessary that this act take effect immediately.

(78 Del. Laws, c. 176, § 5.)

Part I
Insurance

Chapter 20
Rental Vehicle Insurance Producer Limited License Act

§ 2001. Short title.

This chapter shall be known as the "Rental Vehicle Insurance Producer Limited License Act."

(73 Del. Laws, c. 189, § 1.)

§ 2002. Definitions.

As used in this chapter:

(1) "Limited license" means the authority of a person or entity authorized to sell certain coverages relating to the rental of vehicles pursuant to this chapter.

(2) "Rental agreement" means any written agreement setting forth the terms and conditions governing the use of a vehicle provided by the rental company for rental or lease.

(3) "Rental company" means any person or entity in the business of providing primarily motor vehicles to the public under a rental agreement for a rental period not to exceed 90 days.

(4) "Renter" means any person obtaining the use of a vehicle from a rental company under the terms of a rental agreement for a rental period not to exceed 90 days.

(5) "Vehicle" or "rental vehicle" means a motor vehicle of the private passenger type including passenger vans, minivans and sport utility vehicles, and of the cargo type, including cargo vans, pickup trucks with a gross vehicle weight of less than 26,000 pounds and which do not require the operator to possess a commercial driver's license.

(73 Del. Laws, c. 189, § 1.)

§ 2003. General rules.

(a) The Commissioner may issue to a rental company that has complied with the requirements of this chapter a limited license authorizing the limited licensee to offer or sell insurance in connection with the rental of vehicles.

(b) As a prerequisite for issuance of a limited license under this chapter, there shall be filed with the Commissioner a written application for a limited license signed by an officer of the applicant, in such form or forms, and supplement thereto, and containing such information as the Commissioner may prescribe.

(c) The rental company licensed pursuant to subsection (a) of this section may offer or sell insurance only in connection with and incidental to the rental of vehicles, whether at the rental office or by preselection of coverage in master, corporate, group rental or individual agreements, in any of the following general categories:

(1) Personal accident insurance covering the risks of travel, including but not limited to accident and health insurance that provides coverage, as applicable, to renters and other rental vehicle occupants for accidental death or dismemberment and reimbursement for medical expenses resulting from an accident that occurs during the rental period;

(2) Liability insurance which, at the exclusive option of the rental company, may include uninsured and underinsured motorist coverage, whether offered separately or in combination with other liability insurance, that provides protection, as applicable, to renters and other authorized drivers of rental vehicles for liability arising from the operation of the rental vehicle;

(3) Personal effects insurance that provides coverage, as applicable, to renters and other vehicle occupants for the loss of or damage to personal effects that occurs during the rental period;

(4) Roadside assistance and emergency sickness protection programs; and

(5) Any other travel or vehicle related coverage that a rental company offers in connection with and incidental to the rental of vehicles.

(d) No insurance may be offered or sold by a limited licensee pursuant to this chapter unless:

(1) The rental period of the rental agreement does not exceed 90 consecutive days;

(2) At every rental location where rental agreements are executed, brochures or other written materials are readily available to the prospective renter that:

a. Summarize clearly and correctly the material terms of coverage offered to renters, including the identity of the insurer;

b. Disclose that the coverage offered by the rental company may provide a duplication of coverage already provided by a renter's personal automobile insurance policy, homeowner's insurance policy, personal liability insurance policy or other source of coverage;

c. State that the purchase by the renter of the kinds of coverage specified in this section is not required in order to rent a vehicle; and

d. Describe the process for filing a claim in the event the renter elects to purchase coverage and in the event of a claim; and

(3) Evidence of coverage in the rental agreement is disclosed to every renter who elects to purchase such coverage.

(e) Any limited license issued under this chapter shall also authorize any employee of the limited licensee to act individually on behalf and under the supervision of the limited licensee with respect to the kinds of coverage specified in this chapter.

(f) Each rental company licensed pursuant to this chapter shall conduct a training program in which employees being trained shall receive basic instruction about the kinds of coverage specified in this chapter and offered for purchase by prospective renters of rental vehicles.

(g) Notwithstanding any other provision of this chapter or any rule adopted by the Commissioner, a limited licensee pursuant to this chapter shall not be required to treat moneys collected from renters purchasing such insurance when renting vehicles as funds received in a fiduciary capacity or to hold such funds in separate trust accounts.

(h) No limited licensee under this chapter shall advertise, represent or otherwise hold itself or any of its employees out as licensed insurers, insurance agents or insurance brokers.

(73 Del. Laws, c. 189, § 1.)

§ 2004. Termination of limited license.

In the event that any provision of this chapter is violated by a limited licensee, the Commissioner may:

(1) After notice and a hearing, revoke or suspend a limited license issued under this chapter.

(2) After notice and hearing, impose such other penalties, including suspending the transaction of insurance at specific rental locations where violations of this chapter have occurred, as the Commissioner deems to be necessary or convenient to carry out the purposes of this chapter.

(73 Del. Laws, c. 189, § 1.)

§ 2005. Rules and regulations.

The Commissioner may issue reasonable rules and regulations for the implementation and administration of this chapter.

(73 Del. Laws, c. 189, § 1.)

§ 2006. Fees.

The fee for this limited license is the fee set forth in § 701 of this title.

(73 Del. Laws, c. 189, § 1; 85 Del. Laws, c. 12, § 3.)

Part I
Insurance

Chapter 20A
Portable Electronic Device Insurance Producer Limited License Act

§ 2050. Short title.

This chapter shall be known as the "Portable Electronic Device Insurance Producer Limited License Act".

(78 Del. Laws, c. 359, § 5.)

§ 2051. Definitions.

As used in this chapter:

(1) "Customer" means a person who purchases portable electronics or services.

(2) "Enrolled customer" means a customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics.

(3) "Location" means any physical location in the State or any website, call center site or similar location directed to residents of the State.

(4) "Portable electronics" means electronic devices that are portable in nature, their accessories and services related to the use of the device.

(5) a. "Portable electronics insurance" means insurance providing coverage for the repair or replacement of portable electronics which may provide coverage for portable electronics against any 1 or more of the following: loss, theft, inoperability due to mechanical failure, malfunction, damage, or other similar cause of need for repair or replacement.

b. "Portable electronics insurance" does not include:

1. A service contract or extended warranty providing coverage limited to the repair, replacement or maintenance of property for the operational or structural failure of property due to a defect in materials, workmanship, accidental damage from handling power surges, or normal wear and tear;

2. A policy of insurance covering a seller's or a manufacturer's obligations under a warranty; or

3. A homeowner's, renter's, private passenger automobile, commercial multi-peril, or similar policy.

(6) "Portable electronics transaction" means:

a. The sale or lease of portable electronics by a vendor to a customer; or

b. The sale of a service related to the use of portable electronics by a vendor to a customer.

(7) "Supervising entity" means a business entity that is a licensed insurer or insurance producer that is appointed by an insurer to supervise the administration of a portable electronics insurance program.

(8) "Vendor" means a person in the business of engaging in portable electronics transactions directly or indirectly.

(78 Del. Laws, c. 359, § 5.)

§ 2052. Licensure of vendors.

(a) A vendor is required to hold a limited lines license to sell or offer coverage under a policy of portable electronics insurance.

(b) A limited lines license issued under this section shall authorize any employee or authorized representative of the vendor to sell or offer coverage under a policy of portable electronics insurance to a customer at each location at which the vendor engages in portable electronics transactions.

(c) The supervising entity shall maintain a registry of vendor locations which are authorized to sell or solicit portable electronics insurance coverage in this State. Upon request by the Commissioner and with 10 days' notice to the supervising entity, the registry shall be open to inspection and examination by the Commissioner during regular business hours of the supervising entity.

(d) Notwithstanding any other provision of law, a license issued pursuant to this section shall authorize the licensee and its employees or authorized representatives to engage in those activities that are permitted in this section.

(78 Del. Laws, c. 359, § 5.)

§ 2053. Requirements for sale of portable electronics insurance.

(a) At every location where portable electronics insurance is offered to customers, brochures or other written materials must be made available to a prospective customer which:

(1) Disclose that portable electronics insurance may provide a duplication of coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy or other source of coverage;

(2) State that the enrollment by the customer in a portable electronics insurance program is not required in order to purchase or lease portable electronics or services;

(3) Summarize the material terms of the insurance coverage, including:

a. The identity of the insurer;

b. The identity of the supervising entity;

c. The amount of any applicable deductible and how it is to be paid;

d. Benefits of the coverage; and

e. Key terms and conditions of coverage such as whether portable electronics may be repaired or replaced with similar make and model reconditioned or nonoriginal manufacturer parts or equipment;

(4) Summarize the process for filing a claim, including a description of how to return portable electronics and the maximum fee applicable in the event the customer fails to comply with any equipment return requirements; and

(5) State that an enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time and the person paying the premium shall receive a refund or credit of any applicable unearned premium.

(b) Portable electronics insurance may be offered on a month-to-month or other periodic basis as a group or master commercial inland marine policy issued to a vendor of portable electronics for its enrolled customers.

(c) Eligibility and underwriting standards for customers electing to enroll in coverage shall be established for each portable electronics insurance program.

(78 Del. Laws, c. 359, § 5.)

§ 2054. Authority of vendors of portable electronics.

(a) The employees and authorized representatives of vendors may sell or offer portable electronics insurance to customers and shall not be subject to licensure as an insurance producer under this chapter provided that:

(1) The vendor obtains a limited lines license to authorize its employees or authorized representatives to sell or offer portable electronics insurance pursuant to this section;

(2) The insurer issuing the portable electronics insurance either directly supervises or appoints a supervising entity to supervise the administration of the program including development of a training program for employees and authorized representatives of the vendors. The training required by this paragraph shall comply with the following:

a. The training shall be delivered to employees and authorized representatives of vendors who are directly engaged in the activity of selling or offering portable electronics insurance.

b. The training may be provided in electronic form. However, if conducted in an electronic form the supervising entity shall implement a supplemental education program regarding the portable electronics insurance product that is conducted and overseen by licensed employees of the supervising entity; and

c. Each employee and authorized representative shall receive basic instruction about the portable electronics insurance offered to customers and the disclosures required by this section; and

(3) No employee or authorized representative of a vendor of portable electronics shall advertise, represent or otherwise hold himself or herself out as a nonlimited lines licensed insurance producer.

(b) The charges for portable electronics insurance coverage may be billed and collected by the vendor of portable electronics. Any charge to the enrolled customer for coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services shall be separately itemized on the enrolled customer's bill. If the portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services the vendor shall clearly and conspicuously disclose to the enrolled customer that the portable electronics insurance coverage is included with the portable electronics or related services. Vendors billing and collecting such charges shall not be required to maintain such funds in a segregated account provided that the vendor is authorized by the insurer to hold such funds in an alternative manner and remits such amounts to the supervising entity within 60 days of receipt. All funds received by a vendor from an enrolled customer for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. Vendors may receive compensation for billing and collection services.

(78 Del. Laws, c. 359, § 5; 70 Del. Laws, c. 186, § 1.)

§ 2055. Suspension or revocation of license.

If a vendor of portable electronics or its employee or authorized representative violates any provision of this section, the Commissioner may do any of the following:

(1) After notice and hearing, impose fines not to exceed $500 per violation or $5,000 in the aggregate for such conduct.

(2) After notice and hearing, impose other penalties that the commissioner deems necessary and reasonable to carry out the purpose of this chapter, including:

a. Suspending the privilege of transacting portable electronics insurance pursuant to this section at specific business locations where violations have occurred; and

b. Suspending or revoking the ability of individual employees or authorized representatives to act under the license.

(78 Del. Laws, c. 359, § 5.)

§ 2056. Termination of portable electronics insurance.

Notwithstanding any other provision of law:

(1) An insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the policyholder and enrolled customers with at least 30 days' notice.

(2) If the insurer changes the terms and conditions, then the insurer shall provide the vendor policyholder with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure, or other evidence indicating a change in the terms and conditions has occurred and a summary of material changes.

(3) Notwithstanding paragraph (1) of this section, an insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon 15 days' notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim thereunder.

(4) Notwithstanding paragraph (1) of this section, an insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy:

a. For nonpayment of premium;

b. If the enrolled customer ceases to have an active service with the vendor of portable electronics; or

c. If an enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the enrolled customer within 30 calendar days after exhaustion of the limit. However, if notice is not timely sent, enrollment shall continue notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer.

(5) Where a portable electronics insurance policy is terminated by a policyholder, the policyholder shall mail or deliver written notice to each enrolled customer advising the enrolled customer of the termination of the policy and the effective date of termination. The written notice shall be mailed or delivered to the enrolled customer at least 30 days prior to the termination.

(6) Whenever notice or correspondence with respect to a policy of portable electronics insurance is required pursuant to this section or is otherwise required by law, it shall be in writing and sent within the notice period, if any, specified within the statute or regulation requiring the notice or correspondence. Notwithstanding any other provision of law, notices and correspondence may be sent either by mail or by electronic means as set forth in this paragraph. If the notice or correspondence is mailed, it shall be sent to the vendor of portable electronics at the vendor's mailing address specified for such purpose and to its affected enrolled customers' last known mailing addresses on file with the insurer. The insurer or vendor of portable electronics, as the case may be, shall maintain proof of mailing in a form authorized or accepted by the United States Postal Service or other commercial mail delivery service. If the notice or correspondence is sent by electronic means, it shall be sent to the vendor of portable electronics at the vendor's electronic mail address specified for such purpose and to its affected enrolled customers' last known electronic mail address as provided by each enrolled customer to the insurer or vendor of portable electronics, as the case may be. For purposes of this paragraph, an enrolled customer's provision of an electronic mail address to the insurer or vendor of portable electronics, as the case may be, shall be deemed consent to receive notices and correspondence by electronic means. The insurer or vendor of portable electronics, as the case may be, shall maintain proof that the notice or correspondence was sent.

(7) Notice or correspondence required by this section or otherwise required by law may be sent on behalf of an insurer or vendor, as the case may be, by the supervising entity appointed by the insurer.

(78 Del. Laws, c. 359, § 5.)

§ 2057. Application for license and fees.

(a) A person applying for a license under this chapter shall make application to the Insurance Commissioner on forms prescribed by the Commissioner and declare under penalty of refusal, suspension or revocation of the license that the statements made in the application are true, correct and complete to the best of the person's knowledge and belief.

(b) The application shall:

(1) Provide the name, residence address, and other information required by the Insurance Commissioner for an employee or officer of the vendor that is designated by the applicant as the person responsible for the vendor's compliance with the requirements of this chapter. However, if the vendor derives more than 50% of its revenue from the sale of portable electronics insurance the information noted above shall be provided for all officers, directors, and shareholder of record having beneficial ownership of 10% or more of any class of securities registered under the federal securities law; and

(2) The location of the applicant's home office.

(c) Any vendor engaging in portable electronics insurance transactions on or before January 1, 2013, must apply for licensure within 90 days of the application being made available by the Insurance Commissioner. Any applicant commencing operations after January 1, 2013, must obtain a license prior to offering portable electronics insurance.

(d) Initial licenses issued pursuant to this chapter shall be valid for a period of 24 months and expire on February 28 of the renewal year assigned by the Insurance Commissioner.

(e) Each vendor of portable electronics licensed under this chapter shall pay to the Insurance Commissioner the fee set forth in § 701 of this title.

(78 Del. Laws, c. 359, § 5; 85 Del. Laws, c. 12, § 4.)

Part I
Insurance
Chapter 20B
Self-Service Storage Producer Limited License Act.

(81 Del. Laws, c. 437, § 4.)

§ 2060. Short title

This chapter shall be known as the “Self-Service Storage Producer Limited License Act.”

(81 Del. Laws, c. 437, § 4.)

§ 2061. Definitions

As used in this chapter:

(1) “Occupant” means a person or the person’s sublesee, successor, or assign entitled to the use of a storage space or spaces at a self-service storage facility, to the exclusion of others.

(2) “Owner” means the owner, operator, lessor, or sublessor of a self-service storage facility, him or her agent or any other person authorized by him or her to manage the facility or to receive rent from an occupant under a rental agreement.

(3) “Personal property” means movable property that is not affixed to land and includes but is not limited to all of the following:

a. Goods, wares, merchandise, household items, and furnishings.

b. Vehicles, motor vehicles, trailers, and semitrailers.

c. Watercraft and motorized watercraft.

(4) “Self-service storage facility” means any real property designed and used for the purpose of renting or leasing individual storage space to occupants who are to have access to such for the purpose of storing and removing personal property.

(5) “Self-service storage insurance” means insurance offered in connection with and incidental to the rental of space at a self-service storage facility.

(6) “Self-service storage producer” means an owner who is licensed under this section.

(70 Del. Laws, c. 186, § 1; 81 Del. Laws, c. 437, § 4.)

§ 2062. Licensure of self-service storage producers

(a) The Commissioner may issue to an owner that has complied with the requirements of this chapter a limited lines license authorizing the owner to offer, sell, solicit, or negotiate the kinds of insurance prescribed in this section in connection with and incidental to the rental of space at a self-service storage facility.

(b) As a prerequisite for the issuance of a limited lines license under this chapter, a written application in a form and manner prescribed by the Commissioner must be filed with the Commissioner. The application must specify all locations in this State at which the self-service storage producer may conduct business under the license.

(1) An owner is only required to obtain 1 self-service storage producer license for all of its self-service storage facility locations in the state where insurance is transacted.

(2) The self-service storage producer must notify the department within 30 days after commencing business under the self-service storage producer’s license at any additional locations in this State or of those locations in this State that cease to do business under the license.

(c) A self-service storage producer may offer or sell insurance only in connection with and incidental to the rental of space at a self-service storage facility on a master, corporate, commercial, group, or individual policy basis and only with respect to personal property insurance that provides primary coverage to occupants at the self-service storage facility where the insurance is transacted for the loss of or damage to personal property that occurs at that facility or when such property is in transit during the period of the self-service storage rental agreement.

(d) A self-service storage producer may not offer or sell insurance under this section unless each of the following:

(1) The self-service storage producer makes readily available to the prospective purchaser brochures or other written materials that do all of the following:

a. Summarize the material terms of insurance coverage offered to occupants, including the identity of the insurer, price, benefits, deductibles, exclusions, and conditions, or provide the actual terms of insurance coverage.

b. Disclose that the policies offered by the self-service storage producer may provide a duplication of coverage already provided by an occupant’s homeowner’s insurance policy, renter’s insurance policy, vehicle insurance policy, watercraft insurance policy, or other source of property insurance coverage. This disclosure must be prominently displayed in the brochure or other written materials in at least 12-point type bold print.

c. State that the insurance prescribed in this section is primary coverage over any other coverage covering the same loss.

d. State that if insurance is required as a condition of rental, the requirement may be satisfied by the occupant purchasing the insurance prescribed in this section or by presenting evidence of other applicable insurance coverage and that the purchase of the insurance prescribed in this section is not required in order to rent storage space. This statement must be prominently displayed in the brochure or other written materials in at least 12-point type bold print.

e. Describe the process for filing a claim.

f. Include contact information for filing a complaint with the Commissioner.

(2) All costs related to the insurance are stated in writing.

(3) Evidence of coverage in a form approved by the insurer is provided to every occupant who purchases the coverage.

(4) The insurance is provided by an insurer authorized to transact the applicable kinds of insurance in this State or by a surplus lines insurer authorized under Chapter 19 of this title.

(e) An employee or authorized representative of a self-service storage producer may act on behalf of and under the supervision of the self-service storage producer in matters relating to the conduct of business under the license that is issued under this section if all of the following:

(1) The conduct of an employee or authorized representative of a self-service storage producer acting within the scope of employment or agency is deemed the conduct of the self-service storage producer for purposes of this section.

(2) The self-service storage producer must maintain a register, on a form the Commissioner requires, of each employee or authorized representative of the self-service storage producer who offers the insurance prescribed in this section on behalf of the self-service storage producer, and must submit the register for inspection by the Commissioner upon request. Such register must also include a certification that each employee or authorized representative of the self-service storage producer who offers the insurance prescribed in this section has completed the training program set forth in paragraph (e)(3) of this section below.

(3) Each self-service storage producer must provide or cause a licensed producer to provide a training program approved by the Commissioner that gives employees and authorized representatives of the self-service storage producer who offer the insurance prescribed in this section on behalf of the self-service storage producer basic instruction about the provisions of this section, including all of the following:

a. General information about homeowners, renters, business, and similar insurance that an occupant may have that may provide coverage for property stored at a self-service storage facility.

b. General information about the material terms of insurance coverage offered to occupants including the price, benefits, deductibles, exclusions, and conditions of the insurance.

c. The provisions of this section including the required disclosures set forth in this section.

(81 Del. Laws, c. 437, § 4.)

§ 2063. Prohibitions

A self-service storage producer may not:

(1) Offer or sell insurance except in connection with and incidental to the rental of space at a self-service storage facility.

(2) Advertise, represent, or otherwise portray itself or any of its employees or authorized representatives as licensed insurers or insurance producers.

(81 Del. Laws, c. 437, § 4.)

§ 2064. Suspension or revocation of license

The Commissioner may suspend, revoke, or refuse to renew a limited lines license issued under this chapter after notice and opportunity for a hearing if the self-service storage producer, or employee or authorized representative of the self-service storage producer who offers or sells limited lines insurance on behalf of the self-service storage producer, has done any of the following:

(1) Violated any provision of this chapter or this title.

(2) Operated without a limited lines license as required under this chapter.

(3) Failed to make readily available the disclosures required under § 2062(d) this title.

(4) Offered or sold unapproved insurance products.

(5) Failed to train employees or authorized representatives as required under this chapter.

(6) Misrepresented pertinent facts or policy provisions concerning the insurance prescribed in this chapter.

(81 Del. Laws, c. 437, § 4.)

§ 2065. Additional penalties

Instead of, or in addition to, suspending or revoking a limited lines license issued under this chapter, the Commissioner may impose on the self-service storage producer administrative penalties as set forth in Chapter 3 of this title.

(81 Del. Laws, c. 437, § 4.)

§ 2066. Exclusions

(a) An insurer may pay, and a self-service storage producer may receive, a commission, service fee, or other valuable consideration dependent on the sale of insurance.

(b) A self-service storage producer may pay, and its employees or authorized representatives may receive, production payments or incentive payments if the payments are not dependent on the sale of insurance.

(c) An owner is not required to be licensed under this section solely to display and make available to occupants and prospective occupants brochures and other promotional materials created by or on behalf of an authorized insurer or by a surplus lines insurer.

(81 Del. Laws, c. 437, § 4.)

§ 2067. Enforcement

(a) If any of the provisions of this chapter are not satisfied by a self-storage producer, the sale of self-storage insurance by that producer is pursuant to the terms of Chapter 17 of this title.

(b) The self-storage producer offering, selling, soliciting and negotiating self-storage insurance is subject to Chapter 17 of this title, to the extent not inconsistent with this chapter, and Chapter 23 of this title.

(81 Del. Laws, c. 437, § 4.)

Part I
Insurance
Chapter 21
Unauthorized Insurers — Prohibitions, Process and Advertising

§ 2101. Representing or aiding unauthorized insurer prohibited.

(a) No person shall in this State directly or indirectly act as agent for, or otherwise represent or aid on behalf of another, any insurer not then authorized to transact such business in this State in the solicitation, negotiation, procurement or effectuation of insurance or annuity contracts, or renewal thereof, or forwarding of applications for insurance or annuities, or the dissemination of information as to coverage or rates, or inspection of risks, or fixing of rates, or investigation or adjustment of claims or losses, or collection or forwarding of premiums, or in any other manner represent or assist such an insurer in the transaction of insurance with respect to subjects of insurance resident, located or to be performed in this State.

(b) This section does not apply to:

(1) Matters authorized to be done by the Commissioner under the Unauthorized Insurers Process Act, §§ 2103-2108 of this title;

(2) Transactions as to which the insurer is not required to have a certificate of authority pursuant to § 506 (exceptions to certificate of authority requirement) of this title;

(3) A licensed adjuster or attorney-at-law representing such an insurer from time to time in his or her professional capacity;

(4) Persons in this State who secure and furnish information for the purposes of group life insurance, group or blanket health insurance or annuity coverages, or for enrolling individuals under such plans or issuing certificates thereunder or otherwise assisting in administering such plans where no commission is paid for such services and the master policy or contract was lawfully solicited, issued and delivered in and pursuant to the laws of a state in which the insurer was then authorized to transact insurance;

(5) The employee, compensated on salary only, of a Delaware employer who on behalf of the employer assists in the procurement or administration of insurance coverages on the property, risks and insurable interests of the employer.

(18 Del. C. 1953, § 2101; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2102. Purpose of Unauthorized Insurers Process Act and Unauthorized Insurers False Advertising Process Act.

The purpose of §§ 2103 through 2108 (Unauthorized Insurers Process Act) and §§ 2109 through 2111 (Unauthorized Insurers False Advertising Process Act) of this title is to subject certain insurers to the jurisdiction of the Commissioner and the courts of this State in suits and disciplinary proceedings as provided therein, by or on behalf of insureds or beneficiaries under insurance contracts or the Commissioner. The General Assembly declares its concern that many Delaware residents hold insurance policies delivered in this State by unauthorized insurers, other than as to surplus line coverages written pursuant to Chapter 19 of this title, thus presenting to such residents the often insuperable obstacle of resort to distant courts for the assertion of legal rights under their policies, and that such insurers may induce residents to purchase insurance through false advertising sent into this State. In furtherance of such state interest, the General Assembly herein provides a method of substituted service of process upon such insurers, declares that in so doing it exercises its power to protect Delaware residents, to define, for the purposes of this chapter, what constitutes doing business in this State, and also exercises powers and privileges available to the State under 15 U.S.C. § 1011 et seq., as amended, which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states.

(18 Del. C. 1953, § 2102; 56 Del. Laws, c. 380, § 1.)

§ 2103. Unauthorized Insurers Process Act; title; interpretation.

(a) Sections 2103 through 2108 of this title constitute and may be cited as the “Unauthorized Insurers Process Act.”

(b) The act shall be so interpreted as to effectuate its general purpose to make uniform the laws of those states which enact it.

(18 Del. C. 1953, § 2103; 56 Del. Laws, c. 380, § 1.)

§ 2104. Commissioner as process agent.

Solicitation, effectuation or delivery of any insurance contract, by mail or otherwise, within this State by an unauthorized insurer, or the performance within this State of any other service or transaction connected with such insurance by or on behalf of such insurer shall be deemed to constitute an appointment by such insurer of the Commissioner and his or her successors in office as its attorney, upon whom may be served all lawful process issued within this State in any action or proceeding against such insurer arising out of any such contract or transaction, and shall be deemed to signify the insurer’s agreement that any such service of process shall have the same legal effect and validity as personal service of process upon it in this State.

(18 Del. C. 1953, § 2104; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2105. Service of process.

(a) Service of process upon any such insurer pursuant to § 2104 of this title shall be made by delivering to and leaving with the Commissioner or some person in apparent charge of his or her office 2 copies thereof and the payment to him or her of the fees as

prescribed by § 701 of this title. The Commissioner shall forthwith mail by registered or certified mail 1 of the copies of such process to the defendant at its principal place of business last known to the Commissioner, and shall keep a record of all process so served upon him or her. Such service of process is sufficient, provided notice of such service and a copy of the process are sent within 10 days thereafter by registered or certified mail by plaintiff's attorney to the defendant at its last known principal place of business, and the defendant's receipt or receipt issued by the post office with which the letter is registered or certified, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the plaintiff's attorney showing a compliance herewith are filed with the clerk of the court in which such action is pending on or before the date the defendant is required to appear, or within such further time as the court may allow.

(b) Service of process in any such action, suit or proceeding shall in addition to the manner provided in subsection (a) of this section above be valid if served upon any person within this State who, in this State on behalf of such insurer, is:

(1) Soliciting insurance; or

(2) Making any contract of insurance or issuing or delivering any policies or written contracts of insurance; or

(3) Collecting or receiving any premium for insurance, and a copy of such process is sent within 10 days thereafter by registered or certified mail by the plaintiff's attorney to the defendant at the last known principal place of business of the defendant, and the defendant's receipt, or the receipt issued by the post office with which the letter is registered or certified, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the plaintiff's attorney showing a compliance herewith are filed with the clerk of the court in which such action is pending on or before the date the defendant is required to appear, or within such further time as the court may allow.

(c) No plaintiff or complainant shall be entitled to a judgment by default under this section until the expiration of 30 days from the date of the filing of the affidavit of compliance.

(d) Nothing in this section shall limit or abridge the right to serve any process, notice or demand upon any insurer in any other manner now or hereafter permitted by law.

(18 Del. C. 1953, § 2105; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2106. Exemptions from service of process provisions.

Sections 2104 and 2105 of this title shall not apply to surplus line insurance lawfully effectuated under Chapter 19 of this title, or to reinsurance, or to any action or proceeding against an unauthorized insurer arising out of any of the following where the policy or contract contains a provision designating the Commissioner as its attorney for the acceptance of service of lawful process in any action or proceeding instituted by or on behalf of an insured or beneficiary arising out of any such policy, or where the insurer enters a general appearance in any such action:

(1) Wet marine and transportation insurance;

(2) Insurance on or with respect to subjects located, resident or to be performed wholly outside this State, or on vehicles or aircraft owned and principally garaged outside this State;

(3) Insurance on property or operations of railroads engaged in interstate commerce; or

(4) Insurance on aircraft or cargo of such aircraft, or against liability, other than employer's liability, arising out of the ownership, maintenance or use of such aircraft.

(18 Del. C. 1953, § 2106; 56 Del. Laws, c. 380, § 1.)

§ 2107. Defense of action by unauthorized insurer.

(a) Before an unauthorized insurer files or causes to be filed any pleading in any action or proceeding instituted against it under §§ 2104 and 2105 of this title, such insurer shall:

(1) Procure a certificate of authority to transact insurance in this State; or

(2) Deposit with the clerk of the court in which such action or proceeding is pending cash or securities, or file with such clerk a bond with good and sufficient sureties, to be approved by the court, in an amount to be fixed by the court sufficient to secure the payment of any final judgment which may be rendered in such action. The court may in its discretion make an order dispensing with such deposit or bond where the insurer makes a showing satisfactory to the court that it maintains in a state of the United States funds or securities, in trust or otherwise, sufficient and available to satisfy any final judgment which may be entered in such action or proceeding, and that the insurer will pay any final judgment entered therein without requiring suit to be brought on such judgment in the state where such funds or securities are located.

(b) The court in any action or proceeding in which service is made in the manner provided in § 2105 of this title may, in its discretion, order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of subsection (a) of this section above, and to defend such action.

(c) Nothing in subsection (a) of this section above is to be construed to prevent an unauthorized insurer from filing a motion to quash or to set aside the service of any process made in the manner provided in § 2105 of this title on the ground either:

(1) That such unauthorized insurer has not done any of the acts enumerated in § 2104 of this title; or

(2) That the person on whom service was made pursuant to § 2105(b) of this title was not doing any of the acts therein enumerated.

(18 Del. C. 1953, § 2107; 56 Del. Laws, c. 380, § 1.)

§ 2108. Attorneys' fees.

In any such action against an unauthorized insurer, if the insurer has failed for 30 days after demand prior to the commencement of the action to make payment in accordance with the terms of the contract, and it appears to the court that such refusal was vexatious and without reasonable cause, the court shall allow to the plaintiff reasonable attorneys fees and include such fees in any judgment that may be rendered in such action, and in no event shall such fees be less than $100. Failure of an insurer to defend any such action shall be deemed prima facie evidence that its failure to make payment was vexatious and without reasonable cause.

(18 Del. C. 1953, § 2108; 56 Del. Laws, c. 380, § 1.)

§ 2109. Unauthorized Insurers False Advertising Process Act; title.

Sections 2102 and 2109 through 2111 of this title constitute and may be referred to as the "Unauthorized Insurers False Advertising Process Act."

(18 Del. C. 1953, § 2109; 56 Del. Laws, c. 380, § 1.)

§ 2110. Notice to domiciliary supervisory official.

No unauthorized insurer through any estimate, illustration, circular, pamphlet, letter, announcement, statement or any other means or medium shall misrepresent to any person in this State as to its financial condition or the terms of any contract issued or to be issued by it or the advantages thereof, or the dividends or share to be received thereon. Whenever the Commissioner has reason to believe that any such insurer is so misrepresenting, he or she shall so notify the insurer and the insurance supervisory official of the insurer's domiciliary state or province by registered or certified mail.

(18 Del. C. 1953, § 2110; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2111. Action by Commissioner.

(a) If within 30 days following the giving of the notice provided for in § 2110 of this title the insurer has not ceased such dissemination, and if the Commissioner has reason to believe that such insurer is soliciting, issuing or delivering contracts of insurance to residents of this State or collecting premiums on such contracts or performing any other transaction in connection with such insurance, and that a proceeding by him or her in respect to such matters would be to the interest of the public, he or she shall take action against such insurer under Chapter 23 of this title.

(b) If upon such hearing the Commissioner finds that the insurer has misrepresented, as referred to in § 2110 of this title, he or she shall by order on such hearing require the insurer to cease and desist from such violation, and shall mail a copy of the order by registered or certified mail to the insurer at its principal place of business last of record with the Commissioner and to the insurance supervisory official of the insurer's domiciliary state or province. Each violation thereafter of such desist order shall subject the insurer to a penalty of $5,000, to be recovered by a civil action brought against the insurer by the Commissioner. Service of process upon the insurer in such action may be made upon the Commissioner pursuant to § 2105 or Chapter 23 of this title or in any other lawful manner.

(18 Del. C. 1953, § 2111; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 278, § 4; 70 Del. Laws, c. 186, § 1.)

§ 2112. Suits instituted by Commissioner.

(a) Any foreign or alien insurer not thereunto authorized by the Commissioner, who, by mail or otherwise, solicits insurance business in this State or transacts insurance business in this State as defined by § 103 of this title, thereby submits itself to the jurisdiction of the courts of this State in any action, suit or proceeding instituted by or on behalf of the Commissioner arising out of such unauthorized solicitation of insurance business, including, but not limited to, an action for injunctive relief by the Commissioner.

(b) Process against such unauthorized insurer may be served in the manner provided in § 2307 of this title, except that the insurer shall have 40 days from the date of such service within which to plead, answer or otherwise defend the action.

(18 Del. C. 1953, § 2112; 56 Del. Laws, c. 380, § 1.)

Part I
Insurance
Chapter 23
Unfair Practices in the Insurance Business

§ 2301. Declaration of purpose.

(a) The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945, 15 U.S.C. § 1011 et seq., by defining or providing for the determination of all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

(b) Section 2301 through § 2316 of this title constitute and may be cited as the Unfair Trade Practices Act.

(18 Del. C. 1953, § 2301; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 200, § 1.)

§ 2302. Definitions.

When used in this chapter:

(1) "Abuse" means the occurrence of 1 or more of the following acts between family members, current or former household members, or current or former intimate partners:

a. Intentionally or recklessly causing or attempting to cause physical injury, or a sexual offense as defined in § 761 of Title 11;

b. Intentionally or recklessly placing or attempting to place another individual in reasonable apprehension of physical injury or sexual offense to himself or herself or another;

c. Intentionally or recklessly damaging, destroying or taking the tangible property of another individual;

d. Insulting, taunting or challenging another individual or engaging in a course of alarming or distressing conduct in a manner which is likely to provoke a violent or disorderly response or which is likely to cause humiliation, degradation or fear in another individual;

e. Trespassing on or in property of another individual, or on or in property from which the trespasser has been excluded by court order;

f. Child abuse, as defined in Chapter 9 of Title 16;

g. Unlawful imprisonment, kidnapping, interference with custody and coercion, as defined in Title 11;

h. Any other conduct which a reasonable individual under the circumstances would find threatening or harmful.

(2) "Commissioner" shall mean the Commissioner of Insurance of this State.

(3) "Insurance policy" or "insurance contract" shall mean any contract of insurance, indemnity, medical or hospital service, suretyship, or annuity issued, proposed for issuance or intended for issuance by any person.

(4) "Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, fraternal benefit society and other legal entity engaged in the business of insurance, including agents, brokers and adjusters. Person shall also mean medical service plans and hospital service plans as defined in § 6302 of this title. For purposes of this chapter, medical hospital service plans shall be deemed to be engaged in the business of insurance.

(5) "Service contract" is intended to cover the product issued by medical and hospital service plans and should be changed to conform to the laws of each state.

(18 Del. C. 1953, § 2302; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 200, § 1; 70 Del. Laws, c. 186, § 1; 70 Del. Laws, c. 250, § 1.)

§ 2303. Unfair methods of competition and unfair or deceptive acts or practices prohibited.

No person shall engage in this State in any trade practice which is defined in this chapter as, or determined pursuant to this chapter to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

(18 Del. C. 1953, § 2303; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 200, § 1.)

§ 2304. Unfair methods of competition and unfair or deceptive acts or practices defined [For application of this section, see 84 Del. Laws, c. 209, § 3].

The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) *Misrepresentations and false advertising of insurance policies.* — No person shall make, issue, circulate or cause to be made, issued or circulated any estimate, circular, statement, sales presentation, omission or comparison which:

a. Misrepresents the benefits, advantages, conditions or terms of any insurance policy;

b. Misrepresents the dividends or share of the surplus to be received on any insurance policy;

c. Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy;

d. Is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates;

e. Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof;

f. Is a misrepresentation for the purpose of inducing or tending to induce to the lapse, forfeiture, exchange, conversion or surrender of any insurance policy;

g. Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or

h. Misrepresents any insurance policy as being shares of stock.

(2) *False information and advertising generally.* — No person shall make, publish, disseminate, circulate or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of the insurance business, which is untrue, deceptive or misleading.

(3) *Defamation.* — No person shall make, publish, disseminate or circulate, directly or indirectly, or aid, abet or encourage the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, or of an organization proposing to become an insurer, and which is circulated to injure any person engaged or proposing to engage in the business of insurance.

(4) *Boycott, coercion and intimidation.* — No person shall enter into any agreement to commit, or by any concerted action commit, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of or any monopoly in any business of insurance.

(5) *Interlocking ownership, management.* — a. Any insurer may retain, invest in or acquire the whole or any part of the capital stock of any other insurer or insurers, or have a common management with any other insurer or insurers, unless such retention, investment, acquisition or common management is inconsistent with any other provision of this title, or unless by reason thereof the business of such insurers with the public is conducted in a manner which substantially lessens competition generally in the insurance business or tends to create any monopoly therein.

b. Any person otherwise qualified may be a director of 2 or more insurers which are competitors, unless the effect thereof is to lessen substantially competition between insurers generally or tends materially to create any monopoly.

(6) *Prohibited political contributions; penalty.* — a. No insurer or bank acting as an insurer pursuant to § 761(a)(14) of Title 5 shall directly or indirectly pay or use, or offer, consent or agree to pay or use, any money or property for or in aid of any candidate for the office of Insurance Commissioner of the State, or for nomination for such office, or for the reimbursement or indemnification of any person for money or property so used.

b. Any officer, director, stockholder or agent of any insurer which violates any of the provisions of this section, who participates in, aids, abets or advises or consents to any such violation, or any person who solicits or knowingly receives any money or property in violation of this section, shall, in addition to any other penalties imposed by law, be punished by imprisonment for not more than 1 year and a fine of not more than $1,000; and any officer or director abetting in any contribution made in violation of this section shall be liable to the insurer for the amount so contributed.

(7) *Illegal dealing in premiums; excess charges for insurance.* — a. No person shall wilfully collect any sum as premium or charge for insurance, which insurance is not then provided or is not in due course to be provided (subject to acceptance of the risk by the insurer) by an insurance policy issued by an insurer as authorized by this title.

b. No person shall wilfully collect as premium or charge for insurance any sum in excess of the premium or charge applicable to such insurance, and as specified in the policy, in accordance with the applicable classifications and rates as filed with and approved by the Commissioner; or, in cases where classifications, premiums or rates are not required to be so filed and approved, such premiums and charges shall not be in excess of those specified in the policy and as fixed by the insurer. This provision shall not be deemed to prohibit the charging and collection by surplus lines brokers licensed under Chapter 19 of this title of the amount of applicable state and federal taxes and nominal service charge to cover communication expenses, in addition to the premium required by the insurer, nor shall it be deemed to prohibit the charging and collection by a life insurer of amounts actually to be expended for medical examination of an applicant for life insurance or for reinstatement of a life insurance policy.

(8) *Insurance as inducement to purchase.* — No person shall directly or indirectly participate in any plan to offer or effect any kind or kinds of life or health insurance or annuities as an inducement to or in connection with the purchase by the public of any goods, securities, commodities, services or subscriptions to periodicals. This section shall not apply as to insurance written in connection with an indebtedness if the purpose of such insurance is to pay the indebtedness in case of death or disability of the insured.

(9) *Insurer name; deceptive use prohibited.* — No person who is not an insurer shall assume or use any name which deceptively implies or suggests that it is an insurer. This section shall not preclude a corporation heretofore or hereafter formed under the laws of this State from using such a name between the date it is incorporated and the date it begins to engage in any business, if during such period the corporate activities are limited to its organization or reorganization or to those activities it would be permitted to engage in, if it were an insurer, under § 4904(2) of this title.

(10) *Service and processing charges by mortgagee prohibited.* — No mortgagee or agent of any mortgagee shall accept or receive any monetary charge or fee from a mortgagor for handling, servicing or processing insurance policies or endorsements or for the issuances or cancellation of such policies, or property located within this State; provided that this provision shall not apply to charges or fees of an insurance department or division of a corporation established under Chapter 7 or regulated under Chapter 9 of Title 5.

(11) *False statements and entries.* — a. No person shall knowingly file with any supervisory or other public official, or knowingly make, publish, disseminate, circulate or deliver to any person, or place before the public, or knowingly cause directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false, material statement of fact as to the financial condition of an insurer.

b. No person shall knowingly make any false entry of a material fact in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of the affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, knowingly omit to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer.

c. No person shall advertise the capital or assets of any insurer without in the same advertisement setting forth the amount of the insurer's liabilities.

(12) *Stock operations and advisory board contracts.* — a. No person shall offer, issue or deliver or permit its agents, officers or employees to offer, issue or deliver agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts of any kind promising returns and profits as an inducement to insurance.

b. No insurer authorized or proposing to be authorized to transact insurance in this State shall offer, issue or deliver, or permit its agents, officers or employees to offer, issue or deliver in any other state any such agency company stock, certificates, shares or contracts as inducement to insurance.

(13) *Unfair discrimination; life insurance, annuities, and health insurance.* — a. No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

b. No person shall make or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

(14) *Rebates; life, health and annuity contracts.* — Except as otherwise expressly provided by law, no person shall knowingly permit or offer to make or make any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon, or pay or allow, or give or offer to pay, allow or give directly or indirectly, or knowingly accept, as inducement to such insurance or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any paid employment or contract for services of any kind, or any valuable consideration or inducement whatever not specified in the contract, or directly or indirectly give, or sell, or purchase or offer or agree to give, sell or purchase, or allow as an inducement to such insurance contract or annuity or, in connection therewith and whether or not specified in the policy or contract, any agreement of any form or nature promising returns and profits, or any stocks, bonds or other securities, or interest present or contingent therein or as measured thereby, or any insurer or any insurance company or other corporation, association or partnership, or any dividends or profits accrued thereon, or to accrue thereon, or anything of value whatsoever not specified in the contract.

(15) *Unfair discrimination, rebates prohibited; property, casualty, surety insurance.* — a. No property, casualty or surety insurer or any employee or representative thereof, and no broker, agent or solicitor shall pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to insurance, or after insurance has been effected, any rebate, discount, abatement, credit or reduction of the premium named in a policy of insurance, or any special favor or advantage in the dividends or other benefits to accrue thereon, or any valuable consideration or inducement whatever, not specified or provided for in the policy, except to the extent provided for in an applicable filing with the Commissioner as provided by law.

b. No insured named in a policy, nor any employee of such insured, shall knowingly receive or accept directly or indirectly any such rebate, discount, abatement, credit or reduction of premium, or any such special favor or advantage or valuable consideration or inducement.

c. No such insurer shall make or permit any unfair discrimination between insureds or property having life insuring or risk characteristics, in the premium or rates charged for insurance, or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the insurance.

d. Nothing in this section shall be construed as prohibiting the payment of commissions or other compensation to licensed agents, brokers or solicitors, or as prohibiting any insurer from allowing or returning to its participating policyholders, members or subscribers dividends, savings or unabsorbed premium deposits. In this section "insurance" includes suretyship, and "policy" includes bond. This section does not apply to wet marine and transportation insurance.

e. Nothing in paragraph (13) or paragraph (14) of this section shall be construed as including within the definition of discrimination or rebates any of the following practices:

1. In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement or premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

2. In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses;

3. Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year;

4. Reduction of premium rates for policies of large amounts, but not exceeding savings in issuance and administration expenses reasonably attributable to such policies as compared with policies of similar plans issued in smaller amounts;

5. Reduction in premium rates for life or health insurance policies on annuity contracts on salary savings, payroll deductions, preauthorized checks, bank drafts or similar plans in amounts reasonably commensurate with the savings made by the use of such plans.

f. Nothing in this chapter shall be construed as including within the definition of securities as inducement to purchase insurance, the selling or offering for sale, contemporaneously with life insurance or mutual fund shares or face amount certificates of regulated investment companies under offerings registered with the Securities and Exchange Commission where such shares or such face amount certificates or such insurance may be purchased independently of and not contingent upon purchase of the other, at the same price and upon similar terms and conditions as where purchased independently.

(16) *Unfair claim settlement practices.* — No person shall commit or perform with such frequency as to indicate a general business practice any of the following:

a. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

b. Failing to acknowledge and act reasonably promptly upon communication with respect to claims arising under insurance policies;

c. Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

d. Refusing to pay claims without conducting a reasonable investigation based upon all available information;

e. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

f. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

g. Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

h. Attempting to settle a claim for less than the amount to which a reasonable person would have believed that person's own self was entitled by reference to written or printed advertising material accompanying or made part of an application;

i. Attempting to settle claims on the basis of an application which was altered without notice to or knowledge or consent of the insured;

j. Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made;

k. Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

l. Delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

m. Failing to promptly settle claims, where liability has become reasonably clear under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

n. Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(17) *Failure to maintain complaint handling procedures.* — Failure of any person to maintain a complete record of all the complaints which it has received since the date of its last examination as otherwise required in this title. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. For purposes of this subsection, "complaint" shall mean any written communication primarily expressing a grievance.

(18) *Misrepresentation in insurance applications.* — a. Making false or fraudulent statements or representations on or relative to an application for an insurance policy for the purpose of obtaining a fee, commission, money or other benefit from any insurers, agent, broker or individual.

b. No agent, broker, solicitor, examining physician, applicant or other person shall knowingly or wilfully make any false or fraudulent statement or representation in or with reference to any application for insurance or, for the purpose of obtaining any money or benefit, knowingly or wilfully present or cause to be presented a false or fraudulent claim or any proof in support of such a claim for the payment of the loss upon a contract of insurance or prepare, make or subscribe a false or fraudulent account, certificate, affidavit or proof of loss or other document or writing with intent that the same may be presented or used in support of such a claim.

(19) *Fictitious groups.* — a. No insurer, whether an authorized insurer or an unauthorized insurer, shall make available through any rating plan or form property, casualty or surety insurance to any firm, corporation or association of individuals or make any preferred rate or premium based upon any fictitious grouping of such firm, corporation or association.

b. No form or plan of insurance covering any group or combination of persons or risks shall be written or delivered within or outside this State to cover persons or risks in this State at any preferred rate or on any form other than as offered to persons not in such group or combination and to the public generally, unless such form, plan of insurance and the rates or premium to be charged therefor have been submitted to and approved by the Commissioner as being not unfairly discriminatory and as not otherwise being in conflict with subdivision a. above or with any provision of Chapter 25 of this title (Rates and Rating Organizations) to the extent that such Chapter 25 is, by its terms, applicable thereto.

c. This section does not apply to life insurance, health insurance, annuity contracts or wet marine and transportation insurance.

(20) *"Twisting" prohibited.* — No person shall make or issue or cause to be made or issued any written or oral statement misrepresenting or making incomplete comparisons as to the terms, conditions or benefits contained in any policy for the purpose of inducing or attempting or tending to induce the policyholder to lapse, forfeit, surrender, retain, exchange or convert any insurance policy.

(21) *Insurance on public construction contracts.* — a. No officer or employee of this State or of any public agency, public authority or public corporation (except a public corporation or public authority created pursuant to agreement or compact with another state) and no person acting or purporting to act on behalf of such officer or employee or public agency or public authority or public corporation shall, with respect to any public building or construction contract which is about to be or which has been competitively bid, require the bidder to make application to (or furnish financial data to) or to obtain or procure any of the surety bonds or contracts of insurance specified in connection with such contract or specified by any law, general, special or local from a particular insurer or agent or broker.

b. No such officer or employee or any person acting or purporting to act on behalf of such officer or employee shall negotiate, make application for, obtain or procure any of such surety bonds or contracts of insurance (except contracts of insurance for builder's risk or owner's protective liability) which can be obtained or procured by the bidder, contractor or subcontractor.

c. This section shall not, however, prevent the exercise by such officer or employee on behalf of the State or such public agency, public authority or public corporation of its right to approve the form, sufficiency or manner of execution of the surety bonds or contracts of insurance furnished by the insurer selected by the bidder to underwrite such bonds or contracts of insurance.

d. Any provisions in any invitation for bids or in any of the contract documents in conflict with this section are declared to be contrary to the public policy of this State.

e. A violation of this section shall be subject to the penalties provided by § 2308(a) of this title.

(22) *Unfair discrimination in the value of insurance policies and premiums based on race, color, religion, sexual orientation, gender identity, military status, or national origin; penalty.* — a. It is an unlawful practice for any insurance company licensed to do business in this State to discriminate in any way because of the insured's race, color, religion, sexual orientation, gender identity, military status, or national origin, or to make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, to include the writing of any policy or the application therefor, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of the insurance business, which discriminates in any way because of the insured's race, color, religion, sexual orientation, gender identity, military status, or national origin or to classify or refer to any individual on the basis of race, color, religion, sexual orientation, gender identity, military status, or national origin.

b. For purposes of this paragraph (22):

1. "Gender identity" means a gender-related identity, appearance, expression or behavior of a person, regardless of the person's assigned sex at birth.

2. "Military status" means status as any of the following:

A. A member of the uniformed forces, as defined in 10 U.S.C. § 101, or a reserve component thereof listed under 10 U.S.C. § 10101.

B. A "veteran" as defined in 38 U.S.C. § 101.

C. A "dependent" of a servicemember as defined in 50 U.S.C. § 3911.

3. "Protective hairstyle" includes braids, locks, and twists.

4. "Race" includes traits historically associated with race, including hair texture and a protective hairstyle.

5. "Sexual orientation" includes heterosexuality, homosexuality, bisexuality, asexuality, or pansexuality.

c. Nothing in this section is intended to prohibit a distinction or differential treatment based on military status that is allowed by state law or regulation, federal law or regulation, or government contract, including military discounts.

d. The Department of Insurance is empowered, as hereinafter provided, to prevent any licensed or authorized insurance company from engaging in any discriminatory practices as set forth in paragraph (22)a. of this section.

e. Whenever a charge is filed with the Department by or on behalf of a person claiming to have been discriminated against in the purchase of insurance because of race, religion, sexual orientation, gender identity, color, military status, or national origin, the Department shall serve a copy of the charge on such insurance company and shall make an investigation thereof. Charges shall be in writing and shall contain such information and be in such form as the Department requires. Such charges shall not be made public by the Department. If the Department determines after such investigation that there is reasonable cause to believe that the charge is not true, it shall dismiss the charge and promptly notify the person claiming to have been discriminated against and the respondent of its action. Such notice shall be in writing and shall set forth the facts upon which the decision is based.

f. If the Department determines, after the investigation referred to in paragraph (22)e. of this section, that there is reasonable cause to believe that the charge is true, the Department shall endeavor to eliminate any such alleged unlawful practice by informal methods of conference, conciliation and persuasion. Nothing said or done during and as a part of such conciliation endeavors may be made public by the Department, its officers or employees or used as evidence in a subsequent proceeding without the written consent of the persons concerned. The Department shall make its determination on reasonable cause as promptly as possible and, so far as practicable, not later than 120 days from the filing of the charge. A charge under paragraph (22)e. of this section must be filed within 90 days after the alleged unlawful discriminatory practice or 120 days after discovery thereof, whichever is the later.

g. If the Department determines, after attempting to secure voluntary compliance under paragraph (22)f. of this section, that it is unable to secure from the respondent a conciliation agreement acceptable to the Department and to the person aggrieved, which determination shall not be reviewable in any court, the Department shall issue and cause to be served upon the respondent a complaint stating the facts upon which the allegation of the unlawful discriminatory practice is based together with a notice of hearing before the Commissioner or the Commissioner's agent, at a place therein fixed not less than 5 days after the serving of such complaint. The complaint may be amended at any reasonable time provided that the respondent has sufficient time to respond thereto. Related proceedings may be consolidated for hearing.

h. A respondent shall have the right to file an answer to the complaint against the respondent and may amend the respondent's own answer at any reasonable time. The respondent and the person aggrieved shall be parties and may appear at any stage of the proceedings, with or without counsel. All testimony shall be taken under oath and shall be reduced to writing.

i. If the Commissioner or the Commissioner's agent finds that the respondent has engaged in an unlawful discriminatory practice, the Commissioner or the Commissioner's agent shall state its findings of fact in writing and shall issue and cause to be served on the respondent and the person or persons aggrieved by such unlawful discriminatory practice an order requiring the respondent to cease and desist from such unlawful practice. Such order may further require such respondent to make reports from time to time showing the extent to which the respondent has complied with the order. If the Commissioner or the Commissioner's agent finds that the respondent has not engaged in any unlawful discriminatory practice, the Commissioner or the Commissioner's agent shall state those findings of fact in writing and shall issue and cause to be served on the respondent and the person or persons alleged in the complaint to be aggrieved an order dismissing the complaint.

j. 1. Any complainant or aggrieved party, or respondent or intervenor or the Commissioner or the Commissioner's agent may obtain an order of the Court of Chancery for enforcement of the Commissioner's order. The proceeding for enforcement is initiated by filing a petition in the Court of Chancery. Copies of the petition shall be served upon all parties of record. Within 30 days after the service of the petition upon the Commissioner or the Commissioner's agent or its filing by the Commissioner or the Commissioner's agent or within such further time as the Court may allow, the Commissioner or the Commissioner's agent shall transmit to the Court the original or a certified copy of the entire record upon which the order is based, including any transcript of testimony, which need not be printed. By stipulation of all parties to the proceeding, the record may be shortened. The Court may reverse or modify the order if substantial rights of the petitioner have been prejudiced or the findings of fact of the Department are clearly erroneous. The Court shall have power to grant such temporary relief or restraining order as it deems just and to enter an order enforcing, as modified, or setting aside in whole or in part the order of the Commissioner or the Commissioner's agent or remand the case to the Department for further proceedings.

2. A proceeding under this section must be initiated within 30 days after a copy of the order of the Commissioner or the Commissioner's agent is received. If no proceeding is so initiated, the Commissioner or the Commissioner's agent may obtain a decree of the Court for enforcement of its order upon showing that a copy of the petition for enforcement was served on the respondent and that the respondent is subject to the jurisdiction of the Court.

k. After a charge has been filed and until the record has been filed in the Court of Chancery as herein provided, the proceeding may at any time be ended by agreement between the Commissioner or the Commissioner's agent and the parties for the elimination of the alleged unlawful discriminatory practice, approved by the Commissioner or the Commissioner's agent and the Commissioner or the Commissioner's agent may at any time, upon reasonable notice, modify or set aside, in whole or in part, any finding or order made or issued by it.

l. The Superior Court of the county where the violation is alleged to have occurred shall have jurisdiction to hear an appeal from any decision made by the Commissioner or the Commissioner's agent, except as provided in paragraph (22)j. of this section. Such appeal shall be on the record only.

m. In the event that the Court determines that the respondent has engaged in an unlawful discriminatory practice causing economic loss to the petitioner, the respondent shall reimburse or refund to the petitioner, with reasonable interest added thereto, a sum equal to the amount of the economic loss suffered by the petitioner.

(23) *Tying arrangements; cancellation; disclosure.* — a. No person who has received the name of any actual or potential borrower from any bank or trust company which engages, directly or indirectly, in any activity authorized by § 761(a)(14) of Title 5 shall, with respect to such borrower:

1. Engage in any of the activities prohibited to such bank or trust company by § 929 of Title 5;

2. Refuse to allow such borrower to exercise any rights of cancellation or refund set forth in § 930 of Title 5, all of which rights shall be applicable to such borrower;

3. Fail to take any action required of a bank or trust company under § 930 of Title 5, all of which shall be required of such person; or

4. In connection with any application for a policy of insurance submitted to such person by such borrower, or in connection with any policy of insurance thereafter issued to such borrower by such person, fail to disclose or cause to be disclosed to such borrower that such policy, if and when issued, is not a direct liability of such bank or trust company, and that only the assets of the insurer issuing such policy are applicable to the payment and satisfaction of claims made thereunder.

b. The prohibitions set forth in paragraphs (23)a.2. and 3. of this section shall be applicable only with respect to "an individual borrower," as defined in § 930(f) of Title 5.

c. The Commissioner shall by regulation promulgated after consultation with the Bank Commissioner provide for the adequate disclosure of the prohibitions set forth in this paragraph.

(24) *Discriminatory practices against victims of abuse regarding life and health insurance.* — A person or entity engaged in the business of life and/or health insurance in this State may not:

a. Deny, refuse to issue, refuse to renew, refuse to reissue, cancel or otherwise terminate an insurance policy or restrict coverage on any individual because that individual is, has been or may be the subject of abuse or seeks, has sought or should have sought, medical or psychological treatment for abuse, protection from abuse or shelter from abuse;

b. Add any surcharge or rating factor to a premium of an insurance policy because of an individual's history of, status as, or potential to be subject to abuse;

c. Exclude or limit coverage for losses or deny a claim incurred by an insured as a result of abuse or the potential for abuse; or

d. Ask an insured or an applicant for insurance whether that individual is, has been or may be the subject of abuse, or seeks, has sought or should have sought medical or psychological treatment specifically for abuse, protection from abuse or shelter from abuse.

(25) *Discriminatory practices against victims of abuse regarding homeowner's and private passenger motor vehicle insurance.* — A person or entity engaged in the business of homeowner's and/or private passenger motor vehicle insurance in this State may not:

a. Deny, refuse to issue, refuse to renew, refuse to reissue, cancel or otherwise terminate a homeowner's and/or private passenger motor vehicle insurance policy or restrict coverage on any individual solely because that individual or a member of that individual's family or household is, has been or may be the subject of abuse or seeks, has sought or should have sought, medical or psychological treatment for abuse, protection from abuse or shelter from abuse. Nothing in this section shall be construed to prohibit a person from denying, refusing to issue, renew or reissue, cancelling or otherwise terminating an insurance policy based on any existing insurance statute, provided that the insurer routinely underwrites individuals in the same manner without regard to the individual's abuse status, abuse history or abuse-related claim history and that any such action does not have the purpose or effect of treating abuse status as an underwriting criterion, is not based on any actual or perceived correlation between a type of claim or other underwriting information and abuse and is otherwise permissible by law.

b. Add any surcharge or rating factor to a premium of a homeowner's insurance policy solely because of a history of, status as or potential to be a subject of abuse of the applicant or insured or of a member of the family or household of the insured. Nothing in this section shall be construed to prohibit a person from rating or surcharging a policy in accordance with any existing insurance statute provided that the insurer routinely rates or surcharges individuals in the same manner without regard to the individual's abuse status, abuse history or abuse-related claims history, and any such action does not have the purpose or effect of treating abuse status as an underwriting criterion, is not based on any actual or perceived correlation between a type of claim or other underwriting information and abuse and is otherwise permissible by law.

c. Deny coverage for property damage claims or medical payment coverage for an insured, if such coverage is available and purchased under the policy, as a result of abuse, even if such losses are caused by the intentional act, the fraudulent or criminal act or the failure to act of a co-insured and would otherwise have come under a policy's intentional act, criminal act, family, household or similar exclusion, unless:

1. The claim or coverage is ordinarily denied in the same manner to an insured or claimant who is not a victim of abuse;

2. There is collusion or fraudulent acts by the party seeking the insurance coverage or benefits; or

3. The innocent co-insured refuses to cooperate with any law enforcement investigation, the results of which would be made available to the insurer to verify that the claim for loss resulted from a co-insured's wrongful act or omission.

The innocent co-insured shall, at a minimum, be entitled to recover a pro-rata share of the loss of real or personal property and the entire amount of additional living expenses, as the policy may so provide.

Nothing in this subsection shall be construed to prohibit a person from refusing to defend or indemnify the perpetrator of the wrongful act or omission against any claim for liability arising from such individual's wrongful act or omission. The insurer shall retain the right to subrogate against the wrongdoer for any losses incurred by the injured party, including a wrongdoer who was a co-insured with the victim.

d. Ask an insured or an applicant for homeowner's and/or private passenger motor vehicle insurance whether that individual is, has been or may be the subject of abuse or seeks, has sought or should have sought medical or psychological treatment specifically for abuse, protection from abuse or shelter from abuse.

e. A person shall not be held civilly or criminally liable for any cause of action which may be brought because of compliance with this section. Nothing herein shall preclude any action or investigation against an insurer to enforce this paragraph. Nothing in this section shall preclude a person's obligations to report suspected fraudulent activities to the Insurance Department Fraud Prevention Bureau pursuant to Chapter 24 of this title.

Nothing in paragraph (24) of this section and this paragraph (25) shall be construed to prohibit a person from declining to issue an insurance policy insuring the life of an individual who is or has been the subject of abuse if the perpetrator of the abuse is the applicant or would be the owner of the insurance policy. Nothing in paragraph (24) of this section and this paragraph (25) shall be construed to prohibit a person from underwriting or rating a risk on the basis of a preexisting physical or mental condition, even if such condition had been caused by abuse, provided that:

The person routinely underwrites or rates such condition in the same manner with respect to an insured or an applicant who is not a victim of abuse;

No person shall refuse to insure, refuse to continue to insure, limit the amount, extent or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of a physical or mental condition, except where the refusal, limitation or rate differential is based on sound actuarial principles;

The fact that an individual is, has been or may be the subject of abuse may not be considered a physical or mental condition; and

Such underwriting or rating is not used to evade the intent of this law or any other provision of law. A person shall not be held civilly or criminally liable for any cause of action which may be brought because of compliance with paragraph (24) of this section and this paragraph (25).

(26) *Failure to respond to regulatory inquiries.* — No person shall, with such frequency as to indicate a general business practice, fail to provide preliminary substantive responses to inquiries from the Department of Insurance regarding the denial of claims, cancellation, nonrenewal, or refusal of benefits, refusal to pre-authorize benefits, or violations of this title, within 21 calendar days of such inquiry. A response in compliance with this paragraph shall not preclude the provision of additional information responsive to the inquiry.

(27) *Use of credit scoring.* — No person may use consumer reports or credit scores in any manner prohibited by Chapter 83 of this title.

(28) *Volunteer firefighters and ambulance personnel.* — No insurance carrier shall take any negative underwriting action against a policyholder, including, but not limited, to adjustment of rates or termination of a policy, based solely on the membership of a person covered by the policy in a volunteer fire company certified by the Delaware State Fire Prevention Commission or its successor or in a nonprofit organization that provides ambulance and/or rescue services within this State, including, but not limited to, organizations such as volunteer fire companies, the Veterans of Foreign Wars and the American Legion. This paragraph shall not prevent a carrier from taking underwriting action that is permitted by contract and applicable law, provided that the stated basis for such underwriting action is not a pretense for violating this paragraph.

(29) *Discriminatory practices against living donor.* — a. It is an unlawful practice for a person to do any of the following solely on the basis of an individual's status as a living donor and without any unique and material actuarial risks in accordance with sound actuarial principles and actual and reasonably anticipated and expected experience of the individual on the basis of the individual's status as a living organ donor:

1. Deny an insurance policy.

2. Cancel an insurance policy.

3. Refuse to issue an insurance policy.

4. Determine the process or premium for an insurance policy.

5. Otherwise vary a term or condition in an insurance policy.

b. It is an unlawful practice for a person to prohibit an individual from donating all or part of an organ or tissue as a condition of receiving or continuing to receive an insurance policy.

c. For purposes of this paragraph (29):

1. “Living donor” means an individual who has donated all or part of an organ or tissue and was alive at the time of the donation.

2. A. “Organ” means a human kidney, liver, heart, lung, pancreas, esophagus, stomach, small or large intestine or portion of the gastrointestinal tract, or another part of the human body designated by the Commissioner by regulation.

B. “Organ” includes blood vessels recovered during the recovery of an organ if the blood vessels are intended for use in organ transplantation.

3. A. “Tissue” means a portion of the human body other than an organ, including a human eye, skin, bone, bone marrow, heart valve, spermatozoon, ova, artery, vein, tendon, ligament, or pituitary gland or fluid.

B. “Tissue” does not include blood or a blood derivative, unless the blood or blood derivative is donated for the purpose of research or education.

d. The Commissioner shall develop and make publicly available informational materials relating to living donors and the live donation of organs and tissue and the access of living donors to insurance provided under this paragraph (29).

(30) *Prohibited use of certain rating factors in homeowner’s and private passenger motor vehicle insurance. —*

A person or entity engaged in the business of homeowner’s or private passenger motor vehicle insurance in this State may not use any data related to any proposed insured or covered person in the underwriting of such insurance that is any of the following:

a. Related to nonpending arrests, charges, or indictments that do not result in conviction.

b. Related to convictions, arrests, charges, or indictments that do not relate in any way to either fraud or to the type of risk being insured or evaluated for the insurance being sought.

c. Related to the suspension or revocation of a driver’s license when the suspension or revocation is for nondriving-related reasons unless otherwise permitted under this paragraph (30).

(18 Del. C. 1953, § 2304; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 200, § 1; 65 Del. Laws, c. 195, § 1; 66 Del. Laws, c. 297, § 1; 67 Del. Laws, c. 223, §§ 25, 26, 40; 70 Del. Laws, c. 186, § 1; 70 Del. Laws, c. 250, § 1; 70 Del. Laws, c. 510, §§ 1, 2; 75 Del. Laws, c. 55, § 2; 76 Del. Laws, c. 175, § 2; 76 Del. Laws, c. 395, § 1; 77 Del. Laws, c. 90, §§ 13, 14; 79 Del. Laws, c. 47, § 16; 81 Del. Laws, c. 78, § 4; 83 Del. Laws, c. 13, § 12; 83 Del. Laws, c. 195, § 4; 83 Del. Laws, c. 292, § 1; 84 Del. Laws, c. 209, § 1; 84 Del. Laws, c. 530, § 4; 85 Del. Laws, c. 104, § 4.)

§ 2305. Favored agent or insurer; coercion of debtors.

(a) No person shall:

(1) Require, as a condition precedent, concurrent or subsequent to the loaning of money upon the security of any real or personal property or to the selling of any such property under contract or extension of credit or any renewal thereof, that the owner of the property to whom the money is to be loaned or the vendee of the property so being sold, shall place, continue or renew any policy of insurance covering or to cover such property or covering any liability related to such property or the use thereof or that the person to whom such money or credit is extended or whose obligation the creditor is to acquire or finance negotiate any policy or contract of insurance through a particular insurance agent, broker or in a particular insurer or group of insurers or agent or broker or group of agents or brokers, except that this provision shall not prevent the exercise by any such lender or vendor upon a reasonable basis of the right to approve or disapprove of the insurer and representative selected to underwrite the insurance. Such basis shall relate only to:

a. The adequacy and terms of the coverage with respect to the interest of the vendor or lender to be insured thereunder;

b. The financial standards to be met by the insurer; and

c. The ability of the insurer or representative to service the policy;

(2) Unreasonably disapprove the insurance policy provided by a borrower for the protection of the property securing the credit or lien;

(3) Require directly or indirectly that any borrower, mortgagor, purchaser, insurer, broker or agent pay a separate charge to substitute the insurance policy of one insurer for that of another; or

(4) Use or disclose information resulting from a requirement that a borrower, mortgagor or purchaser furnish insurance of any kind on real property being conveyed or used as collateral security to a loan, when such information is to the advantage of mortgagee, vendor or lender or is to the detriment of the borrower, mortgagor, purchaser, insurer or the agent or broker complying with such a requirement.

(b) (1) Paragraph (a)(3) of this section does not include the interest which may be charged on premium loans or premium advancements in accordance with the security instrument.

(2) For purpose of paragraph (a)(2) of this section, such disapproval shall be deemed unreasonable if it is not based solely on reasonable standards uniformly applied, relative to the extent of coverage required and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer, nor shall such standards call for the disapproval of an insurance policy because such policy contains coverage in addition to that required.

(3) The Commissioner may investigate the affairs of any person to whom this subsection applies to determine whether such person has violated this subsection. If a violation of this subsection is found, the person in violation shall be subject to the same procedures and penalties as are applicable under other provisions of this chapter.

(4) For purposes of this section, “person” includes any individual, corporation, association, partnership or other legal entity.

(c) The Commissioner shall by regulation provide for the adequate disclosure of the prohibitions set forth in subsections (a) and (b) of this section and any other similar provisions of law.

(18 Del. C. 1953, § 2305; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 200, § 1; 67 Del. Laws, c. 223, § 27.)

§ 2305A. Banks acting as insurance agents or brokers.

(a) Banks and subsidiaries thereof first authorized to conduct the business of insurance pursuant to § 761(a)(14) of Title 5 shall not act as insurance agents or brokers unless duly licensed to act as such pursuant to the provisions of Chapter 17 of this title; provided, that such banks or subsidiaries thereof may sell insurance pursuant to subsections (b) and (c) of this section without separate license if such sales are conducted exclusively by an individual, partnership or corporation duly licensed as an agent or broker under Chapter 17 of this title with whom such bank or subsidiary thereof shall have contracted. All of the business of acting as an insurance agent or broker undertaken by or on behalf of a bank or subsidiary thereof shall be subject to the provisions of Chapter 17 of this title regulating insurance agents or brokers generally; provided, that the prohibition against sharing commissions set forth in § 1739 of this title shall not apply to an agent employed, or contracting with, a bank with respect to the commissions earned by such agent on insurance sold through or on behalf of said bank.

(b) Subject to subsection (c) of this section, banks or subsidiaries thereof first authorized to conduct the business of insurance pursuant to § 761(a)(14) of Title 5 which are either licensed as insurance agents or brokers, or which shall have contracted with an independent individual, partnership or corporation so licensed, may sell insurance both on branch premises and at other, nonbranch locations.

(c) Until July 1, 1994, all sales of insurance to the Delaware public by a bank or subsidiary thereof, or an individual, partnership or corporation licensed as an agent or broker with whom a bank or subsidiary has contracted for the sale of insurance, shall, at each branch office or other location, be conducted under the supervision of 1 or more insurance agents or brokers, located on the premises, who have been licensed and have actual experience as insurance agents or brokers for a period of not less than 5 years.

(d) Nothing in this section shall be construed as derogating from the authority of any bank or subsidiary thereof whose power to conduct the business of insurance first derives from its charter, or otherwise by operation of law other than § 761(a)(14) of Title 5.

(67 Del. Laws, c. 223, § 36.)

§ 2306. Power of Commissioner.

The Commissioner shall have power to examine and investigate the affairs of every person engaged in the business of insurance in this State in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by § 2303 of this chapter.

(18 Del. C. 1953, § 2306; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 200, § 1.)

§ 2307. Procedures as to defined and undefined practices; hearings; witnesses; appearances; production of books and service of process.

(a) Whenever the Commissioner shall have reason to believe that any such person has been engaged or is engaging in this State in any unfair method of competition or in any unfair or deceptive act or practice, whether or not defined in § 2304 or § 2305 of this title, and that a proceeding by him or her in respect thereto would be in the interest of the public, he or she shall issue and serve upon such person a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice, which shall not be less than 10 days after the date of the service thereof.

(b) At the time and place fixed for such hearing, such person shall have an opportunity to be heard and to show cause why an order should not be made by the Commissioner requiring such person to cease and desist from the acts, methods or practices so complained of. Upon good cause shown, the Commissioner shall permit any person to intervene, appear and be heard at such hearing by counsel or in person.

(c) If such report charges a violation of this chapter, and if such method of competition, act or practice has not been discontinued, the Commissioner may, through the Attorney General, at any time after the service of such report, cause an action to be instituted to enjoin and restrain such person from engaging in such method, act or practice. In such action the court may grant a restraining order or injunction upon such terms as may be just, but the State shall not be required to give security before the issuance of any such order or injunction. If a stenographic record of the proceedings in the hearing before the Commissioner was made, a certified transcript thereof including all evidence taken and the report and findings shall be received in evidence in such action.

(d) If the Commissioner's report made under subsection (a) above, or order on hearing made under § 332 of this title does not charge a violation of this chapter, then any intervenor in the proceedings may appeal therefrom within the time and in the manner provided in this title for appeals from the Commissioner generally.

(e) Nothing contained in this chapter shall require the observance at any such hearing of formal rules of pleading or evidence:

(1) The Commissioner may hold a hearing in Dover or any other place of convenience to parties and witnesses, as the Commissioner determines. The Commissioner, or his or her deputy or assistant, shall preside at the hearing and shall expedite the hearing and all procedures involved therein.

(2) Any party to the hearing shall have the right to appear in person and by counsel, to be present during the giving of all evidence, to have a reasonable opportunity to inspect all documentary and other evidence and to examine and cross-examine witnesses, to present

evidence in support of his or her interest and to have subpoenas issued by the Commissioner to compel attendance of witnesses and production of evidence in his or her behalf. Testimony may be taken orally or by deposition and any party shall have such right of introducing evidence by interrogatories or deposition as may obtain in a Court of Chancery.

(3) Upon good cause shown the Commissioner shall permit to become a party to the hearing by intervention, if timely, only such persons, not original parties thereto, whose pecuniary interests are to be directly and immediately affected by the Commissioner's order made upon the hearing.

(4) Formal rules of pleading or evidence need not be observed at any hearing.

(5) The Commissioner, upon such hearings, as to the subject of any examination, investigation or hearing being conducted by him or her, may administer oaths or affirmations, examine and cross-examine witnesses, receive oral evidence and receive documentary evidence and shall have the power to subpoena witnesses, compel their attendance and require the production of books, papers, records, correspondence or other documents which he or she deems relevant to the inquiry. Any delegation by the Commissioner of power of subpoena shall be in writing. The Commissioner, upon such hearing, may, and upon the request of any party, shall, at such person's expense, cause a stenographic record to be made of all the evidence and all the proceedings had at such hearing. If transcribed, a copy of such record shall be furnished for the Commissioner without cost to the Commissioner or the State and shall be part of the Commissioner's record of the hearing; and a copy shall likewise be furnished to any other party to the hearing, at the request and expense of such other party. If no stenographic record is made, and if a judicial review is sought, the Commissioner shall prepare a statement of the evidence and proceedings for use or review.

(f) Subpoenas of witnesses shall be served in the same manner and at the same cost as if issued by the Court of Chancery. In case of a refusal of any person to comply with any subpoena issued hereunder or to testify with respect to any matter concerning which he or she may be lawfully interrogated, the Court of Chancery of the county where such party resides, on application of the Commissioner, may issue an order requiring such person to comply with such subpoena and to testify and any failure to obey any such order of the Court may be punished by the Court as a contempt thereof. Any person knowingly testifying falsely under oath or making a false affirmation as to any matter material to any such examination, investigation or hearing shall upon conviction thereof be guilty of perjury.

(g) Witness fees and mileage, if claimed, shall be allowed the same as for testimony in the Court of Chancery. Witness fees, mileage and the actual expense necessarily incurred in securing attendance of witnesses and their testimony shall be itemized and shall be a part of examination expense to be paid by the person being examined where payment of examination expense by such person is otherwise provided for in this title, or paid by the person as to whom such proceedings, other than as part of an examination, are held if in such proceedings such person is found to have been in violation of the law or by the person, if other than the Commissioner, at whose request the hearing is held.

(h) (1) Statements of charges, orders and other processes of the Commissioner under this chapter may be served by any one duly authorized by the Commissioner, either in the manner provided by law for service of process in civil actions or by registering and mailing a copy thereof to the person affected by such statement, notice, order or other process at his or her or its residence or principal office or place of business. The verified return by the person so serving such statement, notice, order or other process, setting forth the manner of such service, shall be proof of the same and the return postcard receipt for such statement, notice, order or other process, registered and mailed as aforesaid, shall be proof of the service of the same.

(2) Service of all process, statements of charges, and notices under this chapter upon unauthorized insurers shall be made by any deputy or employee of the Department delivering to and leaving with the Commissioner or some person in apparent charge of his or her office, 2 copies thereof, or in the manner provided for by § 2105(b) of this title.

(3) The Commissioner shall forward all such process, statements of charges and notices to the insurer in the manner provided in § 2105(a) of this title.

(4) No default shall be taken against any such unauthorized insurer until expiration of 30 days after date of forwarding by the Commissioner under paragraph (h)(3) of this section above or date of service of process if under § 2105(b) of this title.

(5) Section 2105 of this title shall apply as to all process, statements of charges and notices under this section.

(18 Del. C. 1953, § 2307; 56 Del. Laws, c. 380; 59 Del. Laws, c. 200, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2308. Cease and desist and penalty orders and modifications thereof.

(a) If, after such hearing, the Commissioner shall determine that the person charged has engaged in an unfair method of competition, or an unfair or deceptive act or practice, the Commissioner shall reduce such findings to writing and shall issue and cause to be served upon the person charged with the violation a copy of such findings and an order requiring such person to cease and desist from engaging in such method of competition, act or practice and if the act or practice is a violation of § 2304 or § 2305 of this title, the Commissioner may at the Commissioner's discretion order any 1 or more of the following:

(1) Payment of a monetary penalty of not more than $1,000 for each and every act or violation but not to exceed an aggregate penalty of $100,000 unless the person knew or reasonably should have known the person was in violation of this chapter, in which case the penalty shall not be more than $10,000 for each and every act or violation but not to exceed an aggregate penalty of $150,000 in any 6-month period;

(2) Suspension or revocation of the person's license if the person knew or reasonably should have known the person was in violation of this chapter; or

(3) Such other relief as is reasonable and appropriate.

(b) Until the expiration of the time allowed under § 2309 of this title for filing a petition for review (by appeal or writ of certiorari), if no such petition has been duly filed within such time, or if a petition for review has been filed within such time, then until the transcript of the record of the proceeding has been filed in the Chancery Court, as hereinafter provided, the Commissioner may at any time, upon such notice and in such manner as he or she shall deem proper, modify or set aside in whole or in part any order issued by him or her under this section.

(c) After the expiration of the time allowed for filing such a petition for review, if no such petition has been duly filed within such time, the Commissioner may at any time, after notice and opportunity for hearing, reopen and alter, modify or set aside, in whole or in part, any order issued by him or her under this section, whenever in his or her opinion conditions of fact or of law have so changed as to require such action or if the public interest shall so require.

(d) Such desist order shall become final upon expiration of the time allowed for appeals from the Commissioner's orders, if no such appeal is taken, or, in the event of such an appeal, upon final decision of the Court if the Court affirms the Commissioner's order or dismisses the appeal. An intervenor in such hearing shall have the right to appeal as provided in § 328 of this title.

(e) In event of such an appeal, to the extent that the Commissioner's order is affirmed the Court shall issue its own order commanding obedience to the terms of the Commissioner's order.

(f) No order of the Commissioner pursuant to this section or order of court to enforce it shall in any way relieve or absolve any person affected by such order from any other liability, penalty or forfeiture under law.

(g) Violation of any such desist order shall be deemed to be and shall be punishable as a violation of this title.

(h) This section shall not be deemed to affect or prevent the imposition of any penalty provided by this title or by other law for violation of any other provision of this chapter, whether or not any such hearing is called or held or such desist order issued.

(18 Del. C. 1953, § 2308; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 200, § 1; 70 Del. Laws, c. 186, § 1; 75 Del. Laws, c. 55, § 1.)

§ 2309. Judicial review of orders.

(a) Except as to matters arising under Chapter 25 of this title, an appeal from the Commissioner shall be taken only from an order on hearing or as to a matter on which the Commissioner has refused or failed to hold a hearing after application therefor under § 323 of this title or as to a matter as to which the Commissioner has refused or failed to make his or her order on hearing as required by § 324 of this title.

(b) Any person subject to an order of the Commissioner under § 2308 or § 2311 of this title and who was a party to such hearing or whose pecuniary interests are directly and immediately affected by any such refusal or failure, and who is aggrieved by such order, refusal or failure, may obtain an appeal from the Commissioner's order by filing in the Court of Chancery in any county, within 60 days from the date of such order, a written verified petition praying that the order of the Commissioner be set aside. The petition shall state the grounds upon which the review is sought, together with a bond with good and sufficient sureties to be approved by the Court conditioned to pay all costs which may be assessed against the appellant or petitioner in such proceedings. If the appeal is from the Commissioner's order on hearing, the petitioner shall also deliver to the Commissioner a sufficient number of copies of the petition and the Commissioner shall mail or otherwise furnish a copy thereof to the other parties to the hearing to the same extent as a copy of the Commissioner's order is required to be furnished to the hearing parties under § 324 of this title. A copy of such petition shall be forthwith served upon the Commissioner, and thereupon the Commissioner shall certify and file in such Court a transcript of the entire record in the proceeding, including all the evidence taken and the report and order of the Commissioner. Upon such filing of the petition and transcript such Court shall have jurisdiction of the proceeding and of the question determined therein, shall determine whether the filing of such petition shall operate as a stay of such order of the Commissioner and shall have power to make and enter upon the pleadings, evidence and proceedings set forth in such transcript a decree modifying, affirming or reversing the order of the Commissioner, in whole or in part. The findings of the Commissioner as to the facts, if supported by the evidence, shall be conclusive.

(c) To the extent that the order of the Commissioner is affirmed, the Court shall thereupon issue its own order commanding obedience to the terms of such order of the Commissioner. If either party shall apply to the Court for leave to adduce additional evidence and shall show to the satisfaction of the Court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the proceeding before the Commissioner, the Court may order such additional evidence to be taken before the Commissioner and thereby adduced upon the hearing in such manner and upon such terms and conditions as to the Court may seem proper. The Commissioner may modify his or her findings of fact or make new findings by reason of the additional evidence so taken, and he or she shall file such modified or new findings, which, if supported by the evidence, shall be conclusive, and his or her recommendation, if any, for the modification or setting aside of his or her original order, with the return of such additional evidence.

(d) An order issued by the Commissioner under § 2308 of this title shall become final:

(1) Upon the expiration of the time allowed for filing a petition for review, if no such petition has been duly filed within such time, except that the Commissioner may thereafter modify or set aside his or her order to the extent provided elsewhere in this title; or

(2) Upon the final decision of the highest state court, if the court directs that the order of the Commissioner be affirmed or the petition for review dismissed. From the judgment of the Court of Chancery either the Commissioner or other party to the appeal may appeal directly to the Supreme Court of the State in the same manner as is provided in civil cases.

(e) No order of the Commissioner under this chapter or order of a court to enforce the same shall in any way relieve or absolve any person affected by such order from any liability of any other laws of this State.

(18 Del. C. 1953, § 2309; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 200, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2310. Judicial review by intervenor.

If after any hearing under § 2306 or § 2311 of this title the Commissioner's report does not charge a violation of this chapter, then any intervenor in the proceedings may within 20 days after the service of such report cause a petition for a review of such report to be filed in the Chancery Court of any county of this State. Upon such review, the Court shall have authority to issue appropriate orders and decrees in connection therewith, including, if the Court finds that it is in the interest of the public, orders enjoining and restraining the continuance of any method of competition, act or practice which it finds, notwithstanding such report of the Commissioner, constitutes a violation of this chapter, and containing penalties pursuant to § 2308 of this title.

(18 Del. C. 1953, § 2311; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 200, § 1.)

§ 2311. Penalty for violation of cease and desist orders.

(a) Any person who violates a cease and desist order of the Commissioner under § 2308 of this title, and while such order is in effect, may after notice and hearing and upon order of the Commissioner be subject at the discretion of the Commissioner to any one or more of the following:

(1) A monetary penalty of not more than $11,500 for each and every act or violation; or

(2) Suspension or revocation of such person's license; or

(3) Such other relief as is reasonable and appropriate.

(b) Prosecutions for any such violation shall be brought in the Superior Court of the county in which the offense occurred.

(c) At the discretion of the Commissioner and the Attorney General, any fine provided for above may be recovered on behalf of the State by a civil action brought against the violator.

(18 Del. C. 1953, § 2312; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 200, § 1; 67 Del. Laws, c. 260, § 1.)

§ 2312. Regulations.

(a) The Commissioner may, after notice and hearing, promulgate reasonable rules and regulations, as are necessary or proper to identify specific methods of competition or acts or practices which are prohibited by § 2304 or § 2305 of this title, but the regulations shall not enlarge upon or extend the provisions of § 2304 or § 2305 of this title. Such regulations shall be subject to review in accordance with § 2309 of this title. No such rule or regulation shall extend, modify or conflict with any law of this State or the reasonable implications thereof.

(b) Wilful violation of any such rule or regulation shall subject the violator to such suspension or revocation of certificate of authority or license, or to such administrative fine in lieu thereof, as may be applicable under this title for violation of the provision to which such rule or regulation relates, but no penalty shall apply to any act done or omitted in good faith in conformity with any such rule or regulation, notwithstanding that such rule or regulation may, after such act or omission, be amended or rescinded or determined by judicial or other authority to be invalid for any reason.

(18 Del. C. 1953, § 2313; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 200, § 1.)

§ 2313. Provisions of chapter additional to existing law.

The powers vested in the Commissioner by this chapter, shall be additional to any other powers to enforce any penalties, fines or forfeitures authorized by law with respect to the method, acts and practices hereby declared to be unfair or deceptive.

(18 Del. C. 1953, § 2314; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 200, § 1.)

§ 2314. Immunity from prosecution.

If any person shall ask to be excused from attending or testifying or from producing any books, papers, records, contracts, correspondence or other documents at any hearing on the ground that the testimony or evidence required of him or her may tend to incriminate him or her or subject him or her to a penalty or forfeiture, and shall thereafter notwithstanding this request be directed to give such testimony or produce such evidence, he or she must nonetheless comply with such direction, but he or she shall not thereafter be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter or thing concerning which he or she may testify or produce evidence thereto, and no testimony so given or evidence produced shall be received against him or her upon any criminal action, investigation or proceeding. However, no such individual so testifying shall be exempt from prosecution or punishment for any perjury committed by him or her while so testifying, and the testimony or evidence so given or produced shall be admissible

against him or her upon any criminal action, investigation or proceeding concerning such perjury, nor shall he or she be exempt from the refusal, suspension or revocation of any license, permission or authority conferred, or to be conferred, pursuant to the Insurance Law of this State. Any such individual may execute, acknowledge and file in the office of the Commissioner and of the Attorney General a statement expressly waiving such immunity or privilege in respect to any transaction, matter or thing specified in such statement, and thereupon the testimony of such person or such evidence in relation to such transaction, matter or thing may be received or produced before any judge or justice, court, tribunal, grand jury or otherwise, and if so received or produced such individual shall not be entitled to any immunity or privileges on account of any testimony he or she may so give or evidence so produced.

(18 Del. C. 1953, § 2315; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 200, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2315. Discrimination against individuals over 65 years of age.

(a) No person shall fail to make available to an insured continued coverage for hospital and medical-surgical expenses in health insurance, group and blanket health insurance, or health service corporation contracts due to such insured's attaining the age of 65.

(b) No person shall knowingly permit or offer to make or make any contract of health insurance, group or blanket health insurance, or health service corporation service agreement with an individual 65 years of age or older unless such contract provides benefits equivalent to the benefits available to insureds under the age of 65 covered by such insurance company; except that such contracts may allow for reductions in coverage to reflect benefits available under governmentally sponsored health-care programs generally available to individuals over 65.

(c) Should any insurance company not have a contract available to insureds under the age of 65, the minimum benefits, if any, available to insureds over 65 must include partial or full coverage of appropriate hospital and surgical-medical expenses as determined by the Commissioner taking into account the prevailing medical practice in the community and the coverage available under governmentally sponsored programs generally available to individuals over 65.

(d) The application of subsections (a), (b) and (c) of this section shall not prohibit differential rates to be charged to any category of risk set forth in this section.

(59 Del. Laws, c. 274, § 1.)

§ 2316. Refusal to issue policy to blind or deaf persons prohibited.

(a) No insurer authorized to issue policies of accident and sickness insurance in the State shall refuse, for the reason of blindness or deafness, to issue an individual policy of accident and sickness insurance, which provides hospital expense and surgical expense coverage, to any person residing in the State.

(b) No insurer authorized to issue life insurance policies in the State shall refuse, for the sole reason of blindness or deafness, to issue a policy of individual life insurance on the life of any such person residing in the State.

(61 Del. Laws, c. 216, § 1.)

§ 2317. Genetics-based discrimination prohibited; health insurance.

(a) For purposes of this section:

(1) "Genetic characteristic" means any inherited gene or chromosome, or alteration thereof, that is scientifically or medically believed to predispose an individual to a disease, disorder, or syndrome, or to be associated with a statistically significant increased risk of development of a disease, disorder, or syndrome.

(2) "Genetic information" means information about inherited genes or chromosomes, and of alterations thereof, whether obtained from an individual or family member, that is scientifically or medically believed to predispose an individual to disease, disorder, or syndrome, or believed to be associated with a statistically significant increased risk of development of a disease, disorder, or syndrome. "Genetic information" includes information regarding carrier status, information regarding an increased likelihood of future disease or increased sensitivity to any substance, information derived from laboratory tests that identify mutations in specific genes or chromosomes, requests for genetic services or counseling, tests of gene products, and direct analysis of genes or chromosomes.

(3) "Genetic test" means a test for determining the presence or absence of an inherited genetic characteristic in an individual, including tests of nucleic acids such as DNA, RNA and mitochondrial DNA, chromosomes or proteins in order to identify a predisposing genetic characteristic associated with disease, disorder, or syndrome.

(4) "Insurance" means "health insurance" as defined in § 3602 of this title. "Insurance" does not include disability insurance or long-term care insurance.

(b) A person may not discriminate against any individual in the issuance, denial, or renewal of or in the fixing of the rates, terms, or conditions for insurance based on any genetic characteristic or genetic information.

(c) No cause of action in the nature of defamation, invasion of privacy or negligence shall arise against any person for disclosing personal or privileged information in accordance with this section, nor shall such a cause of action arise against any person for furnishing personal or privileged information to an insurance institution, agent or insurance support organization; provided however, that this section shall provide no immunity for disclosing or furnishing false information with malice or wilful intent to injure any person. Additionally,

no person shall be found in violation of this section because the person receives genetic information or the results of a genetic test through inadvertent disclosure by a medical professional.

(71 Del. Laws, c. 457, § 1; 83 Del. Laws, c. 283, § 25; 84 Del. Laws, c. 481, § 1.)

§ 2317A. Genetics-based discrimination prohibited; life insurance and annuities.

(a) For purposes of this section:

(1) "Direct-to-consumer genetic testing" means any of the following:

a. A consumer-initiated genetic testing product or service offered directly to a consumer.

b. The collection, use, or analysis of genetic data that is collected or derived from a direct-to-consumer genetic testing product or service and is directly provided by a consumer.

(2) "Life insurance" means contracts for life insurance and annuities under Chapter 29, Chapter 31, or Chapter 32 of this title.

(3) The following terms mean as defined in § 2317 of this title:

a. "Genetic characteristic."

b. "Genetic information."

c. "Genetic test."

(b) Except as provided under subsection (c) of this section, a person engaged in the business of life insurance may not do any of the following based solely on any genetic characteristic or genetic information contained in the result of any genetic test.

(1) Deny, refuse to issue, refuse to renew, refuse to reissue, cancel, or otherwise terminate an insurance policy or restrict coverage.

(2) Add any surcharge or rating factor to a premium of an insurance policy.

(3) Otherwise discriminate in the offering, issuance, cancellation, amount of coverage, price, payment of claims, or any other condition of an insurance policy without additional actuarial justification.

(c) Subsection (b) of this section does not apply to any genetic characteristic, genetic information, or the result of any genetic test that is in an individual's medical record or pertinent family history.

(d) A person engaged in the business of life insurance may not do any of the following:

(1) a. Require or request that an individual or a member of the individual's family take a genetic test.

b. Take into consideration the refusal by an individual to take a genetic test.

(2) a. Require or request that an individual provide genetic information received from an entity providing direct-to-consumer genetic testing.

b. Require or request that an individual provide written consent for an entity providing direct-to-consumer genetic testing to share information about the individual.

c. Take into consideration the refusal by an individual to provide genetic information or written consent under paragraph (d)(2)a. or (d)(2)b. of this section.

(e) A person engaged in the business of life insurance cannot attempt to obtain or obtain information from an entity providing direct-to-consumer genetic testing without the written informed consent of the individual as required under § 1202 of Title 16.

(84 Del. Laws, c. 481, § 2.)

§ 2318. Care by advanced practice registered nurses; certified registered nurse anesthetists [For application of this section, see 85 Del. Laws, c. 455, § 4].

(a) No health insurer, health service corporation or health maintenance organization shall deny benefits for eligible services when the services are rendered or performed by an advanced practice registered nurse as long as the advanced practice registered nurse acts within the scope of practice pursuant to Title 24. Any contract of insurance issued or issued for delivery in this State by health insurers, health service corporations or health maintenance organizations shall not exclude advanced practice registered nurses as providers of services covered in the contract.

(b) All health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State and that provide coverage for a health service that a certified registered nurse anesthetist is licensed to perform under Title 24 shall provide for reimbursement of the service provided by the certified registered nurse anesthetist at a reimbursement rate that is not less than the reimbursement rate paid to licensed physicians providing the same service.

(c) Nothing in this section shall be construed to prohibit a health insurer, health service corporation, or health maintenance organization from establishing variable reimbursement rates based on quality or performance measures.

(67 Del. Laws, c. 452, § 1; 69 Del. Laws, c. 319, § 1; 70 Del. Laws, c. 186, § 1; 85 Del. Laws, c. 455, § 1.)

§ 2319. Carrier post-claim adjudication audit record requests.

(a) For purposes of this section:

(1) “Carrier” means any entity that provides health insurance in this State. “Carrier” includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. “Carrier” also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(2) “Carrier” does not mean an entity that provides a plan of health insurance or health benefits designed for issuance to persons eligible for coverage under Titles XVIII, XIX and XXI of the Social Security Act (42 U.S.C. §§ 1395 et seq., 1396 et seq. and 1397 et seq.), known as Medicare, Medicaid, or any other similar coverage under state or federal governmental plans.

(3) “Post-claim adjudication audit” means any audit of a claim by a carrier post payment.

(b) Except as set forth in subsection (e) of this section, medical records requests for post-claim adjudication audits are limited to 400 claims for a specific episode of care in a 45-day period per provider. Any request for records pursuant to this section shall be made in writing.

(c) A provider shall have no less than 45 days and no more than 60 days from the date of the letter to submit all of the requested records.

(d) A provider shall have no less than 30 days and no more than 60 days from the receipt date of the audit result/determination letter to appeal the audit determination.

(e) This section does not apply to post-claim adjudication audits which are any of the following:

(1) Based on a reasonable belief of fraud, waste, abuse or other intentional misconduct.

(2) Required by, or initiated at the request of a self-insured plan.

(3) Required by the state or federal government or a state or federal government plan.

(82 Del. Laws, c. 111, § 1.)

§ 2320. Discrimination prohibited; pre-exposure prophylaxis medication to prevent HIV infection.

A person engaged in the business of life, disability, or long-term care insurance may not do any of the following solely because an individual has been prescribed pre-exposure prophylaxis medication to prevent HIV infection:

(1) Deny, refuse to issue, refuse to renew, refuse to reissue, cancel, or otherwise terminate an insurance policy or restrict coverage.

(2) Add any surcharge or rating factor to a premium of an insurance policy.

(3) Otherwise discriminate in the offering, issuance, cancellation, amount of coverage, price, payment of claims, or any other condition of an insurance policy without additional actuarial justification.

(83 Del. Laws, c. 41, § 1.)

§ 2321. Provider types, generally; pharmacists.

(a) No health insurer, health service corporation, managed care organization, or health maintenance organization may deny benefits for eligible services based on the type of provider performing the service as long as the provider is acting within the provider’s scope of practice.

(b) No contract of insurance delivered or issued for delivery in this State by a health insurer, health service corporation, managed care organization, or health maintenance organization may exclude pharmacists as providers of services covered in the contract.

(84 Del. Laws, c. 421, § 1.)

Part I
Insurance
Chapter 24
Insurance Fraud

§ 2401. Title.

This chapter shall be known as and may be cited as the “Delaware Insurance Fraud Prevention Act.”

(69 Del. Laws, c. 463, § 1.)

§ 2402. Purpose.

The purpose of this chapter is to confront aggressively the problem of insurance fraud in the State by facilitating the detection of insurance fraud, reducing the occurrence of such fraud through administrative enforcement and deterrence, requiring the restitution of fraudulently obtained insurance benefits and reducing the amount of premium dollars used to pay fraudulent claims.

(69 Del. Laws, c. 463, § 1.)

§ 2403. Definitions.

(a) “Attorney General” means the Attorney General of the State or the Attorney General’s designated representatives.

(b) “Authorized agency” means any appropriate law-enforcement agency.

(c) “Bad faith” means without any reasonable justification.

(d) “Bureau” means the Delaware Insurance Fraud Prevention Bureau established by this chapter.

(e) “Director” means the Director of the Delaware Insurance Fraud Prevention Bureau.

(f) “Financial loss” includes, but is not limited to, loss of earnings, out of pocket and other expenses, repair and replacement costs and claims payments.

(g) “Insurer” includes, but is not limited to, an authorized insurer, self-insurer, reinsurer, broker, producer or any agent thereof.

(h) “Practitioner” means a licensee of this State authorized to practice medicine, surgery, psychology, chiropractic or law or any other licensee or business of this State whose services are compensated, directly or indirectly, by insurance proceeds, or a licensee similarly licensed in any other state, or the practitioner of any nonmedical treatment rendered in accordance with a recognized religious method of healing.

(i) “Statement” includes, but is not limited to, any notice statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or doctor records, x-rays, test result or other evidence of loss, injury or expense.

(69 Del. Laws, c. 463, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2404. Establishment of Delaware Insurance Fraud Prevention Bureau; Delaware Insurance Fraud Auxiliary Fund.

(a) The Delaware Insurance Fraud Prevention Bureau is hereby established within the Department of Insurance and authorized to employ investigators and appropriate support staff as is necessary to carry out its mandate.

(b) The Commissioner shall appoint the full-time supervisory and investigative personnel of the Bureau including the Director and Chief Investigator, who shall hold their employment at the pleasure of the Commissioner and who shall be qualified by training and experience to perform the duties of their positions. The Commissioner shall also appoint the clerical and other staff necessary for the Bureau to fulfill its responsibilities under this chapter.

(c) It shall be the duty of the Bureau:

(1) To initiate independent inquiries and conduct independent investigations when the Bureau has cause to believe that an act of insurance fraud has been, or is currently being committed;

(2) To review reports or complaints of alleged insurance fraud from federal, state and local police, other law-enforcement authorities, governmental agencies or units, insurers and the general public and to determine whether such reports require further investigation and to conduct such investigations;

(3) To conduct independent examinations of insurance fraud, and undertake independent studies to determine the extent of insurance fraud; and

(4) To enforce § 2118(q)(4) of Title 21 by confiscating license plates of uninsured motorists who have failed to provide proof of insurance after being afforded an opportunity to prove proof of insurance as required in § 2118(q)(4) of Title 21.

(d) There is hereby created within the Bureau a special revolving fund to be designated as the Delaware Insurance Fraud Auxiliary Fund which shall be used by the Bureau in the performance of the various functions and duties required of the Bureau by law.

(69 Del. Laws, c. 463, § 1; 75 Del. Laws, c. 59, § 2.)

§ 2405. Evidence, documentation and related materials.

(a) The Commissioner or the Commissioner's designee, in addition to other provisions of this title, shall have the power and authority to administer oaths, subpoena witnesses and to compel the production of nonprivileged evidence, in any form, that is relevant or will lead to the discovery of relevant information regarding fraud investigation. Any natural or other person, as well as any State or governmental entities may be subpoenaed and shall produce the required evidence or to make such evidence available for inspection by the Bureau in a timely manner. The Superior Court of the State shall have exclusive jurisdiction regarding the enforcement or lawfulness of a subpoena on proper application by a party in interest.

(b) If the Bureau seeks evidence, documentation, or related materials located outside this State pertinent to an investigation or examination, the Bureau may designate representatives or deputies, including officials of the State where the matter is located, to secure or inspect the evidence, documentation or materials on its behalf.

(c) Subpoenas may be served in any manner that is authorized for service of original process or subpoenas under the Superior Court Rules of Civil Procedure.

(69 Del. Laws, c. 463, § 1; 70 Del. Laws, c. 422, §§ 1, 2.)

§ 2406. Confidentiality and immunity from subpoena.

(a) All papers, records, documents, reports, materials or other evidence relevant to an insurance fraud investigation or examination shall remain confidential and shall not be subject to public inspection so long as the Bureau deems it is reasonably necessary to protect the privacy of the person or matter investigated or examined, to protect the person furnishing the material or to be in the public interest.

(b) Such papers, records, documents, reports, materials or other evidence relevant to an insurance fraud investigation or examination shall not be subject to subpoena until opened for public inspection by the Bureau.

(69 Del. Laws, c. 463, § 1.)

§ 2407. Insurance fraud.

(a) It shall be a fraudulent insurance act for a person to knowingly, by act or omission, with intent to injure, defraud or deceive:

(1) Present, cause to be presented, prepare, assist, abet, solicit or conspire with another to prepare or make any oral or written statement with knowledge or belief that it will be presented to an insurer in connection with, or in support of, any application for the issuance of an insurance policy, containing false, incomplete or misleading information concerning any fact material to the application for issuance of an insurance policy;

(2) Prepare, present or cause to be presented to any insurer, any oral or written statement including computer-generated documents as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy, containing false, incomplete or misleading information concerning any fact material to such claims;

(3) Assist, abet, solicit or conspire with another to prepare or present any oral or written statement, including computer-generated documents, that is intended to be presented to any insurer in connection with, or in support of, any claim for payment or other benefit pursuant to an insurance policy, which contains false, incomplete or misleading information concerning any fact material to the claim; or

(4) Prepare, present or cause to be presented to any insurer or other person, or demand or require the issuance of, a certificate of insurance that contains any false or misleading information concerning the policy of insurance to which the certificate makes reference, or assist, abet, solicit or conspire with another to do any of the acts described in this sentence. As used in this section, "certificate of insurance" means a document or instrument, regardless of how titled or described, that is, or purports to be, prepared or issued by an insurer or insurance producer as evidence of property or casualty insurance coverage. The term does not include a policy of insurance, insurance binder, policy endorsement, or automobile insurance identification or information card.

(b) It shall be a fraudulent insurance act for a practitioner to knowingly and wilfully assist, conspire with, or urge any person to violate any of the provisions of this chapter, or for any person who due to such assistance, conspiracy or urging by said practitioner, knowingly and wilfully benefits from the proceeds derived from the use of the fraud.

(c) It shall be a fraudulent insurance act for any insurer or any person acting on behalf of such insurer to knowingly, by act or omission, with intent to injure, defraud or deceive:

(1) Present or cause to be presented to an insurance claimant false, incomplete or misleading information regarding the nature, extent and terms of insurance coverage which may or might be available to such claimant under any policy of insurance, whether first or third party.

(2) Present or cause to be presented to any insurance claimant false, incomplete or misleading information regarding or affecting in any fashion the extent of any claimant's right to benefit under, or to make a claim against, any policy of insurance whether first or third party.

(69 Del. Laws, c. 463, § 1; 79 Del. Laws, c. 217, § 2.)

§ 2408. Duties of insurers.

Any insurer which has a reasonable belief that an act of insurance fraud is being, or has been, committed shall send to the Bureau, on a form prescribed by the Bureau, any and all information and such additional information relating to such act as the Bureau may require.

(69 Del. Laws, c. 463, § 1.)

§ 2409. Immunity.

In the absence of fraud or bad faith, no person shall be subject to civil liability (for libel, slander or any other relevant tort cause of action by virtue of filing reports, without malice, or furnishing other information, written or oral, without malice, required by this chapter or required by the Commissioner under the authority granted in this title), and no civil cause of action of any nature shall arise against such person:

(1) For any information relating to suspected fraudulent insurance acts furnished to or received from law-enforcement officials, their agents and employees; or

(2) For any information relating to the suspected fraudulent insurance acts furnished to or received from other persons in this title; or

(3) For any such information furnished in reports to the Insurance Department, the National Association of Insurance Commissioners or any organization established to detect and prevent fraudulent insurance acts, their agents, employees or designees, nor shall the Commissioner or any employee of the Insurance Department, (acting without malice) in the absence of fraud or bad faith, be subject to civil liability (for libel, slander or any other relevant tort) and no civil cause of action of any nature shall arise against such person by virtue of publication of any report or bulletin related to the official activities of the Insurance Department. Nothing herein is intended to abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person.

(69 Del. Laws, c. 463, § 1.)

§ 2410. Other law-enforcement authorities.

This chapter shall not:

(1) Preempt the authority or relieve the duty of any other law enforcement agency to investigate, examine and prosecute suspected violations of law;

(2) Prevent or prohibit a person from voluntarily disclosing any information concerning insurance fraud to any law-enforcement agency other than the Bureau; or

(3) Limit any of the powers granted elsewhere by the laws of this State to the Commissioner of Insurance or the Department of Insurance to investigate and examine possible violations of law and to take appropriate action.

(69 Del. Laws, c. 463, § 1.)

§ 2411. Enforcement, investigations, hearings, administrative penalties and appeals.

(a) The matters of enforcement, investigations, hearings, administrative penalties and appeals shall be conducted in accordance with Chapter 3 of this title and Chapter 101 of Title 29 to the extent that such provisions are not in conflict with the provisions set forth in this chapter.

(b) Upon a showing by a preponderance of evidence that a violation of this chapter has occurred, the Commissioner may impose an administrative penalty of not more than $10,000 for each act of insurance fraud. An act of insurance fraud may be 1 of several such acts which taken together comprise a fraudulent insurance scheme. Assessment of the administrative penalty shall be determined by the nature, circumstances, extent and gravity of the act or acts of insurance fraud, any prior history of such act or acts, the degree of culpability and such other matters as justice may require.

(c) In the event of nonpayment of the administrative penalty after all rights of appeal have been waived or exhausted, a civil action may be brought by the Commissioner in Superior Court for the collection of the administrative penalty, including interest, attorneys' fees and costs, in the following manner:

(1) A praecipe and complaint shall be filed setting forth that administrative action was taken against the defendant in accordance with this chapter, that the defendant either voluntarily entered into a consent order which called for the payment of a specified monetary penalty, or in the alternative, that after proper notice and hearing, the defendant was determined to be in violation of this chapter and that by order of the Commissioner a specified monetary penalty had been assessed against the defendant, that all rights of appeal have been waived or exhausted, and that payment in full has not been made in accordance with the terms of the consent order or other order of the Commissioner. The Department shall attach to the complaint a certified copy of that consent order or other order of the Commissioner.

(2) The Court shall enter judgment in favor of the Department for the amount specified in the complaint upon the Department establishing the following:

a. The defendant is the same person against whom the consent order or other order of the Commissioner applies; and

b. Payment in full has not been made by or on behalf of the defendant according to the terms of the consent or other order of the Commissioner.

(3) Any judgment entered shall be final to the same extent as a judgment entered after trial.

(4) Except as otherwise provided in this section the Superior Court Civil Rules shall govern these proceedings.

(d) Any person who is found to have committed an act of insurance fraud, or violated an order of the Commissioner pursuant to a hearing, shall be liable for costs incurred by the Bureau. The assessment for costs shall be 15% of each penalty assessed pursuant to this section.

(e) In addition to the above, the Commissioner shall have authority to order restitution to the insurer, or self-insured employer of any insurance proceeds paid pursuant to a fraudulent claim.

(f) The expenses or administrative penalties collected by the Bureau under this chapter are appropriated to the Bureau in accordance with § 2404 of this title. All moneys received by the Commissioner from insurers and agents pursuant to this chapter shall be transmitted to the State Treasurer to be deposited in the State Treasury to the credit of the Delaware Insurance Fraud Auxiliary Fund. All such moneys which are deposited in the Auxiliary Fund shall be appropriated to the Bureau to be used exclusively for the support of the Bureau. However, the Department may, in its discretion, pay a reward drawn from the assessed administrative penalty to an individual who reports to the Insurance Department an incident of insurance fraud which results in either an admission or finding of fraud. The reward shall not exceed the lesser of the assessed administrative penalty or $25,000. In order to be eligible to receive a reward pursuant to this subsection, a reporting individual must sign a written complaint that subjects the person to the sanctions of § 1233 of Title 11. An insurance carrier that is the victim of insurance fraud is not eligible to receive a reward pursuant to this subsection for reporting such fraud.

(69 Del. Laws, c. 463, § 1; 71 Del. Laws, c. 331, § 1; 75 Del. Laws, c. 276, § 1; 76 Del. Laws, c. 1, § 1.)

§ 2412. Consent orders.

Any person so requested may enter into a consent order whereby such person, without admitting the conduct complained of, consents to the imposition of an administrative penalty and when so requested agrees to cease and desist the acts or omissions complained of.

(69 Del. Laws, c. 463, § 1.)

§ 2413. Criminal prosecution.

The imposition of any fine or other sanction under this chapter shall not preclude prosecution for a violation of any of the criminal laws of this State.

(69 Del. Laws, c. 463, § 1.)

§ 2414. Application of Administrative Procedures Act.

Except as otherwise provided in this chapter, the State Administrative Procedures Act (Chapter 101 of Title 29) applies to and governs all administrative actions taken by the Bureau.

(69 Del. Laws, c. 463, § 1.)

§ 2415. Funding

The costs of administration and operation of the Delaware Insurance Fraud Prevention Bureau shall be borne by all of the insurance companies admitted or authorized to transact the business of insurance in this State. The Commissioner shall assess $1,050 annually against each insurance company to provide the funds necessary for the operation of the Bureau.

(71 Del. Laws, c. 69, § 2; 78 Del. Laws, c. 205, § 1; 81 Del. Laws, c. 341, § 1; 84 Del. Laws, c. 68, § 1.)

Part I
Insurance
Chapter 25
Rates and Rating Organizations

§ 2501. Purpose of chapter; interpretation.

The purpose of this chapter is to promote the public welfare by regulating insurance rates (in accordance with the intent of Congress as expressed in Public Law 15—79th Congress) and to the end that they shall not be excessive, inadequate or unfairly discriminatory and to authorize and regulate cooperative action among insurers in rate making and in other matters within the scope of this chapter. Nothing in this chapter is intended:

(1) To prohibit or discourage reasonable competition; or

(2) To prohibit, or encourage except to the extent necessary to accomplish the aforementioned purpose, uniformity in insurance rates, rating systems, rating plans or practices.

This chapter shall be liberally interpreted to carry into effect this section.

(18 Del. C. 1953, § 2501; 56 Del. Laws, c. 380, § 1.)

§ 2502. Scope of chapter.

(a) This chapter applies to all of the following:

(1) Casualty insurance and all forms of motor vehicle insurance, on risks or operations in this State.

(2) Surety insurance.

(3) Fire, marine and inland marine insurance, as used in their generally accepted trade sense, on risks located in this State. Inland marine insurance shall be deemed to include insurance as defined by statute, or by ruling of the Commissioner.

(4) Health insurance, group health insurance, blanket health insurance, Medicare supplement insurance and health service corporations.

(5) Title insurance.

(b) This chapter does not apply to any of the following:

(1) Reinsurance, except joint reinsurance as provided in § 2523 of this title.

(2) Insurance of airborne or waterborne vessels or craft, their cargoes, legal liability of aircraft operators, marine protection and indemnity, or other risks commonly insured under aviation or marine, as distinguished from inland marine, insurance policies.

(3) Life insurance.

(4) Workers' compensation and related employers' liability insurance.

(c) Nothing in this chapter shall abridge or restrict the freedom of contract between insurers and agents or brokers with respect to commissions or between insurers and their employees with respect to compensation.

(18 Del. C. 1953, § 2502; 56 Del. Laws, c. 380, § 1; 60 Del. Laws, c. 388, §§ 1, 2; 63 Del. Laws, c. 262, § 3; 70 Del. Laws, c. 186, § 1; 73 Del. Laws, c. 402, § 1; 84 Del. Laws, c. 337, § 1.)

§ 2503. Making of rates [For applicability of this section, see 81 Del. Laws, c. 108, § 3] [Effective until Jan. 1, 2027].

(a) Rates must be made in accordance with the following provisions:

(1) Manual, minimum, class rates, rating schedules or rating plans shall be made and adopted, except in the case of specific inland marine rates on risks specially rated;

(2) Rates shall not be excessive, inadequate or unfairly discriminatory;

(3) Due consideration shall be given:

a. To past and prospective loss experience within and outside this State;

b. To the conflagration and catastrophe hazards;

c. To a reasonable margin for underwriting profit and contingencies;

d. To dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers;

e. To past and prospective expenses both countrywide and those specially applicable to this State;

f. To all other relevant factors within and outside this State; and

g. In the case of fire insurance rates, consideration shall be given to the experience of the fire insurance business during a period of not less than the most recent 5-year period for which such experience is available;

(4) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable;

(5) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions or both. Such standards may measure any differences among risks which may have a probable effect upon losses or expenses;

(6) The Commissioner shall require a reduction in rates for a 3-year period for any person who voluntarily attends and successfully completes a motor vehicle accident prevention course that is approved by the Division of Motor Vehicles.

a. A motor vehicle accident prevention course under this paragraph (a)(6) must educate an individual taking the course on traffic stops by a law-enforcement officer as required under § 2713(e) of Title 21. A motor vehicle accident prevention course under this paragraph (a)(6) must include at least 2 questions on any test given to an individual taking the course to test the individual's knowledge of traffic stops by a law-enforcement officer.

b. Motor vehicle accident prevention course instructors that have been certified by the Division of Motor Vehicles are entitled to the same reduction in rates as those individuals that have successfully completed a motor vehicle accident prevention course, in the manner set forth in regulations promulgated under this section.

c. The reduction must be for any individually owned vehicle classified as a private passenger vehicle and must be in proportion to the number who have completed the course in the event that not all members of a group have completed the course.

d. Voluntary attendance does not include any attendance ordered as permitted by a court or required by the Division of Motor Vehicles pursuant to any violations of Title 21;

(7) The Commissioner shall require a reduction in rates for a 3-year period for any person who voluntarily attends and successfully completes a motorcycle rider course that is approved by the Division of Motor Vehicles.

a. A motorcycle rider course under this paragraph (a)(7) must educate an individual taking the course on traffic stops by a law-enforcement officer as required under § 2713(e) of Title 21. A motorcycle rider course under this paragraph (a)(7) must include at least 2 questions on any test given to an individual taking the course to test the individual's knowledge of traffic stops by a law-enforcement officer.

b. Motorcycle rider course instructors that have been certified by the Division of Motor Vehicles must be entitled to the same reduction in rates as those individuals that have successfully completed a motorcycle rider course, in the manner set forth in regulations promulgated under this section.

c. The reduction must be for any individually owned vehicle classified as a motorcycle and licensed for use on the streets and highways of this State.

d. Voluntary attendance does not include any attendance ordered as permitted by a court or required by the Division of Motor Vehicles pursuant to any violations of Title 21;

(8) The Commissioner shall require insurers to file an actuarially justified reduction in rates for a 3-year period if all operators of a vessel voluntarily attend and successfully complete a boating safety education course which is approved by the Department of Natural Resources and Environmental Control for the purposes of § 2221 of Title 23. The reduction shall be for any individually owned vessel used exclusively for noncommercial purposes. Voluntary attendance shall not include any attendance ordered as permitted by a court or required by the Department of Natural Resources and Environmental Control pursuant to any violations of Title 23;

(9) Rate filings concerning automobile collision insurance shall provide for a credit of 5 percent of annual premiums for such coverage for any individually owned vehicle classified as a private passenger vehicle owned by employees participating in an approved Travelink Traffic Mitigation Act program created pursuant to subchapter IV of Chapter 20 of Title 30;

(10) An insurer authorized to do business in Delaware cannot increase a renewal rate for a personal automobile insurance policy based solely on an insured having attained the age of 75 or older;

(11) With respect to personal automobile insurance for an existing insured, an insurer authorized to do business in Delaware may not charge the insured a higher rate solely based upon a change in the insured's marital status due to the death of a spouse.

(12) a. Rate filings for health benefit plans may not include aggregate unit price growth for nonprofessional services that exceed the following:

1. In 2022, the greater of 3% or Core CPI plus 1%.

2. In 2023, the greater of 2.5% or Core CPI plus 1%.

3. For rate filings filed in 2024, 2025, 2026, and 2027, the greater of 2% or Core CPI plus 1%.

b. For purposes of this paragraph (a)(12) and paragraphs (a)(13) through (a)(15) of this section:

1. "Core CPI" means the average of the 12 preceding bimonthly indices calculating the over-the-year changes of the Consumer Price Index for All Urban Consumers in the Philadelphia-Camden-Wilmington Area, all items less food and energy, developed by the United States Bureau of Labor Statistics.

2. “Health benefit plan” means as defined under §§ 3342A(a)(3)a. and 3559(a)(3)a. of this title.

3. “Inpatient hospital” means noncapitated facility services for medical, surgical, maternity, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

4. “Nonprofessional services” means services categorized as inpatient hospital, outpatient hospital, and other medical services. “Nonprofessional services” does not include professional services.

5. “Other medical services” means noncapitated ambulance, home health care, durable medical equipment, prosthetics, supplies, and the facility component of vision exams, dental services, and other services when billed separately from the professional component.

6. “Outpatient hospital” means noncapitated facility services for surgery, emergency services, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.

7. “Professional services” includes primary care, dental, specialist, therapy, the professional component of laboratory and radiology, and similar services, other than the facility fee component of hospital-based services.

c. The Commissioner shall annually determine the Core CPI by March 31 of the applicable rate filing year using the bimonthly indices ending with the bimonthly index issued in January of the applicable rate filing year through 2027.

d. The Commissioner shall annually communicate, under § 312(c) of this title, the determination under paragraph (a)(12)c. of this section to carriers.

e. Paragraph (a)(12)a.3 of this section does not apply in any of the following circumstances:

1. When a hospital meets the definition of a “free-standing children’s hospital” under this section.

2. When a hospital meets the definition of a “Medicare-dependent rural hospital” pursuant to paragraph (a)(15)g.1. of this section.

3. When a hospital meets the definition of an “urban Medicaid DSH hospital” under this section.

(13) All rate filings for health benefit plans subject to §§ 3342B and 3556A of this title must reflect the spending requirements under §§ 3342B(b)(3) and 3556A(b)(3) of this title.

(14) All rate filings by carriers who have issued health benefit plans in the Delaware commercial market for the last 2 years and whose plans cover more than 5,000 members across all fully-insured products must have either 50% or the highest achievable percentage based on actuarial credibility requirements of total cost of care tied to an alternative payment model contract that meets the Health Care Payment Learning and Action Network (HCP-LAN) Category 3 or Category 4 with a minimum of 15% or the highest achievable percentage based on actuarial credibility requirements of total cost of care covered by an alternative payment model contract that meets the definition of HCP-LAN Category 3B or Category 4.

(15) For rate filings filed in and after 2028, as set forth in paragraphs (a)(15)m. and (a)(15)n.of this section, costs per inpatient hospital service, outpatient service, and emergency department service for health benefit plans may not exceed the applicable Medicare reference-based pricing target set forth in paragraph (a)(15)m. of this section, as of the date of service, for comparable services for the applicable plan year, and free-standing children's hospital outpatient Medicare rates may not exceed the applicable medicare reference-based pricing target set forth in paragraph (a)(15)n. of this section, as of the date of service.

a. “Emergency department service” means services generally performed in an emergency department, including trauma services, triage, and observation.

b. “Free-standing children's hospital” means a dedicated, independent pediatric facility, not integrated within a general adult hospital, identified by the Center for Medicaid and CHIP Services (CMCS) as a hospital that provides specialized care for infants, children, teens, and individuals predominately under 18 years of age.

c. “Free-standing children's hospital Medicare outpatient payment rate” means, for purposes of free-standing children's hospitals, payments for free-standing children's hospitals that include all payments made under the Medicare Outpatient Prospective Payment System (OPPS), as established August 1, 2000, and codified at 42 C.F.R. Part 419.

d. “Full Medicare rate” means the applicable wage-adjusted Medicare rate, inclusive of any applicable adjustments, as updated by the Centers for Medicare and Medicaid Services (CMS) on an annual basis.

e. “Inpatient hospital service” means services generally performed in an inpatient acute hospital care setting, including general inpatient hospital services covered under Medicare Part A, labor and delivery, and intensive care.

f. “Medicare” means the federal Medicare Program (U.S. Public Law 89-87, as amended; 42 U.S.C. § 1395 et seq.).

g. “Medicare-dependent rural hospital” means a hospital that meets at least 1 of the following requirements for the applicable rate filing year:

1. The hospital meets the definition of a Medicare-dependent hospital as defined under 42 C.F.R. § 412.108 for at least 3 of the 5 years immediately preceding the applicable rate filing year.

2. The hospital operates solely within a county that is classified by the federal Health Resources and Services Administration (HRSA) as a rural health area, a medically underserved area, and a health professional shortage area for primary care, and the hospital’s gross patient revenue attributed to Medicare patients accounts for more than 60% of its total gross patient revenue.

h. “Medicare reference-based pricing (RBP) target” means a percentage of the full Medicare rate as set forth in paragraph (a)(15)d. of this section. With respect to free-standing children's hospitals, “Medicare reference-based pricing (RBP) targets” has the meaning as defined in paragraph (n) of this section.

i. “Outpatient service” means nonprofessional services not otherwise captured in the definition of inpatient hospital service or emergency department service.

j. “TEFRA rate” means the target amount under the federal Tax Equity and Fiscal Responsibility Act (TEFRA) Waiver Program applicable to free-standing children's hospitals set forth in 42 U.S.C. § 1395ww(b), including any updates and adjustments thereto.

k. “Urban Medicaid DSH hospital” means a hospital that met the criteria described in § 1923(b) of the federal Social Security Act (42 U.S.C. § 1396r-4(b)) and received Medicaid Disproportionate Share Hospital Program (DSH) payments from this State between July 1, 2021, and July 1, 2026.

l. If a comparable Medicare reimbursement rate is not available to determine the full Medicare rate for inpatient hospital services, outpatient services, or emergency department services, a carrier’s rate filings shall propose reimbursement for services at the rates generally available under Medicare for similar services, which shall be further delineated by regulation, unless otherwise specified in this section.

m. Applicable reference-based pricing targets for inpatient hospital services, outpatient services, and emergency department services. Unless otherwise specified in this section, rate filings for services provided by non-free-standing children's hospitals shall reflect Medicare reference-based pricing targets as follows:

1. For the 2028 and 2029 rate filings applying to plan years 2029 and 2030, all of the following apply:

A. 275% of the full Medicare rate for outpatient services.

B. 310% of the full Medicare rate for inpatient hospital services and emergency department services.

2. For the 2030 and 2031 rate filings applying to plan years 2031 and 2032, all of the following apply:

A. 250% of the full Medicare rate for outpatient services.

B. 275% of the full Medicare rate for inpatient hospital services and emergency department services.

3. For all rate filings occurring on and after 2032 for the following plan year, beginning with plan year 2033, 250% of the full Medicare rate for inpatient hospital services, outpatient services, and emergency department services.

n. Applicable Medicare reference-based pricing targets for free-standing children's hospitals. Unless otherwise specified in this section, rate filings for services provided by free-standing children's hospitals shall reflect Medicare reference-based pricing targets as follows:

1. For the 2028 and 2029 rate filings applying to plan years 2029 and 2030, all of the following apply:

A. 275% of the free-standing children's hospital Medicare outpatient payment rate for outpatient services.

B. 310% of the TEFRA rate for inpatient hospital services.

C. 310% of the free-standing children's hospital Medicare outpatient payment rate for emergency department services.

2. For the 2030 and 2031 rate filings applying to plan years 2031 and 2032, all of the following apply:

A. 250% of the free-standing children's hospital Medicare outpatient payment rate for outpatient services.

B. 275% of the TEFRA rate for inpatient hospital services.

C. 275% of the free-standing children's hospital Medicare outpatient payment rate for emergency department services.

3. For all rate filings occurring on and after 2032 for the following plan year, beginning with plan year 2033, all of the following apply:

A. 250% of the free-standing children's hospital Medicare outpatient payment rate for outpatient services.

B. 250% of the TEFRA rate for inpatient hospital services.

C. 250% of the free-standing children's hospital Medicare outpatient payment rate for emergency department services.

o. Reference-based pricing target exemptions and modifications. —

Paragraphs (a)(15)a. through (a)(15)n. of this section do not apply in any of the following circumstances:

1. When a hospital meets the definition of a “Medicare-dependent rural hospital” pursuant to paragraph (a)(15)g.1. of this section.

2. When a hospital meets the definition of a “Medicare-dependent rural hospital” pursuant to paragraph (a)(15)g.2. of this section and the Office of Value-Based Health Care Delivery has determined that the hospital has made demonstrative progress in adopting and implementing value-based payment models.

3. When a hospital meets the definition of an “urban Medicaid DSH hospital” under this section.

4. When the carrier and the hospital or applicable contracting provider entity are participants in a federal or state multi-payer global budget model approved by the Department. The Department shall provide notice annually of global budget models that are approved pursuant to this paragraph (a)(15)o.4.

(b) Nothing in this section shall be taken to prohibit as unreasonable or unfairly discriminatory the establishment of classifications or modifications of classifications or risks based upon size, expense, management, individual experience, purpose of insurance location or

dispersion of hazard or any other reasonable considerations provided such classifications and modifications apply to all risks under the same or substantially similar circumstances or conditions.

(c) Except to the extent necessary to meet the provisions of paragraphs (a)(2) and (9) of this section, uniformity among insurers in any matters within the scope of this section is neither required nor prohibited.

(18 Del. C. 1953, § 2503; 56 Del. Laws, c. 380, § 1; 63 Del. Laws, c. 175, § 1; 67 Del. Laws, c. 147, § 1; 67 Del. Laws, c. 160, §§ 3, 4; 70 Del. Laws, c. 122, § 1; 70 Del. Laws, c. 186 , § 1; 79 Del. Laws, c. 250, § 1; 81 Del. Laws, c. 108, § 2; 81 Del. Laws, c. 350, § 5; 83 Del. Laws, c. 237, §§ 4, 14; 83 Del. Laws, c. 322, § 1; 85 Del. Laws, c. 348, §§ 5, 8.)

§ 2503. Making of rates [For applicability of this section, see 81 Del. Laws, c. 108, § 3] [Effective Jan. 1, 2027].

(a) Rates must be made in accordance with the following provisions:

(1) Manual, minimum, class rates, rating schedules or rating plans shall be made and adopted, except in the case of specific inland marine rates on risks specially rated;

(2) Rates shall not be excessive, inadequate or unfairly discriminatory;

(3) Due consideration shall be given:

a. To past and prospective loss experience within and outside this State;

b. To the conflagration and catastrophe hazards;

c. To a reasonable margin for underwriting profit and contingencies;

d. To dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers;

e. To past and prospective expenses both countrywide and those specially applicable to this State;

f. To all other relevant factors within and outside this State; and

g. In the case of fire insurance rates, consideration shall be given to the experience of the fire insurance business during a period of not less than the most recent 5-year period for which such experience is available;

(4) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable;

(5) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions or both. Such standards may measure any differences among risks which may have a probable effect upon losses or expenses;

(6) The Commissioner shall require a reduction in rates for a 3-year period for any person who voluntarily attends and successfully completes a motor vehicle accident prevention course that is approved by the Division of Motor Vehicles.

a. A motor vehicle accident prevention course under this paragraph (a)(6) must educate an individual taking the course on traffic stops by a law-enforcement officer as required under § 2713(e) of Title 21. A motor vehicle accident prevention course under this paragraph (a)(6) must include at least 2 questions on any test given to an individual taking the course to test the individual's knowledge of traffic stops by a law-enforcement officer.

b. Motor vehicle accident prevention course instructors that have been certified by the Division of Motor Vehicles are entitled to the same reduction in rates as those individuals that have successfully completed a motor vehicle accident prevention course, in the manner set forth in regulations promulgated under this section.

c. The reduction must be for any individually owned vehicle classified as a private passenger vehicle and must be in proportion to the number who have completed the course in the event that not all members of a group have completed the course.

d. Voluntary attendance does not include any attendance ordered as permitted by a court or required by the Division of Motor Vehicles pursuant to any violations of Title 21;

(7) The Commissioner shall require a reduction in rates for a 3-year period for any person who voluntarily attends and successfully completes a motorcycle rider course that is approved by the Division of Motor Vehicles.

a. A motorcycle rider course under this paragraph (a)(7) must educate an individual taking the course on traffic stops by a law-enforcement officer as required under § 2713(e) of Title 21. A motorcycle rider course under this paragraph (a)(7) must include at least 2 questions on any test given to an individual taking the course to test the individual's knowledge of traffic stops by a law-enforcement officer.

b. Motorcycle rider course instructors that have been certified by the Division of Motor Vehicles must be entitled to the same reduction in rates as those individuals that have successfully completed a motorcycle rider course, in the manner set forth in regulations promulgated under this section.

c. The reduction must be for any individually owned vehicle classified as a motorcycle and licensed for use on the streets and highways of this State.

d. Voluntary attendance does not include any attendance ordered as permitted by a court or required by the Division of Motor Vehicles pursuant to any violations of Title 21;

(8) The Commissioner shall require insurers to file an actuarially justified reduction in rates for a 3-year period if all operators of a vessel voluntarily attend and successfully complete a boating safety education course which is approved by the Department of Natural Resources and Environmental Control for the purposes of § 2221 of Title 23. The reduction shall be for any individually owned vessel used exclusively for noncommercial purposes. Voluntary attendance shall not include any attendance ordered as permitted by a court or required by the Department of Natural Resources and Environmental Control pursuant to any violations of Title 23;

(9) Rate filings concerning automobile collision insurance shall provide for a credit of 5 percent of annual premiums for such coverage for any individually owned vehicle classified as a private passenger vehicle owned by employees participating in an approved Travelink Traffic Mitigation Act program created pursuant to subchapter IV of Chapter 20 of Title 30;

(10) An insurer authorized to do business in Delaware cannot increase a renewal rate for a personal automobile insurance policy based solely on an insured having attained the age of 75 or older;

(11) With respect to personal automobile insurance for an existing insured, an insurer authorized to do business in Delaware may not charge the insured a higher rate solely based upon a change in the insured's marital status due to the death of a spouse.

(12) a. Rate filings for health benefit plans may not include aggregate unit price growth for nonprofessional services that exceed the following:

1. In 2022, the greater of 3% or Core CPI plus 1%.

2. In 2023, the greater of 2.5% or Core CPI plus 1%.

3. For rate filings filed in 2024, 2025, 2026, and 2027, the greater of 2% or Core CPI plus 1%.

b. For purposes of this paragraph (a)(12) and paragraphs (a)(13) through (a)(15) of this section:

1. "Core CPI" means the consumer Price Index for All Urban Consumers, All Items Less Food & Energy, developed by the United States Bureau of Labor Statistics.

2. "Health benefit plan" means as defined under §§ 3342A(a)(3)a. and 3559(a)(3)a. of this title.

3. "Inpatient hospital" means noncapitated facility services for medical, surgical, maternity, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

4. "Nonprofessional services" means services categorized as inpatient hospital, outpatient hospital, and other medical services. "Nonprofessional services" does not include professional services.

5. "Other medical services" means noncapitated ambulance, home health care, durable medical equipment, prosthetics, supplies, and the facility component of vision exams, dental services, and other services when billed separately from the professional component.

6. "Outpatient hospital" means noncapitated facility services for surgery, emergency services, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.

7. "Professional services" includes primary care, dental, specialist, therapy, the professional component of laboratory and radiology, and similar services, other than the facility fee component of hospital-based services.

c., d. [Repealed.]

e. Paragraph (a)(12)a.3 of this section does not apply in any of the following circumstances:

1. When a hospital meets the definition of a "free-standing children's hospital" under this section.

2. When a hospital meets the definition of a "Medicare-dependent rural hospital" pursuant to paragraph (a)(15)g.1. of this section.

3. When a hospital meets the definition of an "urban Medicaid DSH hospital" under this section.

(13) All rate filings for health benefit plans subject to §§ 3342B and 3556A of this title must reflect the spending requirements under §§ 3342B(b)(3) and 3556A(b)(3) of this title.

(14) All rate filings by carriers who have issued health benefit plans in the Delaware commercial market for the last 2 years and whose plans cover more than 5,000 members across all fully-insured products must have either 50% or the highest achievable percentage based on actuarial credibility requirements of total cost of care tied to an alternative payment model contract that meets the Health Care Payment Learning and Action Network (HCP-LAN) Category 3 or Category 4 with a minimum of 15% or the highest achievable percentage based on actuarial credibility requirements of total cost of care covered by an alternative payment model contract that meets the definition of HCP-LAN Category 3B or Category 4.

(15) For rate filings filed in and after 2028, as set forth in paragraphs (a)(15)m. and (a)(15)n.of this section, costs per inpatient hospital service, outpatient service, and emergency department service for health benefit plans may not exceed the applicable Medicare reference-based pricing target set forth in paragraph (a)(15)m. of this section, as of the date of service, for comparable services for the

applicable plan year, and free-standing children's hospital outpatient Medicare rates may not exceed the applicable medicare reference-based pricing target set forth in paragraph (a)(15)n. of this section, as of the date of service.

a. “Emergency department service” means services generally performed in an emergency department, including trauma services, triage, and observation.

b. “Free-standing children's hospital” means a dedicated, independent pediatric facility, not integrated within a general adult hospital, identified by the Center for Medicaid and CHIP Services (CMCS) as a hospital that provides specialized care for infants, children, teens, and individuals predominately under 18 years of age.

c. “Free-standing children's hospital Medicare outpatient payment rate” means, for purposes of free-standing children's hospitals, payments for free-standing children's hospitals that include all payments made under the Medicare Outpatient Prospective Payment System (OPPS), as established August 1, 2000, and codified at 42 C.F.R. Part 419.

d. “Full Medicare rate” means the applicable wage-adjusted Medicare rate, inclusive of any applicable adjustments, as updated by the Centers for Medicare and Medicaid Services (CMS) on an annual basis.

e. “Inpatient hospital service” means services generally performed in an inpatient acute hospital care setting, including general inpatient hospital services covered under Medicare Part A, labor and delivery, and intensive care.

f. “Medicare” means the federal Medicare Program (U.S. Public Law 89-87, as amended; 42 U.S.C. § 1395 et seq.).

g. “Medicare-dependent rural hospital” means a hospital that meets at least 1 of the following requirements for the applicable rate filing year:

1. The hospital meets the definition of a Medicare-dependent hospital as defined under 42 C.F.R. § 412.108 for at least 3 of the 5 years immediately preceding the applicable rate filing year.

2. The hospital operates solely within a county that is classified by the federal Health Resources and Services Administration (HRSA) as a rural health area, a medically underserved area, and a health professional shortage area for primary care, and the hospital’s gross patient revenue attributed to Medicare patients accounts for more than 60% of its total gross patient revenue.

h. “Medicare reference-based pricing (RBP) target” means a percentage of the full Medicare rate as set forth in paragraph (a)(15)d. of this section. With respect to free-standing children's hospitals, “Medicare reference-based pricing (RBP) targets” has the meaning as defined in paragraph (n) of this section.

i. “Outpatient service” means nonprofessional services not otherwise captured in the definition of inpatient hospital service or emergency department service.

j. “TEFRA rate” means the target amount under the federal Tax Equity and Fiscal Responsibility Act (TEFRA) Waiver Program applicable to free-standing children's hospitals set forth in 42 U.S.C. § 1395ww(b), including any updates and adjustments thereto.

k. “Urban Medicaid DSH hospital” means a hospital that met the criteria described in § 1923(b) of the federal Social Security Act (42 U.S.C. § 1396r-4(b)) and received Medicaid Disproportionate Share Hospital Program (DSH) payments from this State between July 1, 2021, and July 1, 2026.

l. If a comparable Medicare reimbursement rate is not available to determine the full Medicare rate for inpatient hospital services, outpatient services, or emergency department services, a carrier’s rate filings shall propose reimbursement for services at the rates generally available under Medicare for similar services, which shall be further delineated by regulation, unless otherwise specified in this section.

m. Applicable reference-based pricing targets for inpatient hospital services, outpatient services, and emergency department services. Unless otherwise specified in this section, rate filings for services provided by non-free-standing children's hospitals shall reflect Medicare reference-based pricing targets as follows:

1. For the 2028 and 2029 rate filings applying to plan years 2029 and 2030, all of the following apply:

A. 275% of the full Medicare rate for outpatient services.

B. 310% of the full Medicare rate for inpatient hospital services and emergency department services.

2. For the 2030 and 2031 rate filings applying to plan years 2031 and 2032, all of the following apply:

A. 250% of the full Medicare rate for outpatient services.

B. 275% of the full Medicare rate for inpatient hospital services and emergency department services.

3. For all rate filings occurring on and after 2032 for the following plan year, beginning with plan year 2033, 250% of the full Medicare rate for inpatient hospital services, outpatient services, and emergency department services.

n. Applicable Medicare reference-based pricing targets for free-standing children's hospitals. Unless otherwise specified in this section, rate filings for services provided by free-standing children's hospitals shall reflect Medicare reference-based pricing targets as follows:

1. For the 2028 and 2029 rate filings applying to plan years 2029 and 2030, all of the following apply:

A. 275% of the free-standing children's hospital Medicare outpatient payment rate for outpatient services.

B. 310% of the TEFRA rate for inpatient hospital services.

C. 310% of the free-standing children's hospital Medicare outpatient payment rate for emergency department services.

2. For the 2030 and 2031 rate filings applying to plan years 2031 and 2032, all of the following apply:

A. 250% of the free-standing children's hospital Medicare outpatient payment rate for outpatient services.

B. 275% of the TEFRA rate for inpatient hospital services.

C. 275% of the free-standing children's hospital Medicare outpatient payment rate for emergency department services.

3. For all rate filings occurring on and after 2032 for the following plan year, beginning with plan year 2033, all of the following apply:

A. 250% of the free-standing children's hospital Medicare outpatient payment rate for outpatient services.

B. 250% of the TEFRA rate for inpatient hospital services.

C. 250% of the free-standing children's hospital Medicare outpatient payment rate for emergency department services.

o. Reference-based pricing target exemptions and modifications. —

Paragraphs (a)(15)a. through (a)(15)n. of this section do not apply in any of the following circumstances:

1. When a hospital meets the definition of a “Medicare-dependent rural hospital” pursuant to paragraph (a)(15)g.1. of this section.

2. When a hospital meets the definition of a “Medicare-dependent rural hospital” pursuant to paragraph (a)(15)g.2. of this section and the Office of Value-Based Health Care Delivery has determined that the hospital has made demonstrative progress in adopting and implementing value-based payment models.

3. When a hospital meets the definition of an “urban Medicaid DSH hospital” under this section.

4. When the carrier and the hospital or applicable contracting provider entity are participants in a federal or state multi-payer global budget model approved by the Department. The Department shall provide notice annually of global budget models that are approved pursuant to this paragraph (a)(15)o.4.

(b) Nothing in this section shall be taken to prohibit as unreasonable or unfairly discriminatory the establishment of classifications or modifications of classifications or risks based upon size, expense, management, individual experience, purpose of insurance location or dispersion of hazard or any other reasonable considerations provided such classifications and modifications apply to all risks under the same or substantially similar circumstances or conditions.

(c) Except to the extent necessary to meet the provisions of paragraphs (a)(2) and (9) of this section, uniformity among insurers in any matters within the scope of this section is neither required nor prohibited.

(18 Del. C. 1953, § 2503; 56 Del. Laws, c. 380, § 1; 63 Del. Laws, c. 175, § 1; 67 Del. Laws, c. 147, § 1; 67 Del. Laws, c. 160, §§ 3, 4; 70 Del. Laws, c. 122, § 1; 70 Del. Laws, c. 186 , § 1; 79 Del. Laws, c. 250, § 1; 81 Del. Laws, c. 108, § 2; 81 Del. Laws, c. 350, § 5; 83 Del. Laws, c. 237, §§ 4, 14; 83 Del. Laws, c. 322, § 1; 85 Del. Laws, c. 348, §§ 5, 8.)

§ 2504. Rate filings.

(a) Every insurer shall file with the Commissioner, except as to inland marine risks which by general custom of the business are not written according to manual rates or rating plans, every manual, minimum, class rate, rating schedule or rating plan and every other rating rule, and every modification of any of the foregoing which it proposes to use. Every such filing shall state the proposed effective date thereof, and shall indicate the character and extent of the coverage contemplated.

(b) When a filing is not accompanied by the information upon which the insurer supports such filing, and the Commissioner does not have sufficient information to determine whether such filing meets the requirements of this chapter he or she shall require the insurer to furnish the information upon which it supports the filing. The information furnished in support of a filing may include:

(1) The experience or judgment of the insurer or rating organization making the filing;

(2) Its interpretation of any statistical data it relies upon; and

(3) The experience of other insurers or rating organizations in conjunction with paragraph (b)(1) of this section; or

(4) Any other relevant factors.

A filing and supporting information shall be open to inspection by parties in interest after the filing becomes effective.

(c) Specific inland marine rates on risks specially rated, made by a rating organization, shall be filed with the Commissioner and shall become effective when filed and shall be deemed approved and in compliance with the requirements of this chapter until such time as the Commissioner rejects the filing.

(18 Del. C. 1953, § 2504; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2505. Exemption from filing.

Under such rules and regulations as he or she adopts, the Commissioner may, by written order, suspend or modify the requirement of filing as to any kind of insurance, subdivision or combination thereof, or as to classes of risks, the rates for which cannot practicably be filed before they are used. Such orders, rules and regulations shall be made known to insurers and rating organizations affected thereby. The Commissioner may make such examination as he or she deems advisable to ascertain whether any rates affected by such order meet the standards set forth in § 2503(a)(2) of this title.

(18 Del. C. 1953, § 2505; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2506. Effective date of filing.

(a) The Commissioner shall review filings as soon as reasonably possible after they have been made in order to determine whether they meet the requirements of this chapter.

(b) Any special filing with respect to a surety or guaranty bond required by law or by court or executive order or by order, rule or regulation of a public body, not covered by a previous filing, shall become effective when filed and shall be deemed to meet the requirements of this chapter until such time as the Commissioner rejects the filing.

(c) Filings shall be submitted to the Commissioner not less than 60 days prior to the proposed effective date. Except as set forth in subsection (b) of this section and § 2504(c) of this title, a filing shall be deemed to meet the statutory requirements of this chapter at the expiration of the 60-day period following the filing date unless, within 45 days of receipt of the filing, the Commissioner either disapproves the filing or notifies the insurer that additional time is needed to review the filing. If the Commissioner determines that additional time is needed to review a rate filing, then each of the following shall apply:

(1) The Commissioner shall notify the filer that the review of the filing shall be extended up to 90 days after the receipt of the filing, unless the insurer shall agree to a longer term of review.

(2) The filing may not become effective and deemed to meet the statutory requirements of this chapter until the earlier of the Commissioner's approval of the filing or the expiration of the timeframe provided in the Commissioner's notice of extended review.

(d), (e) [Repealed.]

(18 Del. C. 1953, § 2506; 56 Del. Laws, c. 380, § 1; 64 Del. Laws, c. 380, §§ 1, 2; 70 Del. Laws, c. 186, § 1; 77 Del. Laws, c. 93, § 1; 84 Del. Laws, c. 186, § 1.)

§ 2507. Disapproval of filing.

If within 30 days after a specific inland marine rate on a risk specially rated by a rating organization subject to § 2504(b) of this title, or a special surety or guaranty bond subject to § 2506(b) of this title, has become effective, or if upon review of any other filing, the Commissioner finds that such filing does not meet the requirements of this chapter, the Commissioner shall issue an order disapproving the filing and state that a hearing will be granted within 20 days after request in writing by the insurer or rating organization which made such filing. The Commissioner's order shall specify in what respects the Commissioner finds that such filing fails to meet the requirements of this chapter and, for filings previously in effect, state when, within a reasonable period thereafter, such filing shall be deemed no longer effective. If a rate filing has not gone into effect and is scheduled for a formal administrative hearing under this section, the filing may not become effective until a final order is issued. A final order shall be issued within 60 days after the entire record of the hearing, including any hearing officer's recommendations and any comments or exceptions thereto, has been presented to the Commissioner for consideration. Copies of the order shall be sent to every such insurer and rating organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

(18 Del. C. 1953, § 2507; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 238, § 1; 70 Del. Laws, c. 186, § 1; 84 Del. Laws, c. 42, § 1; 84 Del. Laws, c. 186, § 2.)

§ 2508. Limitation of disapproval power.

No manual of classifications, rules, rating plans or any modification of any of the foregoing which establishes standards for measuring variations in hazards or expense provisions or both and which has been filed pursuant to § 2503 of this title shall be disapproved if the rates produced meet the requirements of this chapter.

(18 Del. C. 1953, § 2508; 56 Del. Laws, c. 380, § 1.)

§ 2509. Excess rates.

Upon the written application of the insured stating his or her reasons therefor, filed with and approved by the Commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

(18 Del. C. 1953, § 2509; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2510. Filings for members and subscribers of rating organizations authorized.

Insurer may satisfy its obligation to make filings required by § 2503 of this title by becoming a member of, or a subscriber to, a licensed rating organization which makes such filings and by authorizing the Commissioner to accept such filings on its behalf. Nothing contained in this chapter shall be construed as requiring any insurer to become a member of or a subscriber to any rating organization.

(18 Del. C. 1953, § 2510; 56 Del. Laws, c. 380, § 1.)

§ 2511. Licensing of rating organizations.

(a) No rating organization shall make or file rates for risks located in this State without first being licensed therefor under this chapter.

(b) A corporation, an unincorporated association, a partnership or an individual, whether located within or outside this State, may make application to the Commissioner for license as a rating organization for such kinds of insurance, or subdivision or class of risk or a part or combination thereof as are specified in its application and shall file therewith:

(1) A copy of its constitution, its articles of agreement of association or its certificate of incorporation, and of its bylaws, rules and regulations governing the conduct of its business;

(2) A list of its members and subscribers;

(3) The name and address of a resident of this State upon whom notices or orders of the Commissioner or process affecting such rating organization may be served; and

(4) A statement of its qualifications as a rating organization.

(c) If the Commissioner finds that the applicant is competent, trustworthy and otherwise qualified to act as a rating organization and that its constitution, articles of agreement or association or certificate of incorporation, and its bylaws, rules and regulations governing the conduct of its business conform to the requirements of law, he or she may issue a license specifying the kinds of insurance or subdivision or class of risk or part or combination thereof for which the applicant is authorized to act as a rating organization. Every such application shall be granted or denied in whole or in part by the Commissioner within a reasonable period after the same has been filed with him or her.

(d) Licenses issued pursuant to this section shall remain in effect for 1 year unless sooner suspended or revoked by the Commissioner.

(e) Licenses issued pursuant to this section may be suspended or revoked by the Commissioner, after hearing upon notice, in the event the rating organization ceases to meet the requirements of this section.

(18 Del. C. 1953, § 2511; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2512. Subscribers to rating organizations.

(a) Subject to rules and regulations which have been approved by the Commissioner as reasonable, each rating organization shall permit any insurer to be a subscriber to its rating services for any kind of insurance, subdivision or class of risk or a part or combination thereof for which it is authorized to act as a rating organization. Notice of proposed changes in such rules and regulations shall be given to subscribers. Each rating organization shall furnish its rating services without discrimination to its subscribers.

(b) The reasonableness of any rule or regulation in its application to subscribers, or the refusal of any rating organization to admit an insurer as a subscriber, shall, at the request of any subscriber or any such insurer, be reviewed by the Commissioner at a hearing held upon at least 10 days' written notice to such rating organization and to such subscriber or insurer. If the Commissioner finds that such rule or regulation is unreasonable in its application to subscribers, he or she shall order that such rule or regulation shall not be applicable to subscribers. If the rating organization fails to grant or reject an insurer's application for subscribership within 30 days after it was made, the insurer may request a review by the Commissioner as if the application had been rejected. If the Commissioner finds that the insurer has been refused admittance to the rating organization as a subscriber without justification, he or she shall order the rating organization to admit the insurer as a subscriber. If he or she finds that the action of the rating organization was justified, he or she shall make an order affirming its action.

(18 Del. C. 1953, § 2512; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2513. Notice of changes.

Every rating organization shall notify the Commissioner promptly of every change in:

(1) Its constitution, its articles of agreement or association or its certificate of incorporation and its bylaws, rules and regulations governing the conduct of its business;

(2) Its list of members and subscribers; and

(3) The name and address of the resident of this State designated by it upon whom notices or orders of the Commissioner or process affecting such rating organization may be served.

(18 Del. C. 1953, § 2513; 56 Del. Laws, c. 380, § 1.)

§ 2514. Rules not to affect dividends.

No rating organization shall adopt any rule the effect of which would be to prohibit or regulate the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers.

(18 Del. C. 1953, § 2514; 56 Del. Laws, c. 380, § 1.)

§ 2515. Technical services.

Any rating organization may subscribe for or purchase actuarial, technical or other services, and such services shall be available to all subscribers without discrimination.

(18 Del. C. 1953, § 2515; 56 Del. Laws, c. 380, § 1.)

§ 2516. Examinations and rules.

Any rating organization may provide for the examination of its subscribers' policies, daily reports, binders, renewal certificates, endorsements or other evidences of insurance, or the cancellation thereof, and may make reasonable rules governing their submission. Such rules shall contain a provision that in the event any insurer does not within 60 days furnish satisfactory evidence to the rating

organization of the correction of any error or omission previously called to its attention by the rating organization, the rating organization shall notify the Commissioner thereof. All information so submitted for examination shall be confidential.

(18 Del. C. 1953, § 2516; 56 Del. Laws, c. 380, § 1.)

§ 2517. Adherence to filings.

No insurer shall make or issue a contract or policy except in accordance with the filings which are in effect for the insurer as provided in this chapter or in accordance with § 2505 (exemption from filing) or § 2509 (excess rates) of this title. This section shall not apply to contracts or policies for inland marine risks as to which filings are not required.

(18 Del. C. 1953, § 2517; 56 Del. Laws, c. 380, § 1.)

§ 2518. Deviations.

(a) Every subscriber to a rating organization shall adhere to the filings made on its behalf by such organization except that any such insurer may make written application to the Commissioner for permission to file a deviation from the class rates, schedules, rating plans, or rules respecting any kind of insurance, or class of risk within a kind of insurance, or combination thereof. Such application shall specify the basis for the modification, and a copy thereof shall also be sent simultaneously to such rating organization.

(b) The Commissioner shall set a time and place for a hearing at which the insurer and such rating organization may be heard and shall give them not less than 10 days' written notice thereof. If the Commissioner is advised by the rating organization that it does not desire a hearing, he or she may, upon the consent of the applicant, waive such hearings.

(c) In considering the application for permission to file such deviation, the Commissioner shall give consideration to the available statistics and the principles for ratemaking as provided in § 2503 of this title. The Commissioner shall issue an order permitting the deviation for such insurer to be filed if he or she finds it to be justified, and it shall thereupon become effective. He or she shall issue an order denying such application if he or she finds that the modification is not justified or that the resulting premiums would be excessive, inadequate, or unfairly discriminatory.

(d) Each deviation permitted to be filed shall be effective continuously from the date of such permission unless terminated sooner with the approval of the Commissioner or until such time a modification is made to the deviation. All term policies issued pursuant to such deviations may remain in force until their expiring dates.

(18 Del. C. 1953, § 2518; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; 83 Del. Laws, c. 94, § 1.)

§ 2519. Appeal from rating organization.

Any subscriber to a rating organization may appeal to the Commissioner from the action or decision of such rating organization in approving or rejecting any proposed change in or addition to the filings of such rating organization.

(18 Del. C. 1953, § 2519; 56 Del. Laws, c. 380, § 1.)

§ 2520. Appeal by insurers and others as to filings.

(a) Any person or organization in interest, aggrieved with respect to any filing which is in effect may make written application to the Commissioner for a hearing thereon except that the insurer or rating organization that made the filing shall not be authorized to proceed under this section. Such application shall specify the grounds to be relied upon by the applicant.

(b) If the Commissioner finds that the application is made in good faith, that the applicant would be so aggrieved if his or her grounds are established, and that such grounds otherwise justify holding such a hearing, he or she shall, within 30 days after receipt of such application, hold a hearing upon not less than 10 days' written notice to the applicant and to every insurer and rating organization which made such filing.

(c) If, after such hearing, the Commissioner finds that the filing does not meet the requirements of this chapter, he or she shall issue an order specifying in what respects he or she finds that such filing fails to meet the requirements of this chapter and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective. Copies of the order shall be sent to the applicant and to every such insurer and rating organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

(18 Del. C. 1953, § 2520; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2521. Information to be furnished insured.

Every rating organization and every insurer which makes its own rates shall, within a reasonable time after receiving written request therefor and upon payment of such reasonable charge as it may make, furnish to any insured affected by a rate made by it, or to the authorized representative of such insured, all information as to such rate.

(18 Del. C. 1953, § 2521; 56 Del. Laws, c. 380, § 1.)

§ 2522. Advisory organizations.

(a) Every group, association or other organization of insurers, whether located within or outside this State, which assists insurers which make their own filings or rating organizations in rate making, by the collection and furnishing of loss or expense statistics or by the submission of recommendations, but which does not make filings under this chapter shall be known as an advisory organization.

(b) Every advisory organization shall file with the Commissioner:

(1) A copy of its constitution, its articles of agreement or association or its certificate of incorporation and of its bylaws, rules and regulations governing its activities;

(2) A list of its members; and

(3) The name and address of a resident of this State upon whom notice or orders of the Commissioner or process issued at his or her direction may be served.

(c) If, after a hearing, the Commissioner finds that the furnishing of such information or assistance involves any act or practice which is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, he or she may issue a written order specifying in what respects such act or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter and requiring the discontinuance of such act or practice.

(d) No insurer which makes its own filing nor any rating organization shall support its filings by statistics or adopt rate making recommendations, furnished to it by an advisory organization which has not complied with this section or with an order of the Commissioner involving such statistics or recommendations issued under subsection (c) of this section. If the Commissioner finds such insurer or rating organization to be in violation of this subsection, he or she may issue an order requiring the discontinuance of such violation.

(18 Del. C. 1953, § 2522; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2523. Joint underwriters; joint reinsurers.

(a) Every group, association or other organization of insurers which engages in joint underwriting or joint reinsurance shall be subject to regulation with respect thereto as herein provided, subject, however, with respect to joint underwriting, to all other provisions of law, and with respect to joint reinsurance, to § 2524 (examinations) of this title.

(b) If, after a hearing, the Commissioner finds that any activity or practice of any such group, association or other organization is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, he or she may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter and requiring the discontinuance of such activity or practice.

(18 Del. C. 1953, § 2523; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2524. Examinations.

(a) The Commissioner shall, at least once in 5 years, make or cause to be made an examination of each rating organization licensed in this State, as provided in § 2511 of this title, and he or she may, as often as he or she may deem it expedient, make or cause to be made an examination of each advisory organization referred to in § 2522 of this title and of each group, association or other organization referred to in § 2523 of this title. The reasonable costs of any such examination shall be paid by the rating organization, advisory organization or group, association or other organization examined upon presentation to it of a detailed account of such costs. The officers, manager, agent and employees of such rating organization, advisory organization or group, association or other organization may be examined at any time under oath and shall exhibit all books, records, accounts, documents or agreements governing its method of operation.

(b) In lieu of any such examination the Commissioner may accept the report of an examination made by the insurance supervisory official of another state, pursuant to the laws of such state.

(c) The provisions of § 325 of this title (examination report) apply as to such examinations.

(18 Del. C. 1953, § 2524; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2525. Recording and reporting of loss and expense experience.

(a) The Commissioner shall promulgate reasonable rules and statistical plans, reasonably adapted to each of the rating systems on file with him or her, which may be modified from time to time and which shall be used hereafter by each insurer in the recording and reporting of its loss and countrywide expense experience in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid him or her in determining whether rating systems comply with the standards set forth in § 2503 of this title. Such rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this State and are not susceptible of determination by a prorating of countrywide expense experience.

(b) In promulgating such rules and plans the Commissioner shall give due consideration to the rating systems on file with him or her and, in order that such rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for such rating systems in other states. No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it.

(c) The Commissioner may designate 1 or more rating organizations or other agencies to assist him or her in gathering such experience and making compilations thereof, and such compilations shall be made available, subject to reasonable rules promulgated by the Commissioner, to insurers and rating organizations.

(d) Each insurer shall report its loss or expense experience to the lawful rating organization or agency of which it is a member or subscriber but shall not be required to report its loss or expense experience to any rating organization or agency of which it is not a member

or subscriber. Any insurer not reporting such experience to a rating organization or other agency may be required to report such experience to the Commissioner. Any report of such experience of any insurer filed with the Commissioner shall be deemed confidential and shall not be revealed by the Commissioner to any other insurer or other person, but the Commissioner may make compilations including such experience.

(e) This section does not apply to property or casualty insurers to the extent it conflicts with any of the provisions of § 526A of this title [repealed].

(18 Del. C. 1953, § 2525; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 270, § 2; 70 Del. Laws, c. 186, § 1; 83 Del. Laws, c. 184, § 2.)

§ 2526. Interchange of rating plan data; consultation; cooperative action in rate making.

(a) Reasonable rules and plans may be promulgated by the Commissioner for the interchange of data necessary for the application of rating plans.

(b) In order to further uniform administration of rate regulatory laws, the Commissioner and every insurer and rating organization may exchange information and experience data with insurance supervisory officials, insurers and rating organizations in other states and may consult with them with respect to rate making and the application of rating systems.

(c) Cooperation among rating organizations or among rating organizations and insurers in rate making or in other matters within the scope of this chapter is authorized, but the filings resulting from such cooperation are subject to all provisions of this chapter which are applicable to filings generally. The Commissioner may review such cooperative activities and practices and, if after a hearing he or she finds that any such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, he or she may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter and requiring the discontinuance of such activity or practice.

(18 Del. C. 1953, § 2526; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2527. Assigned risk plans.

The Commissioner shall promulgate the necessary regulations to effect:

(1) An equitable apportionment among all the insurers writing automobile insurance in this State of insurance which shall be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods;

(2) Reasonable rates for such insurance; and

(3) Such other rules as are necessary to effect and maintain an assigned risk plan.

(18 Del. C. 1953, § 2527; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 195, § 1.)

§ 2528. False or misleading information.

(a) No person shall wilfully withhold information from or knowingly give false or misleading information to:

(1) The Commissioner;

(2) Any statistical agency designated by the Commissioner;

(3) Any rating organization or insurer which affects rates or premiums chargeable under this chapter.

(b) Violation of this section shall be subject to the penalties provided in § 106 of this title or in lieu thereof, in the Commissioner's discretion, an administrative fine of not over $2,000.

(18 Del. C. 1953, § 2528; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 278, § 6.)

§ 2529. Fleet rates.

Two or more insurers who, by virtue of their business associations in the United States, represent themselves to be or are customarily known as a "group" or similar insurance trade designation may make the same filings or use the same rates for each such insurer subject to the provisions of § 2503 of this title, and nothing contained in this chapter shall be construed to prohibit an agreement to make the same filings or use the same rates and concerted action in connection with such filings or rates by such insurers. This section shall not apply to 2 or more insurers who are not under the same common executive or general management or control and who act in concert in underwriting groups or pools.

(18 Del. C. 1953, § 2529; 56 Del. Laws, c. 380, § 1.)

§ 2530. Penalties.

(a) The Commissioner may, if he or she finds that any person or organization has violated this chapter, impose a penalty of not more than $500 for each such violation, but if he or she finds such violation to be wilful, he or she may impose a penalty of not more than $1,000 for each such violation in addition to any other penalty provided by law.

(b) The Commissioner may suspend the license of any rating organization or insurer which fails to comply with his or her order within the time limited by the order or any extension thereof granted by the Commissioner. The Commissioner shall not so suspend a license for

failure to comply with an order until time prescribed for appeal therefrom has expired or, if appealed, until such order has been affirmed. The Commissioner may determine the period of a suspension, and it shall remain in effect for such period unless he or she modifies or rescinds the suspension or until the order upon which the suspension is based is modified, rescinded or reversed.

(c) No penalty shall be imposed and no license shall be suspended or revoked except upon a written order of the Commissioner stating his or her findings, made after a hearing held upon not less than 10 days' written notice to such person or organization specifying the alleged violation.

(d) Any party aggrieved by an order or decision of the Commissioner may, within 30 days after Commissioner's notice, make written request for hearing thereon pursuant to § 2507 of this title.

(18 Del. C. 1953, § 2530; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 278, § 7; 70 Del. Laws, c. 186, § 1.)

§ 2531. Appeals from Commissioner.

Any order, decision or act of the Commissioner under this chapter is subject to judicial review upon petition of any person aggrieved. The appeal shall be to the Court of Chancery in any county of this State. A petition for review shall be filed within 60 days from notice of the order, decision or act. The commencement of the proceeding shall not affect enforcement or validity of the Commissioner's action unless the Court determines, after notice to the Commissioner, that a stay of enforcement until further direction of the Court will not unduly injure the interests of the public. Section 328(d)-(i) (appeal from the Commissioner) of this title shall apply to such appeals.

(18 Del. C. 1953, § 2531; 56 Del. Laws, c. 380, § 1.)

§ 2532. Certain increases in premiums to peace officers or emergency personnel prohibited.

No insurer shall, in issuing or renewing a private automobile insurance policy to a peace officer, member of the Delaware State Police, ambulance squad member, volunteer or paid, or firefighter, volunteer or paid, with respect to his or her operation of a private motor vehicle, increase the premium on such policy for the reason that the insured or applicant for insurance has been involved in an accident while responding to an emergency during his or her hours of duty in an authorized emergency vehicle as defined under § 4106(e) of Title 21.

(64 Del. Laws, c. 80, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2533. Workers' compensation rates [Transferred].

Transferred to § 2623 of this title by 84 Del. Laws, c. 337, § 2, effective Aug. 2, 2024.

§ 2534. Workers' compensation and employers' liability forms and policies [Transferred].

Transferred to § 2624 of this title by 84 Del. Laws, c. 337, § 3, effective Aug. 2, 2024.

§ 2535. Adverse actions on policies relating to the provision of healthcare services.

No insurer may, in issuing or renewing an insurance policy to a healthcare professional or healthcare organization, increase the premium on such policy or take other adverse action against any healthcare professional or healthcare organization because the healthcare professional or healthcare organization performs or assists in the provision of healthcare services, as that term is defined in § 1702 of Title 24, that is legal in this State to an individual who is from out of the state. This section applies to a policy that covers any medical professional who prescribes medication for the termination of human pregnancy to an out-of-state patient by means of telehealth.

(83 Del. Laws, c. 327, § 5; 85 Del. Laws, c. 102, § 7.)

Part I
Insurance
Chapter 26
Workers' Compensation Rating

§ 2601. Scope of chapter.

This chapter applies to workers' compensation and related employer's liability insurance but shall not apply to reinsurance.

(69 Del. Laws, c. 163, § 1; 70 Del. Laws, c. 172, § 10.)

§ 2602. Definitions.

(a) "Accepted actuarial standards" shall mean the standards adopted by the Casualty Actuarial Society in its Statement of Principles Regarding Property and Casualty Insurance Ratemaking, and the Standards of Practice adopted by the Actuarial Standards Board.

(b) "Advisory organization" shall mean any organization or person which either has 2 or more member insurers or is controlled either directly or indirectly by 2 or more insurers and which assists insurers in ratemaking related activities. Two or more insurers having a common ownership or operating in this State under common management or control constitute a single insurer for purposes of this definition. Advisory organization does not include a joint underwriting association, any actuarial or legal consultant, any employee of an insurer or insurers under common control or management or their employees or manager.

(c) "Classification system" shall mean the plan, system, or arrangement for recognizing differences in exposure to hazards among industries, occupations or operations of insurance policyholders.

(d) "Contingencies" shall mean provisions in rates to recognize the uncertainty of the estimates of losses, loss adjustment expenses, other operating expenses, investment income and profit which comprise those rates. Such provisions may be explicit (i.e., a specific charge to reflect systematic variations of estimated costs from expected costs), implicit (i.e., a consideration in selecting a single estimate from a reasonable range of estimates) or both.

(e) "Developed losses" shall mean adjusted losses (including loss adjustment expenses), using accepted actuarial standards, to eliminate the effect of differences between current payment or reserve estimates and those needed to provide actual ultimate loss (including loss adjustment expense) payments.

(f) "Expenses" shall mean that portion of any rate attributable to acquisition, filed supervision and collection expenses, general expenses and taxes, licenses and fees.

(g) "Experience rating" shall mean a rating procedure utilizing past insurance experience of the individual policyholder to forecast future losses by measuring the policyholder's loss experience against the loss experience of policyholders in the same classification to produce a prospective premium credit, debit or unity modification.

(h) "Insurer" shall mean any person licensed to write workers' compensation insurance under the laws of the State.

(i) "Loss trending" shall mean any procedure for projecting developed losses to the average date of loss for the period during which the policies are to be effective, including loss ratio trending.

(j) "Market" shall mean the interaction in this State between buyers and sellers of workers' compensation and employer's liability insurance pursuant to the provisions of this chapter.

(k) "Prospective loss costs" shall mean historical aggregate losses and loss adjustment expenses, including all assessments that are loss-based, projected through development to their ultimate value and through trending to a future point in time, ascertained by accepted actuarial standards. Prospective loss costs do not include provisions for profit or expenses other than loss adjustment expenses and assessments that are loss-based.

(l) "Pure premium rate" shall mean that portion of the rate which represents the loss cost per unit of exposure including loss adjustment expense.

(m) "Rate" or "rates" shall mean rate of premium, policy and membership fee, or any other charge made by an insurer for or in connection with a contract or policy of workers' compensation and employer's liability insurance, prior to application of individual risk variations based on loss or expense considerations, and does not include minimum premiums.

(n) "Reserve estimates" shall mean provisions for insurer obligations for future payments of loss and/or loss adjustment expenses.

(o) "Statistical plan" shall mean the plan, system or arrangement used in collecting data.

(p) "Supplementary rate information" shall mean any manual or plan of rates, statistical plan, classification system, minimum premium, policy fee, rating rule, rate-related underwriting rule and any other information needed to determine the applicable premium for an individual insured and not otherwise inconsistent with the purposes of this chapter, as prescribed by rule of the Commissioner.

(q) "Supporting information" shall mean the experience and judgment of the filer and the experience or data of other insurers or advisory organizations relied on by the filer, the interpretation of any statistical data relied on by the filer, descriptions of methods used in making the rates and any other similar information required to be filed by the Commissioner.

(69 Del. Laws, c. 163, § 1; 70 Del. Laws, c. 172, § 10.)

§ 2603. Competitive market; hearing.

(a) A competitive market is presumed to exist unless the Commissioner, after a hearing, issues an order stating that a reasonable degree of competition does not exist in the market. Such order shall expire no later than 1 year after issue.

(b) (1) In determining whether a reasonable degree of competition exists, the Commissioner shall consider the following factors:

a. The number of insurers actively engaged in providing coverage;

b. Market shares and changes in market shares;

c. Ease of entry;

d. Market concentration as measured by the Herfindahl-Hirschman Index;

e. Whether long-term profitability for insurers in the market is unreasonably high in relation to the risks being insured;

f. Whether long-term profitability for insurers in the market is reasonable in relation to industries of comparable business risk; and

g. Generally accepted and relevant tests relating to competitive market structure, market performance and market conduct.

(2) The workers' compensation insurance market shall not be deemed noncompetitive if the market concentration of the 50 largest insurers satisfies the United States Department of Justice merger guidelines for an unconcentrated market.

(c) All determinations by the Commissioner shall be made on the basis of findings of fact and conclusions of law.

(69 Del. Laws, c. 163, § 1; 70 Del. Laws, c. 172, § 10.)

§ 2604. Ratemaking standards.

(a) Rates shall not be excessive, inadequate or unfairly discriminatory.

(1) Rates in a competitive market are not excessive. Rates in a noncompetitive market are excessive if they are likely to produce a long-run profit that is unreasonably high in relation to services rendered.

(2) A rate shall not be deemed inadequate unless:

a. 1. It is clearly insufficient to sustain projected losses and expenses; and

2. The rate is unreasonably low, and the use of the rate by the insurer has had or, if continued, will tend to create a monopoly in the market; or

b. Funds equal to the full, ultimate cost of anticipated losses and loss adjustment expenses are not produced when prospective loss costs are applied to anticipated payrolls.

(3) Unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory because different premiums result for policyholders with different loss exposures or expense levels.

(b) In determining whether rates comply with standards under subsection (a) of this section, due consideration shall be given to:

(1) Past and prospective loss experiences within and outside this State, in accordance with accepted actuarial principles;

(2) Catastrophe hazards and contingencies;

(3) Past and prospective expenses, within and outside Delaware;

(4) Loadings for leveling premium rates over time for dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers;

(5) A reasonable margin for underwriting profit; and

(6) All other relevant factors within and outside Delaware.

(c) The systems of expense provisions included in the rates for use by an insurer or group of insurers may differ from those of any other insurers or groups of insurers to reflect the requirements of the operating methods of the insurer or group of insurers.

(d) The rates may contain provisions for contingencies and an allowance permitting a reasonable profit. In determining the reasonableness of a profit, consideration should be given to all investment income attributable to premiums and the reserves associated with those premiums.

(69 Del. Laws, c. 163, § 1.)

§ 2605. Review by Commissioner.

The Commissioner may investigate and determine whether or not rates in this State are excessive, inadequate, or unfairly discriminatory. In any such investigation and determination, the Commissioner shall give due consideration to those factors specified in § 2604 of this title.

(69 Del. Laws, c. 163, § 1.)

§ 2606. Rules not to affect dividends.

No advisory organization shall adopt any rule that would prohibit or regulate the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers. A plan for the payment of dividends, savings

or unabsorbed premium deposits allowed or returned by insurers to their policyholders is not considered a rating plan or system. It is an unfair trade practice to make the payment of a dividend or any portion thereof conditioned upon renewal of the policy or contract.

(69 Del. Laws, c. 163, § 1.)

§ 2607. Membership in advisory organization.

(a) The Commissioner shall designate an advisory organization to assist the Commissioner in gathering, compiling and reporting relevant statistical information. Every workers' compensation insurer shall record and report its workers' compensation experience to the designated advisory organization as set forth in the uniform statistical plan approved by the Commissioner.

(b) Each workers' compensation insurer shall be a member of the workers' compensation advisory organization. Each workers' compensation insurer may adhere to the policy forms filed by the advisory organization.

(c) Every workers' compensation insurer shall adhere to a uniform classification system and uniform experience rating plan that has been filed with the Commissioner by the advisory organization and approved by the Commissioner; provided, however that:

(1) An insurer may develop subclassifications within the uniform classification system for which a rate or rates may be made;

(2) Any subclassification developed under paragraph (c)(1) of this section shall be filed with the advisory organization and the Commissioner 30 days prior to use; and

(3) If the insurer fails to demonstrate that the data produced under a subclassification can be reported in a manner consistent with the advisory organization's uniform statistical plan and classification system, the Commissioner shall disapprove the subclassification.

The advisory organization shall file a rating plan with the Department of Insurance not later than 90 days after the adoption of a health-care payment system provided for by § 2322B of Title 19 and shall also file a rating plan not later than 90 days after the adoption of health-care practice guidelines provided for by § 2322C(7) of Title 19. Thereafter, the advisory organization shall file a rating plan at least annually. Within 60 days of each such rating plan becoming effective pursuant to this chapter, each authorized insurer shall make a rate filing pursuant to § 2609 of this title.

(d) Subject to the approval of the Commissioner, the advisory organization shall develop and file rules reasonably related to the recording and reporting of data pursuant to the uniform statistical plan, uniform experience rating plan and the uniform classification system.

(e) The methodology of the experience rating plan required under subsection (c) of this section shall have as a basis:

(1) Reasonable eligibility standards;

(2) Incentives for loss prevention; and

(3) A premium differential so as to encourage safety.

(f) The uniform experience rating plan shall be the exclusive means of providing prospective premium adjustment based upon measurement of the loss producing characteristics of an individual insured. An insurer may file a rating plan that provides for retrospective premium adjustments based upon an insured's past experience.

(69 Del. Laws, c. 163, § 1; 70 Del. Laws, c. 172, § 10; 74 Del. Laws, c. 348, § 1; 76 Del. Laws, c. 1, § 2; 79 Del. Laws, c. 312, § 2; 81 Del. Laws, c. 79, § 29.)

§ 2608. Interchange of rating plan data; consultation; cooperative action in rate making.

(a) Reasonable rules and plans may be promulgated by the Commissioner for the interchange of data necessary for the application of rating plans.

(b) In order to further conform administration of rate regulatory laws, the Commissioner and every insurer and the advisory organization designated by the Commissioner may exchange information and experience data with insurance supervisory officials, insurers and advisory organizations in other states and may consult with them with respect to rate making and the application of rating systems.

(c) Cooperation among advisory organizations or among advisory organizations and insurers in rate making or in other matters within the scope of this chapter is authorized, but the filings resulting from such cooperation are subject to all provisions of this chapter. The Commissioner may review such cooperative activities and practices and, if after a hearing any such activity or practice is found to violate the provisions of this chapter, a written order may be issued specifying that such activity or practice violates the provisions of this chapter and requiring the discontinuance of such activity.

(69 Del. Laws, c. 163, § 1.)

§ 2609. Rate filings.

(a) Each authorized insurer shall file with the Commissioner all rates, supplementary rate information and any changes and amendments made by it for use in this State as required in § 2610 of this title. An insurer may establish rates and supplementary rate information based upon the factors in § 2604 of this title. An insurer may adopt by reference, with or without deviation, the prospective loss costs filed by the advisory organization or the rates and supplementary rate information filed by another insurer.

(b) An insurer may not make or issue a contract or policy of insurance under this chapter, except in accordance with the filings which are in effect for the insurer as provided in this chapter.

(c) In addition to other prohibitions in this chapter, no advisory organization shall file rates, supplementary rate information or supporting information on behalf of an insurer.

(d) A filing made pursuant to this section should provide for a reduction in premium based upon any savings realized by insurers as a result of workers' compensation cost containment measures implemented pursuant to legislation adopted by the General Assembly.

(69 Del. Laws, c. 163, § 1; 76 Del. Laws, c. 1, § 3.)

§ 2610. Review of insurance filings.

(a) The Commissioner shall investigate and review each insurance filing under the following guidelines:

(1) The effective date of each workers' compensation insurance filing shall be the date specified in the filing. The effective date of the filing may not be earlier than 30 days after the date the filing is received by the Commissioner or the date of receipt of the information furnished in support of the filing if such supporting information is required by the Commissioner.

(2) Upon written application of the insurer or advisory organization, the Commissioner may authorize a filing, which the Commissioner has reviewed, to become effective before the expiration of the period described in paragraph (a)(1) of this section.

(3) A filing shall be deemed to meet the requirements of this chapter unless disapproved by the Commissioner within the period described in paragraph (a)(1) of this section or any extension thereof.

(b) Subject to subsection (a) of this section, a workers' compensation advisory organization shall file with the Commissioner:

(1) Workers' compensation rates and rating plans that are limited to prospective loss costs;

(2) Each workers' compensation policy form to be used by its members;

(3) The uniform classification plan and rules;

(4) The uniform experience rating plan and rules; and

(5) Any other information that the Commissioner requests and is otherwise entitled to receive under this chapter.

(c) Whenever a filing is not accompanied by the information required under this section, the Commissioner shall so inform the filer within 10 days of the initial filing. The filing shall be deemed to be made when the required information is furnished or when the filer certifies to the Commissioner that the additional information requested by the Commissioner is not maintained or cannot be provided.

(d) If each rate in a schedule of workers' compensation rates for specific classifications of risks filed by an insurer is not lower than the prospective loss costs contained in the schedule of workers' compensation rates for those classifications filed by an advisory organization under subsection (b) of this section, and approved by the Commissioner, then the schedule of rates filed by the insurer shall not be subject to subsection (a) of this section but shall become effective upon filing for the purposes of § 2609 of this title.

(e) Upon the filing of any application by a workers' compensation advisory organization with the Commissioner relating to rates or prospective loss costs, the Workers' Compensation Oversight Panel authorized in Title 19 shall, with the consent of the Attorney General, retain a member of the Delaware Bar to represent the interests of Delaware workers' compensation rate-payers during the Commissioner's consideration of the application (the "ratepayer advocate"). The cost of the ratepayer advocate shall be borne by the advisory organization. It is the expectation of the General Assembly that $40,000 should be sufficient to adequately compensate the ratepayer advocate for his or her services during the course of an application (including any appeals), and compensation for the ratepayer advocate is limited to this amount, which may be adjusted by the Attorney General for inflation on an annual basis. The Department of Labor shall provide staff support for the Workers' Compensation Oversight Panel in carrying out this responsibility.

(f) Applications by a workers' compensation advisory organization relating to rates or prospective loss costs shall be subject to the case decision provisions of Title 29, Chapter 101, subchapter III, and the ratepayer advocate shall be considered a party to the case. The Department of Insurance shall promulgate regulations within 60 days to ensure that the ratepayer advocate has adequate time and means to properly participate in the hearing required by Title 29, Chapter 101, subchapter III. The advisory organization may, but need not be, represented by counsel in this proceeding.

(g) The ratepayer advocate shall select an actuary to work with him or her and testify in the rate-setting proceeding outlined in subsections (e) and (f) of this section. The cost of this actuary shall be borne by the advisory organization. It is the expectation of the General Assembly that any other actuaries used by the Department of Insurance during the rate-setting process outlined in subsections (e) and (f) of this section shall be paid for by the Department of Insurance.

(69 Del. Laws, c. 163, § 1; 70 Del. Laws, c. 172, § 10; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 55, § 7; 79 Del. Laws, c. 312, § 1.)

§ 2611. Improper rates; hearing.

(a) If the Commissioner finds that a rate is not in compliance with § 2604 of this title, or that a rate had been set in violation of § 2616 of this title, the Commissioner shall order that its use be discontinued for any policy issued or renewed after the date of the order and the order may prospectively provide for premium adjustment of any such policy then in force. The order shall be issued within 30 days after the close of a hearing, if one is requested by the insurer, or within a reasonable time as fixed by the Commissioner. The order shall expire 1 year after its effective date unless rescinded earlier by the Commissioner.

(b) If the Commissioner disapproves a rate under subsection (a) of this section, disapproval shall take effect not less than 15 days after its order and the last previous rate in effect for the insurer shall be reimposed for a period of 1 year unless the Commissioner approves a rate under subsection (d) or subsection (e) of this section.

(c) All determinations made by the Commissioner under this section shall be in accordance with accepted actuarial standards on the basis of findings of fact and conclusions of law.

(d) For a period of 1 year after the effective date of a disapproval order under subsection (a) of this section, no rate adopted to replace one disapproved under such order may be used until it has been filed with the Commissioner and approved within 30 days thereafter.

(e) Whenever an insurer has no legally effective rates pursuant to subsection (a) of this section, the Commissioner shall, on the insurer's request, specify interim rates for the insurer that are adequate to protect the interests of all parties. The Commissioner may order that a specified portion of the premiums be placed in a special reserve established by the insurer. When new rates become legally effective, the Commissioner shall order the reserved funds or any overcharge in the interim rates to be distributed appropriately, except that minimal adjustments may not be required.

(69 Del. Laws, c. 163, § 1.)

§ 2612. Restrictions on certain insurers; waiting period.

(a) The Commissioner may require that a particular insurer file any or all of its rates and supplementary rate information 30 days prior to their effective date, if the Commissioner finds after a hearing that the protection of the interests of the insurer's insureds and the public in this State requires closer supervision of its rates.

(b) Upon written application by an insurer, the Commissioner may authorize a filing, which the Commissioner has reviewed, to become effective before the expiration of the period described in subsection (a) of this section.

(c) The filing shall be approved or disapproved during the waiting period and if not disapproved before the expiration of the waiting period shall be deemed to meet the requirements of this section.

(d) Any insurer affected by the Commissioner's actions under this section may request a rehearing by the Commissioner after the expiration of 12 months from the date of the Commissioner's former order.

(69 Del. Laws, c. 163, § 1.)

§ 2613. Delay of rates in noncompetitive market.

(a) A 30-day waiting period may be implemented or extended under the following circumstances:

(1) After finding that the market is not competitive, under § 2603 of this title, the Commissioner may adopt a rule requiring that any subsequent changes in rates or supplementary information be filed with the Commissioner at least 30 days before they become effective.

(2) The Commissioner may extend the waiting period under this section for a period not exceeding 30 additional days by written notice to the filer before the first 30-day period expires.

(3) Upon written application by an insurer or advisory organization, the Commissioner may authorize a filing, which the Commissioner has reviewed, to become effective before the expiration of the period described in paragraph (a)(1) or (2) of this section.

(4) The filing shall be approved or disapproved during the waiting period and if not disapproved before the expiration of the waiting period shall be deemed to meet the requirements of this section.

(b) If a rule is adopted under subsection (a) of this section, the Commissioner may require the filing of supporting data as to classes of risks or combinations thereof as the Commissioner deems necessary for the proper functioning of the rate monitoring and regulating process. The supporting data shall include:

(1) The experience and judgment of the filer and, to the extent the filer wishes or the Commissioner requires, the experience and judgment of other insurers or the advisory organization;

(2) The filer's interpretation of any statistical data relied upon;

(3) A description of the actuarial and statistical methods employed in setting the rate; and

(4) Any other relevant matters required by the Commissioner.

(c) A rule adopted under this section shall expire not more than 1 year after issue. The Commissioner may renew it after hearings and appropriate findings under this section.

(d) Whenever a filing is not accompanied by the information as the Commissioner has required under subsection (b) of this section, the Commissioner shall so inform the insurer within 10 days of the initial filing. The filing shall be deemed to be made when the required information is furnished.

(69 Del. Laws, c. 163, § 1.)

§ 2614. Challenge and review of application of rating system.

(a) Each advisory organization and every insurer subject to this chapter that makes its own rates shall provide within this State reasonable means whereby any person aggrieved by the application of its rating system, including, but not limited to, issues of proper formulation and application of experience modification factors and/or proper classification of employers, may upon that person's written request be heard in person or by the person's authorized representative to review the manner in which such advisory organization's or insurer's rating system, experience rating plan or employer classifications have been applied in connection with the insurance afforded the aggrieved person.

(b) Any party affected by the action of the advisory organization or the insurer may, within 30 days after written notice of that action, make application, in writing, for an appeal to the Commissioner, setting forth the basis for the appeal and the grounds to be relied upon by the applicant.

(c) The Commissioner shall review the application and, if the Commissioner finds that the application is made in good faith and that it sets forth on its face grounds which reasonably justify holding a hearing, the Commissioner shall conduct a hearing held not less than 20 days after written notice to the applicant and to the advisory organization or insurer. The Commissioner, after hearing, shall affirm or reverse the action of the advisory organization or insurer.

(69 Del. Laws, c. 163, § 1; 70 Del. Laws, c. 573, §§ 1, 2.)

§ 2615. Consent to rate.

Notwithstanding any other provision of this chapter, upon the written consent of the insured, filed with and approved by the Insurance Commissioner, a rate in excess of that determined in accordance with the other provisions of this chapter may be used on any specific risk.

(69 Del. Laws, c. 163, § 1.)

§ 2616. Acts reducing competition prohibited.

(a) In this section, the word “insurer” includes 2 or more affiliated insurers:

(1) Under common management; or

(2) Under common controlling ownership or under other common effective legal control and in fact engaged in joint or cooperative underwriting, investment management, marketing, servicing or administration of their business and affairs as insurers.

(b) An insurer or advisory organization may not:

(1) Monopolize or attempt to monopolize, or combine or conspire with any other person or persons, or monopolize the business of insurance of any kind, subdivision or class thereof;

(2) Agree with any other insurer or advisory organization to charge or adhere to any rate or rating plan other than the uniform experience rating plan or rating rule except as needed to comply with the requirements of § 2607 of this title;

(3) Make an agreement with any other insurer, advisory organization or other person to unreasonably restrain trade or substantially lessen competition in the business of insurance of any kind, subdivision or class; or

(4) Make any agreement with any other insurer or advisory organization to refuse to deal with any person in connection with the sale of insurance.

(c) The fact that 2 or more insurers, whether or not members or subscribers of a common advisory organization, use consistently or intermittently the same rules, rating plans, rating schedules, rating rules, policy forms, rate classifications, underwriting rules, surveys or inspections or similar materials is not sufficient in itself to support a finding that an agreement exists.

(d) An advisory organization or member or subscriber thereof may not interfere with the right of any insurer to make its rates independently of that advisory organization or to charge rates different from the rates made by that advisory organization.

(e) Except as required under § 2607 of this title, an advisory organization may not have or adopt any rule or exact any agreement or formulate or engage in any program which would require any member, subscriber or other insurer to:

(1) Utilize some or all of its services;

(2) Adhere to its rates, rating plan, rating systems or underwriting rules; or

(3) Prevent any insurer from acting independently.

(69 Del. Laws, c. 163, § 1.)

§ 2617. Advisory organization: permitted activity.

Any advisory organization, in addition to other activities not prohibited, is authorized to:

(1) Develop statistical plans including class definitions;

(2) Collect statistical data from members, subscribers or any other source;

(3) Prepare and distribute pure premium rate data, adjusted for loss development and loss trending, in accordance with its statistical plan. Such data and adjustments should be in sufficient detail so as to permit insurers to modify such pure premiums based upon their own rating methods or interpretations of underlying data;

(4) Prepare and distribute manuals of rating rules and rating schedules that do not contain any rules or schedules including final rates without information outside the manuals;

(5) Distribute information that is filed with the Commissioner and open to public inspection;

(6) Conduct research and collect statistics in order to discover, identify and classify information relating to causes or prevention of losses;

(7) Prepare and file policy forms and endorsements and consult with members, subscribers and others relative to their use and application;

(8) Collect, compile and distribute past and current prices of individual insurers if such information is made available to the general public;

(9) Conduct research and collect information to determine the impact of benefit level changes on pure premium rates;

(10) Prepare and distribute rules and rating values for the uniform experience rating plan; and

(11) Calculate and disseminate individual risk premium modification factors.

(69 Del. Laws, c. 163, § 1.)

§ 2618. Residual market mechanisms.

(a) All insurers authorized to write workers' compensation and employers' liability insurance shall participate in a plan providing for the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods. A residual market plan shall be submitted for the Commissioner's approval within 60 days of October 16, 1993. Rates for the residual market shall be filed by the advisory organization.

(b) The Commissioner may adopt retrospective rating plans for any risks insured through residual market.

(c) The Commissioner may adopt a schedule debit plan for any risks insured through the plan that do not comply with loss-control recommendations, have frequency or severity problems or have any exposure that is greater than average for the class.

(d) The Commissioner shall disapprove any filing that does not meet the requirements of § 2604 of this title. A filing shall be deemed to meet such requirements unless disapproved by the Commissioner within 30 days after the filing is made. In reviewing a filing made pursuant to this section, the Commissioner shall have the same authority and follow the same procedures prescribed by §§ 2611, 2612 and 2613 of this title. The advisory organization shall make and file the plan of operation, rates, rating plans, rules, and policy forms under this section.

(e) The limitation in § 2610(b)(1) of this title shall not apply to the residual market plan filed under this section.

(69 Del. Laws, c. 163, § 1; 70 Del. Laws, c. 172, § 10.)

§ 2619. Penalties.

(a) The Commissioner may, upon finding that any person or organization has violated this chapter, impose a penalty of not more than $500 for each such violation. Upon finding such violation to be wilful, the Commissioner may impose a penalty of not more than $1,000 for each such violation in addition to any other penalty provided by law.

(b) The Commissioner may suspend the license of any advisory organization or insurer which fails to comply with an order within the time set by the order or any extension thereof granted by the Commissioner. The Commissioner shall not so suspend a license for failure to comply with an order until time prescribed for appeal therefrom has expired or, if appealed, until such order has been affirmed. The Commissioner may determine the period of a suspension and it shall remain in effect for such period unless modified or rescinded or until the order upon which the suspension is based is modified, rescinded or reversed.

(c) Absent a consent decree, no penalty shall be imposed and no license shall be suspended or revoked except upon a written order of the Commissioner stating the Commissioner's findings, made after a hearing held after at least 10 days' written notice to such person or organization specifying the alleged violation.

(d) Any party aggrieved by an order or decision of the Commissioner may, within 30 days after receiving the Commissioner's notice, make written request for a hearing.

(69 Del. Laws, c. 163, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2620. Appeals from Commissioner.

Any order, decision or act of the Commissioner under this chapter is subject to judicial review upon petition of any person aggrieved. The appeal shall be to the Court of Chancery in any county of this State. A petition for review shall be filed within 60 days from notice of the order, decision or act. The commencement of the proceeding shall not affect enforcement or validity of the Commissioner's action unless the Court determines, after notice to the Commissioner, that a stay of enforcement until further direction of the Court will not unduly injure the interests of the public. Section 328(d) through (i) (appeal from the Commissioner) of this title shall apply to such appeals.

(69 Del. Laws, c. 163, § 1.)

§ 2621. Transition.

Insurers and the advisory organization are not required to immediately refile rates previously implemented. Any member or subscriber of an advisory organization is authorized to continue to use all rates and deviations filed or approved for its use until the insurer makes its own filing to change its rates, either by making an independent filing or by filing and adopting the advisory organization's prospective loss costs, or modification thereof.

(69 Del. Laws, c. 163, § 1.)

§ 2622. Effective date [Repealed].

(69 Del. Laws, c. 163, § 1; repealed by 84 Del. Laws, c. 337, § 4, effective Aug. 2, 2024.)

§ 2623. Workers' compensation rates.

The rates and rating plans submitted under this chapter for workers' compensation shall provide for discounts on workers' compensation premiums for those Delaware employers who meet criteria as established by the Commissioner to promote and maintain safety in the workplace. The Commissioner shall promulgate a regulation which provides an inspection program to establish the eligibility of any employer for a safe workplace discount, the premium volume to qualify and the percent of discount available to employers.

(67 Del. Laws, c. 63, § 1; 84 Del. Laws, c. 337, § 2.)

§ 2624. Workers' compensation and employers' liability forms and policies.

(a) Every insurer shall file with the Commissioner all forms, endorsements, contracts or policies proposed for use in Delaware in connection with workers' compensation or employers' liability insurance.

(b) As part of rate or form filing, each insurer shall file its classification of risks and all rules governing applications of classification system, including rules or practices relating to payroll audits and collection of premiums. All scheduled rating and deviation schedules shall also be filed with the Commissioner.

(c) Every rating system which provides deviations from normal premium rates shall be uniform in its application to all risks in the class for which the deviation is made. Deviations may remain in effect for a period of more than 1 year unless terminated by the Commissioner.

(73 Del. Laws, c. 266, § 1; 84 Del. Laws, c. 337, § 3.)

Part I
Insurance
Chapter 27
The Insurance Contract
Subchapter I
Insurance Contracts Generally

§ 2701. Scope of chapter.

This chapter applies to all insurance contracts and annuity contracts other than:

(1) Reinsurance;

(2) Policies or contracts not issued for delivery in this State nor delivered in this State;

(3) Wet marine and transportation insurance; and

(4) Funding agreements.

(18 Del. C. 1953, § 2701; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 268, § 3.)

§ 2702. "Policy" defined.

"Policy" means the written contract of or written agreement for or effecting insurance, by whatever name called, and includes all clauses, riders, endorsements and papers which are a part thereof.

(18 Del. C. 1953, § 2702; 56 Del. Laws, c. 380, § 1.)

§ 2703. "Premium" defined.

"Premium" is the consideration for insurance by whatever name called. Any "assessment," or any "membership," "policy," "survey," "inspection," "service" or similar fee or other charge in consideration for an insurance contract is deemed part of the premium.

(18 Del. C. 1953, § 2703; 56 Del. Laws, c. 380, § 1.)

§ 2704. Insurable interest; personal insurance.

(a) Any individual of competent legal capacity may procure or effect an insurance contract upon that individual's own life or body for the benefit of any person, but no person shall procure or cause to be procured any insurance contract upon the life or body of another individual unless the benefits under such contract are payable to the individual insured or that individual's personal representatives or to a person having, at the time when such contract was made, an insurable interest in the individual insured.

(b) If the beneficiary, assignee or other payee under any contract made in violation of this section receives from the insurer any benefits thereunder accruing upon the death, disablement or injury of the individual insured, the individual insured or the individual's executor or administrator, as the case may be, may maintain an action to recover such benefits from the person so receiving them.

(c) "Insurable interest" as to such personal insurance means that every individual has an insurable interest in the life, body and health of such individual and a person has an insurable interest in the life, body and health of other individuals as follows:

(1) In the case of individuals related closely by blood or by law, a substantial interest engendered by love and affection;

(2) In the case of other persons, a lawful and substantial economic interest in having the life, health or bodily safety of the individual insured continue, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the individual insured;

(3) An employer providing life, health, disability, retirement or similar benefits to some or all of its employees or the employees of its affiliates, or their dependents or beneficiaries, has an insurable interest in the lives of all of its employees or the employees of its affiliates. The trustee of a trust established by an employer substantially for the benefit of the employer, or for the benefit of some or all of the employees in which such employer has an insurable interest, or the dependents or beneficiaries of such employees, has the same insurable interest in the life of such employees as does the employer;

(4) An individual heretofore or hereafter party to a contract or option for the purchase or sale of an interest in a business partnership or firm or of shares of stock of a corporation or of an interest in such shares, has an insurable interest in the life of each individual party to such contract and for the purpose of such contract only, in addition to any insurable interest which may otherwise exist as to the life of such individual; and

(5) The trustee of a trust created and initially funded by an individual has an insurable interest in the life of that individual and the same insurable interest in the life of any other individual as does any person who is treated as the owner of such trust for federal income tax purposes without regard to:

a. The identity of the trust beneficiaries;

b. Whether the identity of the trust beneficiaries changes from time to time; and

c. The means by which any trust beneficiary acquires a beneficial interest in the trust.

The trustee of a trust has the same insurable interest in the life of any individual as does any person with respect to proceeds of insurance on the life of such individual (or any portion of such proceeds) that are allocable to such person's interest in such trust. If multiple beneficiaries of a trust have an insurable interest in the life of the same individual, the trustee of such trust has the same aggregate insurable interest in such life as such beneficiaries with respect to proceeds of insurance on the life of such individual (or any portion of such proceeds) that are allocable in the aggregate to such beneficiaries' interest in the trust;

(6) A person obligated to make a payment on the death of an individual to or for the benefit of a person who is designated by such individual has an insurable interest in the life of such individual. For purposes of this section, group insurance premiums paid on an experience-rated basis shall be treated as payments for the benefit of the beneficiary of such policy.

(d) An insurer shall be entitled to rely upon all statements, declarations and representations made by an applicant for insurance relative to the insurable interest of the applicant in the insured, and no insurer shall incur legal liability except as set forth in the policy by virtue of any untrue statements, declarations or representations so relied upon in good faith by the insurer.

(e) As used in this section and in § 2708(4) of this title, and § 702(c) of this title, except as provided in § 702(c)(3) of this title:

(1) The term "employee" shall include any and all directors, officers, partners, employees and retired employees and it shall include any other former employees but only for the purpose of replacing existing life insurance policies that will be surrendered in exchange for new life insurance policies in an amount not exceeding the insurance being surrendered, except that the amount of new life insurance may exceed the insurance being surrendered to the extent application of the cash surrender value from the old insurance as a premium under the new life insurance contract requires a larger amount of insurance to qualify as life insurance, and not be treated as a modified endowment contract, for federal income tax purposes.

(2) The term "employer" shall include corporations, limited liability companies or partnerships, statutory trusts, business trusts and other business entities, including associations of employers, and their affiliates.

(3) An "employer-owned life insurance policy" means an insurance contract for which an insurable interest exists under paragraph (c)(3) of this section, issued for delivery in this State and procured or effected by any employer, or a trust established by an employer, which employer as defined herein, is incorporated, registered or qualified to do business in this State and has at least 50 employees.

(4) A "trust-owned life insurance policy" means an insurance contract for which an insurable interest exists under paragraph (c)(3) or (c)(5) of this section, issued for delivery in this State to a trust established under the laws of this State and having a trustee with its principal place of business in this State, or to an entity formed under the laws of this State that is wholly owned by such a trust, which entity is classified as a disregarded entity for federal income tax purposes.

(5) The term "trust" includes without limitation a business trust.

(6) The term "affiliate" shall have the same meaning as set forth in § 5001(1) of this title.

(f) The insurable interest of an employer or trustee under this section shall be conveyed automatically to another employer or to the trustee of a trust established by such other employer substantially for its benefit which has acquired by purchase, merger or otherwise all or part of the first employer's business. An employer or the trustee of a trust established by such employer substantially for its own benefit or substantially for the benefit of its employees or their dependents may exchange any policy of insurance issued to itself or to another employer or the trustee of a trust established by such other employer substantially for its own benefit from which the exchanging employer has acquired by purchase, merger or otherwise all or part of such other employer's business for a new policy of insurance issued to itself without establishing a new insurable interest at the time of such exchange.

(g) The insurable interests recognized in this section may exist cumulatively or concurrently as appropriate to the relationships between the individual insured and the person having the interest in such individual's life. The existence of an insurable interest with respect to an employer-owned life insurance policy or trust-owned life insurance policy shall be governed by this section without regard to an insured's state of residency or location. An employer-owned life insurance policy, if delivered to the employer's principal place of business in this State or to its registered agent in this State; or in the case of a policy issued to a trust established by an employer, if delivered to the place of business in Delaware of the trustee of said trust; and a trust-owned life insurance policy, if delivered to the place of business in Delaware of the trustee of said trust; shall be deemed to have been delivered in this State. The parties to an employer-owned life insurance policy may arrange for delivery in this State by means other than the method described in the preceding sentence. An employer-owned life insurance policy may be issued on an individual or group basis, and any group policy shall be exempt from Chapter 31 of this title. A group insurance policy issued to an employer for the benefit of persons other than the employer, as permitted by § 3102 of this title, shall not constitute an employer-owned life insurance policy.

(18 Del. C. 1953, § 2704; 56 Del. Laws, c. 380, § 1; 67 Del. Laws, c. 161, §§ 1, 2; 69 Del. Laws, c. 462, §§ 1-3; 70 Del. Laws, c. 186, § 1; 71 Del. Laws, c. 239, § 2; 73 Del. Laws, c. 62, §§ 1, 2; 73 Del. Laws, c. 329, § 63; 78 Del. Laws, c. 117, § 17; 84 Del. Laws, c. 42, § 1; 84 Del. Laws, c. 182, § 13.)

§ 2705. Insurable interest; exception when certain institutions designated beneficiary.

(a) Life insurance contracts may be entered into in which the person paying the consideration for the insurance has no insurable interest in the life of the individual insured, where charitable, benevolent, educational or religious institutions, or their agencies, are designated irrevocably as the beneficiaries thereof.

(b) In making such contracts the person paying the premium shall make and sign the application therefor as owner and shall designate a charitable, benevolent, educational or religious institution, or an agency thereof, irrevocably as the beneficiary or beneficiaries of such contract. The application shall be signed also by the individual whose life is to be insured.

(c) Nothing in this section shall be deemed to prohibit any combination of the applicant, premium payer, owner and beneficiary from being the same person.

(d) Such a contract shall be valid and binding among the parties thereto, notwithstanding the absence otherwise of an insurable interest in the life of the individual insured.

(18 Del. C. 1953, § 2705; 56 Del. Laws, c. 380, § 1.)

§ 2706. Insurable interest; property.

(a) No contract of insurance of property or of any interest in property or arising from property shall be enforceable as to the insurance except for the benefit of persons having an insurable interest in the things insured as at the time of the loss.

(b) "Insurable interest" as used in this section means any actual, lawful and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction or pecuniary damage or impairment.

(c) The measure of an insurable interest in property is the extent to which the insured might be directly or indirectly damnified by loss, injury or impairment thereof.

(18 Del. C. 1953, § 2706; 56 Del. Laws, c. 380, § 1.)

§ 2707. Power to contract; purchase of insurance and annuities by minors.

(a) Any person of competent legal capacity may contract for insurance.

(b) Any minor not less than 15 years of age, with the consent of parent or guardian, if any, unless otherwise emancipated, may, notwithstanding his or her minority, contract for or own annuities or insurance or affirm by novation or otherwise preexisting contracts for annuities or insurance upon his or her own life, body, health, property, liabilities or other interests or on the persons of another in whom the minor has an insurable interest. Such a minor shall, notwithstanding such minority, be deemed competent to exercise all rights and powers with respect to or under:

(1) Any contract for annuity or for insurance upon his or her own life, body or health; or

(2) Any contract such minor effected upon his or her own property, liabilities or other interests; or

(3) Any contract effected or owned by the minor on the person of another as might be exercised by a person of full legal age and may at any time surrender his or her interest in any such contracts and give valid discharge for any benefit accruing or money payable thereunder.

Such a minor shall not, by reason of his or her minority, be entitled to rescind, avoid or repudiate the contract, nor to rescind, avoid or repudiate any exercise of a right or privilege thereunder, except that such a minor not otherwise emancipated shall not be bound by any unperformed agreement to pay by promissory note or otherwise any premium on any such annuity or insurance contract.

(c) Any annuity contract or policy of life or disability insurance procured by or for a minor under subsection (b) of this section above shall be made payable either to the minor or his or her estate or to a person having an insurable interest in the life of the minor.

(18 Del. C. 1953, § 2707; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2708. Consent of insured; life, health insurance.

No life or health insurance contract upon an individual, except a contract of group life insurance or of group or blanket health insurance, shall be made or effectuated unless at the time of the making of the contract the individual insured, being of competent legal capacity to contract, applies therefor or has consented thereto in writing, except in the following cases:

(1) A spouse may effectuate such insurance upon the other spouse;

(2) Any person having an insurable interest in the life of a minor, or any person upon whom a minor is dependent for support and maintenance may effectuate insurance upon the life of or pertaining to such minor;

(3) Family policies may be issued insuring any 2 or more members of a family on an application signed by either parent, a stepparent or by a husband or wife;

(4) An employer, or the trustee of a trust described in § 2704(c)(3) of this title, may effectuate insurance under an employer-owned life insurance policy, as defined in § 2704(e) of this title, upon any employee in whom it has an insurable interest, and the employer or trustee, as the case may be, shall not be required to notify employees of the effectuation of such insurance or obtain their consent. The insurer and any investment sub-advisors shall use best efforts to direct securities transactions relating to such employer-owned variable life insurance policies utilizing separate accounts, through a securities agent licensed and located in this State, as opposed to a securities agent licensed and located in another state, unless a better price for the identical security (securities) is available through the securities agent located in that other state.

(18 Del. C. 1953, § 2708; 56 Del. Laws, c. 380, § 1; 67 Del. Laws, c. 161, § 3; 69 Del. Laws, c. 232, §§ 1, 2; 69 Del. Laws, c. 462, § 4; 71 Del. Laws, c. 239, § 3; 80 Del. Laws, c. 376, § 4.)

§ 2709. Alteration of application, life and health insurance.

No alteration of any written application for any life or health insurance policy shall be made by any person other than the applicant without his or her written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

(18 Del. C. 1953, § 2709; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2710. Application as evidence.

(a) No application for the issuance of any life or health insurance policy or annuity contract shall be admissible in evidence in any action relative to such policy or contract, unless a true copy of the application was attached to or otherwise made a part of the policy or contract when issued. This provision shall not apply to industrial life insurance policies.

(b) If any policy of life or health insurance delivered in this State is reinstated or renewed and the insured or the beneficiary or assignee of the policy makes written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall, within 30 days after receipt of such request at its home office, deliver or mail to the person making such request a copy of such application reproduced by any legible means. If such copy is not so delivered or mailed after having been so requested, the insurer shall be precluded from introducing the application in evidence in any action or proceeding based upon or involving the policy or its reinstatement or renewal. In the case of such a request from a beneficiary, the time within which the insurer is required to furnish a copy of such application shall not begin to run until after receipt of evidence satisfactory to the insurer of the beneficiary's vested interest in the policy or contract.

(c) As to kinds of insurance other than life or health insurance, no application for insurance signed by or on behalf of the insured shall be admissible in evidence in any action between the insured and the insurer arising out of the policy so applied for, if the insurer has failed, at the expiration of 30 days after receipt by the insurer of written demand therefor by or on behalf of the insured, to furnish to the insured a copy of such application reproduced by any legible means.

(18 Del. C. 1953, § 2710; 56 Del. Laws, c. 380, § 1.)

§ 2711. Representations in applications.

All statements and descriptions in any application for an insurance policy or annuity contract by or in behalf of the insured or annuitant shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery under the policy or contract unless either:

(1) Fraudulent; or

(2) Material either to the acceptance of the risk or to the hazard assumed by the insurer; or

(3) The insurer in good faith would either not have issued the policy or contract, or would not have issued it at the same premium rate or would not have issued a policy or contract in as large an amount or would not have provided coverage with respect to the hazard resulting in the loss if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise.

(18 Del. C. 1953, § 2711; 56 Del. Laws, c. 380, § 1.)

§ 2712. Filing, approval of forms.

(a) No basic insurance policy or annuity contract, form, or application form where written application is required and is to be made a part of the policy or contract or printed rider or endorsement form or form of renewal certificate shall be delivered or issued for delivery in this State, unless the form has been filed with the Commissioner. This provision shall not apply to surety bonds or to specially rated inland marine risks nor to policies, riders, endorsements, or forms of unique character designed for and used with relation to insurance upon a particular subject or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or health insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder. With respect to group and blanket health insurance policies issued and delivered to a trust or to an association outside of this State and covering persons resident in this State, the group certificates to be delivered or issued for delivery in this State shall be filed with the Commissioner pursuant to this section provided, however, that this requirement shall not apply to an association group having received a waiver from the Commissioner upon a finding that the association group meets the qualifications set forth in § 3506 of this title. In the case of forms for use in property, marine (other than wet marine and transportation insurance), casualty, surety and title insurance coverages, the filing required by this subsection may be made by rating organizations on behalf of their members and subscribers, but this provision shall not be deemed to prohibit any such member or subscriber from filing any such forms on its own behalf.

(b) Every such filing shall be made not less than 30 days in advance of any such delivery. At the expiration of such 30 days the form so filed shall be effective unless prior thereto it has been affirmatively acknowledged or disapproved by order of the Commissioner. Acknowledgment of any such form by the Commissioner shall constitute a waiver of any unexpired portion of such waiting period. The Commissioner may extend by not more than an additional 30 days the period within which he or she may so affirmatively acknowledge or disapprove any such form, by giving notice to the insurer of such extension before expiration of the initial 30 days period. At the expiration of any such period as so extended, and in the absence of such prior affirmative acknowledgment or disapproval, any such form may be placed in use. The Commissioner may at any time, after notice and for cause shown, withdraw any such acknowledgment or effectiveness.

(c) Any order of the Commissioner disapproving any such form or withdrawing a previous effectiveness shall state the grounds therefor and the particulars thereof in such detail as reasonably to inform the insurer thereof. Any such withdrawal of a previously effective form shall be operative at expiration of such period, not less than 30 days after the giving of notice of withdrawal, as the Commissioner shall in such notice prescribe.

(d) The Commissioner may, by order, exempt from the requirements of this section, for so long as he or she deems proper, any insurance document or form or type thereof as specified in such order, to which, in his or her opinion, this section may not practicably be applied, or the filing and review of which are, in his or her opinion, not desirable or necessary for the protection of the public.

(e) Appeals from orders of the Commissioner disapproving any such form or withdrawing a previous effectiveness may be taken as provided in §§ 327-333 of this title.

(18 Del. C. 1953, § 2712; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 155, § 1; 70 Del. Laws, c. 186, § 1; 73 Del. Laws, c. 402, § 3.)

§ 2713. Grounds for disapproval.

The Commissioner shall disapprove any form filed under § 2712 of this title, or withdraw any previous effectiveness thereof, only on 1 or more of the following grounds:

(1) If it is in any respect in violation of or does not comply with this title.

(2) If it contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.

(3) If it has any title, heading or other indication of its provisions which is misleading.

(4) If the benefits provided therein are unreasonable in relation to the premium charged, or if it contains any unjust, unfair or inequitable provision or provisions.

(5) If it contains a provision or provisions such as to encourage misrepresentation.

(18 Del. C. 1953, § 2713; 56 Del. Laws, c. 380, § 1; 83 Del. Laws, c. 318, § 1.)

§ 2714. Standard provisions.

(a) Insurance contracts shall contain such standard or uniform provisions as are required by the applicable provisions of this title pertaining to contracts of particular kinds of insurance. The Commissioner may waive the required use of a particular provision in a particular insurance policy form if:

(1) He or she finds such provision unnecessary for or unrelated to the protection of the insured and inconsistent with the purposes of the policy; and

(2) The policy is otherwise approved by him or her.

(b) No policy shall contain any provision inconsistent with or contradictory to any standard or uniform provision used or required to be used, but the Commissioner may approve any substitute provision which is, in his or her opinion, not less favorable in any particular to the insured or beneficiary than the provisions otherwise required.

(c) In lieu of the provisions required by this title for contracts for particular kinds of insurance, substantially similar provisions required by the law of the domicile of a foreign or alien insurer may be used when approved by the Commissioner.

(d) A policy issued by a domestic insurer for delivery in another jurisdiction may contain any provision required or permitted by the laws of such jurisdiction.

(18 Del. C. 1953, § 2714; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2715. Charter or bylaw provisions.

No policy shall contain any provision purporting to make any portion of the charter, bylaws or other constituent document of the insurer (other than the subscriber’s agreement or power of attorney of a reciprocal insurer) a part of the contract unless such portion is set forth in full in the policy. Any policy provision in violation of this section shall be invalid.

(18 Del. C. 1953, § 2715; 56 Del. Laws, c. 380, § 1.)

§ 2716. Execution of policies.

(a) Every insurance policy shall be executed in the name of and on behalf of the insurer by its officer, attorney-in-fact, employee or representative duly authorized by the insurer.

(b) A facsimile signature of any such executing individual may be used in lieu of an original signature.

(c) No insurance contract heretofore or hereafter issued and which is otherwise valid shall be rendered invalid by reason of the apparent execution thereof on behalf of the insurer by the imprinted facsimile signature of an individual not authorized so to execute as of the date of the policy.

(18 Del. C. 1953, § 2716; 56 Del. Laws, c. 380, § 1.)

§ 2717. Underwriters' and combination policies.

(a) Two or more authorized insurers may jointly issue, and shall be jointly and severally liable on, an underwriters' policy bearing their names. Any 1 insurer may issue policies in the name of an underwriter's department and such policy shall plainly show the true name of the insurer.

(b) Two or more insurers may, with the approval of the Commissioner, issue a combination policy which shall contain provisions substantially as follows:

(1) That the insurers executing the policy shall be severally liable for the full amount of any loss or damage, according to the terms of the policy, or for specified percentages or amounts thereof, aggregating the full amount of insurance under the policy; and

(2) That service of process, or of any notice or proof of loss required by such policy, upon any of the insurers executing the policy shall constitute service upon all such insurers.

(c) This section shall not apply to cosurety obligations.

(18 Del. C. 1953, § 2717; 56 Del. Laws, c. 380, § 1.)

§ 2718. Validity and construction of noncomplying forms.

(a) A policy hereafter delivered or issued for delivery to any person in this State in violation of this title but otherwise binding on the insurer shall be held valid, but shall be construed as provided in this title.

(b) Any condition, omission or provision not in compliance with the requirements of this title and contained in any policy, rider or endorsement hereafter issued and otherwise valid shall not thereby be rendered invalid but shall be construed and applied in accordance with such condition, omission or provision as would have applied had the same been in full compliance with this title.

(18 Del. C. 1953, § 2718; 56 Del. Laws, c. 380, § 1.)

§ 2719. Delivery of policy.

In event the original policy is delivered or is so required to be delivered to or for deposit with any vendor, mortgagee or pledgee of any motor vehicle, and in which policy any interest of the vendee, mortgagor or pledgor in or with reference to such vehicle is insured, a duplicate of such policy setting forth the name and address of the insurer, insurance classification of vehicle, type of coverage, limits of liability, premiums for the respective coverages and duration of the policy, or memorandum thereof containing the same such information, shall be delivered by the vendor, mortgagee or pledgee to each such vendee, mortgagor or pledgor named in the policy or coming within the group of persons designated in the policy to be so included. If the policy does not provide coverage of legal liability for injury to persons or damage to the property of third parties, a statement of such fact shall be printed, written or stamped conspicuously on the face of such duplicate policy or memorandum. This section does not apply to inland marine floater policies.

(18 Del. C. 1953, § 2719; 56 Del. Laws, c. 380, § 1.)

§ 2720. Assignability.

(a) A policy and its rights and benefits may be assignable or not assignable, as provided by its terms.

(b) Subject to its terms relating to assignability, a life or health insurance policy and its rights and benefits, whether heretofore or hereafter issued, under the terms of which the beneficiary may be changed upon the sole request of the insured or owner, may be assigned either by pledge or transfer of title by an assignment executed by the insured or owner alone and delivered to the insurer, whether or not the pledgee or assignee is the insurer.

(c) Subject to its terms relating to assignability, a property insurance policy, whether heretofore or hereafter issued, under the terms of which the policy and its rights and benefits are assignable, may provide that the rights and benefits under the insurance policy may only be assigned to a person who has the legal authority to represent the named insured and may explicitly prohibit assignment of rights and benefits to any other person, including a property repair contractor. For purposes of this subsection, having "legal authority to represent the named insured" includes the person named by the named insured as having the named insured's power of attorney, the person who is the named insured's licensed public adjuster, or any other comparable person. Property repair contractors operating in this State may not subvert the public adjuster licensing requirements in § 1751 of this title through the acquisition of a power of attorney from the named insured.

(d) Any assignment pursuant to subsection (b) or (c) of this section shall entitle the insurer to deal with the assignee as the owner or pledgee of the policy or its rights and benefits in accordance with the terms of the assignment until the insurer has received at its home office written notice of termination of the assignment or pledge or written notice by or on behalf of some other person claiming some interest in the policy or its rights and benefits in conflict with the assignment.

(18 Del. C. 1953, § 2720; 56 Del. Laws, c. 380, § 1; 83 Del. Laws, c. 93, § 1.)

§ 2720A. Property insurance for beneficiary of transfer on death deed.

(a) As used in this section:

(1) "Beneficiary" means as defined under § 202 of Title 25.

(2) “Insurable interest” means an insured’s interest in real property, concerning which the insured is entitled to the benefits of insurance coverage under a policy.

(3) “Insured” means a person that is entitled to the benefits of a policy.

(4) “Property” means as defined under § 202 of Title 25.

(5) “Transfer on death deed” means as defined under § 202 of Title 25.

(6) “Transferor” means as defined under § 202 of Title 25.

(b) Notwithstanding § 2720 of this title and subject to subsection (c) of this section, a beneficiary of a transfer on death deed is an insured to the extent of the transferor’s insurable interest in property that the beneficiary has acquired or received by a transfer on death deed.

(c) Except as provided in subsections (d) and (e) of this section, for 60 days immediately following the death of the transferor, a beneficiary of a transfer on death deed is an insured under a policy insuring the property of the transferor. At the time of the transferor’s death, and for 60 days after the transferor’s death, the beneficiary succeeds to the rights and obligations of the transferor under the policy to the extent of the transferor’s insurable interest in property that the beneficiary has acquired or received by a transfer on death deed.

(d) (1) Subject to paragraph (d)(2) of this section, if a policy has an expiration date that is less than 60 days after the death of the transferor, insurance coverage continues for 30 days or until the expiration date of the policy, whichever is later.

(2) If the later date under paragraph (d)(1) of this section extends beyond the expiration date of the policy, insurance coverage continues only if the beneficiary has paid the premium applicable to the coverage extending beyond the expiration date.

(e) If a beneficiary obtains a policy insuring the property that the beneficiary acquired or received by a transfer on death deed, the beneficiary is not an insured under subsection (c) of this section.

(f) This section applies to a loss or damage incurred on or after December 4, 2025.

(g) This section applies regardless of whether policy was created before, on, or after December 4, 2025, unless the application of this section to the policy would do any of the following:

(1) For a policy issued before December 4, 2025, give a right to a beneficiary that the beneficiary was not reasonably intended to have, other than the beneficiary’s right to insurance coverage until the time limitation under subsection (c) or (d) of this section.

(2) For a policy issued at any time, relieve a beneficiary from a duty or liability imposed on the transferor by the terms of the policy.

(85 Del. Laws, c. 212, § 5.)

§ 2721. Payment discharges insurer.

Whenever the proceeds of or payments under a life or health insurance policy or annuity contract heretofore or hereafter issued become payable in accordance with the terms of such policy or contract, or the exercise of any right or privilege thereunder, and the insurer makes payment thereof in accordance therewith or in accordance with any written assignment thereof, the person then designated as being entitled thereto shall be entitled to receive such proceeds or payments and to give full acquittance therefor and such payments shall fully discharge the insurer from all claims under the policy or contract unless, before payment is made, the insurer has received at its home office written notice by or on behalf of some other person that such other person claims to be entitled to such payment or some interest in the policy or contract.

(18 Del. C. 1953, § 2721; 56 Del. Laws, c. 380, § 1.)

§ 2722. Forms for proof of loss to be furnished.

An insurer shall furnish, upon written request of any person claiming to have a loss under an insurance contract issued by such insurer, forms of proof of loss for completion by such person, but such insurer shall not, by reason of the requirement so to furnish forms, have any responsibility for or with reference to the completion of such proof or the manner of any such completion or attempted completion.

(18 Del. C. 1953, § 2722; 56 Del. Laws, c. 380, § 1.)

§ 2723. Minor may give acquittance.

Repealed by 72 Del. Laws, c. 310, § 1, effective May 26, 2000.

§ 2724. Claims administration not waiver.

Without limitation of any right or defense of an insurer otherwise, none of the following acts by or on behalf of an insurer shall be deemed to constitute a waiver of any provision of a policy or of any defense of the insurer thereunder:

(1) Acknowledgment of the receipt of notice of loss or claim under the policy;

(2) Furnishing forms for reporting a loss or claim, for giving information relative thereto, or for making proof of loss, or receiving or acknowledging receipt of any such forms or proofs completed or uncompleted;

(3) Investigating any loss or claim under any policy or engaging in negotiations looking toward a possible settlement of any such loss or claim.

(18 Del. C. 1953, § 2724; 56 Del. Laws, c. 380, § 1.)

§ 2725. Exemption of proceeds, life insurance [Repealed].

(18 Del. C. 1953, § 2725; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; repealed by 81 Del. Laws, c. 320, § 7, effective July 11, 2018.)

§ 2726. Exemption of proceeds, health insurance.

Except as may otherwise be expressly provided by the policy or contract, the proceeds or avails of all contracts of health insurance and of provisions providing benefits on account of the insured's disability which are supplemental to life insurance or annuity contracts heretofore or hereafter effected shall be exempt from all liability for any debt of the insured and from any debt of the beneficiary existing at the time the proceeds are made available for his or her use.

(18 Del. C. 1953, § 2726; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2727. Exemption of proceeds—Group insurance.

(a) A policy of group life insurance or group health insurance or the proceeds thereof payable to the individual insured or to the beneficiary thereunder, shall not be liable, either before or after payment, to be applied by any legal or equitable process to pay any debt or liability of such insured individual or his or her beneficiary or of any other person having a right under the policy.

(b) This section shall not apply to group insurance issued pursuant to this title to a creditor covering his or her debtors to the extent that such proceeds are applied to payment of the obligation for the purpose of which the insurance was so issued.

(18 Del. C. 1953, § 2727; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2728. Exemption of proceeds — Annuity contracts; assignability of rights [Repealed].

(18 Del. C. 1953, § 2728; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; repealed by 81 Del. Laws, c. 320, § 7, effective July 11, 2018.)

§ 2729. Retention of proceeds of policy by company.

(a) Any life insurer shall have power to hold payment of proceeds, as shall have been agreed to in writing by the insurer and the insured or beneficiary. The insurer shall not be required to segregate funds so held but may hold them as a part of its general corporate assets.

(b) The provisions of this section shall not impair or affect any rights of creditors under §§ 2725-2728 of this title.

(18 Del. C. 1953, § 2729; 56 Del. Laws, c. 380, § 1.)

§ 2730. Collection of overpayments by health insurers and health plans.

(a) Other than recovery for duplicate payments, a health insurer or health plan, whenever it engages in overpayment recovery efforts, shall provide written notice to the health-care provider that identifies the error made in the processing or payment of the claim and justifies the overpayment recovery.

(b) A health insurer or health plan shall provide a health-care provider with the opportunity to challenge an overpayment recovery, including the sharing of claims information, and shall establish written policies and procedures for health-care providers to follow to challenge an overpayment recovery.

(c) A health insurer or health plan may not initiate overpayment recovery efforts more than 12 months after the original payment for the claim was made. For purposes of this subsection, overpayment recovery efforts are "initiated" when a health insurer or health plan first identifies an error in the original payment for the claim through an initial audit report or similar communication delivered to the health-care provider. No such time limit applies to overpayment recovery efforts which are any of the following:

(1) Based on fraud, abuse, or other intentional misconduct as indicated by physical review or review of claims data or statements.

(2) Required by, or initiated at the request of, a self-insured plan.

(3) Required by a state or federal government plan.

(d) Nothing in this section shall be deemed to limit a health insurer's or health plan's right to pursue recovery of overpayments that occurred prior to June 14, 2018, where the health insurer or health plan has provided the health-care provider with notice of such recovery efforts prior to June 14, 2018.

(e) For purposes of this section "health insurer" shall mean any entity or plan that provides health insurance in this State. Such terms shall include an insurance company, health service corporation, managed care organization, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Health insurer" shall also include any third-party administrator or other entity that adjusts, administers or settles claims in connection with health benefit plans.

(f) For purposes of this section, "health plan" shall mean any hospital or medical policy or certificate, major-medical expense insurance, health service corporation subscriber contract, health maintenance organization subscriber contract, managed care organization subscriber contract, dental or vision plan. "Health plan" does not include accident-only, credit, Medicaid plans, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance or automobile medical payment insurance.

(g) *Waiver prohibited. —*

The provisions of this section cannot be waived by contract. Any contractual arrangement in conflict with the provisions of this section or that purports to waive any requirements of this section is null and void.

(h) A finding of overpayment must be based on the actual overpayment and not a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs.

(i) The entity conducting the audit may not use extrapolation in calculating the recoupment or penalties for audits unless required by state or federal law or regulations.

(81 Del. Laws, c. 216, § 1; 85 Del. Laws, c. 201, § 1.)

Subchapter II

Readability of Automobile Insurance Policy Forms

§ 2740. Statement of policy.

It is the purpose of this subchapter to encourage the Commissioner to promulgate regulations by October 15, 1976, which assure that automobile insurance policies issued in Delaware, after the effective date of said regulations, will be understandable and readable by a person of average intelligence and education; or, in the event of the failure of the Commissioner to promulgate such regulations by October 15, 1976, to establish certain basic minimum readability requirements for automobile insurance policy forms. Accordingly, it is intended that subchapter III of this chapter shall become effective only upon the failure of the Commissioner to promulgate such regulations by October 15, 1976.

(60 Del. Laws, c. 441, § 2.)

§ 2741. Commissioner’s authority to promulgate readability rules and regulations.

(a) In addition to those general powers granted in § 314 of this title, the Commissioner is hereby authorized and empowered to make rules and regulations to the extent the Commissioner deems necessary to assure that automobile insurance policy forms as described in § 2742 of this title [expired] are readable and understandable by a person of average intelligence and education; provided, however, that such rules and regulations shall require, in the manner the Commissioner deems appropriate, that all such automobile insurance policy forms shall have a total “readability score” of 40 or more on the Flesch Scale, although forms with a Flesch Test Score of less than 40 may be approved where the length of sentences and words are sufficiently compensated for by compliance with other standards set forth in such rules and regulations.

(b) The Commissioner shall adopt and promulgate readability rules and regulations only after a hearing thereon of which notice has been given to all persons subject to the Commissioner’s supervision under this title who are to be affected by the proposed rule or regulation. Any readability rules and regulations so adopted and promulgated shall be effective upon the date specified therein.

(60 Del. Laws, c. 441, § 2.)

Part I
Insurance
Chapter 29
Life Insurance and Annuity Contracts

§ 2901. Scope of chapter.

This chapter, except as to § 2932 of this title, applies only to contracts of life insurance and annuities, other than reinsurance, group life insurance and group annuities.

(18 Del. C. 1953, § 2901; 56 Del. Laws, c. 380, § 1.)

§ 2902. "Annuity" defined.

For this title an "annuity" is a contract, issued by a person which is not classified by the Internal Revenue Service as exempt from taxation under § 501(c)(3) of the Internal Revenue Code of 1954 [26 U.S.C. § 501(c)(3)], as subsequently amended, under which obligations are assumed as to periodic payments for specific term or terms or where the making or continuance of all or some such payments, or the amount of any such payment, is dependent upon continuance of human life. Such a contract which includes extra benefits of kinds set forth in §§ 902 ("life insurance" defined) and 903 ("health insurance" defined) of this title shall nevertheless be deemed to be an annuity if such extra benefits constitute a subsidiary or incidental part of the entire contract.

(18 Del. C. 1953, § 2902; 56 Del. Laws, c. 380, § 1; 64 Del. Laws, c. 155, § 1.)

§ 2903. "Industrial life insurance" defined.

For the purposes of this title "industrial life insurance" is that form of life insurance written under policies of face amount of $1,000 or less bearing the words "industrial policy" imprinted on the face thereof as part of the descriptive matter and under which premiums are payable monthly or more often.

(18 Del. C. 1953, § 2903; 56 Del. Laws, c. 380, § 1.)

§ 2904. Standard provisions required.

(a) No policy of life insurance, other than pure endowments with or without return of premiums or of premiums and interest, shall be delivered or issued for delivery in this State unless it contains in substance all of the applicable provisions required by §§ 2905-2916, inclusive, of this title. This section shall not apply to annuity contracts nor to any provision of a life insurance policy, or contract supplemental thereto, relating to disability benefits or to additional benefits in the event of death by accident or accidental means.

(b) Any of such provisions or portions thereof not applicable to single premium or nonparticipating or term policies or insurance granted in exchange for lapsed or surrendered policies shall to that extent not be incorporated therein.

(18 Del. C. 1953, § 2904; 56 Del. Laws, c. 380, § 1.)

§ 2905. Payment of premiums.

There shall be a provision relating to the time and place of payment of premiums.

(18 Del. C. 1953, § 2905; 56 Del. Laws, c. 380, § 1.)

§ 2906. Grace period.

There shall be a provision that a grace period of 30 days or, at the option of the insurer, of 1 month of not less than 30 days, or of 4 weeks in the case of industrial life insurance policies the premiums for which are payable more frequently than monthly shall be allowed within which the payment of any premium after the first may be made, during which period of grace the policy shall continue in full force. The insurer may impose an interest charge not in excess of 6% per annum for the number of days of grace elapsing before the payment of the premium, and, whether or not such interest charge is imposed, if a claim arises under the policy during such period of grace, the amount of any premium due or overdue, together with interest and any deferred installment of the annual premium, may be deducted from the policy proceeds. Grace shall date from the premium due date specified in the policy.

(18 Del. C. 1953, § 2906; 56 Del. Laws, c. 380, § 1.)

§ 2907. Entire contract.

There shall be a provision that except as otherwise expressly provided by law, the policy and the application therefor, if a copy of such application is endorsed upon or attached to the policy when issued, shall constitute the entire contract between the parties and that all statements contained in the application shall, in the absence of fraud, be deemed representations and not warranties.

(18 Del. C. 1953, § 2907; 56 Del. Laws, c. 380, § 1.)

§ 2908. Incontestability.

There shall be a provision that the policy shall be incontestable after it has been in force during the lifetime of the insured for a period of not more than 2 years after its date of issue, except for:

(1) Nonpayment of premiums; and

(2) At the insurer's option, provisions relating to benefits in the event of total and permanent disability and provisions granting additional benefits specifically against death by accident or accidental means.

(18 Del. C. 1953, § 2908; 56 Del. Laws, c. 380.)

§ 2909. Misstatement of age.

There shall be a provision that if the age of the insured or of any other person whose age is considered in determining the premium or benefit has been misstated, any amount payable or benefit accruing under the policy shall be such as the premium would have purchased at the correct age or ages.

(18 Del. C. 1953, § 2909; 56 Del. Laws, c. 380, § 1.)

§ 2910. Dividends.

(a) There shall be a provision in participating policies that, beginning not later than the end of the third policy year, the insurer shall annually ascertain and apportion the divisible surplus, if any, that will accrue on the policy anniversary or other dividend date specified in the policy, provided the policy is in force and all premiums to that date are paid. Except as hereinafter provided, any dividends becoming payable shall at the option of the party entitled to elect such option be either:

(1) Payable in cash; or

(2) Applied to any one of such other dividend options as may be provided by the policy. If any such other dividend options are provided, the policy shall further state which option shall be automatically effective if such party shall not have elected some other option. If the policy specifies a period within which such other dividend option may be elected, such period shall be not less than 30 days following the date on which such dividend is due and payable. The annually apportioned dividend shall be deemed to be payable in cash within the meaning of paragraph (a)(1) of this section above even though the policy provides that payment of such dividend is to be deferred for a specified period, provided such period does not exceed 6 years from the date of apportionment and that interest will be added to such dividend at a specified rate.

(b) Renewable term policies of 10 years or less may provide that the surplus accrued to such policies shall be determined and apportioned each year after the second policy year and accumulated during each renewal period and that at the end of the renewal period, on renewal of the policy by the insured, the insurer shall apply the accumulated surplus as an annuity for the next succeeding renewal term in the reduction of premiums.

(c) In participating industrial life insurance policies, in lieu of the provision required in subsection (a) of this section above, there shall be a provision that, beginning not later than the end of the fifth policy year, the policy shall participate annually in the divisible surplus, if any, in the manner set forth in the policy.

(d) This section does not apply to insurance issued under nonforfeiture provisions of lapsed or surrendered policies.

(18 Del. C. 1953, § 2910; 56 Del. Laws, c. 380, § 1.)

§ 2911. Policy loan.

(a) There shall be a provision that after 3 full years' premiums have been paid and after the policy has a cash surrender value and while no premium is in default beyond the grace period for payment, the insurer will advance, on proper assignment or pledge of the policy and on the sole security thereof, at a rate of interest not exceeding 8% per annum (if payable in advance such interest shall not exceed the rate of 7.4% per annum for policies issued prior to January 1, 1983) an amount equal to or, at the option of the party entitled thereto, less than the loan value of the policy. Before approving any policy provision providing for a rate of interest in excess of 6%, the Commissioner may require assurances by the insurer that the holders of such policies will benefit from the increased earning of the insurer resulting from the use of such higher rates, through the use of higher dividends or lower premiums, or both. The loan value of the policy shall be at least equal to the cash surrender value at the end of the then current policy year, and the insurer may deduct, either from such loan value or from the proceeds of the loan, any existing indebtedness not already deducted in determining such cash surrender value, including any interest then accrued but not due, any unpaid balance of the premium for the current policy year and interest on the loan to the end of the current policy year. The policy may also provide that if interest on any indebtedness is not paid when due it shall then be added to the existing indebtedness and shall bear interest at the same rate and that if and when the total indebtedness on the policy, including interest due or accrued, equals or exceeds the amount of the loan value thereof, then the policy shall terminate and become void, but not until at least 30 days' notice has been mailed by the insurer to the last address on record with the insurer of the insured or other policy owner and of any assignee of record at the insurer's home office. The policy shall reserve to the insurer the right to defer the granting of a loan, other than for the payment of any premium to the insurer, for 6 months after application therefor. Such provision shall also contain a table showing in figures the loan values each year during the first 20 years of the policy or during the term of the policy whichever is shorter. The policy, at the insurer's option, may provide for an automatic premium loan.

(b) (1) Policies issued on or after January 1, 1983, shall provide for policy loan interest rates as follows:

a. A provision permitting a maximum interest rate of not more than 8% per annum; or

b. A provision permitting an adjustable maximum interest rate established from time to time by the life insurer as permitted by law.

(2) The rate of interest charged on a policy loan made under paragraph (b)(1)b. of this section shall not exceed the higher of the following:

a. The published monthly average for the calendar month ending 2 months before the date on which the rate is determined; or

b. The rate used to compute the cash surrender values under the policy during the applicable period plus 1% per annum.

(3) The term "published monthly average" means:

a. Moody's Corporate Bond Yield Average — Monthly Average Corporates as published by Moody's Investors Service, Inc. or any successor thereto; or

b. In the event that the Moody's Corporate Bond Yield Average — Monthly Average Corporates is no longer published, a substantially similar average, established by regulation issued by the Commissioner.

(4) If the maximum rate of interest is determined pursuant to paragraph (b)(1)b. of this section, the policy shall contain a provision setting forth the frequency at which the rate is to be determined for that policy.

(5) The maximum rate for each policy must be determined at regular intervals at least once every 12 months, but not more frequently than once in any 3-month period. At the intervals specified in the policy:

a. The rate being charged may be increased whenever such increase as determined under paragraph (b)(2) of this section would increase that rate by $^{1}/_{2}$% or more per annum;

b. The rate being charged must be reduced whenever such reduction as determined under paragraph (b)(2) of this section would decrease that rate by $^{1}/_{2}$% or more per annum.

(6) The life insurer shall:

a. Notify the policyholder at the time a cash loan is made of the initial rate of interest on the loan;

b. Notify the policyholder with respect to premium loans of the initial rate of interest on the loan as soon as it is reasonably practical to do so after making the initial loan. Notice need not be given to the policyholder when a further premium loan is added, except as provided in paragraph (b)(6)c. of this section below;

c. Send to policyholders with loans reasonable advance notice of any increase in the rate; and

d. Include in the notices required above the substance of the pertinent provisions of paragraphs (b)(1) and (4) of this section.

(7) The loan value of the policy shall be determined in accordance with subsection (a) of this section, but no policy shall terminate in a policy year as the sole result of a change in the interest rate during that policy year, and the life insurer shall maintain coverage during that policy year until the time at which it would otherwise have terminated if there had been no change during that policy year.

(8) The substance of the pertinent provisions of paragraphs (b)(1) and (4) of this section shall be set forth in the policies to which they apply.

(9) For purposes of this section:

a. The rate of interest on policy loans permitted under this subsection includes the interest rate charged on reinstatement of policy loans for the period during and after any lapse of a policy.

b. The term "policy loan" includes any premium loan made under a policy to pay 1 or more premiums that were not paid to the life insurer as they fell due.

c. The term "policyholder" includes the owner of the policy or the person designated to pay premiums as shown on the records of the life insurer.

d. The term "policy" includes certificates issued by a fraternal benefit society and annuity contracts which provide for policy loans.

(10) No other provision of law shall apply to policy loan interest rates unless made specifically applicable to such rates.

(11) This subsection shall not apply to any insurance contract issued before January 1, 1983, unless the policyholder agrees in writing to the applicability of such provisions.

(c) This section shall not apply to term policies or to term insurance benefits provided by rider or supplemental policy provisions or to industrial life insurance policies.

(18 Del. C. 1953, § 2911; 56 Del. Laws, c. 380, § 1; 60 Del. Laws, c. 195, § 1; 63 Del. Laws, c. 399, § 1.)

§ 2912. Table of installments.

In case the policy provides that the proceeds may be payable in installments which are determinable at issue of the policy, there shall be a table showing the amounts of the guaranteed installments.

(18 Del. C. 1953, § 2912; 56 Del. Laws, c. 380, § 1.)

§ 2913. Reinstatement.

There shall be a provision that unless:

(1) The policy has been surrendered for its cash surrender value;

(2) Its cash surrender value has been exhausted; or

(3) The paid-up term insurance, if any, has expired;

the policy will be reinstated at any time within 3 years (or 2 years in the case of industrial life insurance policies) from the date of premium default upon written application therefor, the production of evidence of insurability satisfactory to the insurer, the payment of all premiums in arrears with interest at a rate not exceeding 6% per annum compounded annually, and the payment or reinstatement of any indebtedness to the insurer upon the policy with interest as provided in § 2911 of this title.

(18 Del. C. 1953, § 2913; 56 Del. Laws, c. 380, § 1; 63 Del. Laws, c. 399, § 2.)

§ 2914. Payment of claims.

(a) There shall be a provision that when the benefits under the policy become payable by reason of the death of the insured, settlement must be made upon receipt of due proof of death, which may consist of a certified copy of the insured's death certificate or other lawful evidence providing equivalent information, and, at the insurer's option, surrender of the policy or proof of the interest of the claimant. If an insurer specifies a particular period before the expiration of which settlement must be made, the period may not exceed 30 days from the receipt of such proofs.

(b) There shall be a provision for the payment of interest on the death benefit under the policy as follows:

(1) Interest accrues and is payable from the date of the initial filing of the death benefits claim, which includes due proof of death.

(2) Interest accrues at the rate applicable to the policy for funds left on deposit or, if the insurer has not established a rate for funds left on deposit, at the 2 year Treasury Constant Maturity Rate as published by the Federal Reserve. In determining the effective annual rate, the insurer shall use the rate in effect on the date of the filing of the initial death benefits claim.

(c) Interest accrues at the effective annual rate determined in subsection (b) of this section, plus additional interest at a rate of 10% annually beginning with the date that is 31 calendar days from the latest of paragraphs (c)(1), (2), and (3) of this section to the date the claim is paid, where it is all of the following:

(1) The date that due proof of death is received by the insurer.

(2) The date the insurer receives sufficient information to determine its liability, the extent of the liability, and the appropriate payee legally entitled to the proceeds.

(3) The date that legal impediments to payments of proceeds that depend on the action of parties other than the insurer are resolved and sufficient evidence of the same is provided to the insurer. For purposes of this paragraph (c)(3), "legal impediments to payments" include the establishment of guardianships and conservatorships; appointments and qualification of trustees, executors, and administrators; and the submission of information required to satisfy state and federal reporting requirements.

(18 Del. C. 1953, § 2914; 56 Del. Laws, c. 380, § 1; 82 Del. Laws, c. 114, § 1.)

§ 2915. Beneficiary, industrial policies.

An industrial life insurance policy shall have the name of the beneficiary designated thereon or in the application or other form if attached to the policy, with a reservation of the right to designate or change the beneficiary after the issuance of the policy, unless such beneficiary be irrevocably designated. The policy may also provide that no designation or change of beneficiary shall be binding on the insurer until endorsed on the policy by the insurer and that the insurer may refuse to endorse the name of any proposed beneficiary who does not appear to the insurer to have an insurable interest in the life of the insured. The policy may also provide that if the beneficiary designated in the policy does not make a claim under the policy or does not surrender the policy with due proof of death within the period stated in the policy, which shall not be less than 30 days after the death of the insured, or if the beneficiary is the estate of the insured, or is a minor, or dies before the insured, or is not legally competent to give a valid release, then the insurer may make any payment thereunder to the executor or administrator of the insured, or to any relative of the insured by blood or legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled thereto by reason of having been named beneficiary, or by reason of having incurred expense for the maintenance, medical attention or burial of the insured. The policy may also include a similar provision applicable to any other payment due under the policy.

(18 Del. C. 1953, § 2915; 56 Del. Laws, c. 380, § 1.)

§ 2916. Title.

There shall be a title on the policy, briefly describing the same.

(18 Del. C. 1953, § 2916; 56 Del. Laws, c. 380, § 1.)

§ 2917. Excluded or restricted coverage.

A clause in any policy of life insurance providing that such policy shall be incontestable after a specified period shall preclude only a contest of the validity of the policy and shall not preclude the assertion at any time of defenses based upon provisions in the policy which exclude or restrict coverage, whether or not such restrictions or exclusions are excepted in such clause.

(18 Del. C. 1953, § 2917; 56 Del. Laws, c. 380, § 1.)

§ 2918. Standard provisions; annuity and pure endowment contracts.

(a) No annuity or pure endowment contract, other than reversionary annuities (also called survivorship annuities) or group annuities and except as stated herein, shall be delivered or issued for delivery in this State unless it contains in substance each of the provisions

specified in §§ 2919-2924, inclusive, of this title. Any of such provisions not applicable to single premium annuities or single premium pure endowment contracts shall not, to that extent, be incorporated therein.

(b) This section shall not apply to contracts for deferred annuities included in, or upon the lives of beneficiaries under, life insurance policies.

(18 Del. C. 1953, § 2918; 56 Del. Laws, c. 380, § 1.)

§ 2919. Grace period; annuities.

In an annuity or pure endowment contract, other than a reversionary, survivorship or group annuity, there shall be a provision that there shall be a period of grace of 1 month, but not less than 30 days, within which any stipulated payment to the insurer falling due after the first may be made, subject at the option of the insurer to an interest charge thereon at a rate to be specified in the contract but not exceeding 6% per annum for the number of days of grace elapsing before such payment, during which period of grace the contract shall continue in full force, but in case a claim arises under the contract on account of death prior to expiration of the period of grace before the overdue payment to the insurer or the deferred payments of the current contract year, if any, are made, the amount of such payments, with interest on any overdue payments, may be deducted from any amount payable under the contract in settlement.

(18 Del. C. 1953, § 2919; 56 Del. Laws, c. 380, § 1.)

§ 2920. Incontestability; annuities.

If any statements, other than those relating to age, sex and identity are required as a condition to issuing an annuity or pure endowment contract, other than a reversionary, survivorship or group annuity, and subject to § 2922 of this title, there shall be a provision that the contract shall be incontestable after it has been in force during the lifetime of the person or of each of the persons as to whom such statements are required, for a period of 2 years from its date of issue, except for nonpayment of stipulated payments to the insurer; and at the option of the insurer such contract may also except any provisions relative to benefits in the event of disability and any provisions which grant insurance specifically against death by accident or accidental means.

(18 Del. C. 1953, § 2920; 56 Del. Laws, c. 380, § 1.)

§ 2921. Entire contract; annuities.

In an annuity or pure endowment contract, other than a reversionary, survivorship or group annuity, there shall be a provision that the contract shall constitute the entire contract between the parties or, if a copy of the application is endorsed upon or attached to the contract when issued, a provision that the contract and the application therefor shall constitute the entire contract between the parties.

(18 Del. C. 1953, § 2921; 56 Del. Laws, c. 380, § 1.)

§ 2922. Misstatement of age or sex; annuities.

In an annuity or pure endowment contract, other than a reversionary, survivorship or group annuity, there shall be a provision that if the age or sex of the person or persons upon whose life or lives the contract is made, or of any of them has been misstated, the amount payable or benefits accruing under the contract shall be such as the stipulated payment or payments to the insurer would have purchased according to the correct age or sex and that if the insurer shall make or has made any overpayment or overpayments on account of any such misstatement, the amount thereof with interest at the rate to be specified in the contract but not exceeding 6% per annum, may be charged against the current or next succeeding payment or payments to be made by the insurer under the contract.

(18 Del. C. 1953, § 2922; 56 Del. Laws, c. 380, § 1.)

§ 2923. Dividends; annuities.

If an annuity or pure endowment contract, other than a reversionary, survivorship or group annuity, is participating, there shall be a provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the contract.

(18 Del. C. 1953, § 2923; 56 Del. Laws, c. 380, § 1.)

§ 2924. Reinstatement; annuities.

In an annuity or pure endowment contract, other than a reversionary or group annuity, there shall be a provision that the contract may be reinstated at any time within 1 year from the default in making stipulated payments to the insurer, unless the cash surrender value has been paid, but all overdue stipulated payments and any indebtedness to the insurer on the contract shall be paid or reinstated with interest thereon at a rate to be specified in the contract, but not exceeding 6% per annum payable annually, and, in cases where applicable, the insurer may also include a requirement of evidence of insurability satisfactory to the insurer.

(18 Del. C. 1953, § 2924; 56 Del. Laws, c. 380, § 1.)

§ 2925. Standard provisions; reversionary annuities.

(a) Except as stated herein, no contract for a reversionary annuity shall be delivered or issued for delivery in this State unless it contains in substance each of the following provisions:

(1) Any such reversionary annuity contract shall contain the provisions specified in §§ 2919-2923 of this title except that under § 2919 the insurer may at its option provide for an equitable reduction of the amount of the annuity payments in settlement of an overdue payment in lieu of providing for deduction of such payments from an amount payable upon settlement under the contract;

(2) In such reversionary annuity contracts there shall be a provision that the contract may be reinstated at any time within 3 years from the date of default in making stipulated payments to the insurer, upon production of evidence of insurability satisfactory to the insurer, and upon condition that all overdue payments and any indebtedness to the insurer on account of the contract be paid, or, within the limits permitted by the then cash values of the contract, reinstated, with interest as to both payments and indebtedness at a rate to be specified in the contract but not exceeding 6% per annum compounded annually.

(b) This section shall not apply to group annuities or to annuities included in life insurance policies and any of such provisions not applicable to single premium annuities shall not to that extent be incorporated therein.

(18 Del. C. 1953, § 2925; 56 Del. Laws, c. 380, § 1.)

§ 2926. Limitation of liability.

(a) No policy of life insurance shall be delivered or issued for delivery in this State if it contains any of the following provisions:

(1) A provision limiting the time within which an action at law or in equity may be commenced on such a policy to less than 3 years after the cause of action has accrued;

(2) A provision which excludes or restricts liability for death caused in a certain specified manner or occurring while the insured has a specified status, except that a policy may contain provisions excluding or restricting coverage as specified therein in the event of death under any one or more of the following circumstances:

a. Death as a result, directly or indirectly, of war, declared or undeclared, or of action by military forces, or of any act or hazard of such war or action, or of service in the military, naval or air forces or in civilian forces auxiliary thereto, or from any cause while a member of such military, naval or air forces of any country at war, declared or undeclared, or of any country engaged in such military action;

b. Death as a result of aviation or any air travel or flight;

c. Death as a result of a specified hazardous occupation or occupations or avocation;

d. Death while the insured is a resident outside continental United States and Canada; or

e. Death within 2 years from the date of issue of the policy as a result of suicide, while sane or insane.

(b) A policy which contains any exclusion or restriction pursuant to paragraph (a)(2) of this section shall also provide that in the event of death under the circumstances to which any such exclusion or restriction is applicable, the insurer will pay an amount not less than a reserve determined according to the Commissioner's reserve valuation method upon the basis of the mortality table and interest rate specified in the policy for the calculation of nonforfeiture benefits (or if the policy provides for no such benefits, computed according to a mortality table and interest rate determined by the insurer and specified in the policy) with adjustment for indebtedness or dividend credit.

(c) This section shall not apply to group life insurance, health insurance, reinsurance or annuities or to any provision in a life insurance policy or contract supplemental thereto relating to disability benefits or to additional benefits in the event of death by accident or accidental means.

(d) Nothing contained in this section shall prohibit any provision which in the opinion of the Commissioner is more favorable to the policyholder than a provision permitted by this section.

(18 Del. C. 1953, § 2926; 56 Del. Laws, c. 380, § 1.)

§ 2927. Prohibited provisions.

(a) No life insurance policy, other than industrial life insurance, shall be delivered or issued for delivery in this State, if it contains any of the following provisions:

(1) A provision by which the policy purports to be issued or to take effect more than 1 year before the original application for the insurance was made;

(2) A provision for any mode of settlement at maturity of the policy of less value than the amount insured under the policy, plus dividend additions, if any, less any indebtedness to the insurer on or secured by the policy and less any premium that may by the terms of the policy be deducted;

(3) A provision to the effect that the agent soliciting the insurance is the agent of the person insured under the policy or making the acts or representations of such agent binding upon the person so insured under the policy.

(b) No policy of industrial life insurance shall contain any of the following provisions:

(1) A provision by which the insurer may deny liability under the policy for the reason that the insured has previously obtained other insurance from the same insurer;

(2) A provision giving the insurer the right to declare the policy void because the insured has had any disease or ailment, whether specified or not, or because the insured has received institutional, hospital, medical or surgical treatment or attention, except a provision which gives the insurer the right to declare the policy void if the insured has, within 2 years prior to the issuance of the policy, received institutional, hospital, medical or surgical treatment or attention and if the insured or claimant under the policy fails to show that the condition occasioning such treatment or attention was not of a serious nature or was not material to the risk;

(3) A provision giving the insurer the right to declare the policy void because the insured has been rejected for insurance, unless such right be conditioned upon a showing by the insurer that knowledge of such rejection would have led to a refusal by the insurer to make such contract.

(18 Del. C. 1953, § 2927; 56 Del. Laws, c. 380, § 1.)

§ 2928. Provisions required by law of other jurisdiction.

The policies of a foreign life insurer when issued in this State may contain any provision which the law of the state, territory, district or country under which the insurer is organized prescribes shall be in such policies, and the policies of a domestic life insurer may, when issued or delivered in any other state, territory, district or country, contain any provisions required by the laws thereof, anything in this chapter to the contrary notwithstanding.

(18 Del. C. 1953, § 2928; 56 Del. Laws, c. 380, § 1.)

§ 2929. Standard nonforfeiture law — Generally.

(a) In the case of policies issued on and after the operative date of this section as defined in subsection *(l)* of this section, no policy of life insurance, except as stated in subsection (k) of this section, shall be delivered or issued for delivery in this State unless it shall contain in substance the following provisions, or corresponding provisions which in the opinion of the Commissioner are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements hereinafter specified and are essentially in compliance with subsection (j) of this section:

(1) That, in the event of default in any premium payment, the insurer will grant, upon proper request not later than 60 days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of such amount as may be hereinafter specified. In lieu of such stipulated paid-up nonforfeiture benefit, the insurer may substitute, upon proper request not later than 60 days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.

(2) That, upon surrender of the policy within 60 days after the due date of any premium payment in default after premiums have been paid for at least 3 full years in the case of ordinary insurance or 5 full years in the case of industrial insurance, the insurer will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as may be hereinafter specified.

(3) That a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than 60 days after the due date of the premium in default.

(4) That if the policy shall have become paid up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance or the fifth policy anniversary in the case of industrial insurance, the insurer will pay, upon surrender of the policy within 30 days after any policy anniversary, a cash surrender value of such amount as may be hereinafter specified.

(5) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. In the case of all other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefits, if any, available under the policy on each policy anniversary either during the first 20 policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the insurer on the policy.

(6) A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of the state in which the policy is delivered; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the insurer on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy.

Any of the foregoing provisions or portions thereof not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

The insurer shall reserve the right to defer the payment of any cash surrender value for a period of 6 months after demand therefor with surrender of the policy.

(b) Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, whether or not required by subsection (a) of this section, shall be an amount not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of:

(1) The then present value of the adjusted premiums as defined in subsections (d), (e), (f) and (g) of this section, corresponding to premiums which would have fallen due on and after such anniversary; and

(2) The amount of any indebtedness to the insurer on the policy.

Provided, however, that for any policy issued on or after the operative date of subsection (g) of this section as defined therein, which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in the first paragraph of this subsection shall be an amount not less than the sum of the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and the cash surrender value as defined in such paragraph for a policy which provides only the benefits otherwise provided by such rider or supplemental policy provision.

Provided, further, that for any family policy issued on or after the operative date of subsection (g) of this section as defined therein, which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age 71, the cash surrender value referred to in the first paragraph of this subsection shall be an amount not less than the sum of the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value as defined in such paragraph for a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse.

Any cash surrender value available within 30 days after any policy anniversary under any policy paid up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by subsection (a) of this section, shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the insurer on the policy.

(c) Any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of such anniversary shall be at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value which would have been required by this section in the absence of the condition that premiums shall have been paid for at least a specified period.

(d) This subsection shall not apply to policies issued on or after the operative date of subsection (g) of this section as defined therein. Except as provided in the third paragraph of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts stated in the policy as extra premiums to cover impairments or special hazards, that the present value, at the date of issue of the policy, of all such adjusted premiums shall be equal to the sum of (1) the then present value of the future guaranteed benefits provided for by the policy; (2) 2% of the amount of insurance, if the insurance be uniform in amount, or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with duration of the policy; (3) 40% of the adjusted premium for the first policy year; (4) 25% of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less. In applying the percentages specified in (3) and (4) above, no adjusted premium shall be deemed to exceed 4% of the amount of insurance or level amount equivalent thereto. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined.

In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount thereof for the purpose of this subsection shall be deemed to be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy, provided, however, that in the case of a policy providing a varying amount of insurance issued on the life of a child under age 10, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age 10 were the amount provided by such policy at age 10.

The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to (1) the adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by (2) the adjusted premiums for such term insurance, the foregoing items (1) and (2) being calculated separately and as specified in the first 2 paragraphs of this subsection except that, for the purposes of (2), (3) and (4) of the first such paragraph, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in (2) shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in (1).

Except as otherwise provided in subsections (e) and (f) of this section, all adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the basis of the Commissioners 1941 Standard Ordinary Mortality Table, provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than 3 years younger than the actual age of the insured and such calculations for all policies of industrial insurance shall be made on the basis of the 1941 Standard Industrial Mortality Table. All calculations shall be made on the basis of the rate of interest, not exceeding $3^1/_2$% per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture

benefit, the rates of mortality assumed may not be more than 130% of the rates of mortality according to such applicable table. For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the Commissioner.

(e) This subsection shall not apply to ordinary policies issued on or after the operative date of subsection (g) of this section as defined therein. In the case of ordinary policies issued on or after the operative date of this subsection as defined herein, all adjusted premiums and present values referred to in this section shall be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits provided that such rate of interest shall not exceed $3^1/_2$% per annum except that a rate of interest not exceeding 4% per annum may be used for policies issued on or after June 21, 1973, and prior to July 8, 1980, and a rate of interest not exceeding $5^1/_2$% per annum may be used for policies issued on or after July 8, 1980, and provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than 6 years younger than the actual age of the insured. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1958 Extended Term Insurance Table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the Commissioner.

After May 21, 1959, any insurer may file with the Commissioner a written notice of its election to comply with the provisions of this subsection after a specified date before January 1, 1966. After the filing of such notice, then upon such specified date (which shall be the operative date of this subsection for such insurer), this subsection shall become operative with respect to the ordinary policies thereafter issued by such insurer. If an insurer makes no such election, the operative date of this subsection for such insurer shall be January 1, 1966.

(f) This subsection shall not apply to industrial policies issued on or after the operative date of subsection (g) of this section as defined therein. In the case of industrial policies issued on or after the operative date of this subsection, as defined herein, all adjusted premiums and present values referred to in this section shall be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits provided that such rate of interest shall not exceed $3^1/_2$% per annum, except that a rate of interest not exceeding 4% per annum may be used for policies issued on or after June 21, 1973, and prior to July 8, 1980, and a rate of interest not exceeding $5^1/_2$% per annum may be used for policies issued on or after July 8, 1980, except that for any single premium whole life or endowment insurance policy a rate of interest not exceeding $6^1/_2$% per annum may be used. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table. Provided, further, that for insurance issued on a substandard basis, the calculations of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the Commissioner.

After July 7, 1964, any insurer may file with the Commissioner, a written notice of its election to comply with the provisions of this subsection after a specified date before January 1, 1968. After the filing of such notice, then upon such date (which shall be the operative date of this subsection for such insurer), this subsection shall become operative with respect to the industrial policies thereafter issued by such insurer. If an insurer makes no such election, the operative date of this subsection for such insurer shall be January 1, 1968.

(g) (1) This subsection shall apply to all policies issued on or after the operative date of this subsection as defined herein. Except as provided in paragraph (g)(7) of this section, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of:

a. The then present value of the future guaranteed benefits provided for by the policy;

b. 1% of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years; and

c. 125% of the nonforfeiture net level premium as hereinafter defined.

Provided, however, that in applying the percentage specified in paragraph (g)(1)c. of this section above no nonforfeiture net level premium shall be deemed to exceed 4% of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined.

(2) The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of 1 per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium falls due.

(3) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values

shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(4) Except as otherwise provided in paragraph (g)(7) of this section, the recalculated future adjusted premiums for any such policy shall be such uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums shall be equal to the excess of (A) the sum of (i) the then present value of the then future guaranteed benefits provided for by the policy and (ii) the additional expense allowance, if any, over (B) the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(5) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of:

a. 1% of the excess, if positive, of the average amount of insurance at the beginning of each of the first 10 policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first 10 policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and

b. 125% of the increase, if positive, in the nonforfeiture net level premium.

(6) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing (A) by (B) where (A) equals the sum of (i) the nonforfeiture net level premium applicable prior to the change times the present value of an annuity of 1 per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred, and (ii) the present value of the increase in future guaranteed benefits provided for by the policy, and (B) equals the present value of an annuity of 1 per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

(7) Notwithstanding any other provisions of this subsection to the contrary, in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, such policy has the same tabular mortality costs as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis.

(8) All adjusted premiums and present values referred to in this section shall for all policies or ordinary insurance be calculated on the basis of (i) the Commissioners 1980 Standard Ordinary Mortality table or (ii) at the election of the insurer for any 1 or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with 10-Year Select Mortality Factors; shall for all policies of industrial insurance be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table; and shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this subsection, for policies issued in that calendar year. Provided, however, that:

a. At the option of the insurer, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this subsection, for policies issued in the immediately preceding calendar year.

b. Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by subsection (a) of this section, shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any.

c. An insurer may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

d. In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioners 1961 Industrial Extended Term Insurance Table for policies of industrial insurance.

e. For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables.

f. For policies issued prior to the operative date of the valuation manual, any Commissioners standard ordinary mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the Commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without 10-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table. For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the Commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without 10-year Select Mortality Factors or for the Commissioners 1980 Extended

Term Insurance Table. If the Commissioner approves by regulation any Commissioners standard ordinary mortality table adopted by the NAIC for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

g. For policies issued prior to the operative date of the valuation manual, any Commissioners standard industrial mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the Commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table. For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the Commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table. If the Commissioner approves by regulation any Commissioners standard industrial mortality table adopted by the NAIC for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(9) For policies issued prior to the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to 125% of the calendar year statutory valuation interest rate for such policy as defined in the standard valuation law, rounded to the nearer $^{1}/_{4}$ of 1%; provided, however, that the nonforfeiture interest rate shall not be less than 4%. For policies issued on or after the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be provided by the valuation manual.

(10) Notwithstanding any other provision in this Code to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

(11) After June 21, 1983, any insurer may file with the Commissioner a written notice of its election to comply with this subsection after a specified date before January 1, 1989, which shall be the operative date of this subsection for such insurer. If an insurer makes no such election, the operative date of this subsection for such insurer shall be January 1, 1989.

(h) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or in the case of any plan of life insurance which is of such a nature that minimum values cannot be determined by the methods described in subsection (a), (b), (c), (d), (e), (f) or (g) herein, then:

(1) The Commissioner must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by subsection (a), (b), (c), (d), (f) or (g) herein;

(2) The Commissioner must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds;

(3) The cash surrender values and paid-up nonforfeiture benefits provided by such plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this standard nonforfeiture law for life insurance, as determined by regulations promulgated by the Commissioner.

(i) Any cash surrender value and any paid-up nonforfeiture benefit, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in subsections (b), (c), (d), (e), (f) and (g) of this section may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall be not less than the amounts used to provide such additions. Notwithstanding subsection (b) of this section, additional benefits payable:

(1) In the event of death or dismemberment by accident or accidental means;

(2) In the event of total and permanent disability;

(3) As reversionary annuity or deferred reversionary annuity benefits;

(4) As term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this section would not apply;

(5) As term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is 26, is uniform in amount after the child's age is 1, and has not become paid up by reason of the death of a parent of the child;

(6) As other policy benefits additional to life insurance and endowment benefits, and premiums for all such additional benefits,

shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this section, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

(j) This subsection, in addition to all other applicable subsections of this law, shall apply to all policies issued on or after January 1, 1987. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be in an amount which does not differ by more than $^{2}/_{10}$ of 1% of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years, from the sum of:

(1) The greater of zero and the basic cash value hereinafter specified; and

(2) The present value of any existing paid up additions less the amount of any indebtedness to the insurer under the policy.

The basic cash value shall be equal to the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the insurer, if there had been no default, less the then present value of the nonforfeiture factors, as hereinafter defined, corresponding to premiums which would have fallen due on and after such anniversary. Provided, however, that the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in subsection (b) or (d) of this section, whichever is applicable, shall be the same as are the effects specified in subsection (b) or (d) of this section, whichever is applicable, on the cash surrender values defined in that subsection.

The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in subsection (d) or (g) of this section, whichever is applicable. Except as is required by the next succeeding sentence of this paragraph, such percentage:

(1) Must be the same percentage for each policy year between the second policy anniversary and the later of (i) the fifth policy anniversary and (ii) the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least $^{2}/_{10}$ of 1% of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years; and

(2) Must be such that no percentage after the later of the 2 policy anniversaries specified in the preceding item may apply to fewer than 5 consecutive policy years.

Provided, that no basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in subsection (d) or (g) of this section, whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

All adjusted premiums and present values referred to in this subsection shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other subsections of this section. The cash surrender values referred to in this subsection shall include any endowment benefits provided for by the policy.

Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment shall be determined in manners consistent with the manners specified for determining the analogous minimum amounts in subsections (a), (b), (c), (g) and (i) of this section. The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed as paragraphs (i)(1)-(6) of this section shall conform with the principles of this subsection.

(k) This section shall not apply to any of the following:

(1) Reinsurance;

(2) Group insurance;

(3) Pure endowment;

(4) Annuity or reversionary annuity contract;

(5) Term policy of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy;

(6) Term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in subsections (d), (e), (f) and (g) of this section, is less than the adjusted premium so calculated, on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy;

(7) Policy, which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in subsections (b), (c), (d), (e), (f) and (g) of this section, exceeds $2^{1}/_{2}$% of the amount of insurance at the beginning of the same policy year; nor

(8) Policy which shall be delivered outside this State through an agent or other representative of the insurer issuing the policy.

For purposes of determining the applicability of this section, the age at expiry for a joint term life insurance policy shall be the age at expiry of the oldest life.

(*l*) After March 30, 1943, any insurer may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1948. After the filing of such notice, upon such specified date (which shall be the operative date of this section for such insurer), this section shall become operative with respect to the policies thereafter issued by such insurer. If an insurer makes no such election the operative date of this section for such insurer shall be January 1, 1948.

(m) For purposes of this section, the term "operative date of the valuation manual" means January 1 of the first calendar year that the valuation manual as defined in § 1111(b)(11) of this title is effective.

(18 Del. C. 1953, § 2929; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 92, §§ 5, 6; 62 Del. Laws, c. 348, §§ 14, 15; 64 Del. Laws, c. 55, §§ 13-22; 70 Del. Laws, c. 186, § 1; 80 Del. Laws, c. 117, §§ 3-7.)

§ 2929A. Standard nonforfeiture law; individual deferred annuities [For application of this section, see 83 Del. Laws, c. 105, § 2].

(a) This section shall be known as the standard nonforfeiture law for individual deferred annuities.

(b) This section shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under § 408 of the Internal Revenue Code [26 U.S.C. § 408], as now or hereafter amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which shall be delivered outside this State through an agent or other representative of the company issuing the contract.

(c) In the case of contracts issued on or after the operative date of this chapter as defined in subsection (d) of this section, no contract of annuity, except as stated in subsection (b) of this section, shall be delivered or issued for delivery in this State unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the Commissioner are at least as favorable to the contractholder, upon cessation of payment of considerations under the contract:

(1) That upon cessation of payment of considerations under a contract, upon the written request of the contract owner the company shall grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in subsections (e), (f), (g), (h) and (j) of this section;

(2) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company shall pay in lieu of any paid-up annuity benefit a cash surrender benefit not to exceed such amount as is specified in subsections (e), (f), (h) and (j) of this section. The company may reserve the right to defer the payment of such cash surrender benefit for a period of 6 months after demand therefor with surrender of the contract, after making written request and receiving written approval of the commissioner. The request must address the necessity and equitability of the deferral to all policyholders;

(3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of such benefits;

(4) A statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the State in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract.

Notwithstanding the requirements of this subsection, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of 2 full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid prior to such period would be less than $20 monthly, the company may at its option terminate such contract by payment in cash of the then present value of such portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by such payment shall be relieved of any further obligation under such contract.

(d) The minimum values as specified in subsections (e), (f), (g), (h) and (j) of this section of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this subsection:

(1) With respect to contracts providing for flexible considerations, the minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at a rate of interest of 3% per annum of percentages of the net considerations (as hereinafter defined) paid prior to such time, decreased by the sum of:

a. Any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest of 3% per annum; and

b. The amount of any indebtedness to the company on the contract, including interest due and accrued; and increased by any existing additional amounts credited by the company to the contract.

The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount not less than $0.00 and shall be equal to the corresponding gross considerations credited to the contract during that contract year less an annual contract charge of $30 and less a collection charge of $1.25 per consideration credited to the contract during that contract year. The percentages of net considerations shall be 65% of the net consideration for the first contract year and $87^1/_2$% of the net considerations for the second and later contract years. Notwithstanding the preceding sentence, the percentage shall be 65% of the portion of the total net consideration for any renewal contract year which exceeds by not more than 2 times the sum of those portions of the net considerations in all prior contract years for which the percentage was 65%. Notwithstanding any other provision of this section, the minimum interest rate at which net considerations, prior withdrawals and partial surrenders shall be accumulated, for the purpose of determining nonforfeiture amounts, shall be 1.5% per annum.

(2) With respect to contracts providing for fixed scheduled considerations, minimum nonforfeiture amounts shall be calculated on the assumption that considerations are paid annually in advance and shall be defined as for contracts with flexible considerations which are paid annually with 2 exceptions:

a. The portion of the net consideration for the first contract year to be accumulated shall be the sum of 65% of the net consideration for the first contract year plus $22^{1}/_{2}$% of the excess of the net consideration for the first contract year over the lesser of the net considerations for the second and third contract years.

b. The annual contract charge shall be the lesser of:

1. Thirty dollars; or

2. Ten percent of the gross annual consideration.

(3) With respect to contracts providing for a single consideration, minimum nonforfeiture amounts shall be defined as for contracts with flexible considerations except that the percentage of net consideration used to determine the minimum nonforfeiture amount shall be equal to 90 percent and the net consideration shall be the gross consideration less a contract charge of $75.

(4) Prior to July 1, 2006, a company may elect to comply with the provisions of either paragraph (d)(1)-(3) or (d)(5) of this section. On and after July 1, 2006, all companies shall comply with the provisions of paragraph (d)(5) of this section.

(5) The minimum values as specified in paragraphs (e), (f), (g), (h) and (j) of this section of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this paragraph.

a. 1 The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments is equal to an accumulation up to such time, at rates of interest as indicated in paragraph (d)(5)b. of this section of the net considerations, as defined in paragraph (d)(5)a.2. of this section, paid prior to such time, decreased by the sum of paragraphs (d)(5)a.1.A. through (d)(5)a.1.D. of this section as follows:

A. Any prior withdrawals from or partial surrenders of the contract, accumulated at rates of interest as indicated in paragraph (d)(5)b. of this section;

B. An annual contract charge of $50, accumulated at rates of interest as indicated in paragraph (d)(5)b. of this section;

C. Any premium tax paid by the company for the contract, accumulated at rates of interest as indicated in paragraph (d)(5)b. of this section; and

D. The amount of any indebtedness to the company on the contract, including interest due and accrued.

2. The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to 87.5% of the gross considerations credited to the contract during that contract year.

b. 1. The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of 3% per annum and paragraphs (d)(5)b.1.A. through C. of this section as follows, which must be specified in the contract if the interest rate will be reset:

A. The 5-year Constant Maturity Treasury Rate reported by the Federal Reserve as of a date, or as an average over a period, rounded to the nearest $^{1}/_{20}$th of 1%, specified in the contract no longer than 15 months prior to the contract issue date or redetermination date under paragraph (d)(5)b.2. of this section;

B. Reduced by 125 basis points;

C. Where the resulting interest rate is not less than 0.15%.

2. The above interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis, and period, if any, shall be stated in the contract. The basis is the rate on a date or the rate averaged over a specified period that produces the value of the 5-year Constant Maturity Treasury Rate to be used at each redetermination date.

c. During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in paragraph (d)(5)b.1.B. of this section by up to an additional 100 basis points to reflect the value of the equity indexed benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction may not exceed the market value of the benefit. The Commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. Lacking such a demonstration that is acceptable to the Commissioner, the Commissioner may disallow or limit the additional reduction.

d. The Commissioner may adopt rules to implement paragraph (d)(5)c. of this section and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity indexed benefit and for other contracts that the Commissioner determines adjustments are justified.

(e) Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Such present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

(f) For contracts which provide cash surrender benefits, such cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than 1% higher than the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased

by any existing additional amounts credited by the company to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

(g) For contracts which do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, and increased by any existing additional amounts credited by the company to the contract. For contracts which do not provide any death benefits prior to the commencement of any annuity payments, such present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

(h) For the purpose of determining the benefits calculated under subsections (f) and (g) of this section, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

(i) Any contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

(j) Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

(k) For any contract which provides, within the same contract by rider or supplemental contract provisions, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding subsections (e), (f), (g), (h) and (j) of this section, additional benefits payable (i) in the event of total and permanent disability, (ii) as reversionary annuity or deferred reversionary annuity benefits, or (iii) as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this section. The inclusion of such additional benefits shall not be required in any paid-up benefits, unless such additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

(l) After the effective date of this section, any company may file with the Commissioner a written notice of its election to comply with this section after a specified date before July 8, 1982. After the filing of such notice, then upon such specified date, which shall be the operative date of this section for such company, this section shall become operative with respect to annuity contracts thereafter issued by such company. If a company makes no such election, the operative date of this section for such company shall be the second anniversary of the effective date of this section.

(62 Del. Laws, c. 348, § 17; 73 Del. Laws, c. 410, § 1; 74 Del. Laws, c. 292, §§ 1-6; 83 Del. Laws, c. 105, § 1.)

§ 2930. Incontestability; limitation of liability after reinstatement.

(a) A reinstated policy of life insurance or annuity contract may be contested on account of fraud or misrepresentation of facts material to the reinstatement only for the same period following reinstatement and with the same conditions and exceptions as the policy provides with respect to contestability after original issuance.

(b) When any life insurance policy or annuity contract is reinstated, such reinstated policy or contract may exclude or restrict liability to the same extent that such liability could have been or was excluded or restricted when the policy or contract was originally issued and such exclusion or restriction shall be effective from the date of reinstatement.

(18 Del. C. 1953, § 2931; 56 Del. Laws, c. 380, § 1.)

§ 2931. Participating, nonparticipating policies; right to issue.

A life insurer may issue policies on either the participating basis or the nonparticipating basis, or on both bases, if the right or absence of right of participation is reasonably related to the premium charged and the insurer is otherwise not in violation of Chapter 23 of this title.

(18 Del. C. 1953, § 2932; 56 Del. Laws, c. 380, § 1.)

§ 2932. Variable annuity contracts and life insurance policies; grace, reinstatement, nonforfeiture and reserve liability provisions.

(a) A domestic life insurer, including for the purposes of this section all domestic fraternal beneficiary associations, societies or companies which operate on a legal reserve basis, may establish 1 or more separate accounts, and may allocate thereto amounts (including

without limitation proceeds applied under optional modes of settlement or under dividend options) to provide for life insurance or annuities (and benefits incidental thereto), payable in fixed or variable amounts or both, subject to the following:

(1) The income, gains and losses, realized or unrealized, from assets allocated to a separate account shall be credited to or charged against the account, without regard to other income, gains or losses of the insurer.

(2) Except as may be provided with respect to reserves for guaranteed benefits and funds referred to in paragraph (a)(3) of this section,

a. Amounts allocated to any separate account and accumulations thereon may be invested and reinvested without regard to any requirements or limitations prescribed by this title governing the investments of life insurers; and

b. The investments in such separate account or accounts shall not be taken into account in applying the investment limitations otherwise applicable to the investments of the insurer.

(3) Except with the approval of the Commissioner and under such conditions as to investments and other matters as he or she may prescribe, which shall recognize the guaranteed nature of the benefits provided, reserves for:

a. Benefits guaranteed as to dollar amount and duration; and

b. Funds guaranteed as to principal amount or stated rate of interest shall not be maintained in a separate account.

(4) Unless otherwise approved by the Commissioner, assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to such separate account, provided, that unless otherwise approved by the Commissioner, the portion, if any, of the assets of such separate account equal to the insurer's reserve liability with regard to the guaranteed benefits and funds referred to in paragraph (a)(3) of this section shall be valued in accordance with the rules otherwise applicable to the insurer's assets.

(5) Amounts allocated to a separate account in the exercise of the power granted by this section shall be owned by the insurer and the insurer shall not be, nor hold itself out to be, a trustee with respect to such amounts. If and to the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the insurer may conduct.

(6) No sale, exchange or other transfer of assets may be made by an insurer between any of its separate accounts or between any other investment account and 1 or more of its separate accounts unless, in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless such transfer, whether into or from a separate account, is made:

a. By a transfer of cash; or

b. By a transfer of securities having a readily determinable market value, provided that such transfer of securities is approved by the Commissioner.

The Commissioner may approve other transfers among such accounts if, in his or her opinion, such transfers would not be inequitable.

(7) To the extent such insurer deems it necessary to comply with any applicable federal or state laws, such insurer, with respect to any separate account, including without limitation any separate account which is a management investment company or a unit investment trust, may provide for persons having an interest therein appropriate voting and other rights and special procedures for the conduct of the business of such account, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants and the selection of a committee, the members of which need not be otherwise affiliated with such insurer, to manage the business of such account.

(b) Any contract providing benefits payable in variable amounts delivered or issued for delivery in this State shall contain a statement of the essential features of the procedures to be followed by the insurer in determining the dollar amount of such variable benefits. Any such contract under which the benefits vary to reflect investment experience, including a group contract and any certificate in evidence of variable benefits issued thereunder shall state that such dollar amount will so vary and shall contain on its first page a statement to the effect that the benefits thereunder are on a variable basis.

(c) No insurer shall deliver or issue for delivery within this State variable contracts unless it is licensed or organized to do a life insurance or annuity business in this State and the Commissioner is satisfied that its condition or method of operation in connection with the issuance of such contracts will not render its operation hazardous to the public or its policyholders in this State. In this connection, the Commissioner shall consider among other things:

(1) The history and financial condition of the insurer;

(2) The character, responsibility and fitness of the officers and directors of the insurer; and

(3) The law and regulation under which the insurer is authorized in the state of domicile to issue variable contracts. If the insurer is a subsidiary of an admitted life insurer or affiliated with such insurer through common management or ownership, it may be deemed by the Commissioner to have met the provisions of this subsection if either it or the parent or the affiliated insurer meets the requirements hereof.

(d) Notwithstanding any other provision of law, the Commissioner shall have sole authority to regulate the issuance and sale of variable contracts, and to issue such reasonable rules and regulations as may be appropriate to carry out the purposes and provisions of this section.

(e) Except for §§ 2919, 2924, 2925 and 2929A of this title, in the case of a variable annuity contract, and §§ 2906, 2911, 2912, 2913, 2929 and 3113 of this title, in the case of a variable life insurance policy, and except as otherwise provided in this section, all pertinent

provisions of this title shall apply to separate accounts and contracts relating thereto. Any individual variable life insurance contract delivered or issued for delivery in this State shall contain grace, reinstatement and nonforfeiture provisions appropriate to such a contract. Any individual variable annuity contract delivered or issued for delivery in this State shall contain grace and reinstatement provisions appropriate to such a contract. Any group variable life insurance contract delivered or issued for delivery in this State shall contain a grace provision appropriate to such a contract. The reserve liability for variable contracts shall be established in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

(18 Del. C. 1953, § 2933; 56 Del. Laws, c. 380, § 1; 57 Del. Laws, c. 219; 58 Del. Laws, c. 123, § 2; 62 Del. Laws, c. 348, § 16; 70 Del. Laws, c. 186, § 1.)

§ 2933. Prohibited policy plans.

(a) No life insurer shall hereafter deliver or issue for delivery in this State:

(1) As part of or in combination with any life insurance, endowment or annuity contract, any agreement or plan, additional to the rights, dividends and benefits arising out of any such contract which provides for the accumulation of profits over a period of years and for payment of all or any part of such accumulated profits only to members or policyholders of a designated group or class who continue as members or policyholders until the end of a specified or ascertainable period of years;

(2) Any "registered" policy, that is, any policy (other than one "registered" as a security under applicable state or federal law) purporting to be "registered" or otherwise specially recorded, with any agency of the State, or of any other state, or with any bank, trust company, escrow company or other institution other than the insurer, or purporting that any reserves, assets or deposits are held, or will be so held, for the special benefit or protection of the holder of such policy, by or through any such agency or institution;

(3) Any policy or contract under which any part of the premium or of funds or values arising from the policy or contract or from investment of reserves, or from mortality savings, lapses or surrenders, in excess of the normal reserves or amounts required to pay death, endowment and nonforfeiture benefits in respective amounts as specified in or pursuant to the policy or contract, are on a basis not involving insurance or life contingency features, (i) to be placed in special funds or segregated accounts or specially designated places or, (ii) to be invested in specially designated investments or types thereof, and the funds or earnings thereon be divided among the holders of such policies or contracts, or their beneficiaries or assignees. This provision does not apply as to any contract authorized under § 2932 of this title;

(4) Any policy providing for the segregation of policyholders into mathematical groups and providing benefits for a surviving policyholder arising out of the death of another policyholder of such group, or under any other similar plan;

(5) Any policy providing benefits or values for surviving or continuing policyholders contingent upon the lapse or termination of the policies of other policyholders, whether by death or otherwise;

(6) Any policy containing or referring to 1 or more of the following provisions or statements:

a. Investment returns or profit-sharing, other than as a participation in the divisible surplus of the insurer under a regular participation provision as provided for in § 2910 of this title;

b. Special treatment in the determination of any dividend that may be paid as to such policy;

c. Reference to premiums as "deposits;"

d. Relating policyholder interest or returns to those of stockholders;

e. That the policyholder as a member of a select group will be entitled to extra benefits or extra dividends not available to policyholders generally.

(b) This section shall not be deemed to prohibit the provision, payment, allowance or apportionment of regular annual dividends or "savings" under regular participating forms of policies or contracts.

(18 Del. C. 1953, § 2934; 56 Del. Laws, c. 380, § 1.)

§ 2934. Registered policies, bonds; deposit.

Any domestic life insurer shall deposit with the Commissioner securities of the kind required and authorized by law for the investment of life insurance funds, for the common benefit of the holders of its "registered" policies and bonds heretofore issued, which deposit shall be held by him or her and his or her successors in office, in trust for the purposes and objects specified therein.

(18 Del. C. 1953, § 2935; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2935. Registered policies, bonds — Identification.

All such registered policies or bonds of each kind and class issued shall have imprinted thereon some appropriate designating letter, combination of letters or terms identifying the special forms of contract, and whenever any change or modification is made in the forms of contracts, policy or bond, the designating letters or terms thereon shall be correspondingly changed.

(18 Del. C. 1953, § 2936; 56 Del. Laws, c. 380, § 1.)

§ 2936. Registered policies, bonds — Records of Commissioner; valuation.

(a) The Commissioner shall prepare and keep such records of all "registered" policies and bonds as will enable him or her to ascertain the reserve required thereon at any time according to the method and basis of valuation prescribed in §§ 1111-1113 of this title. Upon

sufficient proof, attested by the president or vice-president and secretary of an insurer which has issued such "registered" policies or bonds, that any of them have been commuted or terminated, the Commissioner shall commute or cancel them upon his or her records.

(b) On December 31 in every year, or within 60 days thereafter, the Commissioner shall cause the registered policies and bonds in force in each insurer to be carefully valued and the net reserve thereon ascertained according to the method and basis of valuation prescribed in §§ 1111-1113 of this title, and he or she shall thereupon furnish a certificate of the aggregate amount of such reserve to the respective insurers. The Commissioner may employ a competent actuary to make such computation, who shall be paid by the insurer for which the services are rendered, or the Commissioner may accept the computations of any of the insurers upon such proof as he or she may determine.

(18 Del. C. 1953, § 2937; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2937. Registered policies, bonds — Additional deposits.

Each insurer which shall have registered policies or bonds outstanding shall make additional deposits from time to time, as the Commissioner may prescribe, in amounts of not less than $5,000, and of such securities as domestic life insurers are authorized by law to invest in, so that the market or amortized value of the securities on deposit shall always at least equal the net reserve required by the method and basis of valuation prescribed in §§ 1111-1113 of this title, on all the registered policies and bonds in force in the insurer.

(18 Del. C. 1953, § 2938; 56 Del. Laws, c. 380, § 1.)

§ 2938. Registered policies, bonds — Deficient deposit.

The Commissioner shall keep a careful record of the securities deposited by each insurer, and when furnishing the annual certificates of value, he or she shall enter thereon the amount and value of the securities deposited by such insurer. If at any time it appears from such certificates or otherwise that the value of securities held on deposit is less than the reserve required by the method and basis of valuation prescribed in §§ 1111-1113 of this title on all the registered policies and bonds in force in such insurer, the insurer shall have made good the deficit. If the insurer fails to make good such deficit for 60 days it shall be deemed insolvent and shall be proceeded against in the manner provided by Chapter 59 (Rehabilitation and Liquidation) of this title.

(18 Del. C. 1953, § 2939; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 2939. Registered policies, bonds — Effect of insolvency.

In case an insurer having securities on deposit as to such registered policies or bonds shall be adjudged insolvent or be dissolved, the proper court shall make and enforce the necessary orders to place said securities, or any part of them, at the sole disposal of the Commissioner.

(18 Del. C. 1953, § 2940; 56 Del. Laws, c. 380, § 1.)

§ 2940. Registered policies, bonds — Applicability of general deposit provisions.

The applicable provisions of Chapter 15 (Administration of Deposits) of this title shall apply as to all deposits relating to such registered policies and bonds, where not inconsistent with the express provisions of §§ 2934-2939 of this title.

(18 Del. C. 1953, § 2941; 56 Del. Laws, c. 380, § 1.)

§ 2941. Notification and reasons for cancellation [For application of this section, see 79 Del. Laws, c. 390, § 8].

A notice of cancellation of life insurance coverage by an insurer due to nonpayment of premiums shall be in writing, shall be delivered to the named policyholder or mailed to the named policyholder at the last known address of the named policyholder, shall state the effective date of the cancellation and shall be accompanied by a written explanation of the specific reasons for the cancellation. Proof of mailing of such cancellation notice shall be retained by the insurer for a period of not less than 1 year.

(79 Del. Laws, c. 390, § 1.)

Part I
Insurance
Chapter 30
Interstate Insurance Product Regulation Compact

(83 Del. Laws, c. 103, § 1.)

§ 3001. Interstate Insurance Product Regulation Compact.

The State hereby enters into the Interstate Insurance Product Regulation Compact ("Compact") as set forth in this chapter. The text of the Compact is as set forth in this chapter.

(83 Del. Laws, c. 103, § 1.)

§ 3002. Purpose and intent.

The purposes of this Compact are, through means of joint and cooperative action among the compacting states, all of the following:

(1) To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income, and long-term care insurance products.

(2) To develop uniform standards for insurance products covered under the Compact.

(3) To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the Compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in 1 or more compacting states.

(4) To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard.

(5) To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the Compact.

(6) To create the Interstate Insurance Product Regulation Commission.

(7) To perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

(83 Del. Laws, c. 103, § 1.)

§ 3003. Definitions.

For purposes of this Compact, the following terms shall have these meanings:

(1) "Advertisement" means any material designed to create public interest in a product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace, or retain a policy, as more specifically defined in the rules and operating procedures of the Commission.

(2) "Bylaws" mean those bylaws established by the Commission for its governance, or for directing or controlling the Commission's actions or conduct.

(3) "Compacting state" means any state which has enacted this Compact legislation and which has not withdrawn pursuant to § 3015(a) of this title, or been terminated pursuant to § 3015(b) of this title.

(4) "Commission" means the "Interstate Insurance Product Regulation Commission" established by this Compact.

(5) "Commissioner" means the chief insurance regulatory official of a State, including commissioner, superintendent, director, or administrator.

(6) "Domiciliary state" means the state in which an insurer is incorporated or organized or, in the case of an alien insurer, its state of entry.

(7) "Insurer" means any entity licensed by a state to issue contracts of insurance for any of the lines of insurance covered by this chapter.

(8) "Member" means the person chosen by a compacting state as its representative to the Commission, or his or her designee.

(9) "NAIC" means the National Association of Insurance Commissioners.

(10) "Non-compacting state" means any state which is not at the time a compacting state.

(11) "Operating procedures" means procedures promulgated by the Commission implementing a rule, uniform standard or a provision of this Compact.

(12) "Product" means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income, or long-term care insurance product that an insurer is authorized to issue.

(13) "Rule" means a statement of general or particular applicability and future effect promulgated by the Commission, including a uniform standard developed pursuant to § 3008 of this title, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the Commission, which shall have the force and effect of law in the compacting states.

(14) "State" means any state, district, or territory of the United States of America.

(15) “Third-party filer” means an entity that submits a product filing to the Commission on behalf of an insurer.

(16) “Uniform standard” means a standard adopted by the Commission for a product line, pursuant to § 3008 of this title, and shall include all of the product requirements in aggregate; provided, that each uniform standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading, or ambiguous provision in a product, and the form of the product made available to the public shall not be unfair, inequitable, or against public policy as determined by the Commission.

(83 Del. Laws, c. 103, § 1.)

§ 3004. Establishment of the Commission and venue.

(a) The compacting states hereby create and establish a joint public agency known as the “Interstate Insurance Product Regulation Commission.” Pursuant to § 3005 of this title, the Commission will have the power to develop uniform standards for product lines, receive and provide prompt review of products filed therewith, and give approval to those product filings satisfying applicable uniform standards; provided, it is not intended for the Commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any insurer from filing its product in any state wherein the insurer is licensed to conduct the business of insurance, and any such filing shall be subject to the laws of the state where filed.

(b) The Commission is a body corporate and politic, and an instrumentality of the compacting states.

(c) The Commission is solely responsible for its liabilities except as otherwise specifically provided in this Compact.

(d) Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located.

(83 Del. Laws, c. 103, § 1.)

§ 3005. Powers of the Commission.

The Commission shall have all of the following powers:

(1) To promulgate rules, pursuant to § 3008 of this title, which shall have the force and effect of law and shall be binding in the compacting states to the extent and in the manner provided in this Compact.

(2) To exercise its rule-making authority and establish reasonable uniform standards for products covered under the Compact, and advertisements related thereto, which shall have the force and effect of law and shall be binding in the compacting states, but only for those products filed with the Commission; provided, that a compacting state shall have the right to opt out of such uniform standard pursuant to § 3008 of this title, to the extent and in the manner provided in this Compact and, provided further, that any uniform standard established by the Commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the NAIC’s Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted in 2001. The Commission shall consider whether any subsequent amendments to the NAIC’s Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the NAIC require amending of the uniform standards established by the Commission for long-term care products.

(3) To receive and review in an expeditious manner products filed with the Commission, and rate filings for disability income and long-term care insurance products, and give approval of those products and rate filings that satisfy the applicable uniform standard, where such approval shall have the force and effect of law and be binding on the compacting states to the extent and in the manner provided in the Compact.

(4) To receive and review in an expeditious manner advertisements related to long-term care insurance products for which uniform standards have been adopted by the Commission, and give approval to all advertisements that satisfy the applicable uniform standard. For any product covered under this Compact, other than long-term care insurance products, the Commission shall have the authority to require an insurer to submit all or any part of its advertisements with respect to that product for review or approval prior to use, if the Commission determines that the nature of the product is such that an advertisement of the product could have the capacity or tendency to mislead the public. The actions of the Commission as provided in this section shall have the force and effect of law and shall be binding in the compacting states to the extent and in the manner provided in the Compact.

(5) To exercise its rule-making authority and designate products and advertisements that may be subject to a self-certification process without the need for prior approval by the Commission.

(6) To promulgate operating procedures, pursuant to § 3008 of this title, which shall be binding in the compacting states to the extent and in the manner provided in this Compact.

(7) To bring and prosecute legal proceedings or actions in its name as the Commission; provided that the standing of any state insurance department to sue or be sued under applicable law shall not be affected.

(8) To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence.

(9) To establish and maintain offices.

(10) To purchase and maintain insurance and bonds.

(11) To borrow, accept, or contract for services of personnel, including employees of a compacting state.

(12) To hire employees, professionals, or specialists, and elect or appoint officers, and to fix their compensation, define their duties, and give them appropriate authority to carry out the purposes of the Compact, and determine their qualifications, and to establish

the Commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation, and qualifications of personnel.

(13) To accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services, and to receive, utilize, and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety.

(14) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use, any property, real, personal, or mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety.

(15) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed.

(16) To remit filing fees to compacting states as may be set forth in the bylaws, rules, or operating procedures.

(17) To enforce compliance by compacting states with rules, uniform standards, operating procedures and bylaws.

(18) To provide for dispute resolution among compacting states.

(19) To advise compacting states on issues relating to insurers domiciled or doing business in non-compacting jurisdictions, consistent with the purposes of this Compact.

(20) To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments.

(21) To establish a budget and make expenditures.

(22) To borrow money.

(23) To appoint committees, including advisory committees comprising members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the bylaws.

(24) To provide and receive information from, and to cooperate with law enforcement agencies.

(25) To adopt and use a corporate seal.

(26) To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of the business of insurance.

(83 Del. Laws, c. 103, § 1.)

§ 3006. Organization of the Commission.

(a) *Membership, voting and bylaws. —*

(1) Each compacting state shall have and be limited to 1 member. Each member shall be qualified to serve in that capacity pursuant to applicable law of the compacting state. Any member may be removed or suspended from office as provided by the law of the state from which he or she shall be appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the compacting state wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a compacting state determines the election or appointment and qualification of its own Commissioner.

(2) Each member shall be entitled to 1 vote and shall have an opportunity to participate in the governance of the Commission in accordance with the bylaws. Notwithstanding any provision herein to the contrary, no action of the Commission with respect to the promulgation of a uniform standard shall be effective unless $^{2}/_{3}$ of the members vote in favor thereof.

(3) The Commission shall, by a majority of the members, prescribe bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the Compact, including all of the following:

a. Establishing the fiscal year of the Compact.

b. Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the management committee.

c. Providing reasonable standards and procedures for all of the following:

1. The establishment and meetings of other committees.

2. The governance of any general or specific delegation of any authority or function of the Commission.

d. Providing reasonable procedures for calling and conducting meetings of the Commission that consist of a majority of Commission members, ensuring reasonable advance notice of each such meeting and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The Commission may meet in camera only after a majority of the entire membership votes en toto or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting, revealing the vote of each member with no proxy votes allowed, and the votes taken during such meeting.

e. Establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the Commission.

f. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any compacting state, the bylaws shall exclusively govern the personnel policies and programs of the Commission.

g. Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees.

h. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment or reserving of all of its debts and obligations.

(4) The Commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the compacting states.

(b) *Management committee, officers and personnel. —*

(1) A management committee comprising no more than 14 members shall be established as follows:

a. One member from each of the 6 compacting states with the largest premium volume for individual and group annuities, life, disability income, and long-term care insurance products, determined from the records of the NAIC for the prior year;

b. Four members from those compacting states with at least 2% of the market based on the premium volume described in paragraph (b)(1)a. of this section, other than the 6 compacting states with the largest premium volume, selected on a rotating basis as provided in the bylaws; and

c. Four members from those compacting states with less than 2% of the market, based on the premium volume described in paragraph (b)(1)a. of this section, with 1 selected from each of the 4 zone regions of the NAIC as provided in the bylaws.

(2) The management committee shall have such authority and duties as may be set forth in the bylaws, including all of the following:

a. Managing the affairs of the Commission in a manner consistent with the bylaws and purposes of the Commission.

b. Establishing and overseeing an organizational structure within, and appropriate procedures for, the Commission to provide for the creation of uniform standards and other rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a compacting state to opt out of a uniform standard; provided that a uniform standard shall not be submitted to the compacting states for adoption unless approved by $^{2}/_{3}$ of the members of the management committee.

c. Overseeing the offices of the Commission.

d. Planning, implementing, and coordinating communications and activities with other state, federal, and local government organizations in order to advance the goals of the Commission.

(3) The Commission shall elect annually officers from the management committee, with each having such authority and duties, as may be specified in the bylaws.

(4) The management committee may, subject to the approval of the Commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the Commission may deem appropriate. The executive director shall serve as secretary to the Commission, but shall not be a member of the Commission. The executive director shall hire and supervise such other staff as may be authorized by the Commission.

(c) *Legislative and advisory committees. —*

(1) A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the Commission, including the management committee; provided that the manner of selection and term of any legislative committee member shall be as set forth in the bylaws. Prior to the adoption by the Commission of any uniform standard, revision to the bylaws, annual budget, or other significant matter as may be provided in the bylaws, the management committee shall consult with and report to the legislative committee.

(2) The Commission shall establish 2 advisory committees, 1 of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.

(3) The Commission may establish additional advisory committees as its bylaws may provide for the carrying out of its functions.

(d) *Corporate records of the Commission. —*

The Commission shall maintain its corporate books and records in accordance with the bylaws.

(e) *Qualified immunity, defense and indemnification. —*

(1) The members, officers, executive director, employees, and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person again whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph (e)(1) shall be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of that person.

(2) The Commission shall defend any member, officer, executive director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; provided, further, that the actual or alleged act, error or omission did not result from that person’s intentional or willful and wanton misconduct.

(3) The Commission shall indemnify and hold harmless any member, officer, executive director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that such person had a reasonable

basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that the actual or alleged act, error or omission did not result from the intentional or willful and wanton misconduct of that person.

(83 Del. Laws, c. 103, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3007. Meetings and acts of the Commission.

(a) The Commission shall meet and take such actions as are consistent with the provision of this Compact and the bylaws.

(b) Each member of the Commission shall have the right and power to cast a vote to which that compacting state is entitled and to participate in the business and affairs of the Commission. A member shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for members' participation in meetings by telephone or other means of communication.

(c) The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

(83 Del. Laws, c. 103, § 1.)

§ 3008. Rules and operating procedures: rulemaking functions of the Commission and opting out of uniform standards.

(a) *Rulemaking authority. —*

The Commission shall promulgate reasonable rules, including uniform standards, and operating procedures in order to effectively and efficiently achieve the purposes of this Compact. Notwithstanding the foregoing, in the event the Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this chapter, or the powers granted hereunder, then such an action by the Commission shall be invalid and have no force and effect.

(b) *Rulemaking procedure. —*

Rules and operating procedures shall be made pursuant to a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981 [15 Uniform Laws Annotated p. 1 et seq.] as amended, as may be appropriate to the operations of the Commission. Before the Commission adopts a uniform standard, the Commission shall give written notice to the relevant state legislative committee(s) in each compacting state responsible for insurance issues of its intention to adopt the uniform standard. The Commission in adopting a uniform standard shall consider fully all submitted materials and issue a concise explanation of its decision.

(c) *Effective date and opt out of a uniform standard. —*

A uniform standard shall become effective 90 days after its promulgation by the Commission or such later date as the Commission may determine; provided, however, that a compacting state may opt out of a uniform standard as provided in this section. "Opt out" shall be defined as any action by a compacting state to decline to adopt or participate in a promulgated uniform standard. All other rules and operating procedures, and amendments thereto, shall become effective as of the date specified in each rule, operating procedure or amendment.

(d) *Opt out procedure. —*

(1) A compacting state may opt out of a uniform standard, either by legislation or regulation duly promulgated by the Insurance Department under the compacting state's Administrative Procedure Act [Chapter 101 of Title 29]. If a compacting state elects to opt out of a uniform standard by regulation, it must give written notice to the Commission no later than 10 business days after the uniform standard is promulgated, or at the time the state becomes a compacting state, and find that the uniform standard does not provide reasonable protections to the citizens of the state, given the conditions in the state. The Commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the state which warrant a departure from the uniform standard and determining that the uniform standard would not reasonably protect the citizens of the state. The Commissioner must consider and balance the following factors and find that the conditions in the state and needs of the citizens of the state outweigh: (i) the intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the products subject to this chapter; and (ii) the presumption that a uniform standard adopted by the Commission provides reasonable protections to consumers of the relevant product.

(2) Notwithstanding paragraph (d)(1) of this section, a compacting state may, at the time of its enactment of this Compact, prospectively opt out of all uniform standards involving long-term care insurance products by expressly providing for such opt out in the enacted Compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any state to participate in this Compact. Such an opt out shall be effective at the time of enactment of this Compact by the compacting state and shall apply to all existing uniform standards involving long-term care insurance products and those subsequently promulgated. In accordance with this paragraph (d)(2), the State of Delaware opts out of all existing and prospective uniform standards involving long-term care insurance products in order to preserve Delaware's statutory requirements governing these insurance products.

(e) *Effect of opt out. —*

If a compacting state elects to opt out of a uniform standard, the uniform standard shall remain applicable in the compacting state electing to opt out until such time the opt out legislation is enacted into law or the regulation opting out becomes effective. Once the opt out of a uniform standard by a compacting state becomes effective as provided under the laws of that state, the uniform standard shall have no further force and effect in that state unless and until the legislation or regulation implementing the opt out is repealed or otherwise

becomes ineffective under the laws of the state. If a compacting state opts out of a uniform standard after the uniform standard has been made effective in that state, the opt out shall have the same prospective effect as provided under § 3015 of this title for withdrawals.

(f) *Stay of uniform standard. —*

If a compacting state has formally initiated the process of opting out of a uniform standard by regulation, and while the regulatory opt out is pending, the compacting state may petition the Commission, at least 15 days before the effective date of the uniform standard, to stay the effectiveness of the uniform standard in that state. The Commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the Commission, the stay or extension thereof may postpone the effective date by up to 90 days, unless affirmatively extended by the Commission; provided, a stay may not be permitted to remain in effect for more than 1 year unless the compacting state can show extraordinary circumstances which warrant a continuance of the stay, including the existence of a legal challenge which prevents the compacting state from opting out. A stay may be terminated by the Commission upon notice that the rulemaking process has been terminated.

(g) Not later than 30 days after a rule or operating procedure is promulgated, any person may file a petition for judicial review of the rule or operating procedure; provided, that the filing of such a petition shall not stay or otherwise prevent the rule or operating procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Commission consistent with applicable law and shall not find the rule or operating procedure to be unlawful if the rule or operating procedure represents a reasonable exercise of the Commission's authority.

(83 Del. Laws, c. 103, § 1.)

§ 3009. Commission records and enforcement.

(a) The Commission shall promulgate rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals' and insurers' trade secrets. The Commission may promulgate additional rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

(b) Except as to privileged records, data and information, the laws of any compacting state pertaining to confidentiality or nondisclosure shall not relieve any compacting state's commissioner of the duty to disclose any relevant records, data or information to the Commission; provided, that disclosure to the Commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and further provided, that, except as otherwise expressly provided in this chapter, the Commission shall not be subject to the compacting state's laws pertaining to confidentiality and nondisclosure with respect to records, data and information in its possession. Confidential information of the Commission shall remain confidential after such information is provided to any commissioner.

(c) The Commission shall monitor compacting states for compliance with duly adopted bylaws, rules, including uniform standards, and operating procedures. The Commission shall notify any non-complying compacting state in writing of its noncompliance with Commission bylaws, rules or operating procedures. If a non-complying compacting state fails to remedy its noncompliance within the time specified in the notice of noncompliance, the compacting state shall be deemed to be in default as set forth in § 3015 of this title.

(d) The commissioner in any state in which an insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise his or her authority to oversee the market regulation of the activities of the insurer in accordance with the provision of the state's law. The commissioner's enforcement of compliance with the Compact is governed by all of the following provisions:

(1) With respect to the commissioner's market regulation of a product or advertisement that is approved or certified to the Commission, the content of the product or advertisement shall not constitute a violation of the provisions, standards, or requirements of the Compact except upon a final order of the Commission, issued at the request of a commissioner after prior notice to the insurer and an opportunity for hearing before the Commission.

(2) Before a commissioner may bring an action for violation of any provision, standard, or requirement of the Compact relating to the content of an advertisement not approved or certified to the Commission, the Commission, or an authorized Commission officer or employee, must authorize the action. However, authorization pursuant to this paragraph (d)(2) does not require notice to the insurer, opportunity for hearing or disclosure of requests for authorization or records of the Commission's action on such requests.

(83 Del. Laws, c. 103, § 1.)

§ 3010. Dispute resolution.

The Commission shall attempt, upon the request of a member, to resolve any disputes or other issues that are subject to this Compact and which may arise between 2 or more compacting states, or between compacting states and non-compacting states, and the Commission shall promulgate an operating procedure providing for resolution of such disputes.

(83 Del. Laws, c. 103, § 1.)

§ 3011. Product filing and approval.

(a) Insurers and third-party filers seeking to have a product approved by the Commission shall file the product with, and pay applicable filing fees to, the Commission. Nothing in this chapter shall be construed to restrict or otherwise prevent an insurer from filing its product

with the insurance department in any state wherein the insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the states where filed.

(b) The Commission shall establish appropriate filing and review processes and procedures pursuant to Commission rules and operating procedures. Notwithstanding any provision herein to the contrary, the Commission shall promulgate rules to establish conditions and procedures under which the Commission will provide public access to product filing information. In establishing such rules, the Commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a product filing or supporting information.

(c) Any product approved by the Commission may be sold or otherwise issued in those compacting states for which the insurer is legally authorized to do business.

(83 Del. Laws, c. 103, § 1.)

§ 3012. Review of Commission decisions regarding filings.

(a) Not later than 30 days after the Commission has given notice of a disapproved product or advertisement filed with the Commission, the insurer or third-party filer whose filing was disapproved may appeal the determination to a review panel appointed by the Commission. The Commission shall promulgate rules to establish procedures for appointing such review panels and provide for notice and hearing. An allegation that the Commission, in disapproving a product or advertisement filed with the Commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with § 3004(d) of this title.

(b) The Commission shall have authority to monitor, review and reconsider products and advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant uniform standard. Where appropriate, the Commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in subsection (a) of this section.

(83 Del. Laws, c. 103, § 1.)

§ 3013. Finance.

(a) The Commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the Commission may accept contributions and other forms of funding from the NAIC, compacting states and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the Commission concerning the performance of its duties shall not be compromised.

(b) The Commission shall collect a filing fee from each insurer and third-party filer filing a product with the Commission to cover the cost of the operations and activities of the Commission and its staff in a total amount sufficient to cover the Commission's annual budget.

(c) The Commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in § 3008 of this title.

(d) The Commission shall be exempt from all taxation in and by the compacting states.

(e) The Commission shall not pledge the credit of any compacting state, except by and with the appropriate legal authority of that compacting state.

(f) The Commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the Commission shall be subject to the accounting procedures established under its bylaws. The financial accounts and reports including the system of internal controls and procedures of the Commission shall be audited annually by an independent certified public accountant. Upon the determination of the Commission, but no less frequently than every 3 years, the review of the independent auditor shall include a management and performance audit of the Commission. The Commission shall make an annual report to the Governor and legislature of the compacting states, which shall include a report of the independent audit. The Commission's internal accounts shall not be confidential and such materials may be shared with the commissioner of any compacting state upon request; provided, however, that any work papers related to any internal or independent audit and any information regarding the privacy of individuals' and insurers' proprietary information, including trade secrets, shall remain confidential.

(g) No compacting state shall have any claim to or ownership of any property held by or vested in the Commission or to any Commission funds held pursuant to the provisions of this Compact.

(83 Del. Laws, c. 103, § 1.)

§ 3014. Compacting states, effective date and amendment.

(a) Any state is eligible to become a compacting state.

(b) The Compact shall become effective and binding upon legislative enactment of the Compact into law by 2 compacting states; provided, the Commission shall become effective for purposes of adopting uniform standards for, reviewing, and giving approval or disapproval of, products filed with the Commission that satisfy applicable uniform standards only after 26 states are compacting states or, alternatively, by states representing greater than 40% of the premium volume for life insurance, annuity, disability income and long-

term care insurance products, based on records of the NAIC for the prior year. Thereafter, it shall become effective and binding as to any other compacting state upon enactment of the Compact into law by that state.

(c) Amendments to the Compact may be proposed by the Commission for enactment by the compacting states. No amendment shall become effective and binding upon the Commission and the compacting states unless and until all compacting states enact the amendment into law.

(83 Del. Laws, c. 103, § 1.)

§ 3015. Withdrawal, default and termination.

(a) *Withdrawal. —*

(1) Once effective, the Compact shall continue in force and remain binding upon each and every compacting state; provided, that a compacting state may withdraw from the Compact by enacting a statute specifically repealing the statute which enacted the Compact into law.

(2) The effective date of withdrawal is the effective date of the repealing statute; however, the withdrawal shall not apply to any product filings approved or self-certified, or any advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the Commission and the withdrawing state unless the approval is rescinded by the withdrawing state as provided in paragraph (a)(5) of this section.

(3) The commissioner of the withdrawing state shall immediately notify the management committee in writing upon the introduction of legislation repealing this Compact in the withdrawing state.

(4) The Commission shall notify the other compacting states of the introduction of such legislation within 10 days after its receipt of notice thereof.

(5) The withdrawing state is responsible for all obligations, duties and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the Commission and the withdrawing state. The Commission's approval of products and advertisements prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the withdrawing state, unless formally rescinded by the withdrawing state in the same manner as provided by the laws of the withdrawing state for the prospective disapproval of products or advertisements previously approved under state law.

(6) Reinstatement following withdrawal of any compacting state shall occur upon the effective date of the withdrawing state reenacting the Compact.

(b) *Default. —*

(1) If the Commission determines that any compacting state has at any time defaulted in the performance of any of its obligations or responsibilities under this Compact, the bylaws or duly promulgated rules or operating procedures, then, after notice and hearing as set forth in the bylaws, all rights, privileges and benefits conferred by this Compact on the defaulting state shall be suspended from the effective date of default as fixed by the Commission. The grounds for default include, but are not limited to, failure of a compacting state to perform its obligations or responsibilities, and any other grounds designated in Commission rules. The Commission shall immediately notify the defaulting state in writing of the defaulting state's suspension pending a cure of the default. The Commission shall stipulate the conditions and the time period within which the defaulting state must cure its default. If the defaulting state fails to cure the default within the time period specified by the Commission, the defaulting state shall be terminated from the Compact and all rights, privileges and benefits conferred by this Compact shall be terminated from the effective date of termination.

(2) Product approvals by the Commission or product self-certifications, or any advertisement in connection with such product, that are in force on the effective date of termination shall remain in force in the defaulting state in the same manner as if the defaulting state had withdrawn voluntarily pursuant to subsection (a) of this section.

(3) Reinstatement following termination of any compacting state requires a reenactment of the Compact.

(c) *Dissolution of Compact. —*

(1) The Compact dissolves effective upon the date of the withdrawal or default of the compacting state which reduces membership in the Compact to 1 compacting state.

(2) Upon dissolution of this Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Commission shall be wound up and any surplus funds shall be distributed in accordance with the bylaws.

(83 Del. Laws, c. 103, § 1.)

§ 3016. Severability and construction.

(a) The provisions of this Compact shall be severable, and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

(b) The provisions of this Compact shall be liberally construed to effectuate its purposes.

(83 Del. Laws, c. 103, § 1.)

§ 3017. Binding effect of Compact and other laws.

(a) *Other laws. —*

(1) Nothing herein prevents the enforcement of any other law of a compacting state, except as provided in paragraph (a)(2) of this section.

(2) For any product approved or certified to the Commission, the rules, uniform standards and any other requirements of the Commission shall constitute the exclusive provisions applicable to the content, approval and certification of such products. For an advertisement that is subject to the Commission's authority, any rule, uniform standard or other requirement of the Commission which governs the content of the advertisement shall constitute the exclusive provision that a commissioner may apply to the content of the advertisement. Notwithstanding the foregoing, no action taken by the Commission shall abrogate or restrict any of the following:

a. The access of any person to state courts.

b. Remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the product.

c. State law relating to the construction of insurance contracts.

d. The authority of the attorney general of the state, including maintaining any actions or proceedings, as authorized by law.

(3) All insurance products filed with individual states shall be subject to the laws of those states.

(b) *Binding effect of this Compact. —*

(1) All lawful actions of the Commission, including all rules and operating procedures promulgated by the Commission, are binding upon the compacting states.

(2) All agreements between the Commission and the compacting states are binding in accordance with their terms.

(3) Upon the request of a party to a conflict over the meaning or interpretation of Commission actions, and upon a majority vote of the compacting states, the Commission may issue advisory opinions regarding the meaning or interpretation in dispute.

(4) In the event any provision of this Compact exceeds the constitutional limits imposed on the legislature of any compacting state, the obligations, duties, powers, or jurisdiction sought to be conferred by that provision upon the Commission shall be ineffective as to that compacting state, and those obligations, duties, powers, or jurisdiction shall remain in the compacting state and shall be exercised by the agency thereof to which those obligations, duties, powers or jurisdiction are delegated by law in effect at the time this Compact becomes effective.

(83 Del. Laws, c. 103, § 1.)

§ 3018. Appointment of state representative.

The Insurance Commissioner of the State of Delaware is hereby designated to serve as the representative of this State to the Commission.

(83 Del. Laws, c. 103, § 1.)

Part I
Insurance
Chapter 31
Group Life Insurance

§ 3101. Group policies must meet group requirements.

Except as provided in § 3109 of this title, no policy of group life insurance shall be delivered in this State unless it conforms to 1 of the descriptions contained in §§ 3102-3108 of this title.

(18 Del. C. 1953, § 3102; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 480, § 1.)

§ 3102. Employee groups.

A policy may be issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(1) The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of 1 or more subsidiary corporations, and the employees, individual proprietors, and partners of 1 or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials. The policy may provide that the term "employee" does not include farm laborers employed in agriculture.

(2) The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees, or from both. Except as provided in paragraph (3) of this section, a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject such coverage in writing.

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(18 Del. C. 1953, § 3103; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 480, § 1.)

§ 3103. Debtor groups.

A policy may be issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by 2 or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditors with respect to their indebtedness, subject to the following requirements:

(1) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes thereof. The policy may provide that the term "debtors" shall include:

a. Borrowers of money or purchasers or lessees of goods, services or property for which payment is arranged through a lease or credit transaction;

b. The debtors of 1 or more subsidiary corporations; and

c. The debtors of 1 or more affiliated corporations, proprietorships or partnerships if the business of the policyholder and of such affiliated corporations, proprietorships or partnerships is under common control.

(2) The premium for the policy shall be paid either from the creditor's funds, or from charges collected from the insured debtors, or from both. Except as provided in paragraph (3) of this section, a policy on which no part of the premium is to be derived from funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

(3) Any insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

(4) The amount of insurance on the life of any debtor shall at no time exceed the greater of the scheduled or actual amount of unpaid indebtedness as to the creditor.

(5) The insurance may be payable to the creditor or any successor to the right, title and interest of the creditor. Such payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of such payment.

(6) Notwithstanding paragraphs (1)-(5) of this section, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

(18 Del. C. 1953, § 3104; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 480, § 1.)

§ 3104. Labor union, employee organization groups.

A policy may be issued to a labor union, or similar employee organization, which shall be deemed to be the policyholder, to insure members of such union or organization for the benefit of persons other than the union or organization or any of its officials, representatives or agents, subject to the following requirements:

(1) The members eligible for insurance under the policy shall be all of the members of the union or organization, or all of any class or classes thereof.

(2) The premium for the policy shall be paid either from funds of the union or organization, or from funds contributed by the insured members specifically for their insurance, or from both. Except as provided in paragraph (3) of this section, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject such coverage in writing.

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(18 Del. C. 1953, § 3105; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 480, § 1.)

§ 3105. Trustee groups.

A policy may be issued to a trust, or to the trustee or trustees of a fund, established or adopted by 2 or more employers, or by 1 or more labor unions or similar employee organizations, or by 1 or more employers and 1 or more labor unions or similar employee organizations, which trust or trustee or trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(1) The persons eligible for insurance shall be all of the employees or all of the members of the unions or organizations, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of 1 or more subsidiary corporations, and the employees, individual proprietor and partners of 1 or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

(2) The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons, or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons from both the insured persons and the employer(s) or union(s) or similar employee organization(s). Except as provided in paragraph (3) of this section, a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing.

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(18 Del. C. 1953, § 3106; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 480, § 1.)

§ 3106. Association groups.

A policy may be issued to an association or to a trust or to the trustee or trustees of a fund established, created or maintained for the benefit of members of 1 or more associations. The association or associations shall have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least 2 years; and shall have a constitution and bylaws and a statement of organization or substantially similar document which provides that: (i) The association or associations hold regular meetings not less than annually to further purposes of the members; (ii) except for credit unions, the association or associations collect dues or solicit contributions from members; and (iii) the members have voting privileges and representation on the governing board of committees. The policy shall be subject to the following requirements:

(1) The policy may insure members of such association or associations, employees thereof or employees of members, or 1 or more of the preceding or all of any class or classes thereof for the benefit of persons other than the employees' employer.

(2) The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations or employer members.

(3) Except as provided in paragraph (4) of this section, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing.

(4) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(18 Del. C. 1953, §§ 3107, 3110; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 347, §§ 1, 2; 65 Del. Laws, c. 480, § 1.)

§ 3107. Credit union groups.

A policy may be issued to a credit union or to a trustee or trustees or agent designated by 2 or more credit unions, which credit union, trustee, trustees or agent shall be deemed the policyholder, to insure members of such credit unions for the benefit of persons other than the credit union or credit unions, trustee or trustees, or agent or any of their officials, subject to the following requirements:

(1) The members eligible for insurance shall be all of the members of the credit union or credit unions, or all of any class or classes thereof.

(2) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in paragraph (3) of this section, must insure all eligible members.

(3) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

(18 Del. C. 1953, § 3109; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 480, § 1.)

§ 3108. Discretionary groups.

A policy may be issued to any other substantially similar group which, in the discretion of the Commissioner, may be subject to the issuance of a group life policy or contract.

(65 Del. Laws, c. 480, § 1.)

§ 3109. Requirements for other groups; out-of-state groups.

(a) Group life insurance offered to a resident of this State under a group life insurance policy issued to a group other than those described in §§ 3102-3108 of this title shall be subject, where applicable, to the requirements of subsections (b)-(e) of this section.

(b) No such group life insurance policy shall be delivered in this State unless the Commissioner finds that:

(1) The issuance of such group policy is not contrary to the best interest of the public;

(2) The issuance of the group policy would result in economies of acquisition or administration; and

(3) The benefits are reasonable in relation to the premiums charged.

(c) No such group life insurance coverage may be offered in this State by an insurer under a policy issued in another state unless this State or another state having requirements substantially similar to those contained in paragraphs (b)(1), (2) and (3) of this section has made a determination that such requirements have been met.

(d) The premium for the policy shall be paid either from the policyholders' funds or from funds contributed by the coverage persons or from both.

(e) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(18 Del. C. 1953, § 3111; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 417, § 2; 65 Del. Laws, c. 480, § 1; 79 Del. Laws, c. 102, § 2.)

§ 3110. Disclosure requirements for other groups.

(a) With respect to a program of insurance which if issued on a group basis would not qualify under §§ 3102-3108 of this title, if compensation of any kind will or may be paid to: (1) A policyholder or sponsoring or endorsing entity in the case of a group policy; or (2) a sponsoring or endorsing entity in the case of individual blanket or franchise policies marketed by means of direct response solicitation; then in such cases the insurer shall cause to be distributed to prospective insureds a written notice that compensation will or may be paid.

(b) The written notice required by subsection (a) of this section shall be distributed:

(1) Whether compensation is direct or indirect; and

(2) Whether such compensation is paid to or retained by the policyholder or sponsoring or endorsing entity, or paid to or retained by a third party at the direction of the policyholder or sponsoring or endorsing entity, or any entity affiliated therewith by way of ownership, contract or employment.

(c) The notice required by subsection (a) of this section shall be placed on or accompany any application or enrollment form provided prospective insureds.

(d) As used in this section, the following terms shall have the meanings indicated:

(1) "Direct response solicitation" means a solicitation through a sponsoring or endorsing entity through the mails, telephone or other mass communications media;

(2) "Sponsoring or endorsing entity" means an organization which has arranged for the offering of a program of insurance in a manner which communicates that eligibility for participation in the program is dependent upon affiliation with such organization or that it encourages participation in the program.

(65 Del. Laws, c. 480, § 1.)

§ 3111. Dependents' coverage.

Except for a policy issued under § 3103 of this title, a group life insurance policy may be extended to insure the employees or members with respect to their family members or dependents, or any class or classes thereof, subject to the following:

(1) The premium for the insurance shall be paid either from funds contributed by the employer, union, association or other person to whom the policy has been issued, or from funds contributed by the covered person, or from both. Except as provided in paragraph (2)

of this section, a policy on which no part of the premium for the family members or dependents' coverage is to be derived from funds contributed by the covered persons must insure all eligible employees or members with respect to their family members or dependents, or any class or classes thereof.

(2) An insurer may exclude or limit the coverage on any family member or dependent as to whom evidence of individual insurability is not satisfactory to the insurer.

(3) The amounts of insurance for any covered spouse or dependent child under policies issued on a group basis may, if requested by the policyholder, be limited to a percentage of the amount of insurance for which the employee or member is insured.

(18 Del. C. 1953, § 3108; 56 Del. Laws, c. 380, § 1; 63 Del. Laws, c. 99, § 1; 65 Del. Laws, c. 480, § 1.)

§ 3112. Group life insurance standard provisions.

No policy of group life insurance shall be delivered in this State unless it contains in substance the provisions set forth in §§ 3113-3127 of this title or provisions which in the opinion of the Commissioner are more favorable to persons insured, or at least as favorable to the persons insured and more favorable to the policyholder; provided, however:

(1) That §§ 3117, 3119-3123, 3125 and 3127 of this title shall not apply to policies insuring persons under § 3103 of this title;

(2) That the standard provisions required for individual life insurance policies shall not apply to group life insurance policies; and

(3) That if the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which in the opinion of the Commissioner is or are equitable to the insured persons and to the policyholder, but nothing herein shall be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies.

(18 Del. C. 1953, § 3111; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 417, § 2; 65 Del. Laws, c. 480, § 1.)

§ 3113. Grace period.

A group life insurance policy shall contain a provision that the policyholder is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period.

(18 Del. C. 1953, § 3112; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 480, § 1.)

§ 3114. Incontestability.

A group life insurance policy shall contain a provision that the validity of the policy shall not be contested except for nonpayment of premiums, after it has been in force for 2 years from its date of issue; and that no statement made by any person insured under the policy relating to insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of 2 years during such person's lifetime nor unless it is contained in a written instrument signed by him or her; provided, however, that no such provision shall preclude the assertion at any time of defenses based upon provisions in the policy which relate to eligibility for coverage.

(18 Del. C. 1953, § 3113; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 480, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3115. Application; statements deemed representations.

A group life insurance policy shall contain a provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or, in the event of the death or incapacity of the insured person, to his or her beneficiary or personal representative.

(18 Del. C. 1953, § 3114; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 480, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3116. Insurability.

A group life insurance policy shall contain a provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his or her coverage.

(18 Del. C. 1953, § 3115; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 480, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3117. Misstatement of age.

A group life insurance policy shall contain a provision specifying an equitable adjustment of premiums or of benefits or of both to be made in the event the age of a person insured has been misstated, such provision to contain a clear statement of the method of adjustment to be made.

(18 Del. C. 1953, § 3116; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 480, § 1.)

§ 3118. Payment of benefits.

A group life insurance policy shall contain a provision that any sum becoming due by reason of the death of the person insured shall be payable to the beneficiary designated by the person insured, except that where the policy contains conditions pertaining to family status the beneficiary may be the family member specified by the policy terms, subject to the provisions of the policy in the event there is no designated beneficiary, as to all or any part of each sums, living at the death of the person insured, and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of such sum not exceeding $2,000 to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured.

(18 Del. C. 1953, § 3117; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 480, § 1.)

§ 3119. Certificate.

A group life insurance policy shall contain a provision that the insurer will issue to the policyholder for delivery to each person insured a certificate setting forth a statement as to the insurance protection to which he or she is entitled, to whom the insurance benefits are payable, a statement as to any dependent's coverage included in such certificate, and the rights and conditions set forth in §§ 3120-3123 of this title.

(18 Del. C. 1953, § 3118; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 480, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3120. Conversion on termination of eligibility.

(a) A group life insurance policy shall contain a provision that if the insurance, or any portion of it, on a person covered under the policy or on the dependent of a person covered, ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, such person shall be entitled to have issued to him or her by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits, provided application for the individual policy shall be made, and the first premium paid to the insurer, within 31 days after such termination, and provided further that:

(1) The individual policy shall, at the option of such person, be on any 1 of the forms then customarily issued by the insurer at the age and for the amount applied for, except that the group may exclude the option to elect term insurance;

(2) The individual policy shall be in an amount not in excess of life insurance which ceases because of such termination, less the amount of any life insurance for which such person becomes eligible under the same or any other group policy within 31 days after such termination, provided that any amount of insurance which shall have matured on or before the date of such termination as an endowment payable to the person insured, whether in 1 sum or in installments or in the form of an annuity, shall not, for the purposes of this provision, be included in the amount which is considered to cease because of such termination; and

(3) The premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such person then belongs, and to the individual age attained on the effective date of the individual policy.

(b) Subject to the same conditions set forth above, the conversion privilege shall be available:

(1) To a surviving dependent, if any, at the death of the employee or member, with respect to the coverage under the group policy which terminates by reason of such death; and

(2) To the dependent of the employee or member upon termination of coverage of the dependent, while the employee or member remains under the group policy, by reason of the dependent ceasing to be a qualified family member under the group policy.

(18 Del. C. 1953, § 3119; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 480, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3121. Conversion on termination of policy.

A group life insurance policy shall contain a provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured person, every person insured thereunder at the date of such termination whose insurance terminates, including the insured dependent of a covered person, and who has been so insured for at least 5 years prior to such termination date shall be entitled to have issued by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by § 3120 of this title, except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of:

(1) The amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which he or she is or becomes eligible under a group policy issued or reinstated by the same or another insurer within 31 days after such termination; and

(2) $10,000.

(18 Del. C. 1953, § 3120; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 480, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3122. Death pending conversion.

A group life insurance policy shall contain a provision that if a person insured under the group policy, or the insured dependent of a covered person, dies during the period within which the individual would have been entitled to have an individual policy issued in accordance with § 3120 or § 3121 of this title and before such an individual policy shall become effective, the amount of life insurance

which he or she would have been entitled to have issued under such individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made.

(18 Del. C. 1953, § 3121; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 480, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3123. Disability provision.

Where active employment is a condition of insurance, the group life insurance policy shall contain a provision that an insured may continue coverage during the insured's total disability by timely payment to the policyholder of that portion, if any, of the premium that would have been required from the insured had total disability not occurred. The continuation shall be on a premium paying basis for a period of 6 months from the date on which the total disability started, but not beyond the earlier of:

(1) Approval by the insurer of continuation of the coverage under any disability provision which the group insurance policy may contain; or

(2) The discontinuance of the group insurance policy.

(65 Del. Laws, c. 480, § 1.)

§ 3124. Information to debtors.

In the case of a policy insuring the lives of debtors, such a group life insurance policy shall contain a provision that the insurer will furnish to the policyholder for delivery to each debtor insured under the policy a certificate of insurance describing the coverage and specifying that the death benefit shall first be applied to reduce or extinguish the indebtedness.

(18 Del. C. 1953, § 3122; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 480, § 1.)

§ 3125. Notice as to conversion right.

If any individual insured under a group life insurance policy hereafter delivered in this State becomes entitled under the terms of such policy to have an individual policy of life insurance issued without evidence of insurability, subject to making of application and payment of the first premium within the period specified in such policy, and if such individual is not given notice of the existence of such right at least 15 days prior to the expiration date of such period, then in such event the individual shall have an additional period within which to exercise such right, but nothing herein contained shall be construed to continue any insurance beyond the period provided in such policy. This additional period shall expire 15 days next after the individual is given such notice but in no event shall such additional period extend beyond 60 days next after the expiration date of the period provided in such policy. Written notice presented to the individual or mailed by the insurer to the last known address of the individual as furnished by the policyholder shall constitute notice for the purpose of this section.

(18 Del. C. 1953, § 3123; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 480, § 1.)

§ 3126. Readjustment of premium.

Any group life insurance contract may provide for a readjustment of the premium rate based upon the experience thereunder.

(18 Del. C. 1953, § 3124; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 480, § 1.)

§ 3127. Application of dividends; rate deduction.

If a policy dividend is hereafter declared or a reduction in rate is hereafter made or continued for the first or any subsequent year of insurance under any policy of group life insurance heretofore or hereafter issued to any policyholder, the excess, if any, of the aggregate dividends or rate reductions under such policy and all other group insurance policies of the policyholder over the aggregate expenditure for insurance under such policies made from funds contributed by the policyholder, or by an employer of insured persons, or by a union or association to which the insured persons belong, including expenditures made in connection with administration of such policies shall be applied by the policyholder for the sole benefit of insured employees or members.

(18 Del. C. 1953, § 3125; 56 Del. Laws, c. 380, § 1; 65 Del. Laws, c. 480, § 1.)

§ 3128. Notification and reasons for cancellation [For application of this section, see 79 Del. Laws, c. 390, § 8].

A notice of cancellation of group life insurance coverage by an insurer due to nonpayment of premiums shall be in writing, shall be delivered to the policyholder or mailed to the policyholder at the last known address of the policyholder, shall state the effective date of the cancellation and shall be accompanied by a written explanation of the specific reasons for the cancellation. Proof of mailing of such cancellation notice shall be retained by the insurer for a period of not less than 1 year.

(79 Del. Laws, c. 390, § 2.)

Part I
Insurance
Chapter 32
Group Life Insurance for State Employees

§ 3201. “Employee” defined.

“Employee” shall mean a person who has been continuously employed by the State for 3 full calendar months immediately preceding the first day of any given month (exclusive of legal holidays and allowable leave) and who works the regularly scheduled full-time hours of the employing agency, or at least 30 or more hours per week, or 130 hours per month (with allowable interruptions) throughout the year. “Employee” shall include all elected and appointed state officials.

(18 Del. C. 1953, § 3201; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 236; 72 Del. Laws, c. 94, § 42.)

§ 3202. Group life insurance.

Subject to Chapter 31 of this title, the State may enter into a contract of group life insurance including accidental death and dismemberment coverage with an insurance company or companies authorized to transact business within this State, which insurance shall specifically cover state employees or any class or classes thereof.

(18 Del. C. 1953, § 3202; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 236.)

§ 3203. Life insurance premiums.

The State may pay part of the premiums or charges for such group life insurance contract or contracts and may appropriate any money necessary to pay such premiums or charges, or portions thereof. Notwithstanding any other provision of the law, any contribution required of any employee toward the cost of such insurance may be deducted from the pay, salary or compensation of such employee. The expenditure of funds of the State for payment of part of the premiums shall be deemed to be a regular business expenditure and shall not be considered compensation paid to the employee so insured.

(18 Del. C. 1953, § 3203; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 236.)

§ 3204. Eligibility and waiver.

Any contract of insurance procured pursuant to this chapter shall provide that each employee becoming eligible for insurance thereunder shall become insured, subject to any “actively at-work” requirement or requirements as to the health of the persons to be covered as specified in the insurance contract, at such time as the eligible employee submits an application for insurance and agrees to pay the applicable premium.

(18 Del. C. 1953, § 3204; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 236; 70 Del. Laws, c. 186, § 1; 74 Del. Laws, c. 23, § 1.)

§ 3205. Amount of coverage.

(a) The amount of group life insurance on the life of any employee shall be at least in the following amount: The employee’s annual regular salary rounded to the next higher even thousand dollar subject to maxima established by the State Employee Benefits Committee. Contributions by the employee and the State to the cost of such insurance may be based on reasonable age classifications.

(b) The State Employee Benefits Committee shall meet at least annually to review the State’s Group Life Insurance Plan and, when appropriate, adopt improvements thereto for the purpose of extending existing amounts or types, or both, of group life insurance coverage for state employees.

(18 Del. C. 1953, § 3205; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 236; 63 Del. Laws, c. 100, § 3; 65 Del. Laws, c. 399, § 1; 72 Del. Laws, c. 204, § 8.)

§ 3206. State Employee Benefits Committee.

(a) After reviewing competitive group plans, the State Employee Benefits Committee established by § 9602 of Title 29 shall select a carrier deemed to offer the best plan to satisfy the interests of the State and of its employees in carrying out the intent of this chapter. Such contract shall be for a uniform term of at least 1 year, but may be continued automatically at the option of the State Employee Benefits Committee from term to term in accordance with recognized group life insurance practices.

(b) The State Employee Benefits Committee shall be empowered to adopt rules and regulations which it deems necessary for the administration of the State’s Group Life Insurance Plan.

(18 Del. C. 1953, § 3206; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 236; 63 Del. Laws, c. 100, § 3; 70 Del. Laws, c. 186, § 1; 72 Del. Laws, c. 204, § 9.)

§ 3207. Legal agent of the State.

The Secretary of the Department of Human Resources shall be the legal agent for the State and shall be empowered to enter into the contract for group life insurance with any insurance carrier designated by the State Employee Benefits Committee.

(18 Del. C. 1953, § 3207; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 236; 69 Del. Laws, c. 64, § 80; 72 Del. Laws, c. 204, § 10; 75 Del. Laws, c. 88, § 20(4); 81 Del. Laws, c. 66, § 12.)

§ 3208. Administration of chapter.

The Secretary of the Department of Human Resources may perform all acts necessary or proper for administration of the insurance coverage provided.

(18 Del. C. 1953, § 3208; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 236; 72 Del. Laws, c. 204, § 11; 75 Del. Laws, c. 88, § 20(4); 81 Del. Laws, c. 66, § 13.)

§ 3209. Application of dividends.

Dividends payable from group life insurance may be used to offset any contribution made by the State in the form of money or administrative costs, including the salaries of employees working full-time on the program and any other related expenses deemed appropriate by the State Employee Benefits Committee.

(18 Del. C. 1953, § 3209; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 236; 72 Del. Laws, c. 204, § 12.)

§ 3210. Group Life Insurance Fund.

Dividends in excess of any deduction made by the State for its contributions may be used solely for the benefit of the subscribers to the group life insurance program, and shall be maintained in a special fund identified as the Group Life Insurance Fund, which Fund shall be administered by the State Employee Benefits Committee. Funds derived from such dividends shall be invested by the State Treasurer in accordance with guidelines established by the Cash Management Policy Board, with all income from such investments reverting to the Group Life Insurance Fund. Under no circumstances shall these funds become a part of the State General Fund, or any fund other than the Group Life Insurance Fund.

(18 Del. C. 1953, § 3210; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 236; 63 Del. Laws, c. 142, § 56; 72 Del. Laws, c. 204, § 13.)

§ 3211. Validity of contracts.

This chapter shall not be construed to impair the validity of any contractive group life insurance plan for employees of the State which shall be in effect on July 9, 1971, but nothing herein contained shall permit duplicate coverage in any instance where the State would be a contributor to more than 1 plan.

(18 Del. C. 1953, § 3211; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 236.)

Part I
Insurance
Chapter 33
Health Insurance Contracts
Subchapter I
General Provisions

§ 3301. Scope of chapter.

This chapter shall not apply to or affect:

(1) Any policy of liability or workers' compensation insurance with or without supplementary expense coverage therein;

(2) Any group or blanket policy;

(3) Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to health insurance as:

a. Provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or as

b. Operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract;

(4) Reinsurance.

(18 Del. C. 1953, § 3301; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3302. Short title.

This subchapter may be cited as the "Uniform Health Policy Provisions Law."

(18 Del. C. 1953, § 3302; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1; 81 Del. Laws, c. 78, § 5.)

§ 3303. Scope, format of policy [For application of this section, see 79 Del. Laws, c. 99, § 19].

No policy of health insurance shall be delivered or issued for delivery to any person in this State unless it otherwise complies with this title and complies with the following:

(1) The entire money and other considerations therefor shall be expressed therein;

(2) The time when the insurance takes effect and terminates shall be expressed therein;

(3) It shall purport to insure only 1 person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the policyholder, any 2 or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed 26 years and any other person dependent upon the policyholder;

(4) The style, arrangement and overall appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than 10 points with a lower case unspaced alphabet length not less than 120 points (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions);

(5) The exceptions and reductions of indemnity shall be set forth in the policy and, other than those contained in §§ 3305-3326, inclusive, of this title, shall be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "exceptions," or "exceptions and reductions," except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies;

(6) Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and

(7) The policy shall contain no provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the Commissioner.

(8) The policy shall contain no provision or nondisclosure clause prohibiting physicians or other health-care providers from giving patients information regarding diagnoses, prognoses and treatment options.

(18 Del. C. 1953, § 3303; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 537, § 1; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 99, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3304. Required provisions; captions; omissions; substitutions.

(a) Except as provided in subsection (b) of this section below, each such policy delivered or issued for delivery to any person in this State shall contain the provisions specified in §§ 3305-3316, inclusive, of this title, in the words in which the same appear; except, that

the insurer may, at its option, substitute for 1 or more of such provisions corresponding provisions of different wording approved by the Commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Each such provision shall be preceded individually by the applicable caption shown, or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve.

(b) If any such provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the Commissioner, shall omit from such policy any inapplicable provision or part of a provision and shall modify any inconsistent provision or part of a provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(18 Del. C. 1953, § 3304; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3305. Entire contract; changes.

There shall be a provision as follows:

"Entire Contract; Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions."

(18 Del. C. 1953, § 3305; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3306. Time limit on certain defenses.

(a) There shall be a provision as follows: "Time Limit on Certain Defenses:

(1) After 2 years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or deny a claim for loss incurred as disability (as defined in the policy) commencing after the expiration of such 2-year period.

(2) No claim for loss incurred as disability (as defined in the policy) commencing 2 years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."

(b) The policy provision required by paragraph (a)(1) of this section above shall not be so construed as to affect any legal avoidance of a policy or denial of a claim during such initial 2-year period, nor to limit the application of §§ 3318-3320 of this title in the event of misstatement with respect to age or occupation or other insurance.

(c) A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50, or (2) in the case of a policy issued after age 44, for at least 5 years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "Incontestable":

"After this policy has been in force for a period of 2 years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to any statements, other than fraudulent statements, contained in the application."

(18 Del. C. 1953, § 3306; 56 Del. Laws, c. 380, § 1; 64 Del. Laws, c. 142, § 2; 80 Del. Laws, c. 310, § 1.)

§ 3307. Grace period.

There shall be a provision as follows:

"A grace period of . . . (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force."

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision:

"Unless not less than five days prior to the premium due date the company has delivered to the insured or has mailed to his/her last address as shown by the records of the company written notice of its intention not to renew this policy beyond the period for which the premium has been accepted."

(18 Del. C. 1953, § 3307; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3308. Reinstatement.

(a) There shall be a provision as follows:

"Reinstatement: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy, provided, however, that if the company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the company or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the company has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness

as may begin more than ten days after such date. In all other respects the insured and company shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed herein or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement."

(b) The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums:

(1) Until at least age 50; or

(2) In the case of a policy issued after age 44, for at least 5 years from its date of issue.

(18 Del. C. 1953, § 3308; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3309. Notice of claim.

(a) There shall be a provision as follows:

"Notice of Claim: Written notice of claim must be given to the company within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the company at . . . . . (insert the location of such office as the company may designate for the purpose), or to any authorized agent of the company, with information sufficient to identify the insured, shall be deemed notice to the company."

(b) In a policy providing a loss-of-time benefit which may be payable for at least 2 years, an insurer may at its option insert the following between the first and second sentences of the above provision:

"Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he/she shall, at least once in every six months after having given notice of the claim, give to the company notice of continuance of the disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the company on account of such claim or any denial of liability in whole or in part by the company shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given."

(18 Del. C. 1953, § 3309; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3310. Claim.

There shall be a provision as follows:

"Claim Forms: The company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The nonhospital claim form to be used under this provision is the Health Care Financing Administration Form-1500 or its successor. This form requirement shall not apply to medical payments made by the federal government, prescription drug claims, dental claims or claims using an electronic paperless submission process."

(18 Del. C. 1953, § 3310; 56 Del. Laws, c. 380, § 1; 68 Del. Laws, c. 416, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3311. Proofs of loss.

There shall be a provision as follows:

"Proofs of Loss: Written proof of loss must be furnished to the company at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the company is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required."

(18 Del. C. 1953, § 3311; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3312. Time of payment of claims.

There shall be a provision as follows:

"Time of Payment of Claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid . . . . . (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof."

(18 Del. C. 1953, § 3312; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3313. Payment of claims.

(a) There shall be a provision as follows:

"Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the company, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured."

(b) The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

(1) "If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the company may pay such indemnity, up to an amount not exceeding $. . . . . (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the company to be equitably entitled thereto. Any payment made by the company in good faith pursuant to this provision shall fully discharge the company to the extent of such payment."

(2) "Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the company's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services, but it is not required that the service be rendered by a particular hospital or person."

(c) There shall be a provision as follows in contracts issued by an insurer, health service corporation or health maintenance organization:

"Payment of claims when coverage terminated during a period of hospitalization: If you are in the hospital when this policy nonrenews or terminates for any reason except nonpayment of premium, this policy shall continue coverage for that hospitalization at the same benefit level for a 10-day period from the date of termination."

(d) There shall be a provision as follows in contracts issued by an insurer, health service corporation or health maintenance organization:

"If this policy immediately succeeds prior coverage, and if you are in the hospital when this coverage becomes effective, benefits for that hospitalization will start at the end of 10 consecutive days of hospitalization under this policy at the level provided by this policy notwithstanding any preexisting conditions or other similar exclusions for the duration of the single continuing period of hospitalization."

The requirements of this subsection shall not apply to specified accident, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit health insurance policies.

(18 Del. C. 1953, § 3313; 56 Del. Laws, c. 380, § 1; 68 Del. Laws, c. 323, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3314. Physical examination; autopsy.

There shall be a provision as follows:

"Physical Examinations and Autopsy: The company at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law."

(18 Del. C. 1953, § 3314; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3315. Legal actions.

There shall be a provision as follows:

"Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished."

(18 Del. C. 1953, § 3315; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3316. Change of beneficiary.

(a) There shall be a provision as follows:

"Change of Beneficiary: Unless the insured make an irrevocable designation of beneficiary, the right to change the beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy."

(b) The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

(18 Del. C. 1953, § 3316; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3317. Optional policy provisions.

Except as provided in § 3304 of this title, no such policy delivered or issued for delivery to any person in this State shall contain provisions respecting the matters set forth in §§ 3318-3325, inclusive, of this title unless such provisions are in the words in which the same appear in the applicable section, except that the insurer may, at its option, use in lieu of any such provision a corresponding provision

of different wording approved by the Commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption or at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve.

(18 Del. C. 1953, § 3317; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3318. Change of occupation.

There may be a provision as follows:

"Change of Occupation: If the insured be injured or contract sickness after having changed his/her occupation to one classified by the company as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the company will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the company for such more hazardous occupation. If the insured changes his/her occupation to one classified by the company as less hazardous than that stated in this policy, the company, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the company prior to the occurrence of the loss for which the company is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued, but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the company in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation."

(18 Del. C. 1953, § 3318; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3319. Misstatement of age.

There may be a provision as follows:

"Misstatement of Age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age."

(18 Del. C. 1953, § 3319; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3320. Overinsurance; all coverages.

(a) There may be a provision as follows:

"Overinsurance: If, with respect to a person covered under this policy, benefits for allowable expense incurred during a claim determination period under this policy together with benefits for allowable expense during such period under all other valid coverage (without giving effect to this provision or to any 'overinsurance provision' applying to such other valid coverage), exceed the total of such person's allowable expense during such period, this company shall be liable only for such proportionate amount of the benefits for allowable expense under this policy during such period as:

(1) The total allowable expense during such period bears to

(2) The total amount of benefits payable during such period for such expense under this policy and all other valid coverage (without giving effect to this provision or to any 'overinsurance provision' applying to such other valid coverage) less in both (1) and (2) any amount of benefits for allowable expense payable under other valid coverage which does not contain an 'overinsurance provision.' In no event shall this provision operate to increase the amount of benefits for allowable expense payable under this policy with respect to a person covered under this policy above the amount which would have been paid in the absence of this provision. This company may pay benefits to any insurer providing other valid coverage in the event of overpayment by such insurer. Any such payment shall discharge the liability of this company as fully as if the payment had been made directly to the insured, his/her assignee or his/her beneficiary. In the event that this company pays benefits to the insured, his/her assignee or his/her beneficiary, in excess of the amount which would have been payable if the existence of other valid coverage had been disclosed, this company shall have a right of action against the insured, his/her assignee or his/her beneficiary, to recover the amount which would not have been paid had there been a disclosure of the existence of the other valid coverage. The amount of other valid coverage which is on a provision of service basis shall be computed as the amount the services rendered would have cost in the absence of such coverage.

For the purposes of this provision:

(1) 'Allowable expense' means 110% of any necessary, reasonable and customary item of expense which is covered, in whole or in part, as a hospital, surgical, medical or major medical expense under this policy or under any other valid coverage.

(2) 'Claim determination period' with respect to any covered person means the initial period of . . . (insert period of not less than 30 days) and each successive period of a like number of days, during which allowable expense covered under this policy is incurred on account of such person. The first such period begins on the date when the first such expense is incurred, and successive periods shall begin when such expense is incurred after expiration of a prior period.

or, in lieu thereof:

'Claim determination period' with respect to any covered person means each . . . (insert calendar or policy period of not less than a month) during which allowable expense covered under this policy is incurred on account of such person.

(3) 'Overinsurance provision' means this provision and any other provision which may reduce an insurer's liability because of the existence of benefits under other valid coverage."

(b) The foregoing policy provisions may be inserted in all policies providing hospital, surgical, medical or major medical benefits. The insurer may make this provision applicable to either or both (1) other valid coverage with other insurers, and (2) other valid coverage with the same insurer. The insurer shall include in this provision a definition of "other valid coverage" approved as to form by the Commissioner. Such term may include hospital, surgical, medical or major medical benefits provided by group, blanket or franchise coverage, individual and family-type coverage, Blue Cross-Blue Shield coverage and other prepayment plans, group practice and individual practice plans, uninsured benefits provided by labor-management trusteed plans, or union welfare plans, or by employer or employee benefit organizations, benefits provided under governmental programs, workers' compensation insurance or any coverage required or provided by any other statute, and medical payments under automobile liability and personal liability policies. Other valid coverage shall not include payments made under third-party liability coverage as a result of a determination of negligence, but an insurer may at its option include a subrogation clause in its policy. The insurer may require, as part of the proof of claim, the information necessary to administer this provision.

(c) If by application of any of the foregoing provisions the insurer effects a material reduction of benefits otherwise payable under the policy, the insurer shall refund to the insured any premium unearned on the policy by reason of such reduction of coverage subject to the insurer's right to provide in the policy that no such reduction of benefits or refund will be made unless the unearned premium to be so refunded amounts to $5.00 or such larger sum as the insurer may specify.

(18 Del. C. 1953, § 3321; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3321. Relation of earnings to insurance.

(a) There may be a provision as follows:

"After the loss-of-time benefit of this policy has been payable for 90 days, such benefit will be adjusted, as provided below, if the total amount of unadjusted loss-of-time benefits provided in all valid loss-of-time coverage upon the insured should exceed . . . % of the insured's earned income, provided, however, that if the information contained in the application discloses that the total amount of loss-of-time benefits under this policy and under all other valid loss-of-time coverage expected to be effective upon the insured in accordance with the application for this policy exceeded . . . % of the insured's earned income at the time of such application, such higher percentage will be used in place of . . . %. Such adjusted loss-of-time benefit under this policy for any month shall be only such proportion of the loss-of-time benefit otherwise payable under this policy as:

(1) The product of the insured's earned income and . . . % (or, if higher the alternative percentage described at the end of the first sentence of this provision)

bears to

(2) The total amount of loss-of-time benefits payable for such month under this policy and all other valid loss-of-time coverage on the insured (without giving effect to the 'overinsurance provision' in this or any other coverage) less in both (1) and (2) any amount of loss-of-time benefits payable under other valid loss-of-time coverage which does not contain an 'overinsurance provision.' In making such computation, all benefits and earnings shall be converted to a consistent (insert 'weekly' if the loss-of-time benefit of this policy is payable weekly, 'monthly' if such benefit is payable monthly, etc.) basis. If the numerator of the foregoing ratio is zero or is negative, no benefit shall be payable under this policy. In no event shall this provision (i) operate to reduce the total combined amount of loss-of-time benefits for such month payable under this policy and all other valid loss-of-time coverage below the lesser of $300 and the total combined amount of loss-of-time benefits determined without giving effect to any 'overinsurance provision,' nor (ii) operate to increase the amount of benefits payable under this policy above the amount which would have been paid in the absence of this provision, nor (iii) take into account or operate to reduce any benefit other than the loss-of-time benefit.

For purposes of this provision:

(A) 'Earned income', except where otherwise specified, means the greater of the monthly earnings of the insured at the time disability commences and his/her average monthly earnings for a period of two years immediately preceding the commencement of such disability and shall not include any investment income or any other income not derived from the insured's vocational activities.

(B) 'Overinsurance provision' shall include this provision and any other provision with respect to any loss-of-time coverage which may have the effect of reducing an insurer's liability if the total amount of loss-of-time benefits under all coverage exceeds a stated relationship to the insured's earnings."

(b) The foregoing provision may be included only in a policy which provides a loss-of-time benefit which may be payable for at least 52 weeks, which is issued on the basis of selective underwriting of each individual application, and for which the application includes a question designed to elicit information necessary either to determine the ratio of the total loss-of-time benefits of the insured to the insured's earned income or to determine that such ratio does not exceed the percentage of earnings, not less than 60% selected by the insurer and inserted in lieu of the blank factor above. The insurer may require, as part of the proof of claim, the information necessary

to administer this provision. If the application indicates that other loss-of-time coverage is to be discontinued, the amount of such other coverage shall be excluded in computing the alternative percentage in the first sentence of the overinsurance provision. The policy shall include a definition of "valid loss-of-time coverage," approved as to form by the Commissioner, which definition may include coverage provided by governmental agencies and by organizations subject to regulation by insurance law and by insurance authorities of this or any other state of the United States or of any other country or subdivision thereof, coverage provided for such insured pursuant to any disability benefits statute or any workers' compensation or employer's liability statute, benefits provided by labor-management trusteed plans or union welfare plans or by employer or employee benefit organizations, or by salary continuance or pension programs, and any other coverage the inclusion of which may be approved by the Commissioner.

(c) If by application of any of the foregoing provisions the insurer effects a material reduction of benefits otherwise payable under the policy, the insurer shall refund to the insured any premium unearned on the policy by reason of such reduction of coverage, subject to the insurer's right to provide in the policy that no such reduction of benefits or refund will be made unless the unearned premium to be so refunded amounts to $5.00 or such larger sum as the insurer may so specify.

(18 Del. C. 1953, § 3322; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3322. Unpaid premiums.

There may be a provision as follows:

"Unpaid Premium: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom."

(18 Del. C. 1953, § 3323; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3323. Conformity with state statutes.

There may be a provision as follows:

"Conformity with State Statutes: Any provision of this policy which, on its effective date is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes."

(18 Del. C. 1953, § 3324; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3324. Illegal occupation.

There may be a provision as follows:

"Illegal Occupation: The company shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation."

(18 Del. C. 1953, § 3325; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3325. Intoxicants and narcotics.

There may be a provision as follows:

"Intoxicants and Narcotics: The company shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician."

(18 Del. C. 1953, § 3326; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3326. Renewability.

Health insurance policies, other than accident insurance only policies, in which the insurer reserves the right to refuse renewal on an individual basis, shall provide in substance in a provision thereof or in an endorsement thereon or rider attached thereto that subject to the right to terminate the policy upon nonpayment of premium when due, such right to refuse renewal may not be exercised so as to take effect before the renewal date occurring on, or after and nearest, each policy anniversary (or in the case of lapse and reinstatement, at the renewal date occurring on, or after and nearest, each anniversary of the last reinstatement), and that any refusal of renewal shall be without prejudice to any claim originating while the policy is in force. (The parenthetic reference to lapse and reinstatement may be omitted at the insurer's option.)

(18 Del. C. 1953, § 3327; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3327. Order of certain provisions.

The provisions which are the subject of §§ 3305-3326, inclusive, of this title, or any corresponding provisions which are used in lieu thereof in accordance with such sections shall be printed in the consecutive order of the provisions in such sections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided that the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

(18 Del. C. 1953, § 3328; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3328. Third-party ownership.

The word "insured," as used in this subchapter, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits, and rights provided therein.

(18 Del. C. 1953, § 3329; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3329. Requirements of other jurisdictions.

(a) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this State, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of this chapter and which is prescribed or required by the law of the state or country under which the insurer is organized.

(b) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

(18 Del. C. 1953, § 3330; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3330. Policies issued for delivery in another state.

If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public official of such other state has informed the Commissioner that any such policy is not subject to approval or disapproval by such official, the Commissioner may by ruling require that the policy meet the standards set forth in §§ 3303-3329, inclusive, of this title.

(18 Del. C. 1953, § 3331; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3331. Conforming to statute.

(a) No policy provision which is not subject to this chapter shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this chapter.

(b) A policy delivered or issued for delivery to any person in this State in violation of this chapter shall be held valid but shall be construed as provided in this chapter. When any provision in a policy subject to this chapter is in conflict with any provision of this chapter, the rights, duties, and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of this chapter.

(18 Del. C. 1953, § 3332; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3332. Age limit.

If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force until the end of the period for which the premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

(18 Del. C. 1953, § 3333; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3333. Filing of rates.

Each insurer issuing health insurance policies for delivery in this State shall, before use thereof, file with the Commissioner its premium rates and classification of risks pertaining to such policies. The insurer shall adhere to its rates and classifications as filed with the Commissioner. The insurer may change such filings from time to time as it deems proper. The filing of rates shall be made pursuant to and under the requirements of Chapter 25 of this title.

(18 Del. C. 1953, § 3334; 56 Del. Laws, c. 380, § 1; 60 Del. Laws, c. 388, § 3; 80 Del. Laws, c. 310, § 1.)

§ 3334. Franchise health insurance law.

Health insurance on a franchise plan is hereby declared to be that form of health insurance issued to:

(1) Three or more employees of any corporation, copartnership, or individual employer or any governmental corporation, agency or department thereof; or

(2) Ten or more members, employees or employees of members of any trade or professional association or of a labor union or of any other association having had an active existence for at least 2 years where such association or union has a constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance;

where such persons with or without their dependents are issued the same form of an individual policy varying only as to amounts and kinds of coverage applied for by such persons under an arrangement whereby the premiums on such policies may be paid to the insurer periodically by the employer, with or without payroll deductions, or by the association or union for its members, or by some designated person acting on behalf of such employer or association or union. The term "employees" as used herein may be deemed to include the

officers, managers and employees and retired employees of the employer and the individual proprietor or partners if the employer is an individual proprietor or partnership.

(18 Del. C. 1953, § 3335; 56 Del. Laws, c. 380, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3335. Newborn children.

(a) All individual and group health insurance policies providing coverage on an expense-incurred basis, and individual and group service or indemnity-type contracts issued by a nonprofit corporation, which provide coverage for a family member of the insured or subscriber, shall, as to such family members' coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth.

(b) The coverage for newly born children shall consist of coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities as well as routine care furnished any infant from the moment of birth.

(c) If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of the birth of a newly born child, and payment of the required premium or fees, must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth in order to have the coverage continued beyond such 31-day period.

(59 Del. Laws, c. 529, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3336. Midwife services reimbursement.

(a) This section shall apply to every individual policy, contract or certificate issued thereunder, of health or sickness or accident insurance delivered or issued for delivery within the State which meets the requirements of subsection (d) of this section.

(b) This section shall apply to all such policies, contracts, certificates or programs issued, renewed, modified, altered, amended or reissued on or after September 9, 1988.

(c) This section shall apply to all private and public programs for health services and facilities reimbursement, including but not limited to any such reimbursement programs operated by the State.

(d) Whenever an insurance policy, contract or certificate or health services reimbursement program provides for reimbursement for any health-care service which is within those areas of practice for which a midwife may be licensed pursuant to § 122 of Title 16 or pursuant to statute in the state where the service is delivered, or for the cost of birthing facilities, the insured or any other person covered by the policy, contract or certificate, or health services or facilities reimbursement program shall be entitled to reimbursement for such service or use of the facilities performed by a duly licensed certified nurse midwife practicing within those areas for which the certified nurse midwife is licensed in the state where the licensed certified nurse midwife is practicing. Whenever such service is performed by a licensed certified nurse midwife and reimbursed by a professional health services plan corporation, the licensed certified nurse midwife shall be granted such rights of participation, plan admission and registration as may be granted by the professional health services plan corporation, to a physician or osteopath performing such a service. When payment is made for health-care services performed by a licensed certified nurse midwife, no payment or reimbursement shall be payable to a physician or osteopath for the services performed by the licensed certified nurse midwife.

(e) For the purposes of this section, "midwifery" shall only include those having the following qualifications:

(1) Age of 21 years or older;

(2) Licensed as a registered professional nurse in the State;

(3) Possesses a valid certification by the American College of Nurse Midwives;

(4) Submits a sworn statement that he or she has not been convicted of a felony; been professionally penalized or convicted of substance addiction; had a professional nursing license suspended or revoked in this or another state; been professionally penalized or convicted of fraud; is physically and mentally capable of engaging in the practice of midwifery; and

(5) Has formed an alliance which is defined as a relationship between a midwife and a physician(s) licensed to practice medicine or osteopathy in Delaware whereby medical consultation and referral, available on a 24-hour basis, is agreed upon in writing, signed by both parties, and filed with the Department of Health and Social Services.

(66 Del. Laws, c. 331, § 1; 70 Del. Laws, c. 186, § 1; 70 Del. Laws, c. 149, § 203; 80 Del. Laws, c. 310, § 1.)

§ 3337. Lead poisoning screening reimbursement [For application of this section, see 83 Del. Laws, c. 75, § 9].

(a) All individual health insurance policies which are delivered or issued for delivery in this State by any health insurer, health service corporation, health maintenance organization, or any health services and facilities reimbursement program operated by the State and which provide a benefit for outpatient services shall provide a benefit for a baseline lead poisoning screening or testing, as defined in § 2601 of Title 16.

(b) Benefits must also be provided for lead poisoning screening, testing, diagnostic evaluations, screening and testing supplies, and home-visits for children who are at high risk for lead poisoning under guidelines and criteria established by the Division of Public Health.

(c) The benefits required under subsections (a) and (b) of this section are a covered service, notwithstanding any policy exclusions for services which are part of or related to annual or routine examinations.

(d) Nothing in this section prevents the operation of policy provisions such as deductibles, coinsurance allowable charge limitations, coordination of benefits, or provisions restricting coverage to services rendered by licensed, certified, or carrier-approved providers or facilities.

(e) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, or other limited health insurance policies.

(69 Del. Laws, c. 310, § 2; 80 Del. Laws, c. 310, § 1; 83 Del. Laws, c. 75, § 6.)

§ 3338. Coverage of ovarian cancer monitoring and screening tests [For application of this section, see 84 Del. Laws, c. 254, § 4].

(a) Every individual health, sickness or accident insurance policy, contract or certificate, which is delivered or issued for delivery in this State by any health insurer, health service corporation or health maintenance organization, and which provides benefits for outpatient services, shall provide to covered persons residing in this State a benefit for monitoring tests for ovarian cancer subsequent to treatment and annual screening tests for women at risk for ovarian cancer. Such monitoring or screening tests shall be deemed a covered service. The terms of such coverage, including cost-sharing requirements, shall be no less favorable than the terms of coverage, including cost-sharing requirements, applicable to screening mammography for breast cancer.

(b) This section does not apply to any of the following:

(1) Accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.

(2) A high deductible health plan if providing coverage under subsection (a) of this section would cause the plan to fail to be treated as a high deductible health plan under § 223(c)(2) of the Internal Revenue Code [26 U.S.C. § 223(c)(2)].

(3) A catastrophic health plan if providing coverage under subsection (a) of this section would cause the plan to fail to be treated as a catastrophic plan under § 1302(e) of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18022(e).

(c) If, at any time, the State is required under federal law to defray the cost of any coverage required under this section, the requirements under this section are inoperative and the State does not assume any obligation for the cost of coverage.

(d) For purposes of this section:

(1) “At risk for ovarian cancer” means any of the following:

a. Having a family history of any of the following:

1. One or more first- or second-degree relatives with ovarian cancer.
2. Clusters of women relatives with breast cancer.
3. Nonpolyposis colorectal cancer.
4. Breast cancer in a male relative.

b. Testing positive for any of the following genetic mutations:

1. BRCA1 or BRCA2.
2. Lynch syndrome.

c. Having a personal history of any of the following:

1. Ovarian cancer.
2. Endometriosis.
3. Unexplained infertility.
4. Uterine fibroids.
5. Polycystic ovarian syndrome.

(2) “Cost-sharing requirement” means a deductible, coinsurance, or copayment and any maximum limitation on the application of such a deductible, coinsurance, payment, or similar out-of-pocket expense.

(3) “Monitoring tests” and “screening tests” mean tests and examinations for ovarian cancer using any of the following methods that are recommended by a patient’s physician:

a. Tumor marker tests supported by national clinical guidelines, national standards of care, or peer-reviewed medical literature.

b. Transvaginal ultrasound.

c. Pelvic examination.

d. Other screening tests supported by national clinical guidelines, national standards of care, or peer reviewed medical literature.

(69 Del. Laws, c. 405, § 1; 80 Del. Laws, c. 310, § 1; 84 Del. Laws, c. 254, § 1.)

§ 3338A. Equal reimbursement for oral and intravenous anticancer medication.

(a) Every individual policy or contract of health insurance, or certificate issued thereunder, which is delivered, issued for delivery, renewed, modified, altered, or amended in this State on or after January 1, 2013, and which provides medical, major medical, or similar

comprehensive-type coverage, and provides coverage for prescription drugs, and which also provides coverage for anticancer medication, must provide coverage for a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells, and must apply the lower cost sharing of either:

(1) Anticancer medication under the prescription drug benefit; or

(2) Intravenous or injected anticancer medications.

For purposes of this section, the term "cost sharing" may include co-pays, coinsurance, and deductibles, as considered appropriate by the Commissioner.

(b) An insurer who provides coverage under this section and any participating entity through which the insurer offers health services may not:

(1) Vary the terms of the policy for the purpose of or with the effect of avoiding compliance with this section;

(2) Provide incentives, monetary or otherwise, to encourage a covered person to accept less than the minimum protections available under this section;

(3) Penalize in any way or reduce or limit the compensation of a healthcare practitioner for recommending or providing care to a covered person in accordance with this section;

(4) Provide incentives, monetary or otherwise, to a healthcare practitioner relating to the services provided pursuant to this section, intended to induce or have the effect of inducing the practitioner to provide care to a covered person in a manner inconsistent with this section; or

(5) Achieve compliance with this section by imposing an increase in cost sharing for an oral, intravenous, or injected anticancer medication covered under the policy on and following May 1, 2012.

(c) Nothing in this section may be interpreted to prohibit an insurer from requiring prior authorization for any anticancer treatment.

(d) Nothing in this section may be interpreted to require coverage for anticancer medication.

(78 Del. Laws, c. 233, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3338B. Coverage of drugs approved for treatment of certain cancers [For application of this section, see 81 Del. Laws, c. 180, §§ 3 and 4; 84 Del. Laws, c. 338, 3].

(a) No individual policy or contract of health insurance, or certificate issued thereunder, which is delivered, issued for delivery, renewed, modified, altered, or amended in this State by any health insurer, health service corporation or health maintenance organization that directly or indirectly covers the treatment of cancer shall limit or exclude coverage for a drug approved by the United States Food and Drug Administration by mandating that the insured shall first be required to fail to successfully respond to a different drug or drugs or prove a history of failure of a different drug or drugs; provided, however that the use of such drug or drugs is consistent with best practices for the treatment of stage 4 advanced, metastatic cancer or, in the case of other cancers, the use of the drug is supported by national clinical guidelines, national standards of care, or peer reviewed medical literature for the treatment of the cancer, or in the case of targeted therapy, the target at issue.

(b) No individual policy or contract of health insurance, or certificate issued thereunder, which is delivered, issued for delivery, renewed, modified, altered, or amended in this State by any health insurer, health service corporation, or health maintenance organization that directly or indirectly cover the associated conditions of metastatic cancer shall limit or exclude coverage for drugs approved by the United States Food and Drug Administration by mandating that the insured shall first be required to fail to successfully respond to a different drug or drugs or prove a history of failure of a different drug or drugs; provided, however that the use of such drug is consistent with best practices for the treatment of the associated conditions of metastatic cancer and is supported by national clinical guidelines, national standards of care, or peer reviewed medical literature.

(c) For purposes of this section, "associated conditions" mean the symptoms or side effects associated with metastatic cancer or its treatment and which, in the judgment of the health-care practitioner, further jeopardizes the health of a patient if left untreated.

(81 Del. Laws, c. 180, § 1; 84 Del. Laws, c. 338, § 1.)

§ 3339. Refusal to contract.

(a) An insurer shall not refuse to contract with or compensate for covered services a participating or contracting healthcare provider solely because that provider has in good faith communicated with 1 or more of the provider's current, former or prospective patients regarding the provisions, terms or requirements of the insurer's products or services as they relate to the needs of that provider's patients.

(b) An insurer that proposes to terminate or not renew a contract with a professional health-care provider shall give a minimum of 60 days written notice thereof to the provider prior to the effective date of the termination of the contract. This notice shall include a statement of the provider's right to request a written explanation and to request an internal administrative review within 20 days. For purposes of this section, "provider" shall mean a health-care professional licensed pursuant to Title 24.

(c) Upon the request of a provider who has received notice pursuant to subsection (b) of this section, an insurer shall provide written explanation by certified or registered mail of the reasons for the proposed termination or nonrenewal (unless such explanation has already been provided), and an opportunity for an internal administrative review of the decision to terminate. The provider's request for written

explanation and administrative review must be made within 20 days after receipt of the insurer's notice of termination or nonrenewal. The insurer shall provide the written explanation and administrative review not less than 20 days after receipt of the provider's request for same.

(d) A provider who reasonably believes than an insurer's decision to terminate or not renew a contract was solely based on reasons prohibited pursuant to subsection (a) of this section may request that this concern be addressed in the written explanation and administrative review provided by the insurer. Upon request, such a provider shall submit to the insurer a list of the insurer's enrollees with whom the provider has communicated and upon whom the provider relies to support his or her belief and a statement of the nature of the information provided to each enrollee that is protected by this section.

(e) If an insurer collects and maintains professional profiling data and the written explanation provided pursuant to subsection (c) of this section states that the insurer used such data to evaluate the performance or practice of the provider, this data shall be provided to the provider and be discussed during the administrative review pursuant to subsection (c) of this section. Data provided by an insurer pursuant to this section shall be confidential and shall not be disclosed by a provider or an insurer to third parties without the consent of the other party, except such data may be disclosed to a party's attorney or as otherwise required by law.

(f) This section shall not apply to a decision by an insurer to terminate or renew a provider's contract because of breach of contract, loss of professional liability insurance, indictment or arrest or conviction for a felony or crime of moral turpitude, final internal disciplinary action (excluding judicial appeals) by a hospital, licensing board or other governmental agency that impairs the provider's ability to practice or clinical privileges, failure to meet the minimum requirements for participation in the insurer's plan, as previously disclosed to the provider, adjudication of fraud or in cases involving imminent harm to patient care.

(g) Nothing in this section shall be construed to prohibit an insurer from terminating or not renewing a provider's contract with or without cause for economic reasons or any other reason not prohibited by subsection (a) of this section, but a written explanation of the reasons for the proposed termination or nonrenewal must be provided pursuant to subsection (c) of this section.

(h) This section shall not be deemed to create a private cause of action as a result of an insurer's termination or nonrenewal of a provider's contract. This subsection shall not abrogate any cause of action or remedy to which a provider may have a right pursuant to contract.

(i) Any insurer who violates the provisions of this section may be subject to the administrative orders and penalties imposable for a violation of Chapter 23 of this title as specified in § 2308(a)(1) and (a)(2) of Title 18.

(j) Providers, insurers and their respective employees, agents, attorneys and other representatives who have acted in good faith while participating in the written explanation or administrative review provided pursuant to subsection (c) of this section, shall have immunity and shall not be held liable as a result of any such participation in a case alleging slander, libel, defamation or in any other private cause of action. Such persons shall be presumed to have acted in good faith in the absence of evidence of malice or wilful misconduct.

(70 Del. Laws, c. 537, § 2; 70 Del. Laws, c. 186, § 1; 71 Del. Laws, c. 370, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3340. Child abuse or neglect — Individual coverage.

No individual policy or contract, or certificate issued thereunder, of health insurance which provides medical coverage for a child and which (1) covers a child who resides in this State, or (2) is delivered or issued for delivery within the State, shall limit medical insurance coverage for any child referred by the Division of Family Services or law enforcement agency for suspected child abuse or neglect, including requiring referral by a primary physician.

(71 Del. Laws, c. 199, § 16; 80 Del. Laws, c. 310, § 1.)

§ 3341. Newborns and mothers health protection.

A carrier offering a health benefit plan shall comply with the provisions of 42 U.S.C. § 300gg-51 and any subsequent changes in federal law.

(71 Del. Laws, c. 143, § 16; 80 Del. Laws, c. 310, § 1.)

§ 3342. Obstetrical and gynecological coverage.

(a) This section applies to every individual policy or contract of health insurance, or certificate issued thereunder, which is delivered or issued for delivery in this State that requires an insured, participant, policyholder, subscriber, or beneficiary to designate a participating primary care provider.

(b) Any such policy or contract shall permit each female enrolled insured, participant, policyholder, subscriber or beneficiary to designate a participating, in-network, obstetrician-gynecologist as the enrollee's primary care provider if: (i) the obstetrician-gynecologist meets the standards established by the insurance plan for primary care providers; (ii) the obstetrician-gynecologist requests that the insurer makes the obstetrician-gynecologist available for designation as a primary care provider; (iii) the obstetrician-gynecologist agrees to accept the payment terms applicable under the plan to primary care providers for services other than obstetrician-gynecological services; and (iv) the obstetrician-gynecologist agrees to abide by all other terms and conditions applicable to primary care physicians under the plan generally.

(c) If a female enrolled insured, participant, policyholder, subscriber or beneficiary has designated a primary care provider who is not an obstetrician-gynecologist, then the policy or contract shall not require as a condition to the coverage of the services of a participating in-network obstetrician-gynecologist that a female enrollee first obtain a referral from another primary care physician, and shall permit the female enrolled insured, participant, policyholder, subscriber or beneficiary to have direct access to the health-care services of an in-

network obstetrician-gynecologist participating in the plan, within the benefits provided under that plan. In such cases the obstetrician-gynecologist shall consult with the primary care physician with respect to the care given and any follow-up care, and the plan may require a visit to the primary care physician, if necessary, before the patient may be directed to another specialty provider, or for inpatient hospitalization or outpatient surgical procedures.

(d) For purposes of this section, "health-care services" means the full scope of medically necessary services provided by the participating obstetrician-gynecologist within the benefits provided under that plan.

(e) This section shall not be construed to require an individual obstetrician-gynecologist to accept primary care physician status if the obstetrician-gynecologist does not wish to be designated as a primary care physician, nor to interfere with the credentialing and other selection criteria usually applied by a health benefit plan with respect to other physicians within its network.

(f) Any such policy or contract may not impose a copayment, coinsurance requirement, or deductible for directly accessed obstetric and gynecologic services as required in this section, unless such additional cost sharing is imposed for access to health-care practitioners for other types of health-care services.

(g) If a policy or contract limits an insured's access to a network of participating providers for other health-care services, then it may limit access for obstetric and gynecologic services, but the policy or contract shall include in all its provider networks sufficient numbers of obstetrician-gynecologists to accommodate the direct access needs of their female enrollees.

(h) Each such policy or contract shall provide notice to female enrolled participants, policyholders, subscribers and beneficiaries regarding the coverage required by this section. The notice shall be in writing, printed in type not less than 8-point, and prominently positioned in any literature or correspondence, including benefit handbooks and enrollment materials. Policies or contracts shall include an explanation of any voluntary process of preauthorization of services available to female enrollees and obstetrician-gynecologists. The enrollee handbook explanation shall include information regarding any limitation to direct access, including, but not limited to, a closed network of providers, or any limitation on access to an obstetrician-gynecologist based on a female's choice of primary care provider.

(i) (1) For purposes of this subsection:

a. "Iatrogenic infertility" means an impairment of fertility due to surgery, radiation, chemotherapy, or other medical treatment.

b. "Infertility" means a disease or condition that results in impaired function of the reproductive system whereby an individual is unable to procreate or to carry a pregnancy to live birth, including the following:

1. Absent or incompetent uterus.
2. Damaged, blocked, or absent fallopian tubes.
3. Damaged, blocked, or absent male reproductive tract.
4. Damaged, diminished, or absent sperm.
5. Damaged, diminished, or absent oocytes.
6. Damaged, diminished, or absent ovarian function.
7. Endometriosis.
8. Hereditary genetic disease or condition that would be passed to offspring.
9. Adhesions.
10. Uterine fibroids.
11. Sexual dysfunction impeding intercourse.
12. Teratogens or idiopathic causes.
13. Polycystic ovarian syndrome.
14. Inability to become pregnant or cause pregnancy of unknown etiology.
15. Two or more pregnancy losses, including ectopic pregnancies.
16. Uterine congenital anomalies, including those caused by diethylstilbestrol ("DES").

c. "Standard fertility preservation services" means procedures consistent with established medical practices and professional guidelines published by professional medical organizations, including the American Society for Clinical Oncology and the American Society for Reproductive Medicine.

(2) All individual health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State by any health insurer, health service corporation, or health maintenance organization and that provide for medical or hospital expenses shall include coverage for fertility care services, including in vitro fertilization services for individuals who suffer from a disease or condition that results in the inability to procreate or to carry a pregnancy to live birth and standard fertility preservation services for individuals who must undergo medically necessary treatment that may cause iatrogenic infertility. Such benefits must be provided to covered individuals, including covered spouses and covered nonspouse dependents, to the same extent as other pregnancy-related benefits and include the following:

a. Intrauterine insemination.

b. Assisted hatching.

c. Cryopreservation and thawing of eggs, sperm, and embryos.

d. Cryopreservation of ovarian tissue.

e. Cryopreservation of testicular tissue.

f. Embryo biopsy.

g. Consultation and diagnostic testing.

h. Fresh and frozen embryo transfers.

i. Six completed egg retrievals per lifetime, with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine, using single embryo transfer ("SET") when recommended and medically appropriate.

j. In vitro fertilization ("IVF"), including IVF using donor eggs, sperm, or embryos, and IVF where the embryo is transferred to a gestational carrier or surrogate.

k. Intra-cytoplasmic sperm injection ("ICSI").

l. Medications.

m. Ovulation induction.

n. Storage of oocytes, sperm, embryos, and tissue.

o. Surgery, including microsurgical sperm aspiration.

p. Medical and laboratory services that reduce excess embryo creation through egg cryopreservation and thawing in accordance with an individual's religious or ethical beliefs.

(3) An individual qualifies for coverage under this subsection if all of the following requirements are met:

a. A board-certified or board-eligible obstetrician-gynecologist, subspecialist in reproductive endocrinology, oncologist, urologist, or andrologist verifies that the covered individual is diagnosed with infertility or is at risk of iatrogenic infertility.

b. When the covered individual is diagnosed with infertility, the covered individual has not been able to obtain a successful pregnancy through reasonable effort with less costly infertility treatments covered by the policy, contract, or certificate, except as follows:

1. No more than 3 treatment cycles of ovulation induction or intrauterine inseminations may be required before in vitro fertilization services are covered.

2. If IVF is medically necessary, no cycles of ovulation induction or intrauterine inseminations may be required before in vitro fertilization services are covered.

3. IVF procedure must be performed at a practice that conforms to American Society for Reproductive Medicine and American Congress of Obstetricians and Gynecologists guidelines.

c. For IVF services, retrievals are completed before the individual is 45 years old and transfers are completed before the individual is 50 years old.

(4) A policy, contract, or certificate may not impose any exclusions, limitations, or other restrictions on coverage of fertility medications that are different from those imposed on any other prescription medications, nor may it impose deductibles, copayments, coinsurance, benefit maximums, waiting periods, or any other limitations on coverage for required fertility care services, which are different from those imposed upon benefits for services not related to infertility.

(5) A policy, contract, or certificate is not required to cover experimental fertility care services, monetary payments to gestational carriers or surrogates, or the reversal of voluntary sterilization undergone after the covered individual successfully procreated with the covered individual's partner at the time the reversal is desired.

(71 Del. Laws, c. 178, § 1; 70 Del. Laws, c. 186, § 1; 80 Del. Laws, c. 310, § 1; 81 Del. Laws, c. 78, § 6; 81 Del. Laws, c. 284, § 1.)

§ 3342A. Contraceptive coverage.

(a) For purposes of this section:

(1) "Carrier" means any entity that provides health insurance in this State. "Carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(2) "FDA" means the Food and Drug Administration.

(3) a. "Health benefit plan" means any hospital or medical policy or certificate, major medical expense insurance, health service corporation subscriber contract, or health maintenance organization subscriber contract. "Health benefit plan" does not include accident-only, credit, dental, vision, Medicaid plans, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical payment insurance.

b. "Health benefit plan" does not include policies or certificates of specified disease, hospital confinement indemnity, or limited benefit health insurance, if the carrier offering such policies or certificates has done the following:

1. Filed on or before March 1 of each year a certification with the Commissioner that contains the following statement and information:

A. A statement from the carrier certifying that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance.

B. A summary description of each policy or certificate described in this paragraph, including the average annual premium rates or range of premium rates in cases where premiums vary by age, gender, or other factors charged for such policies and certificates in this State.

2. In the case of a policy or certificate that is described in this paragraph (a)(3)b. and that is offered for the first time in this State on or after January 1, 1999, the carrier files with the Commissioner the information and statement required in this paragraph (a)(3)b. at least 30 days prior to the date such a policy or certificate is issued or delivered in this State.

(4) "Therapeutic equivalent" means a contraceptive drug, device, or product that is all of the following:

a. Approved as safe and effective.

b. Pharmaceutically equivalent to another contraceptive drug, device, or product in that it contains an identical amount of the same active drug ingredient in the same dosage form and route of administration and meets compendial or other applicable standards of strength, quality, purity, and identity.

c. Assigned, by the FDA, the same therapeutic equivalence code as another contraceptive drug, device, or product.

(b) Carriers shall provide coverage for contraceptive methods in all health benefit plans delivered or issued for delivery in this State. Coverage for contraceptive methods must include all of the following:

(1) All FDA-approved contraceptive drugs, devices, and other products as follows:

a. If the FDA has approved 1 or more therapeutic equivalents of a contraceptive drug, device, or product, the health benefit plan is not required to include all such therapeutically equivalent versions in its formulary as long as at least 1 is included and covered without cost-sharing and in accordance with this section.

b. If there is a therapeutic equivalent of a drug, device, or other product for an FDA-approved contraceptive method, the health benefit plan may provide coverage for more than 1 drug, device, or other product and may impose cost-sharing requirements as long as at least 1 drug, device, or other product for that method is available without cost-sharing. If, however, an individual's attending provider recommends a particular FDA-approved contraceptive based on a medical determination with respect to that individual, regardless of whether the contraceptive has a therapeutic equivalent, the health benefit plan shall provide coverage for the prescribed contraceptive drug, device, or product without cost-sharing.

c. The health benefit plan is not required to provide coverage for male condoms.

(2) FDA-approved contraception available over-the-counter, including emergency contraception, whether with or without a prescription, or dispensed consistent with the requirements of Chapter 25 of Title 24.

(3) A prescription for contraceptives intended to last for no more than a 12-month period which may be dispensed all at once or over the course of the 12-month period, regardless of whether the covered individual was enrolled in the health benefit plan under this chapter at the time the prescription contraceptive was first dispensed.

(4) Voluntary female sterilization procedures.

(5) Patient education and counseling on contraception.

(6) Follow-up services related to the drugs, devices, products, and procedures covered under this subsection, including management of side effects, counseling for continued adherence, and device insertion and removal.

(7) Immediate postpartum insertion of long-acting reversible contraception.

(c) (1) Coverage provided under this section is not subject to any deductible, coinsurance, copayment, or any other cost-sharing requirement, except under paragraph (b)(1) of this section or as otherwise required under federal law. Coverage offered under this section may not impose unreasonable restrictions or delays in the coverage, except that reasonable medical management techniques may be applied to coverage within a method category, as defined by the FDA, but not across types of methods.

(2) Coverage provided to a covered individual under this section shall be the same for the covered individual's covered spouse and covered dependents.

(d) This section does not preclude coverage for contraceptive drugs, devices, products, and procedures as prescribed by a provider for reasons other than contraceptive purposes, including decreasing the risk of ovarian cancer, eliminating symptoms of menopause, or providing contraception that is necessary to preserve the life or health of the covered individual.

(e) The plan is not required under this section to cover experimental or investigational treatments.

(81 Del. Laws, c. 323, § 1; 70 Del. Laws, c. 186, § 1; 84 Del. Laws, c. 374, § 1.)

§ 3342B. Primary care coverage [For application of this section, see 81 Del. Laws, c. 392, § 12].

(a) For purposes of this section:

(1) a. "Carrier" means any entity that provides health insurance in this State. "Carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to

state insurance regulation. “Carrier” also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

b. “Carrier” does not mean a plan of health insurance or health benefits designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act (42 U.S.C. §§ 1395 et seq., 1396 et seq. and 1397aa. et seq.), known as Medicare, Medicaid, or any other similar coverage under state or federal governmental plans.

(2) “Chronic care management” means the services in the Chronic Care Management Services Program, as administered by the Centers for Medicare and Medicaid Services, and includes Current Procedural Terminology (“CPT”) codes 99487, 99489, and 99490.

(3) “Medicare” means the federal Medicare Program (U.S. Public Law 89-87, as amended) (42 U.S.C. § 1395 et seq.).

(4) “Primary care” means health care provided by a physician or an individual licensed under Title 24 to provide health care, with whom the patient has initial contact and by whom the patient may be referred to a specialist and includes family practice, pediatrics, internal medicine, and geriatrics.

(b) (1) A carrier shall provide coverage for chronic care management and primary care at a reimbursement rate that is not less than the Medicare reimbursement for comparable services.

(2) This subsection applies to an individual health insurance policy, plan, or contract that is delivered, issued for delivery, or renewed by a carrier on or after January 1, 2019.

(3) A carrier shall do the following:

a. By 2022, spend at least 7% of its total cost of medical care on primary care.

b. By 2023, spend at least 8.5% of its total cost of medical care on primary care.

c. By 2024, spend at least 10% of its total cost of medical care on primary care.

d. By 2025, spend at least 11.5% of its total cost of medical care on primary care.

e. By 2026 and each year thereafter, spend at least 11.5%, 5% of which must be via prospective primary care management payments, of its total cost of medical care on primary care.

(c) Coverage for chronic care management must not be subject to patient deductibles, copayments, or fees.

(d) If a comparable Medicare reimbursement rate is not available, a carrier shall reimburse for services at the rates generally available under Medicare for services such as office visits and prolonged preventive services, which may be further delineated by regulation.

(e) (1) The Department shall arbitrate disagreements regarding rates under this section. The parties must pay the cost of the arbitration.

(2) The Department shall adopt regulations to implement the requirements of this subsection no later than March 31, 2019.

(f) The provisions of this section may not be waived by contract. Any contractual arrangement in conflict with the provisions of this section or that purports to waive any requirements of this section is void.

(g) (1) A carrier shall offer value-based care programs that meet the program design element requirements issued by the Department by the first full plan year following the Department’s promulgation of regulations pursuant to § 334 of this title.

(2) A carrier may not deny a contracted provider the opportunity to participate in an offered value-based care program if the provider is willing to accept the terms and conditions established for other providers as a condition of program participation.

(h) In calculating total cost of medical care for purposes of this section, the Commissioner shall, by regulation, authorize the exclusion of high-cost claims and may authorize the exclusion of other costs actually incurred by carriers.

(81 Del. Laws, c. 392, § 5; 82 Del. Laws, c. 141, § 24; 83 Del. Laws, c. 237, §§ 5, 14; 85 Del. Laws, c. 348, §§ 6, 8.)

§ 3343. Insurance coverage for serious mental illness [For application of this section, see 81 Del. Laws, c. 29, § 3; and 82 Del. Laws, c. 199, § 3] [Effective until Jan. 1, 2028].

(a) *Definitions.* — For purposes of this section:

(1) “ASAM criteria” means the comprehensive set of guidelines for placement, continued stay, and transfer or discharge of patients with addiction established by the American Society of Addiction Medicine (“ASAM”) for use in determining medically necessary treatment.

(2) “Carrier” means any entity that provides health insurance in this State. For the purposes of this section, “carrier” includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. “Carrier” also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(3) “Drug and alcohol dependencies” means substance abuse disorder or the chronic, habitual, regular, or recurrent use of alcohol, inhalants, or controlled substances as identified in Chapter 47 of Title 16.

(4) “FDA” means the U.S. Food and Drug Administration.

(5) “Health benefit plan” means any hospital or medical policy or certificate, major medical expense insurance, health service corporation subscriber contract, or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, credit, dental, vision, Medicaid plans, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, worker’s compensation or similar insurance, or automobile medical payment insurance.

"Health benefit plan" shall not include policies or certificates of specified disease, hospital confinement indemnity, or limited benefit health insurance, provided that the carrier offering such policies or certificates complies with the following:

a. The carrier files on or before March 1 of each year a certification with the Commissioner that contains the statement and information described in paragraph (a)(5)b. of this section.

b. The certification required in paragraph (a)(5)a. of this section shall contain the following:

1. A statement from the carrier certifying that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance.

2. A summary description of each policy or certificate described in this paragraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age, gender, or other factors) charged for such policies and certificates in this State.

c. In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this State on or after January 1, 1999, the carrier files with the Commissioner the information and statement required in paragraph (a)(5)b. of this section at least 30 days prior to the date such a policy or certificate is issued or delivered in this State.

(6) "Medication-assisted treatment" means the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of drug and alcohol dependencies.

(7) "Serious mental illness" means any of the following biologically based mental illnesses: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo affective disorder, and delusional disorder. The diagnostic criteria set out in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders shall be utilized to determine whether a beneficiary of a health benefit plan is suffering from a serious mental illness.

(b) *Coverage of serious mental illnesses and drug and alcohol dependencies.* — (1) a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide all of the following:

1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.

2. Unlimited medically necessary treatment for drug and alcohol dependencies as required by the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a) and determined by the use of the full set of ASAM criteria, in all of the following:

A. Treatment provided in residential setting.

B. Intensive outpatient programs.

C. Inpatient withdrawal management.

b. Subject to subsections (a), (c) through (f), and (h) of this section, no carrier may issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines.

(2) a. A health benefit plan that provides coverage for prescription drugs must provide coverage for the treatment of serious mental illnesses and drug and alcohol dependencies that includes immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications covered under the health benefit plan for the medically necessary treatment of serious mental illnesses and drug and alcohol dependencies where an emergency medical condition, as defined in § 3349(e) of this title, exists, including a prescribed drug or medication associated with the management of opioid withdrawal or stabilization, except where otherwise prohibited by law.

b. Coverage of an emergency supply of prescribed medications must include medication for opioid overdose reversal otherwise covered under the health benefit plan prescribed to a covered person.

c. Coverage provided under this paragraph (b)(2) of this section may be subject to copayments, coinsurance, and annual deductibles that are consistent with those imposed on other benefits within the health benefit plan; provided, however, a health benefit plan must not impose an additional copayment or coinsurance on a covered person who received an emergency supply of the same medication in the same 30-day period in which the emergency supply of medication was dispensed.

d. This paragraph (b)(2) of this section does not preclude the imposition of a copayment or coinsurance on the initial emergency supply of medication in an amount that is less than the copayment or coinsurance otherwise applicable to a 30-day supply of such medication, provided that the total sum of copayments or coinsurance for an entire 30-day supply of the medication does not exceed the copayment or coinsurance otherwise applicable to a 30-day supply of such medication.

(3) A health benefit plan that provides coverage for prescription drugs must place at least 1 formulation of a medication-assisted treatment on the lowest tier of the drug formulary developed and maintained by the carrier, including each of the following:

a. Buprenorphine.

b. Naltrexone.

c. Naloxone.

d. A product containing both buprenorphine and naloxone.

(4) A health benefit plan that provides coverage for prescription drugs must cover the fees associated with the administration or dispensing of methadone dispensed at an opioid treatment program as defined under 42 C.F.R. § 8.2.

(c) *Eligibility for coverage.* — (1) Subject to the limitations under subsection (d) of this section, a health benefit plan may condition coverage of services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency on any of the following requirements:

a. That the services must be rendered by a mental health professional licensed or certified by the State Board of Licensing including, but not limited to, psychologists, psychiatrists, social workers, and other such mental health professionals, or a drug and alcohol counselor who has been certified by the Delaware Certified Alcohol and Drug Counselors Certification Board, or in a mental health facility licensed by the State or in a treatment facility approved by the Department of Health and Social Services or the Bureau of Alcoholism and Drug Abuse as set forth in Chapter 22 of Title 16, or substantially similar licensing entities in other states.

b. That the services must be medically necessary.

c. That the services must be covered services subject to any administrative requirements of the health benefit plan.

(2) A health benefit plan may further condition coverage of services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency in the same manner and to the same extent as coverage for all other illnesses and diseases is conditioned. Such conditions include precertification and referral requirements.

(d) *Benefit management.* — (1) A carrier may, directly or by contract with another qualified entity, manage the benefit prescribed by subsection (b) of this section in order to limit coverage of services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency to those services that are deemed medically necessary as follows:

a. The management of benefits for serious mental illnesses and drug and alcohol dependencies may be by methods used for the management of benefits provided for other medical conditions, or may be by management methods unique to mental health benefits, including pre-admission screening, prior authorization of services, utilization review, and the development and monitoring of treatment plans.

b. A carrier may not impose precertification, prior authorization, pre-admission screening, or referral requirements for the diagnosis and medically necessary treatment of drug and alcohol dependencies, including inpatient treatment or on a prescription medication under paragraph (b)(3) of this section.

c. The benefit prescribed by paragraph (b)(1) of this section may not be subject to concurrent utilization review during the first 14 days of any inpatient admission to a facility approved by a nationally recognized health-care accrediting organization or the Division of Substance Abuse and Mental Health, 30 days of intensive outpatient program treatment, or 5 days of inpatient withdrawal management, provided that the facility notifies the carrier of both the admission and the initial treatment plan within 48 hours of the admission. The facility shall perform daily clinical review of the patient, including the periodic consultation with the carrier to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the carrier which is designated by the American Society of Addiction Medicine ("ASAM") or, if applicable, any state-specific ASAM criteria, and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient.

d. Any utilization review of treatment provided under paragraph (b)(1) of this section may include a review of all services provided during such inpatient treatment, including all services provided during the first 14 days of such inpatient treatment, 30 days of intensive outpatient program treatment, or 5 days of inpatient withdrawal management; provided, however, the carrier may only deny coverage for any portion of the initial 14-day inpatient treatment on the basis that such treatment was not medically necessary if such inpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the carrier which is designated by ASAM or, if applicable, any state-specific ASAM criteria.

e. A covered person does not have any financial obligation to the facility for any treatment under paragraph (b)(1) of this section other than any copayment, coinsurance, or deductible otherwise required under the health benefit plan.

f. A carrier must authorize coverage of prescription medicine without imposing a step therapy requirement for at least 1 formulation of each prescription medication for medication-assisted treatment that is on each tier of the drug formulary developed and maintained by the carrier.

(2) This section shall not be interpreted to require a carrier to employ the same benefit management procedures for serious mental illnesses and drug and alcohol dependencies that are employed for the management of other illnesses or diseases covered by the health benefit plan or to require parity or equivalence in the rate, or dollar value of, claims denied.

(e) *Exclusions.* — This section does not apply to plans or policies not within the definition of health benefit plan, as set out in subsection (a) of this section.

(f) *Out of network services.* — Where a health benefit plan provides benefits for the diagnosis and treatment of serious mental illnesses and drug and alcohol dependencies within a network of providers and where a beneficiary of the health benefit plan obtains services consisting of diagnosis and treatment of a serious mental illness and drug and alcohol dependency outside of the network of providers, this section shall not apply. The health benefit plan may contain terms and conditions applicable to out of network services without reference to this section.

(g) *Reporting requirements. —*

Each carrier must submit a report to the Delaware Health Information Network in conjunction with the Commissioner on or before July 1 2019, and any year thereafter during which the carrier makes significant changes to how it designs and applies its medical management protocols; the report must contain the following information:

(1) A description of the process used to develop or select the medical necessity criteria for mental illness and drug and alcohol dependencies benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits.

(2) Identification of all nonquantitative treatment limitations (NQTLs) that are applied to mental illness and drug and alcohol dependencies benefits and medical and surgical benefits within each classification of benefits; there may be no separate NQTLs that apply to mental illness and drug and alcohol dependencies benefits that do not also apply to medical and surgical benefits within any classification of benefits.

(3) The results of an analysis that demonstrates that for the medical necessity criteria described in paragraph (g)(1) of this section and for each NQTL identified in paragraph (g)(2) of this section, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to mental illness and drug and alcohol dependencies benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to medical and surgical benefits within the corresponding classification of benefits; at a minimum, the results of the analysis shall:

a. Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected.

b. Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each NQTL.

c. Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written, for mental illness and drug and alcohol dependencies benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each NQTL, as written, for medical and surgical benefits.

d. Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each NQTL, in operation, for mental illness and drug and alcohol dependencies benefits are comparable to, and applied no more stringently than, the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits.

e. Disclose the specific findings and conclusions reached by the carrier that the results of the analyses above indicate that the carrier is in compliance with this section and the Mental Health Parity and Addiction Equity Act of 2008 [P.L. 104-204] and its implementing regulations, which includes 45 C.F.R. 146.136, 45 C.F.R. 147.160, and any other related federal regulations found in the Code of Federal Regulations.

(4) Any information submitted to the Delaware Health Information Network and the Commissioner by a carrier that is considered proprietary by the carrier shall not be made public record.

(5) The Insurance Commissioner shall retain the authority to enforce the provisions of this section. The provisions of this section shall not give rise to a private cause of action.

(h) Nothing in this section shall be construed to limit or reduce any benefit, entitlement, or coverage conferred by § 3366 of this title including, but not limited to, provider and service eligibility.

(i) This section does not apply to plans of health insurance or health benefits designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act, 42 U.S.C. §§ 1395 et seq., 1396 et seq., and 1397aa et seq., known as Medicare, Medicaid, or any other coverage under a state or federal government plan.

(71 Del. Laws, c. 275, § 1; 73 Del. Laws, c. 199, §§ 1-4, 11; 74 Del. Laws, c. 157, § 1; 78 Del. Laws, c. 398, § 2; 80 Del. Laws, c. 310, § 1; 81 Del. Laws, c. 29, § 1; 81 Del. Laws, c. 190, §§ 1-3; 81 Del. Laws, c. 406, § 1; 82 Del. Laws, c. 199, § 1.)

§ 3343. Insurance coverage for mental health disorders and substance use disorders [For application of this section, see 81 Del. Laws, c. 29, § 3; and 82 Del. Laws, c. 199, § 3] [Effective Jan. 1, 2028].

(a) Definitions. —

For purposes of this section:

(1) “ASAM criteria” means the latest version of comprehensive set of guidelines for placement, continued stay, and transfer or discharge of individuals with a primary diagnosis of a substance use disorder established by the American Society of Addiction Medicine (“ASAM”).

(2) “Carrier” means any entity that provides health insurance in this State. For the purposes of this section, “carrier” includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. “Carrier” also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(3) “Child and Adolescent Level of Care Utilization System / Service Intensity Instrument” or “CALOCUS-CASII” means the latest version of comprehensive set of guidelines for placement, continued stay, and transfer or discharge of children and adolescents aged 6 to

18 with a primary diagnosis of a mental health disorder established by the American Association for Community Psychiatry ("AACP") and the American Academy of Child and Adolescent Psychiatry ("AACAP").

(4) "Early Childhood Service Intensity Instrument" or "ECSII" means the latest version of the service planning tool established by AACAP for determination of the intensity of services for children and families with emotional, behavioral, or developmental needs, including those who are experiencing environmental stressors that may put them at risk for such problems.

(5) "Emergency care" means care provided to treat a mental health disorder or substance use disorder that meets the definition of an "emergency medical condition" as defined in § 3349 of this title.

(6) "FDA" means the U.S. Food and Drug Administration.

(7) "Generally accepted standards of mental health disorder and substance use disorder care" means standards of care and clinical practice that are generally recognized by health-care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical social work, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental health disorder and substance use disorder care include published peer-reviewed scientific studies and medical literature and clinical practice guidelines and other recommendations of nonprofit health-care professional associations.

(8) "Health benefit plan" means any hospital or medical policy or certificate, major medical expense insurance, health service corporation subscriber contract, or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, credit, dental, vision, Medicaid plans, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical payment insurance.

"Health benefit plan" shall not include policies or certificates of specified disease, hospital confinement indemnity, or limited benefit health insurance, provided that the carrier offering such policies or certificates complies with the following:

a. The carrier files on or before March 1 of each year a certification with the Commissioner that contains the statement and information described in paragraph (a)(5)b. of this section.

b. The certification required in paragraph (a)(5)a. of this section shall contain the following:

1. A statement from the carrier certifying that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance.

2. A summary description of each policy or certificate described in this paragraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age, gender, or other factors) charged for such policies and certificates in this State.

c. In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this State on or after January 1, 1999, the carrier files with the Commissioner the information and statement required in paragraph (a)(5)b. of this section at least 30 days prior to the date such a policy or certificate is issued or delivered in this State.

(9) "Level of Care Utilization System" or "LOCUS" means the latest version of comprehensive set of guidelines for placement, continued stay, and transfer or discharge of adults over 18 years of age with a primary diagnosis of a mental health disorder established by AACP.

(10) "Medically necessary" means a service or product addressing the specific needs of a covered person, for the purpose of screening, preventing, diagnosing, managing or treating a mental health disorder or substance use disorder, including minimizing the progression of a disorder or its symptoms, in a manner that is all of the following:

a. In accordance with the generally accepted standards of mental health disorder and substance use disorder care.

b. Clinically appropriate in terms of type, frequency, extent, site, and duration.

c. Not primarily for the economic benefit of the carrier or for the convenience of the covered person, treating physician, or other health-care provider.

(11) "Mental health disorders and substance use disorders" means a mental health disorder or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood.

(12) "Nonprofit health-care professional associations" means a not-for-profit health-care provider professional association or specialty society that is generally recognized by clinicians practicing in the relevant clinical specialty and that issues peer-reviewed guidelines, criteria, or other clinical recommendations developed through a transparent process, including the American Psychiatric Association, American Psychological Association, American Society of Addiction Medicine, American Academy of Child and Adolescent Psychiatry, and American Association for Community Psychiatry.

(13) "Serious mental illness" means any of the following mental health disorders: neurodevelopmental disorders; schizophrenia spectrum and other psychotic disorders; bipolar and related disorders; depressive disorders; anxiety disorders; obsessive-compulsive and related disorders; trauma- and stressor-related disorders; dissociative disorders; somatic symptom and related disorders; feeding

and eating disorders; personality disorders; and disruptive, impulse-control, and conduct disorders. The diagnostic criteria set out in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders must be utilized to determine whether a beneficiary of a health benefit plan has a serious mental illness.

(14) "Urgent mental health disorder and substance use disorder care" means care that is delivered on an expedited basis for the treatment of an acute mental health disorder or substance use disorder with symptoms of sufficient severity pursuant to a determination by a licensed treating health-care provider, operating within the health-care provider's scope of practice and professional expertise, that the failure to provide the service is likely to result in serious, long-term health complications or a material deterioration in the covered person's or enrollee's condition and prognosis.

(15) "Utilization review" means reviewing and approving, modifying, delaying, or denying, requests by health-care providers, covered persons, or their authorized representatives for coverage of health-care services, based in whole or in part on medical necessity, or for out-of-network services required pursuant to subsection (f) of this section.

(16) "Utilization review criteria" means any criteria, standards, protocols, or guidelines used by a carrier to conduct utilization review.

(b) *Coverage of mental health disorders and substance use disorders. —*

(1) a. Carriers shall provide coverage for all medically necessary services for mental health disorders or substance use disorders under all health benefit plans delivered or issued for delivery in this State. Coverage for mental health disorders and substance use disorders must provide all of the following:

1. The levels of care described in the ASAM criteria, LOCUS, CALOCUS-CASII, and ECSII.

2. Unlimited medically necessary services for mental health disorders and substance use disorders as required by the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a) and determined by the use of the full set of ASAM criteria, LOCUS, CALOCUS-CASII, and ECSII, including all of the following levels of care:

A. Residential settings.

B. Intensive outpatient programs.

C. Inpatient settings, including withdrawal management.

3. Emergency services to treat mental health disorders and substance use disorders, including emergency transportation to an appropriate provider or facility for the purposes of stabilization, mobile crisis response teams, crisis receiving and stabilization services, and other services necessary to screen, evaluate, and stabilize an individual experiencing a mental health disorder or substance use disorder emergency.

4. For purposes of paragraph (b)(1)a.3. of this section, mobile crisis response services provided by a state-operated program or by a program authorized by the Division of Substance Abuse and Mental Health are considered emergency services. A carrier shall reimburse a state-operated or state-authorized mobile crisis program that submits claims for covered services consistent with this section. Nothing in this section requires a carrier to establish or duplicate a mobile crisis delivery system where this State operates or authorizes such services.

5. Nothing in this subsection requires a carrier to cover nonclinical placements or supports, including foster care or recovery residences that are not licensed or certified as behavioral treatment programs under Delaware law; provided, however, that if a carrier provides coverage for such services or settings, the carrier shall apply the requirements of this section to that coverage and shall cover medically necessary clinical services, including services delivered in residential treatment settings, as required under paragraph (b)(1)a.2. of this section.

b. Subject to subsections (a), (c) through (f), and (h) of this section, no carrier may issue for delivery, or deliver, in this State any health benefit plan that does any of the following:

1. Contains terms that place a greater financial burden on a covered person for covered services provided in the diagnosis and treatment of a mental health disorder or substance use disorder than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines.

2. Discriminates, in its benefit design or implementation of its benefit design, against covered persons because of their history of, present, or predicted mental health disorder or substance use disorder.

(2) a. A health benefit plan that provides coverage for prescription drugs must provide coverage for the treatment of mental health disorders and substance use disorders that includes immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications covered under the health benefit plan for the medically necessary services of mental health disorders and substance use disorders where an "emergency medical condition," as defined in § 3349(e) of this title, exists, including a prescribed drug or medication associated with the management of opioid withdrawal or stabilization, except where otherwise prohibited by law.

b. Coverage of an emergency supply of prescribed medications must include medication for opioid overdose reversal otherwise covered under the health benefit plan prescribed to a covered person.

c. Coverage provided under this paragraph (b)(2) of this section may be subject to copayments, coinsurance, and annual deductibles that are consistent with those imposed on other benefits within the health benefit plan and in compliance with the Mental Health

Parity and Addiction Equity Act of 2008's [29 U.S.C. § 1185a] financial requirements; provided, however, a health benefit plan must not impose an additional copayment or coinsurance on a covered person who received an emergency supply of the same medication in the same 30-day period in which the emergency supply of medication was dispensed.

d. This paragraph (b)(2) of this section does not preclude the imposition of a copayment or coinsurance on the initial emergency supply of medication in an amount that is less than the copayment or coinsurance otherwise applicable to a 30-day supply of such medication, provided that the total sum of copayments or coinsurance for an entire 30-day supply of the medication does not exceed the copayment or coinsurance otherwise applicable to a 30-day supply of such medication.

(3) A health benefit plan that provides coverage for prescription drugs must place at least 1 formulation of each FDA-approved medication to treat 1 or more substance use disorders, regardless of whether the prescription drug is formulary, nonformulary, or excluded, on the lowest tier of the drug formulary developed and maintained by the carrier, including each of the following:

a. Buprenorphine.

b. Naltrexone.

c. Naloxone.

d. A product containing both buprenorphine and naloxone.

e. Disulfiram.

f. Acamprosate.

(4) A health benefit plan that provides coverage for prescription drugs must cover the fees associated with the administration or dispensing of methadone dispensed at an “opiod treatment program” as defined under 42 C.F.R. § 8.2.

(c) *Eligibility for coverage. —*

(1) Subject to the limitations under subsection (d) of this section, a health benefit plan may condition coverage of services provided in the diagnosis and treatment of a mental health disorder or substance use disorder on any of the following requirements:

a. That the services must be rendered by a mental health disorder or substance use disorder professional licensed or certified by the State Board of Licensing, including psychologists, psychiatrists, social workers, and other such mental health professionals, or a drug and alcohol counselor who has been certified by the Delaware Certified Alcohol and Drug Counselors Certification Board, or in a mental health disorder or substance use disorder facility licensed by this State or in a treatment facility approved by the Department of Health and Social Services or the Bureau of Alcoholism and Drug Abuse as set forth in Chapter 22 of Title 16, or substantially similar licensing entities in other states. Nothing in this paragraph (c)(1)a. affects a health benefit plan’s obligation to cover medically necessary team-based services, including coordinated specialty care and assertive community treatment, of a mental health disorder or substance use disorder so long as such services are supervised by a licensed or certified professional.

b. That the services must be medically necessary.

c. That the services must be covered services subject to any administrative requirements of the health benefit plan.

(2) A health benefit plan may further condition coverage of services provided in the diagnosis and treatment of a mental health disorder or substance use disorder in the same manner and to the same extent as coverage for all other illnesses and diseases is conditioned. Such conditions include precertification and referral requirements.

(d) *Benefit management. —*

(1) A carrier may, directly or by contract with another qualified entity, manage the benefit prescribed by subsection (b) of this section in order to limit coverage of services provided in the diagnosis and treatment of a mental health disorder or substance use disorder to those services that are deemed medically necessary as follows:

a. The management of benefits for mental health disorders or substance use disorders may be by methods used for the management of benefits provided for other medical conditions, including utilization review, and the development and monitoring of treatment plans.

b. A carrier may not impose precertification, prior authorization, pre-admission screening, or referral requirements for the diagnosis and medically necessary services of serious mental illnesses or substance use disorders, including inpatient treatment or on a prescription medication under paragraph (b)(3) of this section. No other provision of this section may be construed to expand the prohibition in this paragraph (d)(1)b. to mental health disorder benefits not subject to this paragraph (d)(1)b.

c. The benefit prescribed by paragraph (b)(1) of this section may not be subject to concurrent utilization review during the first 14 days of any inpatient admission to a facility approved by a nationally recognized health-care accrediting organization or the Division of Substance Abuse and Mental Health, 30 days of intensive outpatient program treatment, or 5 days of inpatient withdrawal management, provided that the facility notifies the carrier of both the admission and the initial treatment plan within 48 hours of the admission. The facility shall perform daily clinical review of the patient and conduct periodic assessments using ASAM, LOCUS, CALOCUS-CASII, or ECSII as appropriate to the covered person’s age and primary diagnosis, to determine continued stay, transfer or discharge to ensure that the inpatient treatment is medically necessary for the covered person.

d. Any utilization review of treatment provided under paragraph (b)(1) of this section may include a review of all nonemergency care provided during such inpatient treatment, including all services provided during the first 14 days of such inpatient treatment, 30 days of intensive outpatient program treatment, or 5 days of inpatient withdrawal management; provided, however, the carrier

may only deny coverage for any portion of the initial 14-day inpatient treatment on the basis that such nonemergency care was not medically necessary if such inpatient treatment was contrary to the ASAM criteria, LOCUS, CALOCUS-CASII, or ECSII.

e. A carrier must ensure that a covered person does not have any financial obligation to an in-network provider for any treatment under paragraph (b)(1) of this section other than any copayment, coinsurance, or deductible otherwise required under the health benefit plan.

f. A carrier must authorize coverage of prescription medicine without imposing a step therapy requirement for at least 1 formulation of each prescription medication for the treatment of mental health disorder or substance use disorder that is on each tier of the drug formulary developed and maintained by the carrier. A carrier may impose a step therapy requirement for a prescription medication only to require use of a therapeutically equivalent generic drug that is rated as therapeutically equivalent (AB-rated) by the United States Food and Drug Administration and has the same active ingredient, dosage form, and strength as the prescribed medication. Notwithstanding any step therapy requirement permitted under this subsection, a carrier shall authorize coverage of the prescribed dosage form or formulation of the prescribed medication when the prescribed formulation is reasonably expected to provide clinical benefit for the covered person.

g. Utilization review and utilization review criteria may not deviate from current generally accepted standards of mental health disorder and substance use disorder care. In conducting utilization review, a carrier shall apply the relevant, age-appropriate criteria or guidelines set forth in the most recent version of treatment criteria or guidelines developed by the nonprofit health-care association for the relevant clinical specialty and shall not apply different, additional, conflicting, or more restrictive utilization review criteria. In conducting utilization review permitted by this subsection relating to service intensity or level of care placement, continued stay, or transfer or discharge, the carrier shall apply the ASAM criteria, LOCUS, CALOCUS-CASII, or ECSII, as applicable, and shall authorize placement at the service intensity and level of care consistent with that criteria. If the carrier's application of the applicable patient placement criteria is not consistent with the service intensity or level of care placement requested by the covered person or the covered person's provider, any adverse benefit determination notice must include full details of the carrier's assessment under the applicable criteria to the provider and the covered person.

h. Notwithstanding paragraph (d)(1)g. of this section, the Commissioner, in consultation with the Division of Substance Abuse and Mental Health, may designate a specific edition or version of the ASAM criteria, LOCUS, CALOCUS-CASII, ECSII, or other nonprofit health-care professional association treatment criteria or guidelines required under paragraph (d)(1)g. of this section during a transition from 1 edition or version to a subsequent edition or version to ensure alignment with state licensure standards.

(2) [Repealed.]

(e) *Exclusions.*

This section does not apply to plans or policies not within the definition of health benefit plan, as set out in subsection (a) of this section.

(f) *Availability of in-network services. —*

(1) A carrier shall maintain an adequate network in each of its health benefit plans to ensure timely access to nonurgent mental health disorder and substance use disorder services within 10 business days and to urgent mental health disorder and substance use disorder services within 24 hours. If a covered person requests assistance to obtain medically necessary services and the carrier fails to secure the delivery of those services from an appropriate in-network provider within applicable network adequacy standards established under state or federal law, the carrier shall, in a timely manner, execute a single-case agreement that allows the covered person to receive medically necessary services, including any follow-up services to complete a course of treatment, from an appropriate out-of-network provider. If the carrier identifies an appropriate in-network provider who can deliver medically necessary services within the applicable network adequacy standards and the covered person declines those services, the carrier has satisfied its obligation under this subsection. For the purposes of this subsection, "appropriate provider" includes providers who have the training and experience necessary to provide age- and condition-appropriate services to treat the covered person under the requirements of this section.

(2) The single-case agreement executed pursuant to this subsection shall do all of the following:

a. Reimburse the out-of-network provider for covered services at a rate negotiated by the provider and the carrier.

b. Apply no greater cost-sharing requirements than would apply if the services were provided by an in-network provider, with such cost-sharing amounts accruing toward the in-network deductible and out-of-pocket maximum.

c. Specify the duration, scope, and services covered under the agreement.

d. Treat services provided pursuant to the agreement as covered services under the health benefit plan for the duration of the agreement.

e. Specify that the provider shall accept payment from the carrier and the covered person's in-network cost sharing as payment in full.

(3) If the Commissioner determines that the carrier failed to execute a single-case agreement under this section in a timely manner, the Commissioner may order the carrier to hold the covered person harmless for any costs in excess of in-network cost-sharing that the covered person incurred to obtain medically necessary services from an out-of-network provider.

(4) A carrier shall disclose, in the health benefit plan policy and on the carrier's publicly accessible website, a covered person's rights under this subsection and the process by which a covered person may request assistance from the carrier in obtaining medically necessary

services from an appropriate in-network provider within applicable network adequacy standards, including a telephone number and a dedicated webpage or electronic submission mechanism to make such requests, and the circumstances under which the carrier must enter into a single-case agreement with an out-of-network provider, with no greater cost-sharing than would apply if the services were provided by an in-network provider.

(g) *Reporting requirements. —*

Each carrier must submit a report to the Delaware Health Information Network in conjunction with the Commissioner on or before July 1 2019, and any year thereafter during which the carrier makes significant changes to how it designs and applies its medical management protocols; the report must contain the following information:

(1) A description of the process used to develop or select the utilization review criteria for mental health disorder and substance use disorder benefits and the process used to develop or select the utilization review criteria for medical and surgical benefits.

(2) Identification of all nonquantitative treatment limitations (NQTLs) that are applied to mental health disorder or substance use disorder benefits and medical and surgical benefits within each classification of benefits; there may be no separate NQTLs that apply to mental health disorder or substance use disorder benefits that do not also apply to medical and surgical benefits within any classification of benefits.

(3) The results of an analysis that demonstrates that for the medical necessity criteria described in paragraph (g)(1) of this section and for each NQTL identified in paragraph (g)(2) of this section, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to mental health disorder or substance use disorder benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to medical and surgical benefits within the corresponding classification of benefits; at a minimum, the results of the analysis shall:

a. Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected.

b. Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each NQTL.

c. Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written, mental health disorder or substance use disorder benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each NQTL, as written, for medical and surgical benefits.

d. Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each NQTL, in operation, for mental health disorder or substance use disorder benefits are comparable to, and applied no more stringently than, the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits.

e. Disclose the specific findings and conclusions reached by the carrier that the results of the analyses above indicate that the carrier is in compliance with this section and the Mental Health Parity and Addiction Equity Act of 2008 [P.L. 104-204] and its implementing regulations, which includes 45 C.F.R. 146.136, 45 C.F.R. 147.160, and any other related federal regulations found in the Code of Federal Regulations.

(4) Any information submitted to the Delaware Health Information Network and the Commissioner by a carrier that is a trade secret or confidential or privileged commercial or financial information shall not be made public record.

(5) The Insurance Commissioner shall retain the authority to enforce the provisions of this section. The provisions of this section shall not give rise to a private right of action.

(h) Nothing in this section shall be construed to:

(1) Limit or reduce any benefit, entitlement, or coverage conferred by § 3366 of this title including provider and service eligibility.

(2) Prohibit exclusions for experimental or investigational services that comply with the parity requirements of this section.

(3) Require a carrier to switch to the latest version of the ASAM criteria, LOCUS, CALOCUS-CASII, or ECSII criteria, or diagnostic manuals or classifications during a plan year when a new version of the criteria or manuals is released after a plan year has begun.

(i) This section does not apply to plans of health insurance or health benefits designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act, 42 U.S.C. §§ 1395 et seq., 1396 et seq., and 1397aa et seq., known as Medicare, Medicaid, or any other coverage under a state or federal government plan.

(j) *Disclosure of nonquantitative treatment limitation parity compliance analyses. —*

(1) A health-care provider, a current covered person, or a prospective covered person may request of a carrier any nonquantitative treatment limitation parity compliance analysis (NQTL parity compliance analysis) that a carrier is required to have completed by 29 U.S.C. § 1185a or 42 U.S.C. § 37 300gg-26.

(2) Within 30 days of receiving a request pursuant to paragraph (j)(1) of this section, a carrier must provide a copy of the requested NQTL parity compliance analysis to the requesting person, free of charge.

(3) Every health benefit plan policy and mental health disorder and substance use disorder provider contract must disclose the following information:

a. A notification of the right to request an NQTL parity compliance analysis.

b. Instructions for how to request an NQTL parity compliance analysis.

(k) The provisions published at 89 Federal Register 77586 et seq. on September 23, 2024, are incorporated into this section in their entirety and apply as state law. This incorporation remains in effect notwithstanding any subsequent amendment, repeal, or nonenforcement of the referenced federal provisions.

(*l*) Under all health benefit plans delivered or issued for delivery in this State, if a carrier provides any benefits for a mental health disorder or substance use disorder in any classification of benefits, it must provide meaningful benefits for that mental health disorder or substance use disorder in every classification in which medical or surgical benefits are provided. For purposes of this subsection, "core treatments" means standard treatments or courses of treatment, therapy, service, or intervention indicated by generally accepted standards of mental health disorder or substance use disorder care. For purposes of this subsection, whether the benefits provided are considered "meaningful benefits" is determined in comparison to the benefits provided for medical conditions and surgical procedures in the classification and requires, at a minimum, coverage of benefits for that condition or disorder in each classification in which the carrier provides benefits for 1 or more medical conditions or surgical procedures. A carrier does not provide meaningful benefits under this subsection unless it provides benefits for core treatments for that condition or disorder in each classification in which the carrier provides benefits for core treatments for 1 or more medical conditions or surgical procedures. If there is no core treatment for a covered mental health disorder or substance use disorder with respect to a classification, the carrier is not required to provide benefits for core treatments for such condition or disorder in that classification, but must provide benefits for such condition or disorder in every classification in which medical or surgical benefits are provided.

(m) For the purposes of determining comparability and stringency for nonquantitative treatment limitations, a carrier may not rely upon discriminatory factors or evidentiary standards to design a nonquantitative treatment limitation to be imposed on mental health disorder or substance use disorder benefits. A factor or evidentiary standard is discriminatory if the information, evidence, sources, or standards on which the factor or evidentiary standard are based are biased or not objective in a manner that discriminates against mental health disorder or substance use disorder benefits as compared to medical or surgical benefits.

(n) A nonquantitative treatment limitation applicable to mental health disorder or substance use disorder benefits in a classification may not be more restrictive than the predominant nonquantitative treatment limitation applied to substantially all medical or surgical benefits in the classification. To test compliance with this subsection, a carrier shall collect and evaluate relevant data in a manner reasonably designed to assess the impact of the nonquantitative treatment limitation on relevant outcomes related to access to mental health disorder or substance use disorder benefits and medical or surgical benefits and carefully consider the impact as part of the plan's evaluation. As part of its evaluation, the carrier may not disregard relevant outcomes data that it knows or reasonably should know suggest that a nonquantitative treatment limitation is associated with material differences in access to mental health disorder or substance use disorder benefits as compared to medical or surgical benefits. To the extent the relevant data evaluated suggest that the nonquantitative treatment limitation contributes to material differences in access to mental health disorder or substance use disorder benefits as compared to medical or surgical benefits in a classification, those differences will be considered a strong indicator of a noncompliant nonquantitative treatment limitation. Where the relevant data suggest that the nonquantitative treatment limitation contributes to material differences in access to mental health disorder or substance use disorder benefits as compared to medical or surgical benefits in a classification, the carrier must take reasonable action to address the material differences to ensure compliance and must document the actions that have been or are being taken by the carrier to address material differences in access to mental health disorder or substance use disorder benefits, as compared to medical or surgical benefits.

(71 Del. Laws, c. 275, § 1; 73 Del. Laws, c. 199, §§ 1-4, 11; 74 Del. Laws, c. 157, § 1; 78 Del. Laws, c. 398, § 2; 80 Del. Laws, c. 310, § 1; 81 Del. Laws, c. 29, § 1; 81 Del. Laws, c. 190, §§ 1-3; 81 Del. Laws, c. 406, § 1; 82 Del. Laws, c. 199, § 1; 85 Del. Laws, c. 480, § 2.)

§ 3344. Insurance coverage for diabetes.

(a) Every individual or group hospital service corporation contract, individual or group medical service corporation contract, individual or group health service corporation contract, individual health insurance policy, group health insurance policy and contract for health-care services that provides hospital services, outpatient services or medical expense benefits, provides coverage for prescription drugs; and is delivered, issued, executed or renewed in this State pursuant to Title 18 or is approved for issuance or renewal in this State by the Insurance Commissioner shall provide benefits to any subscriber or other person covered thereunder for expenses incurred for the following equipment and supplies for the treatment of diabetes, if recommended in writing or prescribed by a physician: insulin pumps, blood glucose meters and strips, urine testing strips, insulin, syringes, and pharmacological agents for controlling blood sugar.

(b) The benefits required by this section shall be provided to the same extent as for any other sickness under the contract.

(c) This section shall apply to all hospital service corporation contracts in which the hospital service corporation has reserved the right to change the premium.

(d) The Insurance Commissioner may promulgate and periodically update a list of additional diabetes equipment and related supplies that are medically necessary for the treatment of diabetes and for which benefits shall be provided according to the provisions of this section.

(e) This section shall apply to all contracts and policies issued, renewed, modified, altered, amended or reissued 90 days and thereafter from the date of enactment.

(f) Nothing in this section shall apply to accident-only, specified disease, hospital indemnity, Medicare supplement long-term care, disability income or other limited benefit health insurance policies.

(72 Del. Laws, c. 376, § 2; 80 Del. Laws, c. 310, § 1.)

§ 3344B. Cost sharing in prescription insulin drugs.

(a) For purposes of this section, "prescription insulin drug" means a drug containing insulin that is dispensed under Chapter 47 of Title 16 for the treatment of diabetes.

(b) An individual health insurance policy, contract, or certificate that is delivered, issued for delivery, renewed, extended, or modified in this State that provides coverage for prescription insulin drugs must do all of the following:

(1) Cap the total amount that a covered individual is required to pay for covered prescription insulin drugs at no more than $100 per month for each enrolled individual, regardless of the amount or types of insulin needed to fill the covered individual's prescriptions. The $100 per month cap includes deductible payments and cost-sharing amounts charged once a deductible is met.

(2) Include at least 1 formulation of each of the following types of prescription insulin drugs on the lowest tier of the drug formulary developed and maintained by the carrier:

a. Rapid-acting.

b. Short-acting.

c. Intermediate-acting.

d. Long-acting.

(3) For purposes of paragraph (b)(2) of this section, the "lowest tier of the drug formulary" means either of the following:

a. If the prescription insulin drug is a generic drug, the lowest tier for generic drugs.

b. If the prescription insulin drug is a brand-name drug, the lowest tier for brand-name drugs.

(c) Except as provided under paragraph (b)(1) of this section, nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(d) This section applies to all policies, contracts, or certificates issued, renewed, modified, altered, amended, or reissued after December 31, 2020.

(82 Del. Laws, c. 250, § 1.)

§ 3344C. Coverage for insulin pumps.

(a) For purposes of this section, "insulin pump" means a small, portable medical device that is approved by the U.S. Food and Drug Administration to provide continuous subcutaneous insulin infusion.

(b) All individual health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State shall provide coverage for a medically-necessary insulin pump at no cost to a covered individual, including deductible payments and cost-sharing amounts charged once a deductible is met.

(c) Except as provided under subsection (b) of this section, nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(d) This section does not apply to any of the following:

(1) Accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.

(2) A high deductible health plan if providing coverage under subsection (b) of this section would cause the plan to fail to be treated as a high deductible health plan under § 223(c)(2) of the Internal Revenue Code [26 U.S.C. § 223(c)(2)].

(3) A catastrophic health plan if providing coverage under subsection (b) of this section would cause the plan to fail to be treated as a catastrophic plan under § 1302(e) of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18022(e).

(e) This section applies to all policies, contracts, or certificates issued, renewed, modified, altered, amended, or reissued after December 31, 2021.

(83 Del. Laws, c. 241, § 1.)

§ 3344D. Cost sharing in diabetes equipment and supplies.

(a) For purposes of this section, "diabetes equipment and supplies" means blood glucose meters and strips, urine testing strips, syringes, continuous glucose monitors and supplies, and insulin pump supplies.

(b) An individual health insurance policy, contract, or certificate that is delivered, issued for delivery, renewed, extended, or modified in this State that provides coverage for any diabetes equipment or supplies must cap the total amount that a covered individual is required to pay for diabetes equipment and supplies at no more than $35 per month for each enrolled individual, regardless of the amount or types

of diabetes equipment or supplies needed to fill the individual's prescriptions. The $35 per month cap includes deductible payments and cost-sharing amounts charged once a deductible is met, except that the $35 cap does not apply to deductible payments charged by high deductible health plans or catastrophic health plans.

(c) Except as provided under subsection (b) of this section, nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(d) This section does not apply to any of the following:

(1) Accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.

(2) A high deductible health plan if providing coverage under subsection (b) of this section would cause the plan to fail to be treated as a high deductible health plan under § 223(c)(2) of the Internal Revenue Code (26 U.S.C. § 223(c)(2)).

(3) A catastrophic health plan if providing coverage under subsection (b) of this section would cause the plan to fail to be treated as a catastrophic plan under § 1302(e) of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18022(e).

(e) This section applies to all policies, contracts, or certificates issued, renewed, modified, altered, amended, or reissued after December 31, 2023.

(83 Del. Laws, c. 521, § 1.)

§ 3345. Annual pap smear coverage reimbursement.

All individual health insurance policies which are delivered or issued for delivery in this State by any health insurer, health service corporation, health maintenance organization or any health services and facilities reimbursement program operated by the State and which provide a benefit for outpatient services shall also provide a benefit for an annual benefit for 1 cervical cancer screening, known as a "pap smear," for all females aged 18 and over.

This section shall apply to all policies, contracts, certificates or programs issued, renewed, modified, altered, amended or reissued on or after January 1, 2001.

(72 Del. Laws, c. 408, § 1; 73 Del. Laws, c. 61, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3346. Colorectal cancer screening.

(a) Every individual health, sickness or accident insurance policy contract or certificate which is delivered or issued for delivery in this State by any health insurer, health service corporation or health maintenance organization shall provide coverage for colorectal cancer screening under any such policy, contract or plan delivered, issued for delivery, or renewed in this State on or after January 1, 2001. The terms "health, sickness or accident insurance policy contract or certificate" shall not include, unless specifically provided in the policy, the following types of insurance or combination thereof: accident only, fixed or hospital confinement indemnity, limited benefit, credit, vision, specified disease, Medicare supplement, Champus supplement, long-term care, disability income workers compensation or automobile medical payment.

(b) Colorectal cancer screening covered by this section shall include:

(1) For persons 50 years of age or older screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging or other screening modalities, shall be provided as determined by the Secretary of Health and Social Services of this State after consideration of recommendations of the Delaware Cancer Consortium and the most recently published recommendations established by the American College of Gastroenterology, the American Cancer Society, the United States Preventive Task Force Services, for the ages, family histories and frequencies referenced in such recommendations and deemed appropriate by the attending physician.

(2) For persons who are deemed at high risk for colon cancer because of:

a. Family history of familial adenomatous polyposis;

b. Family history of hereditary nonpolyposis colon cancer;

c. Chronic inflammatory bowel disease;

d. Family history of breast, ovarian, endometrial or colon cancer or polyps; or

e. A background, ethnicity or lifestyle such that the health-care provider treating the participant or beneficiary believes that person is at elevated risk;

screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging or other screening modalities, shall be provided as determined by the Secretary of Health and Social Services of this State after consideration of recommendations of the Delaware Cancer Consortium and the most recently published recommendations established by the American College of Gastroenterology, the American Cancer Society, the United States Preventive Task Force Services for the ages, family histories and frequencies referenced in such recommendations and deemed appropriate by the attending physician.

(3) For all persons covered pursuant to paragraph (b)(1) or (b)(2) of this section, colorectal cancer screening shall include the use of anesthetic agents, including general anesthesia, in connection with colonoscopies and endoscopies performed in accordance with

generally-accepted standards of medical practice and all applicable patient safety laws and regulations, if the use of such anesthetic agents is medically necessary in the judgment of the treating physician.

(72 Del. Laws, c. 416, § 1; 70 Del. Laws, c. 186, § 1; 76 Del. Laws, c. 338, §§ 1, 2; 76 Del. Laws, c. 406, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3346A. Prostate cancer screening [For application of this section, see 84 Del. Laws, c. 511, § 4].

(a) For purposes of this section, "prostate screening" means a medically-necessary and clinically-appropriate method for the detection and diagnosis of prostate cancer, including a digital rectal exam and prostate specific antigen test, and associated laboratory work.

(b) All individual health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State after December 31, 2025, shall provide coverage for prostate screenings at no cost to a covered individual, including deductible payments and cost-sharing amounts charged once a deductible is met. In accordance with the American Cancer Society guidelines, coverage shall begin at:

(1) Age 50 for men at average risk of developing prostate cancer.

(2) Age 45 for men at high risk for developing prostate cancer, including African American men and men who have a first-degree relative diagnosed with prostate cancer.

(3) Age 40 for men at even higher risk for prostate cancer, including men who have more than 1 first-degree relative diagnosed with prostate cancer.

(c) Except as provided under subsection (b) of this section, nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(d) (1) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.

(2) The cost-sharing limitation under subsection (b) of this section does not apply to a catastrophic health plan to the extent this cost-sharing limitation would cause the plan to fail to be treated as a catastrophic plan under § 1302(e) of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18022(e).

(3) a. The cost-sharing limitation under subsection (b) of this section does not apply to a high deductible health plan to the extent this cost-sharing limitation would cause the plan to fail to be treated as a high deductible health plan under § 223(c)(2) of the Internal Revenue Code [26 U.S.C. § 223(c)(2)].

b. If the cost-sharing limitation under subsection (b) of this section would result in an enrollee becoming ineligible for a health savings account under federal law, this cost-sharing limitation only applies to a qualified high deductible health plan after the enrollee's deductible has been met.

(84 Del. Laws, c. 511, § 1.)

§ 3347. Required coverage for reconstructive surgery following mastectomies.

(a) All individual health insurance policies, contracts or certificates that are delivered or issued for delivery in this State by any health insurer, health service corporation or managed care organization which provide medical and surgical benefits with respect to a mastectomy shall provide, in a case of an insured, participant, policyholder, subscriber, and beneficiary who is receiving benefits in connection with such mastectomy, in a manner determined in consultation with the attending physician and the patient, coverage for:

(1) All stages of reconstruction of the breast on which the mastectomy has been performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) Prostheses and physical complications of mastectomy, including lymphedemas.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan of coverage. Written notice of the availability of such coverage shall be delivered to the insured, participant, policyholder, subscriber and beneficiary upon enrollment and annually thereafter.

(b) All individual health benefit plans shall provide notice to each insured, participant, policyholder, subscriber and beneficiary under such plan regarding the coverage required by this section in accordance herewith. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan and shall be transmitted:

(1) In the next mailing made by the plan to the insured, participant, policyholder, subscriber and beneficiary;

(2) As part of any yearly informational packet sent to the insured, participant, policyholder, subscriber and beneficiary; or

(3) Not later than June 30, 2001, whichever is earliest.

(c) An individual health benefit plan may not deny to a patient eligibility or continued eligibility to enroll or to renew coverage under the terms of the plan solely for the purpose of avoiding the requirements of this section, and may not penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, or induce such provider to provide care to an individual insured, participant, policyholder, subscriber and beneficiary in a manner inconsistent with this section.

(d) Nothing in this section shall be construed to prevent a health benefit plan from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

(73 Del. Laws, c. 89, § 2; 80 Del. Laws, c. 310, § 1.)

§ 3348. Referrals.

(a) This section applies to every policy or contract of health insurance which is delivered or issued for delivery in this State, including each policy or contract issued by a health service corporation, and which designates network physicians or providers or preferred physicians or providers (hereinafter referred to collectively as "network providers"). In such circumstances, the non-network provider may not balance bill the insured.

(b) All individual and group health insurance policies shall provide that if medically necessary covered services are not available through network providers, or the network providers are not available within a reasonable period of time, the insurer, on the request of a network provider, within a reasonable period, shall allow referral to a non-network physician or provider and shall reimburse the non-network physician or provider at a previously agreed-upon or negotiated rate. In such circumstances, the non-network physician or provider may not balance bill the insured. Such a referral shall not be refused by the insurer absent a decision by a physician in the same or a similar specialty as the physician to whom a referral is sought that the referral is not reasonably related to the provision of medically necessary services.

(c) All individual and group health insurance policies which do not allow insureds to have direct access to health-care specialists shall establish and implement a procedure by which insureds can obtain a standing referral to a health-care specialist.

(d) The procedure established under subsection (c) of this section:

(1) Shall provide for a standing referral to a specialist if the insured's network provider determines that the insured needs continuing care from the specialist; and

(2) May require the insurer's approval of an initial treatment plan designed by the specialist containing (i) a limit on the number of visits to the specialist, (ii) a time limit on the duration of the referral, and (iii) mandatory updates on the insured's condition. Such approval shall not be withheld absent a decision by a qualified physician that the treatment sought in the treatment plan is not reasonably related to the appropriate treatment of the insured's condition.

Within the treatment period referred to in paragraph (d)(2) of this section, the specialist shall be permitted to treat the insured without a further referral from the insured's network provider and may authorize such further referrals, procedures, tests and other medical services as the individual's network provider would otherwise be permitted to provide or authorize, provided that such further referrals, procedures, tests and other medical services are part of treating the patient for the condition for which the patient was referred to the specialist. Referrals, procedures, tests, and other medical services referred to in this subsection shall be provided by network providers unless such services are not available through network providers, or the network providers are not available within a reasonable period of time. If services are not available through network providers, or the network providers are not available within a reasonable period of time, the out-of-network provider shall be reimbursed at an agreed-upon or negotiated rate. In such circumstances, the non-network provider may not balance bill the insured.

(e) Nothing in this section shall prevent the operation of policy provisions involving deductibles or copayments.

(73 Del. Laws, c. 96, § 5; 73 Del. Laws, c. 315, §§ 1, 7; 80 Del. Laws, c. 310, § 1.)

§ 3349. Emergency care.

(a) This section applies to every policy or contract of health insurance, including each policy or contract issued by a health service corporation, which is delivered or issued for delivery in this State, and which designates network physicians or providers or preferred physicians or providers (hereinafter referred to collectively as "network providers"). However, this section applies only to conditions for which coverage is provided by those policies or contracts.

(b) All individual and group health insurance policies shall provide that persons covered under those policies will be insured for emergency care services performed by nonnetwork providers at an agreed-upon or negotiated rate, regardless of whether the physician or provider furnishing the services has a contractual or other arrangement with the insurer to provide items or services to persons covered under the policies. In the event that the provider of emergency services and the insurer cannot agree upon the appropriate rate, the provider shall be entitled to those charges and rates allowed by the Insurance Commissioner or the Commissioner's designee following an arbitration of the dispute. The Insurance Commissioner shall adopt regulations concerning the arbitration of such disputes. In such circumstances, the nonnetwork provider may not balance bill the insured.

(c) Prior to a determination by the Insurance Commissioner (or the Commissioner's designee) of those charges and rates allowed by the providers of emergency services pursuant to subsection (b) of this section, the insurer will pay directly to the non-network emergency care provider the highest allowable charge for each emergency care service allowed by the insurer for any other network or non-network emergency care provider during the full 12-month period immediately prior to the date of each emergency care service performed by the non-network provider. The Insurance Commissioner is authorized to adopt regulations concerning the provisions of this subsection (c).

(d) Plans described in subsections (a) and (b) of this section shall cover:

(1) Any medical screening examination or other evaluation medically required to determine whether an emergency medical condition exists;

(2) Necessary emergency care services, including treatment and stabilization of an emergency medical condition; and

(3) Services originated in a hospital emergency facility or comparable facility following treatment or stabilization of an emergency medical condition as approved by the insurer with respect to services performed by non-network providers, provided that the insurer is required to approve or disapprove coverage of poststabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of services and the condition of the patient, but in no case to exceed 1 hour from the time of the request.

(e) Nothing in this section shall prevent the operation of policy provisions involving deductibles or copayments. As used in this section "emergency medical condition" means a medical or behavioral condition the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

(2) Serious impairment to such person's bodily functions;

(3) Serious impairment or dysfunction of any bodily organ or part of such person; or

(4) Serious disfigurement of such person.

(f) This section shall not apply to services provided by a volunteer fire department recognized as such by the State Fire Prevention Commission.

(g) The Insurance Commissioner shall establish a schedule of fees for arbitration. The nonprevailing party at arbitration shall reimburse the Commissioner for the expenses related to the arbitration process. Funds paid to the Insurance Commissioner under this subsection shall be placed in the arbitration fund and shall be used exclusively for the payment of appointed arbitrators. The Insurance Commissioner may, in the Commissioner's discretion, impose a schedule of maximum fees that can be charged by an arbitrator for a given type of arbitration.

(73 Del. Laws, c. 96, § 6; 70 Del. Laws, c. 186, § 1; 73 Del. Laws, c. 315, §§ 2, 11; 78 Del. Laws, c. 111, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3349A. Required coverage for volunteer ambulance company services.

(a) For the purpose of this section:

(1) "Ambulance run" means a volunteer ambulance company response to dispatched calls for service.

(2) "Basic life support (BLS)" shall have the same meaning as set forth in § 9702 of Title 16.

(3) "Volunteer ambulance company" means a nonprofit ambulance company that is certified by the State Fire Prevention Commission and is providing basic life support (BLS) services.

(b) Every individual health insurance policy, contract, certificate, or plan which is delivered or issued for delivery in this State by any health insurer, health service corporation, health maintenance organization, or managed care organization shall include coverage of not less than the cost of every ambulance run and associated basic life support (BLS) services provided by a volunteer ambulance company, inclusive of an allowance for uncompensated service, whether in the form of:

(1) An allowable charge;

(2) Through 100% payment; or

(3) Any combination of the foregoing.

(c) In the event that the volunteer ambulance company and the health insurer, health service corporation, health maintenance organization, or managed care organization cannot agree upon the allowable charge or the amount of payment to be made for an ambulance run and associated basic life support (BLS) services, then the volunteer ambulance company shall be entitled to those charges and rates allowed by the Insurance Commissioner or the Commissioner's designee following an arbitration of the dispute.

(1) The Insurance Commissioner shall adopt regulations concerning the arbitration of such disputes.

(2) The Insurance Commissioner shall establish a schedule of fees for arbitration. The nonprevailing party at arbitration shall reimburse the Commissioner for the expenses related to the arbitration process. Funds paid to the Insurance Commissioner under this subsection shall be placed in the arbitration fund and shall be used exclusively for the payment of appointed arbitrators. The Insurance Commissioner may, in the Commissioner's discretion, impose a schedule of maximum fees that can be charged by an arbitrator for a given type of arbitration.

(d) Prior to the determination by the Insurance Commissioner, or the Commissioner's designee, of the allowable charge or the amount of payment to be made for an ambulance run and associated basic life support (BLS) services, the health insurer, health service corporation, health maintenance organization, or managed care organization will pay directly to the volunteer ambulance company the charge assessed by the volunteer ambulance company for the run and basic life support (BLS) services provided, which shall not be subject to reimbursement after the Commissioner's determination. The Insurance Commissioner is authorized to adopt regulations concerning the provisions of this subsection.

(e) Nothing in this section shall prevent the operation of policy provisions involving deductibles or copayments.

(f) This section shall not apply to policies that exclusively cover the following, and do not provide expense or reimbursement coverage for ambulance runs and associated basic life support (BLS) services provided by a volunteer ambulance company:

(1) Hospital confinement indemnity;

(2) Disability income;

(3) Long-term care;

(4) Medicare supplement;

(5) Specified disease indemnity;

(6) Individual and group supplemental health insurance; or

(7) Other limited benefit policies, to the extent the policies do not cover ambulance runs and associated basic life support (BLS) services provided by a volunteer ambulance company.

(g) Notwithstanding subsections (a)-(e) of this section, managed care organizations that contract with the State shall be exempt from this section with regard to that portion of their plans that serve Medicaid and Delaware Health Children Program recipients.

(h) This section shall apply to all policies, contracts, certificates, or plans issued, renewed, modified, altered, amended, or reissued on or after January 1, 2015.

(79 Del. Laws, c. 435, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3350. Prescription medication.

(a) This section applies to every policy or contract of health insurance, including each policy or contract issued by a health service corporation, which is delivered or issued for delivery in this State and which provides coverage for outpatient prescription drugs.

(b) Every policy or contract of health insurance described in subsection (a) of this section shall provide coverage for any outpatient drug prescribed to treat a covered person for a covered chronic, disabling or life-threatening illness if the drug:

(1) Has been approved by the Food and Drug Administration for at least 1 indication; and

(2) Is recognized for treatment of the indication for which the drug is prescribed in:

a. A prescription drug reference compendium approved by the Insurance Commissioner for purposes of this section; or

b. Substantially accepted peer reviewed medical literature.

(c) Coverage of a drug required by this section shall include coverage of medically necessary services associated with administration of the drug.

(d) This section does not require coverage for:

(1) Medication that may be obtained without a physician's prescription;

(2) Experimental drugs not otherwise approved for the proposed use or indication by the Food and Drug Administration; or

(3) Any disease, condition, service or treatment that is excluded from coverage under the policy.

(e) Nothing in this section shall prevent the operation of policy provisions involving deductibles, coinsurance, allowable charge limitations, maximum dollar policy limitations or coordination of benefits.

(73 Del. Laws, c. 96, § 7; 73 Del. Laws, c. 315, § 4; 80 Del. Laws, c. 310, § 1.)

§ 3350B. Copayment or coinsurance for prescription drugs limited [For application of this section, see 82 Del. Laws, c. 57, § 3 and 83 Del. Laws, c. 522, § 4].

(a) *Definitions.* — (1) "Carrier" means any entity that provides health insurance in this State. "Carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(2) "Contract price" means the lowest price a pharmacy is paid for the acquisition of a prescription drug based on a contract that a pharmacy has with a carrier or pharmacy benefits manager. "Contract price" includes a dispensing fee set by a contract between a pharmacy and a carrier or pharmacy benefits manager.

(3) "Cost-sharing requirement" means any copayment, coinsurance, deductible, or annual limitation on cost-sharing (including a limitation subject to 42 U.S.C. §§ 18022(c) and 300gg-6(b)), required by or on behalf of an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health benefit plan.

(4) "Health benefit plan" means as defined in § 3343 of this title.

(5) "Health care service" means an item or service furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

(6) "Person" means as defined in § 102 of this title.

(7) "Pharmacy" means as defined in § 2502 of Title 24.

(8) "Pharmacy benefit manager" means as defined under § 3302A of this title.

(b) *Application. —*

This section applies to a carrier that provides coverage, either directly or through a pharmacy benefits manager, for prescription drugs under a health insurance policy, health benefit plan, or contract that is issued or delivered in this State.

(c) A carrier subject to this section may not impose a copayment or coinsurance requirement for a covered prescription drug that exceeds the lesser of one of the following:

(1) The applicable copayment or coinsurance that would apply for the prescription drug in the absence of this section.

(2) The amount an individual would pay for the prescription drug if the individual were paying the usual and customary price.

(3) The contract price for the prescription drug.

(d) *Cost-sharing calculation. —*

When calculating an enrollee contribution to any applicable cost-sharing requirement, a carrier shall include any cost-sharing amounts paid by the enrollee or on behalf of the enrollee by another person. If under federal law, application of this requirement would result in health savings account ineligibility under § 223 of the federal Internal Revenue Code [26 U.S.C. § 223], this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under [26 U.S.C.] § 223, except with respect to items or services that are preventive care pursuant to [26 U.S.C.] § 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of this subsection shall apply regardless of whether the minimum deductible under [26 U.S.C.] § 223 has been satisfied.

(e) *Rule-making. —*

The Insurance Commissioner may promulgate rules and regulations as may be necessary or appropriate to implement and administer this section.

(82 Del. Laws, c. 57, § 1; 83 Del. Laws, c. 522, § 1.)

§ 3351. Clinical trials.

(a) This section applies to every policy or contract of health insurance, including each policy or contract issued by a health service corporation, which is delivered or issued for delivery in this State.

(b) *Definitions. —* (1) "Clinical trials," for purposes of this section, include clinical trials that are approved or funded by use of the following entities:

a. One of the National Institutes of Health (NIH);

b. An NIH cooperative group or center which is a formal network of facilities that collaborate on research projects and have an established NIH-approval peer review program operating within the group, including, but not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;

c. The federal Departments of Veterans' Affairs or Defense;

d. An institutional review board of an institution in this State that has a multiple project assurance contract approval by the Office of Protection for the Research Risks of the NIH; and

e. A qualified research entity that meets the criteria for NIH Center Support grant eligibility.

(2) "Routine patient care costs," as used in this section, include all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

a. The investigational items or service itself;

b. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patients; and

c. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

(3) Any clinical trial receiving coverage for routine costs under this section must meet the following requirements:

a. The subject or purpose of the trial must be the evaluation of an item or service that falls within the covered benefits of the policy and is not specifically excluded from coverage.

b. The trial must not be designed exclusively to test toxicity or disease pathophysiology.

c. The trial must have therapeutic intent.

d. Trials of therapeutic interventions must enroll patients with diagnosed disease.

e. The principal purpose of the trial is to test whether the intervention potentially improves the participant's health outcomes.

f. The trial is well supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use.

g. The trial does not unjustifiably duplicate existing studies.

h. The trial is in compliance with federal regulations relating to the protection of human subjects.

(c) Every policy described in subsection (a) of this section, including each policy or contract issued by a health service corporation, shall provide coverage for routine patient care costs as defined in paragraph (b)(2) of this section for covered persons engaging in clinical

trials for treatment of life-threatening diseases. Nothing in this section, however, independently requires coverage for expense of such clinical trials which are otherwise not covered under the policy or contract.

(73 Del. Laws, c. 315, § 9; 80 Del. Laws, c. 310, § 1.)

§ 3351B. Experimental treatment coverage.

(a) No individual policy or contract of health insurance, or certificate issued thereunder, which is delivered, issued for delivery, or renewed in this State by any health insurer, health service corporation, or health maintenance organization shall deny coverage, payment, or reimbursement for a National Coverage Determination Service on the basis that the service, item, test, or treatment is experimental or investigational.

(b) "National Coverage Determination Service" as used in this section shall mean a service, item, test, or treatment which has been determined to be covered nationally by the Secretary of the U.S. Department of Health and Human Services pursuant to the Social Security Act, § 1869 (f) [42 U.S.C. § 1395ff].

(81 Del. Laws, c. 266, § 1.)

§ 3352. Newborn and infant hearing screening; coverage and reimbursement.

(a) Any individual health insurance policy which is delivered, issued for delivery, renewed, extended, or modified in this State by any health-care insurer and which provides coverage for a child shall be deemed to provide coverage for hearing loss screening tests of newborns and infants provided by a hospital before discharge.

(b) The amount of reimbursement for newborn or infant hearing screening provided under such a policy shall be consistent with reimbursement of other medical expenses under the policy, including the imposition of co-payment, coinsurance, deductible, or any dollar limit or other cost-sharing provisions otherwise applicable under the policy.

(75 Del. Laws, c. 116, § 2; 80 Del. Laws, c. 310, § 1.)

§ 3353. Use of social security numbers on insurance cards.

(a) As used in this section, "insurance card" means a card that a person or entity provides to an individual so that the individual may present the card to establish the eligibility of the individual or the individual's dependents to receive health, dental, optical, or accident insurance benefits, prescription drug benefits, or benefits under a managed care plan or a plan provided by a health maintenance organization, a health services plan corporation, or a similar entity.

(b) No person or entity which provides an insurance card shall use an individual's social security number as the identification number on that insurance card.

(75 Del. Laws, c. 179, § 1; 70 Del. Laws, c. 186, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3354. Supplemental coverage for children of insureds [For application of this section, see 79 Del. Laws, c. 99, § 19].

(a) *Definitions.* — As used in this section:

(1) "Carrier" means any entity that provides health insurance in this State. For the purposes of this section, "carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(2) "Covered person" means a person who claims to be entitled to receive benefits from a carrier.

(3) "Dependent" means a covered person's child by blood or by law who is less than 26 years of age.

(b) If a carrier's contract with a subscriber provides coverage for a covered person's dependent under which coverage of the dependent terminates at a specific age before the dependent's twenty-sixth birthday, the contract must nevertheless provide coverage to the dependent after that specific age until the dependent's twenty-sixth birthday.

(c) Subsection (b) of this section may not be construed to require:

(1) Coverage for services provided to a dependent prior to May 30, 2007;

(2) That an employer pay all or part of the cost of coverage for a dependent as provided pursuant to this section; or

(3) Coverage for services rendered prior to a dependent's election pursuant to subsection (e) of this section and payment of premium required under subsection (g) of this section.

(d) A dependent covered by a covered person's contract, where coverage under the contract's language would terminate at a specific age before the dependent's twenty-sixth birthday, may make a written election for coverage as a dependent pursuant to this section, until the dependent's twenty-sixth birthday. The election must be made:

(1) Within 30 days prior to the termination of coverage at the specific age provided in the contract's language;

(2) Within 30 days after meeting the requirements for dependent status as set forth in subsection (a) of this section, when coverage for the dependent under the contract's language had previously terminated; or

(3) During an open enrollment period, as provided pursuant to the contract, if the dependent meets the requirements for dependent status as set forth in subsection (a) of this section during the open enrollment period.

Coverage for a dependent who makes a written election for coverage may not be conditioned upon or discriminate on the basis of lack of evidence of insurability.

(e) Notwithstanding the time limitations imposed by subsection (d) of this section, until May 30, 2008, a dependent who qualifies for dependent status as set forth in subsection (a) of this section, but whose coverage as a dependent under a covered person's contract terminated under the terms of the contract prior to May 30, 2007, may make a written election to reinstate coverage under that contract as a dependent pursuant to this section.

(f) Coverage for a dependent who makes a written election for coverage pursuant to subsection (d) of this section consists of coverage which is identical to the coverage that would have been provided to that dependent had that dependent not been terminated from the contract due to the dependent's age.

(g) A covered person's contract may require payment of a premium by the covered person or dependent, subject to any approvals required by Delaware law, for any period of coverage relating to a dependent's written election for coverage pursuant to subsection (d) of this section. The payment may not exceed 102% of the applicable portion of the premium previously paid for that dependent's coverage under the contract prior to the termination of coverage at the specific age provided in the contract.

(h) The applicable portion of the premium previously paid for a dependent's coverage under subsection (g) of this section is determined pursuant to regulations promulgated by the Department of Insurance, based upon the difference between the contract's rating tiers for adult and dependent coverage or family coverage, as appropriate, and single coverage, or based upon any other formula or dependent rating tier which provides a substantially similar result and is considered appropriate by the Department of Insurance.

(i) Coverage for a dependent provided pursuant to this section must be provided until the earlier of the following:

(1) The dependent is no longer a dependent as defined in subsection (a) of this section;

(2) The date on which coverage ceases under the contract by reason of a failure to make a timely payment of any premium required under the contract by the covered person or dependent for coverage provided pursuant to this section. The payment of any premium is considered to be timely if made within 30 days after the due date or within a longer period as provided for by the contract; or

(3) The date upon which the employer under whose contract coverage is provided to a dependent ceases to provide coverage to the covered person.

(j) Prominent notice regarding coverage for a dependent as provided pursuant to this section must be provided to a covered person by the carrier:

(1) In the certificate of coverage prepared for covered persons by the carrier on or about the date of commencement of coverage; and

(2) Upon each renewal, but at least once annually; and

(3) By June 29, 2007.

(75 Del. Laws, c. 419, § 1; 70 Del. Laws, c. 186, § 1; 78 Del. Laws, c. 159, § 1; 79 Del. Laws, c. 99, §§ 2, 3; 80 Del. Laws, c. 310, § 1.)

§ 3355. Phenylketonuria (PKU) and other inherited metabolic diseases.

(a) *Definitions.* — In this section the following words shall have the meanings indicated:

(1) "Inherited metabolic diseases" shall mean diseases caused by an inherited abnormality of biochemistry. The words "inherited metabolic diseases" shall also include any diseases for which the State screens newborn babies.

(2) a. "Low protein modified formula or food product" means a formula or food product that is:

1. Specially formulated to have less than 1 gram of protein per serving; and

2. Intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease.

b. "Low protein modified food product" does not include a natural food that is naturally low in protein.

(3) "Medical formula or food" means a formula or food that is:

a. Intended for the dietary treatment of an inherited metabolic disease for which nutritional requirements and restrictions have been established by medical research; and

b. Formulated to be consumed or administrated enterally under the direction of a physician.

(b) *Application of this section.* — The provisions of this section shall apply to any health insurance contract that:

(1) Provides coverage for a family member of the insured;

(2) Is delivered or issued for delivery in the State.

(c) A health insurance contract shall, under the family member coverage, include coverage for medical formulas and foods and low protein modified formulas and modified food products for the treatment of inherited metabolic diseases, if such medical formulas and foods or low protein modified formulas and food products are:

(1) Prescribed as medically necessary for the therapeutic treatment of inherited metabolic diseases; and

(2) Administered under the direction of a physician.

(76 Del. Laws, c. 176, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3356. Required coverage for scalp hair prosthesis.

(a) Every individual health insurance policy, contract or certificate that is delivered or issued for delivery in this State by any health insurer, health service corporation or managed care organization which provide for medical or hospital expenses and also provide coverage for other prostheses, shall provide coverage for expenses for a scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata, resulting from an autoimmune disease. Such coverage shall be subject to the same limitations and guidelines as other prostheses, provided that such coverage for alopecia areata shall not exceed $500 per year.

(b) For purposes of this section:

(1) "Prostheses" means artificial appliances used to replace lost natural structures. Prostheses include, but are not limited to, artificial arms, legs, breasts, or glass eyes.

(2) "Scalp hair prosthesis" means an artificial substitute for scalp hair that is made specifically for a specific individual.

(c) Such coverage may be subject to annual deductibles and co-insurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan of coverage. Written notice of the availability of such coverage shall be delivered to the insured, participant, policyholder, subscriber and beneficiary upon enrollment and annually thereafter.

(d) All group and blanket health benefit plans shall provide notice to each insured, participant, policyholder, subscriber and beneficiary under such plan regarding the coverage required by this section in accordance herewith. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan and shall be transmitted as part of any yearly informational packet sent to the insured, participant, policyholder, subscriber and beneficiary.

(76 Del. Laws, c. 314, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3357. Hearing aid coverage.

(a) For purposes of this section, the term "hearing aid" means any nonexperimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, but excluding batteries, cords, and other assistive listening devices such as FM systems.

(b) Every individual health insurance contract, including each policy or contract issued by a health service corporation, which is delivered, issued for delivery, or renewed in this State on or after January 1, 2009, shall provide coverage of up to $1000 per individual hearing aid, per ear, every 3 years, for children less than 24 years of age, covered as a dependent by the policy holder.

(c) The insured may choose a hearing aid exceeding $1,000 and pay the difference in cost above the amount of coverage required by this section. Reimbursement shall be provided according to the respective principles and policies of the insurer. The insurer may require the policyholder to provide a prescription or show proof through other suitable documentation of the need for a hearing aid and nothing contained in this section shall preclude the insurer from conducting managed care, medical necessity, or utilization review or prevent the operation of such policy provisions as deductibles, coinsurance, allowable charge limitations, coordination of benefits or provisions restricting coverage to services by licensed, certified or carrier-approved providers or facilities.

(d) This section does not apply to insurance coverage providing benefits for:

(1) Hospital confinement indemnity;

(2) Disability income;

(3) Accident only;

(4) Long-term care;

(5) Medicare supplement;

(6) Limited benefit health;

(7) Specified diseased indemnity;

(8) Sickness or bodily injury or death by accident, or both; and

(9) Other limited benefit policies.

(76 Del. Laws, c. 244, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3358. Dental services for children with a severe disability.

(a) *Definitions.* — As used in this section:

(1) "Child with a severe disability" means a person under the age of 21 who, due to a significant mental or physical condition, illness, or disease, is likely to require specialized treatment or supports to secure effective access to dental care. The written certification of a child's treating physician, advanced practice nurse, or licensed psychologist shall be sufficient to qualify a person as a "child with a severe disability."

(2) "Dental services" means the full range of diagnostic and treatment services within the scope of benefits available under the health insurance contract or policy.

(b) *Application of section.* — This section applies to every individual health insurance contract, including each policy or contract issued by a health service corporation, which is delivered, issued for delivery, or renewed in this State which provides coverage for dental services for a child.

(c) *Payment authorization.* — Every contract or policy described in subsection (b) of this section shall authorize payment to a licensed practitioner for dental services to a child with a severe disability irrespective of lack of contractual or network status. Unless otherwise negotiated with the practitioner in advance, such payment shall be in an amount at least equal to the insurer's reasonable and customary compensation for the same or similar services in the same geographical area. A nonnetwork practitioner accepting payment under this section may not balance bill the insured.

(d) *Preservation of contract limits.* — Nothing in this section shall prevent the application of contract or policy provisions involving deductibles, coinsurance, maximum dollar limitations or coordination of benefits, provided that such limits shall be applied using in-network standards.

(e) *Waiver*. — The Commissioner may establish, by regulation, standards authorizing the issuance of a waiver to an insurer from application of this section. At a minimum, such waiver standards shall only permit a time-limited, renewable waiver upon submission of clear and convincing documentation of the numerical and geographical availability of in-network practitioners willing and able to effectively treat a child with a severe disability.

(77 Del. Laws, c. 54, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3359. Health insurance; pharmacies; electronic reimbursement.

(a) This section shall apply to:

(1) Insurers and nonprofit health service plans that provide, directly or through a pharmacy benefit manager, coverage for prescription drugs under health insurance policies or contracts that are issued or delivered in this State; and

(2) Health maintenance organizations that provide, directly or through a pharmacy benefit manager, coverage for prescription drugs under contracts that are issued or delivered in this State.

(b) If an entity subject to this section requires a pharmacy to submit a request for payment electronically, then the pharmacy or its designated agent may choose to be reimbursed electronically, and in that event the entity shall electronically reimburse such pharmacy and shall provide the appropriate payment data electronically, provided that the electing pharmacy agrees to, and can accept claims details for the payments electronically and provide accurate electronic funds transfer information to the entity making payments.

(c) An entity subject to this section may not impose on a pharmacy a processing fee for the electronic reimbursement or for providing payment data electronically.

(d) Subsequent to January 6, 2010, any pharmacy that requires electronic reimbursement under this section shall allow an entity 45 days to become compliant herewith from the date of the pharmacy's initial request to commence electronic reimbursement between the parties.

(77 Del. Laws, c. 116, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3359B. Electronic medical (non-pharmaceutical) claims.

(a) This section shall apply to all claims for healthcare services that are submitted and are not covered by § 3359 of this title.

(b) For purposes of this section:

(1) "Carrier" means any entity that provides health insurance in this State. "Carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(2) "Carrier" does not mean an entity that provides a plan of health insurance or health benefits designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act (42 U.S.C. §§ 1395 et seq., 1396 et seq. and 1397 et seq.), known as Medicare, Medicaid, or any other similar coverage under state or federal governmental plans.

(c) A carrier shall accept primary and secondary claims electronically from providers regardless of network status.

(d) A carrier shall permit a provider to receive electronic remittance advice (ERA/835) files for claims payments upon the completion of the necessary agreements required by the carrier.

(e) Any electronic claim shall be acknowledged by the carrier electronically no later than 2 business days following receipt of the claim to the entity submitting the claim.

(82 Del. Laws, c. 111, § 2.)

§ 3360. Screening of infants and toddlers for developmental delays.

(a) *Definitions.* — As used in this section:

(1) "Carrier" means any entity that provides health insurance in this State. For the purposes of this section, "carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(2) "Developmental screening" shall mean any developmental screening tool favorably mentioned by the American Academy of Pediatrics Committee on Children with Disabilities in its position paper on "Developmental Surveillance and Screening of Infants and Young Children," or any program judged by the Department of Health and Social Services to be an equivalent program.

(b) This section shall apply to any health insurance contract that provides coverage for a family member of the insured and is delivered by a carrier or issued by a carrier for delivery in the State.

(c) This section shall not apply to policies that exclusively cover:

(1) Hospital confinement indemnity;

(2) Disability income;

(3) Accident only;

(4) Long-term care;

(5) Medicare supplement;

(6) Specified disease indemnity; or

(7) Sickness or bodily injury or death by accident, or both.

(d) Every health insurance policy covered by this section shall entitle children covered by the policy to receive developmental screenings at ages 9 months, 18 months, and 30 months.

(77 Del. Laws, c. 207, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3361. Limitations on preexisting condition limitations for minor children [Repealed].

(78 Del. Laws, c. 141, § 1; 80 Del. Laws, c. 310, § 1; repealed by 82 Del. Laws, c. 186, § 1, effective Aug. 6, 2019.)

§ 3362. Reimbursement for orthotic and prosthetic services.

(a) *Definitions.* — For purposes of this section:

(1) "Federal reimbursement rates" means the current listed fee schedule from the Centers for Medicare and Medicaid Services, listing the current Healthcare Common Procedure Coding System (HCPCS) and the corresponding reimbursement rates.

(2) "Orthosis" means a custom fabricated brace or support that is designed based on medical necessity. Orthosis does not include prefabricated or direct-formed orthotic devices or any of the following assistive technology devices: commercially available knee orthoses used following injury or surgery; spastic muscle-tone inhibiting orthoses; upper extremity adaptive equipment; finger splints; hand splints; wrist gauntlets; face masks used following burns; wheelchair seating that is an integral part of the wheelchair and not worn by the patient independent of the wheelchair; fabric or elastic supports; corsets; low-temperature formed plastic splints; trusses; elastic hose; canes; crutches; cervical collars; dental appliances; and any other similar devices, as determined Secretary of the Department of Health and Social Services, commonly carried in stock by a pharmacy, department store, or surgical supply facility.

(3) "Orthotics" means the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, adjusting, or servicing, as well as providing the initial training necessary to accomplish the fitting of, an orthosis for the support, correction, or alleviation of neuromuscular or musculoskeletal dysfunction, disease, injury, or deformity. The practice of orthotics encompasses evaluation, treatment, and consultation; with basic observational gait and postural analysis, orthotists assess and design orthoses to maximize function and provide not only the support but also the alignment necessary to either prevent or correct a deformity or to improve the safety and efficiency of mobility, locomotion, or both. Orthotic practice includes providing continuing patient care in order to assess its effect on the patient's tissues and to assure proper fit and function of the orthotic device through periodic evaluation.

(4) "Prosthesis" means an artificial limb that is alignable or, in lower-extremity applications, capable of weight bearing. "Prosthesis" means an artificial medical device that is not surgically implanted and that is used to replace a missing limb, appendage, or other external human body part including an artificial limb, hand, or foot. The term does not include artificial eyes, ears, noses, dental appliances, ostomy products, or devices such as eyelashes or wigs.

(5) "Prosthetics" means the science and practice of evaluation, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing, as well as providing the initial training necessary to accomplish the fitting of, a prosthesis through the replacement of external parts of a human body lost due to amputation, congenital deformities, or abscesses. The practice of prosthetics also includes the generation of an image, form, or mold that replicates the patient's body or body segment and that requires rectification of dimensions, contours, and volumes for use in the design and fabrication of a socket to accept a residual anatomic limb to, in turn, create an artificial appendage that is designed either to support body weight or to improve or restore function or cosmesis, or both. Involved in the practice of prosthetics is observational gait analysis and clinical assessment of the requirements necessary to refine and mechanically fix the relative position of various parts of the prosthesis to maximize function, stability, and safety of the patient. The practice of prosthetics includes providing and continuing patient care in order to assess the prosthetic device's effect on the patient's tissues and to assure proper fit and function of the prosthetic device through periodic evaluation.

(b) Every individual health insurance contract, plan, or policy which is delivered, issued for delivery, or renewed in this State on or after January 1, 2012, and which provides medical coverage that includes coverage for physician services in a physician's office, and every policy which provides major medical or similar comprehensive type coverage, shall provide reimbursement for orthotic and prosthetic

devices at least equal to federal reimbursements rates provided for under federal laws for health insurance for the aged and disabled pursuant to 42 U.S.C. §§ 1395k, 1395l, and 1395m and 42 C.F.R. §§ 414.202, 414.210, 414.228, and 410.100, as applicable to this section.

(c) A health insurance contract, plan, or policy may require prior authorization for orthotic and prosthetic devices in the same manner that prior authorization is required for any other covered benefit.

(d) Covered benefits for orthotic or prosthetic devices shall be limited to the most appropriate model that adequately meets the medical needs of the patient.

(e) The repair and replacement of orthotic or prosthetic devices also shall be covered subject to co-payments and deductibles, unless necessitated by misuse or loss.

(f) An insurer may require, if coverage is provided through a managed care plan, that benefits mandated pursuant to this section be covered benefits only if the orthotic or prosthetic devices are provided by a vendor, and orthotic or prosthetic services are rendered by a provider, who is licensed by the State to provide orthotics and prosthetics.

(g) This section shall not apply to policies that exclusively cover:

(1) Hospital confinement indemnity;

(2) Disability income;

(3) Accident only;

(4) Long-term care;

(5) Medicare supplement;

(6) Limited benefit health;

(7) Specified disease indemnity;

(8) Sickness or bodily injury or death by accident or both; or

(9) Other limited benefit policies.

(78 Del. Laws, c. 171, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3363. Recommended immunizations and preventive services.

(a) This section applies to any health carrier providing coverage under an individual or group health benefit plan.

(1) This section does not apply to grandfathered plan coverage.

(2) For purposes of this section, “grandfathered plan coverage” means coverage provided by a health carrier in which an individual was enrolled on March 23, 2010, for as long as it maintains that status in accordance with federal regulations.

(b) A health carrier shall provide coverage for the following items and services. A health carrier shall not impose any costs, such as a copayment, coinsurance or deductible with respect to the following items and services:

(1) Except as otherwise provided in this section, evidence-based items or services that had a rating of “A” or “B” in the recommendations of the United States Preventive Services Task Force that were in effect on January 1, 2025, with respect to the individual involved.

(2) Immunizations for routine use in children, adolescents and adults that were recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in effect on January 1, 2025, or other immunizations that were supported by national clinical guidelines or national standards of care in effect on January 1, 2025, with respect to the individual involved. For purposes of this paragraph, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention.

(3) With respect to infants, children and adolescents, evidence-informed preventive care, and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration in effect on January 1, 2025.

(4) With respect to women, to the extent not described in paragraph (b)(1) of this section, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration in effect on January 1, 2025.

(c) [Repealed.]

(d) Other provisions of state or federal law may apply in connection with a health carrier’s ceasing to provide coverage for any such items or services including § 2715(d)(4) of the Public Health Service Act [42 U.S.C. § 300gg-15(d)(4)], which requires a health carrier to give 60 days’ advance notice to a covered person before any material modification will become effective.

(e), (f) [Repealed.]

(g) A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in this section is billed separately or is tracked as individual encounter data separately from the office visit.

(h) A health carrier shall not impose cost-sharing requirements with respect to an office visit if an item or service described in this section is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the item or service.

(i) A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in this section is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service.

(j) Nothing in this section requires a health carrier that has a network of providers to provide benefits for items and services described herein that are delivered by an out-of-network provider.

(k) Nothing in this section precludes a health carrier that has a network of providers from imposing cost-sharing requirements for items or services described herein that are delivered by an out-of-network provider.

(*l*) Nothing in this section prohibits a health carrier from using reasonable medical management techniques to determine the frequency, method, treatment or setting for an item or service described herein to the extent not specified in the recommendation or guideline.

(m) Nothing in this section prohibits a health carrier from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided by guidelines supported by the Health Resources and Services Administration. A health carrier may impose cost-sharing requirements for a treatment not described in this section even if the treatment results from an item or service described herein.

(78 Del. Laws, c. 194, § 1; 70 Del. Laws, c. 186, § 1; 80 Del. Laws, c. 310, § 1; 85 Del. Laws, c. 419, § 1.)

§ 3364. Specialty tier prescription coverage.

(a) Unless otherwise specifically provided, the definitions herein apply throughout this section.

(1) “Class of drugs” means a group of medications having similar actions designed to treat a particular disease process.

(2) “Coinsurance” means a cost-sharing amount set as a percentage of the total cost of the drug.

(3) “Commissioner” means the Insurance Commissioner of this State.

(4) “Copayment” means a cost-sharing amount set as a dollar value.

(5) “Nonpreferred drug” means a specialty drug formulary classification for certain specialty drugs deemed nonpreferred and therefore subject to limits on eligibility for coverage or to higher cost-sharing amounts than preferred specialty drugs.

(6) “Preferred drug” means a specialty drug formulary classification for certain specialty drugs deemed preferred and therefore not subject to limits on eligibility for coverage or not subject to higher cost-sharing amounts than nonpreferred specialty drugs.

(7) “Specialty drug” means a prescription drug that:

a. Is prescribed for a person with:

1. A complex or chronic medical condition, defined as a physical, behavioral, or developmental condition that may have no known cure and/or is progressive and/or can be debilitating or fatal if left untreated or under-treated, such as multiple sclerosis, hepatitis C, and rheumatoid arthritis; or

2. A rare medical condition, defined as any disease or condition that affects fewer than 200,000 persons in the United States, or about 1 in 1,500 people, such as cystic fibrosis, hemophilia, and multiple myeloma; and

b. The total monthly cost of the prescription is $600 or more; and

c. The drug is not stocked at a majority of retail pharmacies; and

d. The drug has 1 or more of the following characteristics:

1. It is an oral, injectable, or infusible drug product.

2. It has unique storage or shipment requirements, such as refrigeration.

3. Patients receiving the drug require education and support beyond traditional dispensing activities.

(8) “Specialty drug formulary” means a specialty drug benefit design that distinguishes for purposes of eligibility for coverage or for cost sharing between preferred drugs and nonpreferred drugs.

(9) “Specialty drug tier” means a tier of cost sharing designed for specialty drugs that imposes a cost-sharing obligation for specialty drugs that exceeds the amount for nonspecialty drugs and such a cost-sharing amount is based on a coinsurance.

(b) A health plan that provides coverage for prescription drugs and utilizes a specialty drug tier shall ensure that any required copayment or coinsurance applicable to specialty drugs on a specialty tier does not exceed $150 per month for each specialty drug up to a 30-day supply of any single drug.

(c) A health plan that provides coverage for prescription drugs and utilizes a specialty drug formulary shall implement an exceptions process that allows enrollees to request an exception to the formulary. Under such an exception, a nonformulary specialty drug could be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the individual, or would have adverse effects for the individual, or both. In the event an enrollee is denied an exception, such denial shall be considered an adverse event and will be subject to the health plan internal review process set forth in § 332 of this title and the state external review process set forth in § 6416 of this title.

(d) A health plan that provides coverage for prescription drugs shall be prohibited from placing all drugs in a given class of drugs on a specialty tier.

(e) Nothing in this section shall be construed to require a health plan to:

(1) Provide coverage for any additional drugs not otherwise required by law;

(2) Implement specific utilization management techniques, such as prior authorization or step therapy; or

(3) Cease utilization of tiered cost-sharing structures, including those strategies used to incent use of preventive services, disease management, and low-cost treatment options.

(f) Nothing in this section shall be construed to require a pharmacist to substitute a drug without the consent of the prescribing physician.

(g) Nothing contained in any other provision of Delaware law or regulation shall preclude a health plan or other entity subject to this chapter from requiring specialty drugs to be obtained through a designated pharmacy or other source of such drugs.

(79 Del. Laws, c. 133, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3365. School-based health centers.

(a) For purposes of this section, a school-based health center (SBHC) is a health clinic that:

(1) Is located in or near a school facility;

(2) Is organized through school and health provider relationships;

(3) Except as provided by subsection (h) of this section, provides through licensed professionals primary health services to children, including comprehensive health assessments, diagnosis, and treatment of minor, acute, and chronic medical conditions, referrals to and follow-up for specialty care and oral and vision health services, mental health and substance use disorder assessments, crisis intervention, counseling, treatment, and referral to a continuum of mental health and substance abuse services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs; and

(4) Is recognized by the State pursuant to relevant regulations and law.

(b) The Delaware Division of Public Health (DPH) shall have sole authority to determine whether a facility is an SBHC as defined in subsection (a) of this section.

(c) Except as noted herein, benefits provided under insurance contracts delivered, issued for delivery, or renewed in this State shall reimburse SBHCs for covered services provided by SBHCs as if those services were provided by a network provider under the relevant contract of insurance. In the absence of an agreement between a carrier and an SBHC on reimbursement, reimbursement for such services shall be at the rate established by the Division of Medicaid and Medical Assistance for those services. Any insurance contract term purporting to exclude otherwise covered services on the basis that they are performed by an SBHC shall be void except as specifically permitted under this chapter.

(d) If DPH has approved an SBHC, that approval shall be deemed sufficient to meet the carrier's standards for inclusion in its network or for being eligible for payment by the carrier.

(e) SBHCs shall not charge co-pays or any other out-of-pocket fees to students for use of SBHC services. Insurance carriers shall not incur any additional financial liability by virtue of this subsection.

(f) The Delaware DPH, in coordination with the State's SBHCs, insurance carriers, and the Department of Insurance, shall issue regulations to ensure that SBHCs are properly integrated into the State's spectrum of health-care providers that provide covered services to youth. These regulations shall include, but are not limited to:

(1) Regulations governing reporting to and interaction with students' primary care providers; and

(2) Regulations regarding promotion of vaccinations among student users of SBHCs.

(g) Nothing in this chapter shall prevent the enforceability of an agreement negotiated between an SBHC and an insurance carrier governing claims submission, reimbursement, quality standards, credentialing and similar matters, provided, however, that in the absence of such agreement the terms of this chapter shall govern.

(h) DPH shall have the authority to approve supervised clinical training rotations for mental health providers at SBHCs.

(78 Del. Laws, c. 276, § 1; 80 Del. Laws, c. 310, § 1; 85 Del. Laws, c. 196, § 1.)

§ 3366. Autism spectrum disorders coverage.

(a) All individual health benefit plans as defined in § 3343(a) of this title shall provide coverage for the screening and diagnosis of autism spectrum disorders and the treatment of autism spectrum disorders in individuals less than 21 years of age. To the extent that the diagnosis of autism spectrum disorders and the treatment of autism spectrum disorders are not already covered by a health benefit plan, coverage under this section shall be included in health benefit plans that are delivered, issued, executed or renewed in this State pursuant to this title after December 11, 2012. No insurer shall terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual or a family member is diagnosed with 1 of the autism spectrum disorders or has received treatment for autism spectrum disorders. Coverage under this section shall not be denied on the basis that the treatment is habilitative or nonrestorative in nature.

(b) Coverage for applied behavior analysis services under this section by an insurer shall be subject to a maximum benefit of $36,000 per 12-month period per person, but shall not be subject to any limits on the number of visits an individual may make to an autism services provider or that a provider may make to an individual regardless of the locations in which services are provided. After December 31, 2012, the Insurance Commissioner shall, on or before April 1 of each calendar year, publish in the Delaware Register of Regulations an adjustment to the maximum benefit equal to the change in the United States Department of Labor Consumer Price Index for all Urban Consumers (CPI-U) in the preceding year and the published adjusted maximum benefit shall be applicable to all health insurance policies issued or renewed thereafter. Payments made by an insurer on behalf of a covered individual for treatment unrelated to applied behavior analysis shall not be applied toward any maximum benefit established under this subsection.

(c) The coverage required under this section shall not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally under the health benefit plan, except as otherwise provided in subsection (b) of this section.

(d) This section shall not be construed as limiting benefits that are otherwise available to an individual or family member under their health benefit plan.

(e) As used in this section:

(1) “Applied behavior analysis” means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(2) “Autism services provider” means any person, entity, or group authorized by this section that provides treatment of autism spectrum disorders. This includes licensed physicians, psychologists or their assistants, psychiatrists, speech therapists or their aides, occupational therapists or their aides, physical therapists or their assistants, practitioners with the national certification of board-certified behavior analyst or those working under their supervision, licensed professional counselors of mental health, licensed clinical social workers, advanced practice nurses, or any person, entity, or group meeting the standards set by the Department of Health and Social Services as authorized by subsection (f) of this section.

(3) “Autism spectrum disorders” means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including Autistic Disorder, Asperger’s Disorder and Pervasive Developmental Disorder Not Otherwise Specified, as such may be amended hereafter from time to time.

(4) “Behavioral health treatment” means professional counseling, guidance services or treatment programs, including applied behavior analysis, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. This definition also applies to treatment or counseling to improve social skills and function.

(5) “Medically necessary” means reasonably expected to do the following:

a. Prevent the onset of an illness, condition, injury, or disability;

b. Reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or

c. Assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individuals of the same age.

(6) “Pharmacy care” means medications prescribed by a licensed practitioner and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

(7) “Psychiatric care” means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

(8) “Psychological care” means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices or by a psychological assistant acting under the supervision of a psychologist.

(9) “Screening and diagnosis of autism spectrum disorders” means medically necessary assessments, evaluations, or tests to diagnose whether an individual has or is at risk for 1 of the autism spectrum disorders.

(10) “Therapeutic care” means services provided by speech, occupational, or physical therapists or an aide or assistant under their supervision.

(11) “Treatment for autism spectrum disorders” shall include the following care prescribed or ordered for an individual diagnosed with 1 of the autism spectrum disorders by a licensed physician or licensed psychologist who determines the care to be medically necessary:

a. Behavioral health treatment;

b. Pharmacy care;

c. Psychiatric care;

d. Psychological care;

e. Therapeutic care;

f. Items and equipment necessary to provide, receive, or advance in the above-listed services, including those necessary for applied behavioral analysis; and

g. Any care for individuals with autism spectrum disorders that is determined by the Secretary of the Department of Health and Social Services, based upon their review of best practices and/or evidence-based research, to be medically necessary. The Secretary shall inform the Insurance Commissioner of such determination, and upon receiving notice the Insurance Commissioner shall issue a bulletin stating that any such care, treatment, intervention, service, or item that was not previously covered shall be included in any health benefit plan delivered, executed, issued, amended, adjusted, or renewed on or after 120 days following the date of such bulletin.

(f) The Department of Health and Social Services shall promulgate regulations establishing standards for certifying qualified autism services providers by June 11, 2013, If an autism services provider meets recognized national certification as a board-certified behavior analyst, such autism services provider shall be deemed to have met the standards to be established under this section, to provide applied behavioral analysis services. Once the regulations are promulgated, payment for the treatment of autism spectrum disorders covered under this section shall only be required to be made to autism services providers who meet the standards.

(g) Except for inpatient services, if an individual is receiving treatment for autism spectrum disorders, an insurer will have the right to request a review of that treatment not more than once every 12 months unless the insurer and the licensed physician or licensed psychologist agree that a more frequent review is necessary. The cost of obtaining any review shall be borne by the insurer.

(h) This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan (IFSP); an individualized education program (IEP); an individual plan for employment (IPE); a 504 plan; or an individualized service plan, including an essential lifestyle plan (ELP).

(i) The Insurance Commissioner may promulgate rules and regulations as may be necessary or appropriate to implement and administer this section, except for subsection (f) of this section.

(78 Del. Laws, c. 398, § 1; 80 Del. Laws, c. 310, § 1; 81 Del. Laws, c. 29, § 1.)

§ 3367. Payment for emergency medical services.

(a) As used in this section:

(1) "Ambulance" shall have the same definition set forth in § 9702 of Title 16.

(2) "Basic life support" shall have the same definition set forth in § 9702 of Title 16.

(3) "Emergency medical services provider agency" shall have the same definition set forth in § 9802 of Title 16.

(4) "Volunteer fire company" shall mean the duly organized volunteer fire companies in the State.

(b) Notwithstanding any provision precluding an assignment of benefits in any individual health insurance policy, contract, certificate or plan, delivered or issued for delivery in this State by any insurer, health service corporation, or health maintenance organization, when a volunteer fire company or other emergency medical services provider agency certified by the Delaware State Fire Prevention Commission renders covered emergency medical services or supplies, including but not limited to basic life support and ambulance service, any payment or reimbursement made by an insurer, health service corporation or health maintenance organization for such covered emergency medical services or supplies shall be paid directly to the volunteer fire company or other certified emergency medical services provider agency, or their designee, without regard to whether a contract exists between the volunteer fire company or certified emergency medical services provider agency and the insurer, health service corporation or health maintenance organization, and otherwise without regard to whether the volunteer fire company or emergency medical services provider agency is a part of any network maintained by the insurer, health service corporation or health maintenance organization.

(c) The limitations on balance billing provided in § 3348 of this title shall not apply to billing for emergency medical services within the scope of this section provided by volunteer fire companies or emergency medical services provider agencies certified by the Delaware State Fire Prevention Commission.

(d) This section shall apply to all policies, contracts, certificates or plans issued, renewed, modified, altered, amended or reissued on or after July 1, 2013.

(e) Nothing in this section should apply to supplemental health insurance policies that do not provide expense or reimbursement coverage for emergency medical services, basic life support or ambulance services.

(79 Del. Laws, c. 76, § 1; 80 Del. Laws, c. 310, § 1.)

§ 3368. No lifetime or annual limits [For application of this section, see 79 Del. Laws, c. 99, § 19].

(a) (1) Except as provided in subsection (b) of this section, a health insurance issuer offering group or individual health insurance coverage may not establish any lifetime limit on the dollar amount of benefits for any individual.

(2) a. Except as provided in paragraph (a)(2)b., subsections (b) and (d) of this section, a health insurance issuer offering group or individual health insurance coverage may not establish any annual limit on the dollar amount of benefits for any individual.

b. A health flexible spending arrangement (as defined in § 106(c)(2) of the Internal Revenue Code) [26 U.S.C. § 106(c)(2)] is not subject to the requirement in paragraph (a)(2)a. of this section.

(b) (1) The rules of this section do not prevent a health insurance issuer offering group or individual health insurance coverage from placing annual or lifetime dollar limits with respect to any individual on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable federal or state law.

(2) The rules of this section do not prevent a health insurance issuer offering group or individual health insurance coverage from excluding all benefits for a condition. However, if any benefits are provided for a condition, then the requirements of this section apply. Other requirements of federal or state law may require coverage of certain benefits.

(c) The term "essential health benefits" as used in this section means essential health benefits under § 1302(b) of the Patient Protection and Affordable Care Act [42 U.S.C. § 18022(b)], as the law and its implementing regulations were in effect on January 1, 2025; Delaware law; and applicable state regulations.

(d) (1) With respect to policy years beginning prior to January 1, 2014, a health insurance issuer offering group or individual health insurance coverage may establish, for any individual, an annual limit on the dollar amount of benefits that are essential health benefits, provided the limit is no less than the following amounts:

a. For a policy year beginning on or after September 23, 2010, but before September 23, 2011, $750,000.

b. For a policy year beginning on or after September 23, 2011, but before September 23, 2012, $1,250,000.

c. For policy years beginning on or after September 23, 2012, but before January 1, 2014, $2,000,000.

(2) In determining whether an individual has received benefits that meet or exceed the applicable amount described in paragraph (d) (1) of this section, an issuer must take into account only essential health benefits.

(79 Del. Laws, c. 99, § 4; 80 Del. Laws, c. 310, § 1; 82 Del. Laws, c. 186, § 2; 85 Del. Laws, c. 89, § 1.)

§ 3369. Notification and reasons for cancellation or nonrenewal [For application of this section, see 79 Del. Laws, c. 390, § 8].

A notice of cancellation or nonrenewal of health insurance coverage by an insurer due to nonpayment of premiums shall be in writing, shall be delivered to the named policyholder or mailed to the named policyholder at the last known address of the named policyholder, shall state the effective date of the cancellation or nonrenewal and shall be accompanied by a written explanation of the specific reasons for the cancellation or nonrenewal. Proof of mailing of such cancellation or nonrenewal notice shall be retained by the insurer for a period of not less than 1 year. This section shall not apply to any policy issued under the Delaware Healthy Children Program or any long-term care policy where notice provisions regarding cancellations or nonrenewals are specifically addressed elsewhere in this title or in regulations promulgated thereunder.

(79 Del. Laws, c. 390, § 3; 80 Del. Laws, c. 310, § 1.)

§ 3370. Telehealth and telemedicine.

(a) For purposes of this section:

(1) "Distant site" means a site at which a health-care provider legally allowed to practice in Delaware is located while providing health-care services by means of telemedicine or telehealth.

(2) "Originating site" means a site in Delaware at which a patient is located at the time health-care services are provided to the patient by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used. Notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

(3) "Store and forward transfer" means the transmission of a patient's medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

(4) "Telehealth" means the use of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which support clinical health-care provider consultation, patient and professional health-related education, public health, health administration, and other services as authorized in Chapter 60 of Title 24.

(5) "Telemedicine" is a subset of telehealth which is the delivery of clinical health-care services and other services, as authorized in Chapter 60 of Title 24, by means of real time 2-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support health-care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care by a health-care provider legally allowed to practice in Delaware and practicing within the health-care provider's scope of practice as would be practiced in-person with a patient, while such patient is at an originating site and the health-care provider is at a distant site.

(b) Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each health service corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health-care plan for health-care services shall provide coverage for the cost of such health-care services provided through telemedicine.

(c) Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each health service corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health-care plan for health-care services shall provide coverage for the cost of such health-care services provided through telehealth as directed through regulations promulgated by the Department.

(d) An insurer, health service corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through in-person consultation or contact between a health-care provider and a patient for services appropriately provided through telemedicine services.

(e) An insurer, health service corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis and at least at the rate that the insurer, health service corporation, or health maintenance organization is responsible for coverage for the provision of the same service through in-person consultation or contact. Payment for telemedicine interactions shall include reasonable compensation to the originating or distant site for the transmission cost incurred during the delivery of health-care services.

(f) No insurer, health service corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

(g) The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended on and after January 1, 2016, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

(h) This section shall not apply to short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts, nor shall it contravene any telehealth requirements made in policies or contracts designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act [42 U.S.C. §§ 1395 et seq., 1396 et seq., and 1397aa et seq.], known as Medicare, Medicaid, or any other similar coverage under state or federal governmental plans.

(80 Del. Laws, c. 80, § 1; 70 Del. Laws, c. 186, § 1; 80 Del. Laws, c. 310, § 1; 82 Del. Laws, c. 261, §§ 2, 16; 83 Del. Laws, c. 52, § 2; 83 Del. Laws, c. 283, § 27.)

§ 3370A. Network disclosure and transparency.

(a) This section applies to every policy or contract of health insurance which is delivered or issued for delivery in this State, including each policy or contract issued by a health-service corporation, which provides medical, major medical, or similar comprehensive-type coverage, and which designates network physicians or providers (hereinafter referred to collectively as “network providers”). However, this section applies only to items, services or conditions for which coverage is provided by those policies or contracts (hereinafter referred to as “covered services”).

(b) For purposes of this section “facility-based provider” means a provider who provides health-care services to covered persons who are in an in-patient or ambulatory facility, including services such as pathology, anesthesiology, or radiology.

(c) For purposes of this section “health-care provider” means any provider who provides health-care services to covered persons who are not in a facility-based setting, and includes a provider who provides health-care services to a covered person based upon a referral from another provider without the knowledge of or input from the covered person.

(d) *Nonemergency out-of-network services. —*

(1) When a facility-based provider schedules a procedure, seeks prior authorization from a health carrier for the provision of nonemergency covered services to a covered person or prior to the provision of any nonemergency covered services, the facility shall ensure that the covered person has received a timely written out-of-network disclosure that states the following:

a. That discloses whether the facility is a participating or out-of-network facility;

b. That certain facility-based providers may be called upon to render care to the covered person during the course of treatment;

c. That those facility-based providers may not have a contract with the covered person’s health insurer and are therefore considered to be out-of-network;

d. That the services therefore will be provided on an out-of-network basis, which may result in additional charges for which the covered person may be responsible, and a statement that these charges are in addition to any coinsurance, deductibles and copayments applicable under the covered person’s health insurance policy;

e. A listing, including name and contact information, of those facility-based providers who may be called upon to render care to the covered person during the course of treatment, and a statement that the covered person should contact their health insurer to determine the network status of those facility-based providers;

f. Notification that an estimate of the range of charges charged by the out-of-network provider for any out-of-networks services for which the covered person may be responsible may be requested from, and will be timely provided by, the out-of-network provider; and

g. That the covered person may contact the covered person’s health insurer for additional assistance or may rely on whatever other rights and remedies may be available under state or federal law.

h. The written out-of-network disclosure required by this paragraph (d)(1) shall include a written consent form which would enable a covered person who wishes to utilize the services of an out-of-network provider to: (i) acknowledge a provider may be a

non-network provider; (ii) acknowledge that the services provided by the non-network provider may not be covered by the covered person's policy; (iii) acknowledge receipt of the notification that an estimate of the range of charges for any out-of-network services for which the covered person may be responsible may be obtained from the out-of-network providers; and (iv) affirmatively elect to obtain the services and agree to accept and pay the charges for the out-of-network services.

i. If a covered person requests from an out-of-network provider an estimate of the range of charges for any out-of-network services for which the covered person may be responsible, the out-of-network provider shall provide the estimate in writing to the covered person within 3 business days of the request.

j. If the facility and all facility-based providers participate in the covered person's network, this disclosure shall not be required.

(2) Prior to the delivery of nonemergency covered services to a covered person, an out-of-network health-care provider shall provide the covered person with a timely, written out-of-network disclosure that states the following:

a. That the health-care provider is an out-of-network provider and the services therefore will be provided on an out-of-network basis;

b. That out-of-network services may result in additional charges for which the covered person may be responsible, and a statement that these charges are in addition to any coinsurance, deductibles and copayments applicable under the person's health insurance policy;

c. Identification of the range of charges charged by the out-of-network health-care provider for any out-of-network services for which the covered person may be responsible; and

d. That the covered person may contact the covered person's health insurer for additional assistance or may rely on whatever other rights and remedies may be available under state or federal law.

e. The written out-of-network disclosure required by this paragraph (d)(2) shall contain a written consent form which would enable a covered person who wishes to utilize the services of an out-of-network provider to: (i) acknowledge a provider may be a non-network provider; (ii) acknowledge that the services provided by the non-network provider may not be covered by the insured's policy; (iii) acknowledge receipt of the identification of the range of charges for any out-of-network services for which the covered person may be responsible; and (iv) affirmatively elect to obtain the services and agree to accept and pay the charges for the out-of-network services.

(3) A facility-based provider or a health-care provider may not balance bill a covered person for health-care services not covered by an insured's health insurance contract, if the facility-based provider or health-care provider:

a. Fails to provide to the covered person the written out-of-network disclosure required by paragraphs (d)(1) or (2) of this section.

b. Fails to obtain from the covered person in a timely manner, before the health-care services are provided, a copy of the consent form required by paragraphs (d)(1) or (2) of this section that has been signed by the covered person.

(4) Nothing in paragraph (d)(3) of this section shall prevent the operation of policy provisions involving coinsurance, deductibles and copayments payable under the insured health insurance policy.

(5) In the event a facility-based provider or a health-care provider fails to comply with the requirements of paragraphs (d)(3)a. or (3)b. of this section, and the provider of services and insurer cannot agree on the appropriate rate of reimbursement, the provider shall be entitled to those charges and rates allowed by the Insurance Commissioner or the Commissioner's designee following arbitration of the dispute pursuant to the procedures set forth in § 333 of this title and any regulation promulgated thereunder.

(6) This section shall not apply to those out-of-network services provided pursuant to §§ 3348 and 3349 of this title.

(e) Health insurers shall be required to maintain accurate and complete provider directories, to update provider directories frequently, to audit the accuracy and completeness of such directories and make the directories easily accessible to the covered person in a variety of formats.

(f) The Insurance Commissioner shall adopt regulations to implement the requirements of this section, including:

(1) Regulations concerning the form and content of the written out-of-network disclosures and written consent form required by paragraphs (d)(1) and (2) of this section.

(2) Regulations requiring health insurers and out-of-network providers to inform covered persons of their rights with respect to payment of balance bills.

(3) *Regulations concerning the provisions of subsection (e) of this section. —*

The regulations adopted and arbitrations authorized pursuant to this section shall reflect the objectives of protecting consumers from surprise bills and not creating incentives for providers to be out-of-network.

(80 Del. Laws, c. 339, § 1.)

§ 3370B. Coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome.

(a) All individual health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State by any health insurer, health service corporation, or health maintenance organization shall provide coverage

for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy.

(b) At any time that the State determines it is required under federal law to defray the cost of any coverage for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome required under subsection (a) of this section, the requirements under subsection (a) of this section are inoperative and the State may not assume any obligation for the cost of coverage for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome.

(81 Del. Laws, c. 400, § 1; 84 Del. Laws, c. 233, § 38.)

§ 3370C. Time of submitting claim for reimbursement.

(a) For purposes of this section:

(1) "Carrier" means any entity that provides health insurance in this State. "Carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(2) "Carrier" does not mean an entity that provides a plan of health insurance or health benefits designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act (42 U.S.C. §§ 1395 et seq., 1396 et seq. and 1397 et seq.), known as Medicare, Medicaid, or any other similar coverage under state or federal governmental plans.

(b) Regardless of network status, a carrier shall permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement. Any contract between a carrier and provider that prohibits a provider from submitting a claim beyond the minimum time limit required under this section shall not be deemed a violation of this section.

(82 Del. Laws, c. 111, § 3.)

§ 3370D. Coverage for epinephrine autoinjectors.

(a) For purposes of this section, "epinephrine autoinjector" means a single-use device used for the automatic injection of a premeasured dose of epinephrine into the human body.

(b) All individual health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State shall provide coverage for medically-necessary epinephrine autoinjectors by including at least 1 formulation of epinephrine autoinjectors on the lowest tier of the drug formulary developed and maintained by the carrier.

(c) Nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(d) (1) For individuals who are 18 years of age or under, this section applies to all policies, contracts, or certificates issued, renewed, modified, altered, amended, or reissued after December 31, 2021.

(2) For individuals who are more than 18 years of age, this section applies to all policies, contracts, or certificates issued, renewed, modified, altered, amended, or reissued after December 31, 2024.

(e) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.

(83 Del. Laws, c. 42, § 1; 83 Del. Laws, c. 283, § 26; 84 Del. Laws, c. 36, § 1.)

§ 3370E. Annual behavioral health well check.

(a) As used in this section:

(1) "Behavioral health well check" means a predeductible annual visit with a licensed mental health clinician with at minimum a masters level degree. The well check must include but is not limited to a review of medical history, evaluation of adverse childhood experiences, use of a group of developmentally-appropriate mental health screening tools, and may include anticipatory behavioral health guidance congruent with stage of life using the diagnosis of "annual behavioral health well check."

(2) "Carrier" means any entity that provides health insurance in this State that is subject to the provisions of this chapter. "Carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(b) All carriers shall provide coverage of an annual behavioral health well check, which, except as provided in subsection (d) of this section, shall be reimbursed through the following common procedural terminology (CPT) codes at the same rate that such CPT codes are reimbursed for the provision of other medical care, provided that reimbursement may be adjusted for payment of claims that are billed by a nonphysician clinician so long as the methodology to determine such adjustments is comparable to and applied no more stringently than the methodology for adjustments made for reimbursement of claims billed by nonphysician clinicians for other medical care, in accordance with 45 CFR § 146.136(c)(4):

(1) 99381.
(2) 99382.
(3) 99383.
(4) 99384.
(5) 99385.
(6) 99386.
(7) 99387.
(8) 99391.
(9) 99392.
(10) 99393.
(11) 99394.
(12) 99395.
(13) 99396.
(14) 99397.

(c) (1) The Commissioner shall update this list of codes through the promulgation of rules if the CPT codes listed in subsection (b) of this section are altered, amended, changed, deleted, or supplemented.

(2) Reimbursement of any of the CPT codes listed in subsection (b) of this section or promulgated under paragraph (c)(1) of this section for the purpose of covering an annual behavioral health well check may not be denied because such CPT code was already reimbursed for the purpose of covering a service other than an annual behavioral health well check.

(3) Reimbursement of any of the CPT codes listed in subsection (b) of this section or promulgated under paragraph (c)(1) of this section for the purpose of covering a service other than an annual behavioral health well check may not be denied because such CPT code was already reimbursed for the purpose of covering an annual behavioral health well check.

(d) An annual behavioral health well check may be reimbursed through a value-based arrangement, a capitated arrangement, a bundled payment arrangement, or any other alternative payment arrangement that is not a traditional fee-for-service arrangement, provided that a carrier must have documentation demonstrating that within such payment arrangement the annual behavioral health well check is valued commensurate to the value established under subsection (b) of this section.

(e) An annual behavioral health well check may be incorporated into and reimbursed within any type of integrated primary care service delivery method including, but not limited to, the psychiatric collaborative care model, the primary care behavioral health model or behavioral health consultant model, any model that involves co-location of mental health professionals within general medical settings, or any other integrated care model that focuses on the delivery of primary care.

(f) Nothing in this section prevents the operation of policy provisions such as copayments, coinsurance, allowable charge limitations, coordination of benefits, or provisions restricting coverage to services rendered by licensed, certified, or carrier-approved providers or facilities.

(83 Del. Laws, c. 388, § 1.)

§ 3370F. Supplemental and diagnostic breast examinations [For application of this section, see 84 Del. Laws, c. 121, § 5].

(a) As used in this section:

(1) “Breast magnetic resonance imaging” or “breast MRI” means a diagnostic tool, including standard and abbreviated breast MRI, that uses radio waves and magnets to produce detailed images of structures within the breast. A breast MRI may be used as a screening tool when clinically indicated, including after indeterminant results from a mammogram that requires additional evaluation and for those at high risk for breast cancer.

(2) “Breast ultrasound” means a noninvasive diagnostic tool that uses high-frequency sound waves and their echoes to produce detailed images of structures within the breast. A breast ultrasound may be used as a screening tool when clinically indicated, including after indeterminant results from a mammogram that requires additional evaluation and for those at high risk for breast cancer.

(3) “Cost-sharing requirement” means a deductible, coinsurance, or copayment and any maximum limitation on the application of such a deductible, coinsurance, copayment, or similar out-of-pocket expense.

(4) “Diagnostic breast examination” means a medically-necessary and clinically-appropriate examination of the breast, including such examination using breast MRI, breast ultrasound, or mammogram, that is used for either of the following:

a. To evaluate an abnormality seen or suspected from a screening examination for breast cancer.

b. To evaluate an abnormality detected by another means of examination.

(5) “Mammogram” means a diagnostic or screening mammography exam using a low-dose X-ray to produce an image of the breast.

(6) “Supplemental breast screening examination” means a medically-necessary and clinically-appropriate examination of the breast, including such examination using breast MRI, breast ultrasound, or mammogram, that is used for either of the following:

a. To screen for breast cancer when there is no abnormality seen or suspected in the breast.

b. Based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer.

(b) All individual health insurance policies, contracts, or certificates that are delivered, issued for delivery, extended, or modified in this State shall provide coverage for diagnostic breast examinations and supplemental breast screening examinations. The terms of such coverage, including cost-sharing requirements, shall be no less favorable than the cost-sharing requirements applicable to screening mammography for breast cancer.

(c) This section does not apply to any of the following:

(1) A high deductible health plan if providing coverage under subsection (b) of this section would cause the plan to fail to be treated as a high deductible health plan under § 223(c)(2) of the Internal Revenue Code [26 U.S.C. § 223(c)(2)].

(2) A catastrophic health plan if providing coverage under subsection (b) of this section would cause the plan to fail to be treated as a catastrophic plan under § 1302(e) of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18022(e).

(3) A specified accident, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit health insurance policy.

(d) If, at any time, the State is required under federal law to defray the cost of any coverage required under this section, the requirements under this section are inoperative and the State does not assume any obligation for the cost of coverage.

(84 Del. Laws, c. 121, § 2.)

§ 3370G. Coverage for allergenic protein dietary supplements [For application of this section, see 84 Del. Laws, c. 376, § 5].

(a) For purposes of this section:

(1) "Dietary supplement" means as defined in the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 321.

(2) "Early egg allergen introduction dietary supplement" means a dietary supplement that is prescribed to an infant by a health-care practitioner and contains sufficient infant-safe, well-cooked egg protein to reduce the risk of food allergies.

(3) "Early peanut allergen introduction dietary supplement" means a dietary supplement that is prescribed to an infant by a health-care practitioner and contains sufficient infant-safe peanut protein to reduce the risk of food allergies.

(4) "Health-care practitioner" means an individual licensed and authorized to write medical orders for an individual under Title 24.

(5) "Infant" means a child who has not attained the age of 1 year.

(b) (1) All individual health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State shall provide coverage for at least 1 of each of the following:

a. An early egg allergen introduction dietary supplement.

b. An early peanut allergen introduction dietary supplement.

(2) The coverage required under paragraph (b)(1) of this section shall be provided at no cost to a covered individual, including deductible payments and cost-sharing amounts charged once a deductible is met.

(c) Except as provided under subsection (b) of this section, nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(d) (1) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.

(2) The cost-sharing limitation under paragraph (b)(2) of this section does not apply to a catastrophic health plan to the extent this cost-sharing limitation would cause the plan to fail to be treated as a catastrophic plan under § 1302(e) of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18022(e).

(3) a. The cost-sharing limitation under paragraph (b)(2) of this section does not apply to a high deductible health plan to the extent this cost-sharing limitation would cause the plan to fail to be treated as a high deductible health plan under § 223(c)(2) of the Internal Revenue Code [26 U.S.C. § 223(c)(2)].

b. If the cost-sharing limitation under paragraph (b)(2) of this section would result in an enrollee becoming ineligible for a health savings account under federal law, this cost-sharing limitation only applies to a qualified high deductible health plan after the enrollee's deductible has been met.

(84 Del. Laws, c. 376, § 1.)

§ 3370H. Services related to termination of pregnancy.

(a) As used in this section:

(1) "Carrier" means any entity that provides health insurance in this State that is subject to the provisions of this chapter. "Carrier" includes an insurance company, health service corporation, managed care organization, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(2) “Health benefit plan” means as defined in § 3342A of this title.

(b) A carrier shall cover services related to the termination of pregnancy for enrollees.

(1) a. Except as provided in paragraphs (b)(1)b. and (b)(1)c. of this section, coverage provided under this section may not be subject to any deductible, coinsurance, copayment, or any other cost-sharing requirement.

b. The limitations on cost-sharing in paragraph (b)(1)a. of this section do not apply to a high deductible health plan or a catastrophic health plan if the limitations would cause such plan to lose its status as a high deductible health plan under § 223(c)(2) of the Internal Revenue Code [26 U.S.C. § 223(c)(2)] or a catastrophic health plan under § 1302(e) of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18022(e).

c. Coverage under this section may be limited to $750 per covered individual per year.

(2) A carrier must provide coverage for the full scope of services permissible under the law.

(3) Coverage provided under this section may not require a referral or prior authorization as a condition of coverage.

(4) If a policy or contract limits an insured’s access to a network of participating providers for other health-care services, then it may limit access for services related to termination of pregnancy, but the policy or contract must include in all its provider networks sufficient numbers of providers of termination of pregnancy services to accommodate the direct access needs of their enrollees.

(c) This section applies to all policies, contracts, or certificates issued, renewed, modified, altered, amended, or reissued after December 31, 2025.

(84 Del. Laws, c. 402, § 3.)

§ 3370I. Coverage for doula services.

(a) “Doula services” means services provided by a trained doula and designed to provide physical, emotional, and educational support to pregnant and birthing persons, before, during, and after childbirth. “Doula services” include the following:

(1) Support and assistance during labor and childbirth.

(2) Prenatal and postpartum support and education.

(3) Breastfeeding assistance and lactation support.

(4) Parenting education.

(5) Support for a birthing person following loss of pregnancy.

(b) All individual health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State after December 31, 2025, shall provide coverage for doula services, when provided by a doula who is certified by the Delaware Certification Board, that includes all of the following:

(1) Three prenatal visits of up to 90 minutes.

(2) Three postpartum visits of up to 90 minutes.

(3) Attendance through labor and birth.

(c) Coverage must be provided for additional postpartum doula visits with a recommendation from a practitioner or clinician licensed under Title 24 acting within their scope of practice.

(d) (1) Nothing in this section prevents the operation of policy provisions such as deductibles, coinsurance, allowable charge limitations, or coordination of benefits.

(2) Carriers may require doulas to be certified or registered in the same manner required by the Division of Medicaid and Medical Assistance under § 530 of Title 31.

(e) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.

(84 Del. Laws, c. 420, § 1.)

§ 3370J. Pharmacist services reimbursement [For application of this section, see 85 Del. Laws, c. 253, § 23].

(a) For purposes of this section, “carrier” means any entity that provides health insurance in this State. “Carrier” includes any insurance company, managed care organization, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. “Carrier” also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(b) For any individual insurance policy, contract, or certificate that is delivered, issued for delivery, renewed, extended, or modified in this State after January 1, 2025, a carrier must provide reimbursement to a pharmacist for a service or procedure at a rate not less than that provided to other nonphysician practitioners if the service or procedure is all of the following:

(1) Within the scope of practice of a pharmacist.

(2) Would otherwise be covered under the policy, plan, or contract if the service or procedure is provided by any health-care service provider or practitioner, including a physician, advance practice registered nurse, or physician associate.

(c) Whenever a service is performed by a licensed pharmacist and reimbursed by a carrier, the licensed pharmacist must be granted such rights of participation, plan admission, and registration as may be granted by the carrier to any health-care service provider or practitioner, including a physician, advance practice registered nurse, or physician associate performing such a service.

(84 Del. Laws, c. 421, § 2; 85 Del. Laws, c. 253, § 14.)

§ 3370K. Annual mammograms.

(a) As used in this section, "Carrier" means any entity that provides health insurance in this State that is subject to the provisions of this chapter. "Carrier" includes an insurance company, health service corporation, health maintenance organization, managed care organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(b) All carriers shall provide coverage for annual mammograms for the purpose of early detection for a woman 40 years of age or older, with or without referral from the woman's health-care provider.

(c) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term disability income, or other limited benefit health insurance policies.

(84 Del. Laws, c. 483, § 1.)

§ 3370L. Developmentally-delayed speech coverage [For application of this section, see 84 Del. Laws, c. 520, § 3].

(a) For the purpose of this section "child" means a child from birth to age 18.

(b) Every individual health insurance contract, including each policy or contract delivered, issued for delivery, or renewed in this State after December 31, 2024, shall provide coverage for any therapy or services required to treat a child diagnosed with any of the following speech-language disorders classified in the International Classification of Diseases (ICD-10):

(1) Childhood onset fluency disorder.

(2) Developmental disorder of speech and language unspecified.

(3) Expressive language disorder.

(4) Mixed receptive-expressive language disorder.

(5) Phonological disorder.

(6) Receptive language disorder.

(7) Social pragmatic communication disorder.

(c) This section does not apply to insurance coverage providing benefits exclusively for:

(1) Hospital confinement indemnity.

(2) Disability income.

(3) Accident only.

(4) Long-term care.

(5) Medicare supplement.

(6) Limited benefit health.

(7) Specified disease indemnity.

(8) Sickness or bodily injury or death by accident; or both.

(d) Nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(84 Del. Laws, c. 520, § 1.)

§ 3370M. Coverage for removal of excess skin and subcutaneous tissue [For application of this section, see 85 Del. Laws, c. 88, § 5].

(a) For purposes of this section:

(1) "Medically necessary" means as defined in § 3371 of this title.

(2) "Panniculectomy" means an operative procedure used to contour the abdominal wall by removing significant excess skin and subcutaneous adipose tissue.

(b) All individual health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State must provide coverage for medically necessary removal of excess skin and subcutaneous tissue, including a panniculectomy.

(c) Nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(d) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.

(85 Del. Laws, c. 88, § 1.)

§ 3370N. Coverage for pre-exposure prophylaxis treatment and post-exposure prophylaxis treatment [For application of this section, see 85 Del. Laws, c. 452, § 5].

(a) As used in this section:

(1) "Cost-sharing requirement" includes a deductible, coinsurance, copayment, and out-of-pocket expense.

(2) "Essential support services" include all of the following:

a. HIV testing.

b. Hepatitis B and C testing.

c. Kidney function assessment through creatinine testing and calculated estimated creatinine clearance or glomerular filtration rate.

d. Pregnancy testing.

e. Sexually transmitted infection screening and counseling.

f. Adherence counseling.

(3) "FDA" means the United States Food and Drug Administration.

(4) "HIV" means the human immunodeficiency virus.

(5) "Medically necessary" means as defined in § 3371 of this title.

(6) "PEP" means post-exposure prophylaxis medication for preventing HIV infection after possible HIV exposure.

(7) "PrEP" means pre-exposure prophylaxis medication for preventing HIV infection before possible HIV exposure.

(8) "Therapeutic equivalent" means a PrEP or a PEP that is all of the following:

a. Approved as safe and effective.

b. Pharmaceutically equivalent to another PrEP or another PEP because it contains an identical amount of the same active drug ingredient in the same dosage form and route of administration and meets compendial or other applicable standards of strength, quality, purity, and identity.

c. Assigned, by the FDA, the same therapeutic equivalence code as another PrEP or another PEP.

(b) (1) All individual health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State must provide coverage for all of the following:

a. Medically necessary PrEP.

b. Medically necessary PEP.

c. Medically necessary essential support services.

(2) Except as otherwise provided in paragraph (b)(3) of this section, the coverage required under paragraph (b)(1) of this section must be provided without any of the following:

a. Cost-sharing requirements.

b. Prior authorization or step therapy requirements.

c. Unreasonable delay in coverage determination.

(3) a. If the FDA has approved 1 or more therapeutic equivalents of a PrEP or a PEP, a health benefit plan is not required to cover all of the therapeutic equivalent versions of that PrEP or that PEP, so long as at least 1 therapeutic equivalent version of that PrEP and at least 1 therapeutic equivalent version of that PEP are covered without cost-sharing, prior authorization, or step therapy requirements. For purposes of this section, a long-acting version of a PrEP or a PEP is not therapeutically equivalent to another long-acting version of a PrEP or a PEP with a different duration.

b. If there is a therapeutic equivalent of a PrEP or a PEP, a health benefit plan may provide coverage for more than 1 version of that PrEP or that PEP and may impose cost-sharing, prior authorization, or step therapy requirements, so long as at least 1 version of that PrEP and at least 1 version of that PEP in the same method of administration is covered without cost-sharing, prior authorization, or step therapy requirements. But a health benefit plan must provide coverage for a particular PrEP or a particular PEP without cost-sharing, prior authorization, or step therapy requirements, regardless of whether the PrEP or the PEP has a therapeutic equivalent, if a covered individual's treating health-care provider recommends that particular PrEP or that particular PEP based on a medical determination regarding that covered individual.

(c) Except as otherwise provided in subsection (b) of this section, nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(d) (1) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited health insurance policies.

(2) The cost-sharing limitation under paragraph (b)(2) of this section does not apply to a catastrophic health plan to the extent this cost-sharing limitation would cause the plan to fail to be treated as a catastrophic health plan under § 1302(e) of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18022(e).

(3) a. The cost-sharing limitation under paragraph (b)(2) of this section does not apply to a high deductible health plan to the extent this cost-sharing limitation would cause the plan to fail to be treated as a high deductible health plan under § 223(c)(2) of the Internal Revenue Code [26 U.S.C. § 223(c)(2)].

b. If the cost-sharing limitation under paragraph (b)(2) of this section would result in an enrollee becoming ineligible for a health savings account under federal law, the cost-sharing limitation only applies to a qualified high deductible plan after the enrollee's deductible has been met.

(85 Del. Laws, c. 452, § 1.)

§ 3370O. Coverage for diagnostic services and treatment for menopause and perimenopause [For application of this section, see 85 Del. Laws, c. 482, § 5].

(a) As used in this section:

(1) "Hormone replacement therapy" means medical treatment, approved by the United States Food and Drug Administration, that replaces a hormone that an individual's body is no longer making or no longer making enough of, as determined by a licensed health-care professional. "Hormone replacement therapy" includes prescribing any of the following:

a. A cream.

b. An oral medication.

c. A vaginal device.

d. Another method approved by the United States Food and Drug Administration.

(2) "Medically necessary" means providing of health-care services or products that a prudent licensed health-care professional would provide to a patient for the purpose of diagnosing or treating an illness, injury, disease or its symptoms in a manner that is all of the following:

a. In accordance with generally accepted standards of medical practice.

b. Consistent with the symptoms or treatment of the condition.

c. Not solely for anyone's convenience.

d. Not including investigational or experimental health-care services.

(3) "Menopause" means the permanent end of menstruation due to loss of ovarian follicular function, characterized by the end of ovulation and a decline in estrogen and progesterone production.

(4) "Menopause and perimenopause symptoms" include any of the following:

a. Irregular menstrual periods.

b. Hot flashes.

c. Vaginal or bladder changes, including genitourinary syndrome of menopause.

d. Decreased fertility.

e. Loss of bone density, including osteoporosis.

f. Elevated low-density lipoprotein cholesterol levels.

g. Sleep disturbances, including night sweats.

(5) "Perimenopause" means the transitional period leading to menopause, marked by fluctuating hormone levels and changes in the menstrual cycle.

(b) (1) All individual health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State must provide coverage for medically necessary diagnostic services and treatment for menopause, perimenopause, and menopause and perimenopause symptoms, including all of the following:

a. Consultation and diagnostic testing.

b. Hormonal therapies, including hormone replacement therapy and bioidentical hormone treatments, that are approved by the United States Food and Drug Administration.

c. Nonhormonal treatments, including selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, neurokinin B antagonists, and other medications to manage menopause and perimenopause symptoms.

d. All drugs, devices, and combination products approved by the United States Food and Drug Administration for the treatment of menopause and perimenopause symptoms.

e. Therapy to treat menopause induced by a hysterectomy.

f. Behavioral health care services.

g. Pelvic floor physical therapy.

h. Bone health treatments due to hormonal changes related to menopause and perimenopause, including screenings and medications.

i. Preventative services for early detection and treatment of health conditions related to menopause and perimenopause, including osteoporosis and cancer.

j. Counseling and education regarding menopause management.

(2) An insurer shall provide clear and accessible information to each covered individual regarding covered diagnostic services and treatment for menopause, perimenopause, and menopause and perimenopause symptoms.

(3) Coverage for medically necessary hormone replacement therapy provided under this section may not be any of the following:

a. Denied or limited, if the use of the hormone replacement therapy is supported by national clinical guidelines, national standards of care, or peer-reviewed medical literature for the treatment of menopause, perimenopause, or menopause and perimenopause symptoms.

b. Subject to prior authorization or step therapy requirements.

(4) Except as otherwise provided in paragraph (b)(3) of this section, benefits provided under this section must be provided to covered individuals to the same extent as other benefits for any other medical condition covered under the individual health insurance policy, contract, or certificate.

(c) Nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(d) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long- term care, disability income, or other limited health insurance policies.

(85 Del. Laws, c. 482, § 1.)

§ 3370P. Biomarker testing [For application of this section, see 85 Del. Laws, c. 484, § 5].

(a) For purposes of this section:

(1) “Biomarker” means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered. Biomarkers include gene mutations, characteristics of genes, and protein expression. A biomarker is not an assessment of how a covered person or enrollee feels, functions or survives.

(2) “Biomarker testing” means the analysis of an individual’s tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes single-analyte tests, multi-plex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing.

(3) “Investigatory and experimental biomarker tests” means biomarker tests that are subject to the United States food and drug administration’s investigational device exemption (C.F.R. Part 812).

(4) “Medically necessary” means as defined in § 3371 of this title.

(5) “Nationally recognized clinical practice guideline” means an evidence-based clinical practice guideline developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and with a conflict-of-interest policy. A clinical practice guideline establishes a standard of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options and includes recommendations intended to optimize patient care.

(6) “Screening” means a medical procedure or test for a covered person who has yet to display symptoms of a particular disease or condition for the purpose of determining the person’s likelihood of having the disease or condition.

(b) All individual health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State shall provide coverage for biomarker testing to guide or inform treatment decisions for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a covered person’s disease or condition when the test is medically necessary as demonstrated by medical and scientific evidence, including any of the following:

(1) Labeled indications for an FDA-approved or FDA-cleared test.

(2) Indicated tests for an FDA-approved drug.

(3) Warnings and precautions on FDA-approved drug labels.

(4) Centers for Medicare and Medicaid Services (CMS) national coverage determinations or Medicare administrative contractor (MAC) local coverage determinations.

(5) Nationally recognized clinical practice guidelines.

(c) A biomarker test that meets 1 of the medical and scientific evidence outlined in paragraphs (b)(1) through (b)(5) of this section shall not be considered an investigational or experimental health-care service.

(d) Insurers, health-benefit plans, and health-service corporations must ensure that coverage for biomarker testing, as required by subsection (b) of this section, is provided in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples.

(e) Nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(f) Nothing in this section restricts the use of utilization management.

(g) Nothing in this section shall be construed to require coverage of biomarker testing for screening purposes or coverage of investigatory and experimental biomarker tests.

(h) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.

(85 Del. Laws, c. 484, § 1.)

Subchapter II

Pre-Authorization Transparency

(80 Del. Laws, c. 310, § 1.)

§ 3371. Definitions [For application of this section, see 82 Del. Laws, c. 44, § 3; 85 Del. Laws, c. 176, § 4].

In this section, the following words have the meanings indicated:

(1) "Adverse determination" means a benefit denial, reduction or termination, or determination that an admission or continued stay, or course of treatment, or other covered health service does not satisfy the insurance policy's clinical requirements for appropriateness, necessity, health-care setting and/or level of care.

(2) "Clean pre-authorization" means when a submission is made to satisfy any pre-authorization in which the relevant data is provided as called for by the utilization review entity. Any request submitted by a provider or covered person that includes an unspecified, unclassified or miscellaneous code or data element to constitute a clean request shall also include appropriate supporting documentation or narrative which explains the unspecified, unclassified or miscellaneous code and describes the diagnosis and treatment rendered.

(3) "Clinical criteria" means the written policies, written screening procedures, drug formularies or lists of covered drugs, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols and any other criteria or rationale used by the utilization review entity to determine the necessity and appropriateness of health-care services.

(4) "Covered person" means an individual and/or family who has entered into a contractual arrangement, or on whose behalf a contractual arrangement has been entered into, with a carrier, pursuant to which the carrier provides health insurance for such person or persons.

(5) "Electronic pre-authorization" [ePA] means a submission of information via a website, the Delaware Health Information Network, or other method via the Internet as delineated by regulation and as accepted by the utilization review entity. Electronic pre-authorization does not include any form of request that is transmitted to the utilization review entity through facsimile.

(6) "Emergency health-care services" means those services identified in §§ 3349 and 3565 of this title.

(7) "Episode of care" means care that meets all of the following:

a. Is for a specific medical problem, condition, or illness being managed by a health-care provider, including tests, procedures, and rehabilitation initially requested by the health-care provider.

b. Is performed at the site of service.

c. Is not out-of-network care.

(8) "Health-care service" means any services or supplies included in the furnishing to any individual of medical care, or hospitalization or incidental to the furnishing of such care or hospitalization, as well as the furnishing to any individual of any and all other services for the purpose of preventing, alleviating, curing or healing human illness, injury, disability or disease.

(9) "Medically necessary" or "medical necessity" means providing of health-care services or products that a prudent physician would provide to a patient for the purpose of diagnosing or treating an illness, injury, disease or its symptoms in a manner that is all of the following:

a. In accordance with generally accepted standards of medical practice;

b. Consistent with the symptoms or treatment of the condition;

c. Not solely for anyone's convenience; and

d. Not including investigational or experimental health-care services.

(10) "NCPDP SCRIPT standard" means the most recent standard adopted of the National Council for Prescription Drug Programs SCRIPT adopted by the United States Department of Health and Human Services. To fall within this definition, any version released subsequent to passage of this section must be compatible to the current version adopted by the United States Department of Health and Human Services.

(11) "Pre-authorization" means a requirement by a carrier or health-insurance plan that providers submit a treatment plan, service request, or other prior notification to the carrier for evaluation of appropriateness of the plan or if the service is medically necessary

before treatment is rendered. Pre-authorization lets the insured and provider know in advance which procedures and pharmaceuticals are considered by the insurer to be medically necessary.

(12) "Step therapy exception determination" means a determination as to whether a step therapy protocol should apply in a particular situation, or whether the step therapy protocol should be overridden in favor of immediate coverage of the health-care provider's selected prescription drug. This determination is based on a review of the request for an override, along with supporting rationale and documentation.

(13) "Step therapy protocol" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition and medically appropriate for a particular patient are covered by an insurer or health plan.

(14) "Urgent health-care service" means a covered health-care service subject to prior authorization that is delivered on an expedited basis for the treatment of an acute condition with symptoms of sufficient severity pursuant to a determination by a licensed treating health-care provider, operating within the health-care provider's scope of practice and professional expertise, that the failure to provide the service is likely to result in serious, long-term health complications or a material deterioration in the covered person's or enrollee's condition and prognosis.

(15) "Utilization review entity" means an individual or entity which performs pre-authorization or step therapy protocol review for 1 or more of the following entities:

a. An employer with employees who are covered under a health-benefit plan or health-insurance policy or contract issued for delivery in this State or delivered in this State which does not fall under the Employee Retirement Income Security Act (ERISA) [29 U.S.C. § 1001 et seq.];

b. An insurer, health-benefit plan, or health-service corporation that writes health-insurance policies, performs pre-authorization, performs step therapy protocol review or an entity to which these capabilities have been delegated;

c. A preferred-provider organization, managed-care organization, or health-maintenance organization;

d. Any other individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits to a person treated by a health-care provider in Delaware under a policy, plan, or contract;

e. This definition does not include accident-only, credit, dental, vision, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation,similar insurance or automobile medical payment insurance, or any coverage under state or federal governmental plans.

(80 Del. Laws, c. 310, § 1; 82 Del. Laws, c. 44, § 1; 85 Del. Laws, c. 176, § 1.)

§ 3372. Disclosure and review of pre-authorization requirements; adverse determinations [For application of this section, see 85 Del. Laws, c. 176, § 4].

(a) A utilization review entity shall make any current pre-authorization requirements and restrictions readily accessible on its website and in written or electronic form upon request for covered persons, health-care providers, and others with access to the website. Information from a utilization review entity that is not an insurer, health-benefit plan, or health-service corporation shall make this information available at an electronic pre-authorization portal that is accessible in real time. Requirements shall be described in detail but also in clear, easily-understandable language. Clinical criteria shall be described in language easily understandable by a health-care provider practicing in the same clinical area.

(b) If an insurer, health-benefit plan, or health-service corporation intends either to implement a new pre-authorization requirement or restriction, or amend an existing requirement or restriction, they shall ensure that the new or amended requirement is not implemented unless their website has been updated to reflect the new or amended requirement or restriction. This shall not extend to expansion of coverage for new health-care services.

(c) (1) If an insurer, health-benefit plan, health-service corporation, or utilization review entity intends either to implement a new pre-authorization requirement or restriction, either to implement a new pre-authorization requirement or restriction, or amend an existing requirement or restriction, they shall provide covered persons who are currently authorized by the utilization review entity for coverage of the affected health-care service care service and all contracted health-care providers who provide the affected health-care service or services of written notice of the new or amended requirement or amendment no less than 60 days before the requirement or restriction is implemented. Such notice may be delivered electronically or by other means.

(2) Notwithstanding the provisions of paragraph (c)(1) of this section, if an insurer, health-benefit plan, health-service corporation, or utilization review entity changes utilization review terms, such as clinical criteria, for a health-care service, the change in utilization review terms does not apply to covered persons with an existing authorization for the health-care service, and will apply only upon re-authorization of the health-care service. An insurer, health-benefit plan, health-service corporation, or utilization review entity must provide notice to covered persons at least 6 months before any changes to utilization review terms for a health-care service, unless those changes were due to clinical guideline status changes, recalls, market withdrawals or relevant FDA published safety information.

(d) Insurers, health-benefit plans, and health-service corporations utilizing pre-authorization shall report de-identified statistics regarding pre-authorization approvals, denials, and appeals to the Delaware Health Information Network in a format and frequency, no less than twice annually, of the Delaware Health Information Network's request. The Department may also request this data at any time. The statistics shall include, but may be expanded upon or further delineated by regulation, categories for all of the following:

(1) For denials, the aggregated reasons for denials such as medical necessity or incomplete pre-authorization submission.

(2) For appeals:

a. Practitioner specialty.

b. Medication, diagnostic test, or diagnostic procedure.

c. Indication offered.

d. Reason for underlying denial.

e. Number of denials overturned upon appeal.

(e) *Utilization review; specific requirements related to adverse determinations. —*

(1) When a clean pre-authorization request is submitted by a physician or representative of a physician, an insurer, health-benefit plan, health-service corporation, or utilization review entity must ensure that any adverse determination is made by a physician who meets all of the following requirements:

a. Any compensation paid to the physician is not contingent upon the outcome of the review.

b. At least 1 of the following requirements is satisfied:

1. The physician is licensed in any United States jurisdiction with appropriate training, knowledge, or experience in the same or similar specialty that typically manages or consults on the health-care service in question.

2. The physician is licensed in any United States jurisdiction, in consultation with an appropriately qualified third-party health-care provider licensed in the same or similar medical specialty as the requesting physician, or a health-care provider with experience related to the covered person's associated condition. Any compensation paid to the consulting health-care provider may not be contingent upon the outcome of the review.

(2) An insurer, health-benefit plan, health-service corporation, or utilization review entity must ensure that all appeals of an adverse determination related to a clean pre-authorization request submitted by a physician or representative of a physician are reviewed and determined by a physician who meets all of the following requirements, in addition to the requirements set forth in paragraph (e)(1) of this section:

a. Possesses a current, unrestricted license in good standing to practice medicine in any United States jurisdiction.

b. Was not directly involved in making the adverse determination under appeal.

c. Reviews and considers all clinical aspects of the health-care service under appeal, including all medical records of the covered person submitted as part of the pre-authorization process.

(3) When a clean pre-authorization request is submitted by a health-care provider other than a physician, an adverse determination or review in an appeal from an adverse determination must be made by a health-care provider licensed in the same or similar profession as the health-care provider submitting the request for pre-authorization, or a licensed health-care provider in consultation with an appropriately qualified third-party health-care provider licensed in the same or similar medical specialty as the requesting health-care provider. Any compensation paid to the health-care provider or consulting health-care provider may not be contingent upon the outcome of the review of the clean pre-authorization request or appeal from an adverse determination.

(4) A utilization review entity must, within 15 days of the receipt of an appeal of an adverse determination, notify the covered person and health-care provider submitting the request for pre-authorization of determination on the appeal. If the utilization review entity cannot make a determination within the 15-day period because additional information, documentation, or medical records are required to complete a review of the health-care service under appeal, the utilization review entity must notify the covered person and health-care provider submitting the request for pre-authorization in writing within the 15-day period specifying the additional information, documentation, or medical records required to complete the determination on appeal and shall have 15 days from the receipt thereof to make a determination on the appeal and notify the covered person and health-care provider. The written notification required by this paragraph (e)(4) must include all of the following:

a. A summary of the findings supporting the determination made in the appeal.

b. The qualifications of any reviewer involved in making the determination in the appeal, including any license, certification, or specialty designation of any reviewer.

c. The relationship between the covered person's diagnosis or disease being treated and the review criteria used as the basis for the determination in the appeal, including the specific basis for the determination made.

(5) An insurer, health-benefit plan, or health-service corporation must ensure that any utilization review entity used to perform utilization review complies with all of the following:

a. Performs utilization review on weekends.

b. Provides access to a medical director or other clinical decision maker Monday through Friday between the hours of 7:00 a.m. and 7:00 p.m. and during reasonable business hours Saturday through Sunday.

c. Has established procedures for the submission of appeals in writing, electronically, or by telephone.

d. Provides a minimum of 30 days from the date of an adverse determination for the submission of an appeal.

(80 Del. Laws, c. 310, § 1; 85 Del. Laws, c. 176, § 1.)

§ 3373. Utilization review entity's obligation with respect to pre-authorization [For application of this section, see 85 Del. Laws, c. 176, § 4].

(a) If a utilization review entity requires pre-authorization of a pharmaceutical, the utilization review entity must complete its process or render an adverse determination and notify the covered person's health-care provider within 2 business days of obtaining a clean pre-authorization using services described in § 3377 of this title.

(b) If a utilization review entity requires pre-authorization of a health-care service, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 5 business days of receipt of a clean pre-authorization not submitted using services described in § 3377 of this title. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(c) If a utilization review entity requires pre-authorization of a health-care service, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 3 business days of receipt of a clean pre-authorization submitted using services described in § 3377 of this title. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(d) If a utilization review entity requires pre-authorization of an urgent health-care service, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 24 hours of receipt of a clean pre-authorization submitted using services described in § 3377 of this title. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(e) (1) If a utilization review entity requires pre-authorization of a patient transfer, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 24 hours of receipt of a clean pre-authorization submitted using services described in § 3377 of this title. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(2) Notwithstanding the provisions in paragraph (e)(1) of this section, when an insurer, health-benefit plan, or health-service corporation has determined that a lower level of care at a health-care facility is clinically appropriate, the insurer, health-benefit plan, or health-service corporation may not require pre-authorization for medically necessary interfacility transport of the covered person.

(f) If a utilization review entity requires pre-authorization of an urgent health-care service, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 48 hours of receipt of a clean pre-authorization submitted not using services described in § 3377 of this title. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(g) If a utilization review entity requires pre-authorization of a patient transfer, the review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 48 hours of receipt of a clean pre-authorization not submitted using services described in § 3377 of this title. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(80 Del. Laws, c. 310, § 1; 85 Del. Laws, c. 176, § 1.)

§ 3374. Utilization review entity's obligations with respect to pre-authorization concerning emergency health-care services.

A utilization review entity must follow all emergency procedures and mandates as delineated in §§ 3349 and 3565 of this title.

(80 Del. Laws, c. 310, § 1.)

§ 3375. Retrospective denial.

The utilization review entity may not revoke, limit, condition or restrict a pre-authorization on ground of medical necessity after the date the health-care provider received the pre-authorization. Any language attempting to disclaim payment for services on the basis of changes to medical necessity that have been pre-authorized and delivered while under coverage shall be null and void. A proper notification of policy changes validly delivered as per § 3372 of this title may void a pre-authorization if received after pre-authorization but before delivery of the service.

(80 Del. Laws, c. 310, § 1.)

§ 3376. Effect and length of pre-authorization; limitation per episode of care [For application of this section, see 85 Del. Laws, c. 176, § 4].

(a) A pre-authorization for pharmaceuticals shall be valid for 1 year from the date the health-care provider receives the pre-authorization, subject to confirmation of continued coverage and eligibility and to policy changes validly delivered as per § 3372 of this title and except as otherwise set by evidence-based treatment protocol.

(b) A pre-authorization for a health-care service shall be valid for a period of time that is reasonable and customary for the specific service, but no less than 90 days, from the date the health-care provider receives the pre-authorization, subject to confirmation of continued coverage and eligibility and to policy changes validly delivered as per § 3372 of this title.

(c) *Limitation per episode of care. —*

An insurer, health-benefit plan, or health-service corporation may not require more than 1 pre-authorization for an episode of care. Any new treatment or additional testing or procedures related o r unrelated to the specific medical problem, condition, or illness being managed may require a separate pre-authorization.

(d) *Pre-authorization of other covered services in-network. —*

If a utilization review entity gives pre-authorization of a health-care service as part of a group of services for which a bundled payment is charged, pre-authorization of all other covered health-care services provided by in-network providers included in the group is deemed to be approved.

(80 Del. Laws, c. 310, § 1; 85 Del. Laws, c. 176, § 1.)

§ 3377. Electronic standards for pre-authorization [For application of this section, see 85 Del. Laws, c. 176, § 4].

(a) No later than January 1, 2018, the insurer must accept and respond to pre-authorization requests under the pharmacy benefit through a secure electronic transmission using the NCPDP SCRIPT standard ePA transactions. Facsimile, proprietary payer portals, and electronic forms shall not be considered electronic transmission.

(b) No later than January 1, 2027, an insurer, health-benefit plan, health-service corporation, or utilization review entity must allow for and accept electronic pre-authorization requests and must respond to electronic pre-authorization requests through the same website, mobile application, digital platform, or other method as the electronic pre-authorization request was submitted.

(c) No later than January 1, 2027, an insurer, health-benefit plan, health-service corporation, or utilization review entity must establish a provider portal that includes all of the following features:

(1) Electronic submission of pre-authorization requests.

(2) Access to the insurer's, health-benefit plan's, health-service corporation's, or utilization review entity's applicable medical policies.

(3) Information necessary to request a peer-to-peer review.

(4) Contact information for the insurer's, health-benefit plan's, health-service corporation's, or utilization review entity's relevant clinical or administrative staff.

(5) For any health-care service that requires pre-authorization that is not subject to electronic submission via the provider portal, copies of applicable forms.

(6) Instructions for the submission of pre-authorization requests if the insurer's, health-benefit plan's, health-service corporation's, or utilization review entity's provider portal is unavailable for any reason.

(d) Within 12 months following establishment of a provider portal under subsection (c) of this section, the insurer, health-benefit plan, health-service corporation, or utilization review entity may require a health-care provider seeking pre-authorization to submit the request via the provider portal unless 1 of the following exemptions applies:

(1) The portal is not available and operational at the time of attempted submission.

(2) The health-care provider does not have access to the insurer's, health-benefit plan's, health-service corporation's, or utilization review entity's operational provider portal.

(3) The health-care provider satisfies an allowance by the insurer, health-benefit plan, health service corporation, or utilization review entity for submission other than through the provider portal.

(80 Del. Laws, c. 310, § 1; 85 Del. Laws, c. 176, § 1.)

§ 3378. Health-care services deemed preauthorized if a utilization review entity fails to comply with the requirements of this subchapter.

Any failure by a utilization review entity to comply with the deadlines and other requirements specified in this subchapter will result in any health-care services subject to review to be automatically deemed preauthorized.

(80 Del. Laws, c. 310, § 1.)

§ 3379. Waiver prohibited.

The provisions of this subchapter cannot be waived by contract issued or renewed after January 1, 2017. Any contractual arrangement in conflict with the provisions of this subchapter or that purports to waive any requirements of this subchapter is null and void.

(80 Del. Laws, c. 310, § 1.)

§ 3380. Exemptions.

This subchapter shall not apply to policies or contracts designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act [42 U.S.C. § 1395 et seq., § 1396 et seq. and § 1397aa. et seq.], known as Medicare, Medicaid, or any other similar coverage under state or federal governmental plans.

(80 Del. Laws, c. 310, § 1.)

§ 3381. Step therapy exception process [For application of this section, see 82 Del. Laws, c. 44, § 3].

(a) When coverage of a prescription drug for the treatment of any medical condition is restricted for use by an insurer, health plan, or utilization review entity through the use of a step therapy protocol, the patient and prescribing practitioner shall have access to a clear, readily accessible and convenient process to request a step therapy exception determination. An insurer, health service corporation, health plan, or utilization review entity may use its existing medical exceptions process to satisfy this requirement. The process shall be made easily accessible via the insurer's, health plan's, or utilization review entity's website. A step therapy exception determination shall be expeditiously granted in any one of the following circumstances:

(1) The required prescription drug is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient.

(2) The required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen.

(3) The patient has tried the required prescription drug while under the patient's current or previous health insurance or health benefit plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

(4) The required prescription drug is not in the best interest of the patient, based on medical necessity.

(5) The patient is stable, for the medical condition under consideration, on a prescription drug prescribed by the patient's health-care provider or while the patient was insured by the patient's current or a previous insurance or health benefit plan.

(b) (1) The insurer, health services corporation, health plan, or utilization review entity shall grant or deny a step therapy exception request, which shall be from a health-care provider, and which shall state the circumstance which qualifies the patient for a step therapy exception pursuant to subsection (a) of this section, within 2 business days of receipt of such request. A step therapy exception determination not granted or denied in writing at the end of 2 days shall be deemed granted.

(2) During a step therapy exception determination under (a)(5) of this section, a determination will be deemed granted until the insurer, health services corporation, health plan, or utilization review entity issues a step therapy exception determination.

(c) In cases where emergency circumstances exist, as outlined in § 3349 of this title, an insurer, health plan, or utilization review entity shall grant or deny a step therapy exception request within 24 hours of receipt of a request, which shall be from a health care provider, and which shall state the circumstance which qualifies the patient for a step therapy exception pursuant to subsection (a) of this section. A request shall be deemed granted if the required response is not received by the requesting or appealing party within the times set forth in this subsection.

(d) Upon the granting of a step therapy exception determination, the insurer, health plan, or utilization review entity shall authorize coverage for the prescription drug prescribed by the patient's treating health-care provider.

(e) This section shall not be construed to prevent any of the following:

(1) An insurer, health plan, or utilization review entity from requiring a patient to try either of the following:

a. An AB-rated generic equivalent or an "interchangeable" biological product as defined in 42 U.S.C. § 262 prior to providing coverage for the equivalent branded prescription drug.

b. A "biosimilar" as defined in 42 U.S.C. § 262 prior to providing coverage for the brand name prescription reference product drug or drugs.

(2) A health-care provider from prescribing a prescription drug that is determined to be medically necessary.

(f) Clinical criteria used to establish a step therapy protocol shall be based on clinical criteria that:

(1) Recommend that the prescription drugs be taken in the specific sequence required by the step therapy protocol.

(2) Developed and endorsed by a multidisciplinary panel of experts that manages conflicts of interest among the members of the writing and review groups by:

a. Requiring members to disclose any potential conflict of interests with entities, including insurers, health plans, and pharmaceutical manufacturers and recuse themselves of voting if they have a conflict of interest.

b. Using a methodologist to work with writing groups to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus.

(3) Offer opportunities for public review and comments.

(4) Based on peer reviewed studies, research, and medical practice.

(5) Created by an explicit and transparent process that:

a. Minimizes biases and conflicts of interest.

b. Explains the relationship between treatment options and outcomes.

c. Rates the quality of the evidence supporting recommendations.

d. Considers relevant patient subgroups and preferences.

e. Continually updated through a review of new evidence, research and newly developed treatments.

(6) When establishing a step therapy protocol, a utilization review entity shall also take into account the needs of atypical patient populations and diagnoses when establishing clinical criteria.

(7) This section shall not be construed to require insurers, health plans or the state to set up a new entity to develop clinical review criteria used for step therapy protocols.

(g) Any step therapy exception determination as defined by this subsection shall be eligible for appeal by an insured or their authorized representative, as outlined in Chapter 3 and Chapter 64 of this title.

(82 Del. Laws, c. 44, § 1; 85 Del. Laws, c. 401, § 1.)

Part I
Insurance

Chapter 33A
Pharmacy Benefits Managers [For application of this chapter, see 80 Del. Laws, c. 245, § 2]

(80 Del. Laws, c. 245, § 1.)

Subchapter I
Pharmacy Audit Integrity Program [For application of this subchapter, see 80 Del. Laws, c. 245, § 2]

(80 Del. Laws, c. 245, § 1.)

§ 3301A. Pharmacy Audit Integrity Program [For application of this section, see 80 Del. Laws, c. 245, § 2].

The Pharmacy Audit Integrity Program is established to provide standards for an audit of pharmacy records carried out by a pharmacy benefits manager or any entity that represents pharmacy benefits managers.

(80 Del. Laws, c. 65, § 1; 80 Del. Laws, c. 245, § 1.)

§ 3302A. Definitions [For application of this section, see 80 Del. Laws, c. 245, § 2; 83 Del. Laws, c. 256, § 15; 85 Del. Laws, c. 481, § 7].

For purposes of this subchapter:

(1) "Entity" means a pharmacy benefits manager or any person or organization that represents these companies, groups, or organizations.

(2) "Pharmacy benefits manager" or "PBM" means an entity that contracts with pharmacists or pharmacies on behalf of a person to do any of the following:

a. Process claims for prescription drugs or medical supplies or provide retail network management for pharmacies or pharmacists.

b. Pay pharmacies or pharmacists for prescription drugs or medical supplies.

c. Negotiate rebates with manufacturers for drugs paid for or procured as described in this chapter.

(3) "Plan sponsor" means as defined under § 4405 of this title.

(4) "Recoupment" means a reduction, offset, adjustment, or other act that lowers or lessens the payment of a claim or any other amount owed to a pharmacy or pharmacist for any reason unrelated to that claim or other amount owed to that pharmacy or pharmacist.

(5) "Similarly situated contracted pharmacy" includes any contracted pharmacy that has the capability of complying with standard terms and conditions for a pharmacy type, even if the pharmacy does not operate exclusively as that type of pharmacy.

(6) "Wholesale invoice audit" means review of supplier invoices to verify accuracy, compliance with contracted rates, and receipt of goods.

(80 Del. Laws, c. 65, § 1; 80 Del. Laws, c. 245, § 1; 83 Del. Laws, c. 256, § 1; 85 Del. Laws, c. 481, § 1.)

§ 3303A. Pharmacy benefit manager contract [For application of this section, see 80 Del. Laws, c. 245, § 2].

An amendment to pharmacy audit terms in a contract between a PBM and a pharmacy must be disclosed to the pharmacy at least 60 days prior to the effective date of the proposed change.

(80 Del. Laws, c. 65, § 1; 80 Del. Laws, c. 245, § 1.)

§ 3304A. Procedure and process for conducting and reporting an audit [For application of this section, see 80 Del. Laws, c. 245, § 2; 85 Del. Laws, c. 481, § 7].

(a) *Audit procedures. —*

Unless otherwise prohibited by federal requirements or regulations, any entity conducting a pharmacy audit must adhere to the following procedures:

(1) A pharmacy must be given notice 14 days before an audit is conducted.

(2) An audit that involves clinical or professional judgment must be conducted by or in consultation with a licensed pharmacist.

(3) Each pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies.

(4) A pharmacy must be given a range of prescription numbers no less than 5 business days before the audit.

(5) A pharmacy benefits manager shall provide a pharmacy or pharmacist being audited with a phone number, secured facsimile number, or, if available, access to a secure portal that the pharmacy or pharmacist may use to ask questions regarding the audit.

(6) An entity may not initiate an audit of a pharmacy more often than once every 12 months.

(b) *Audit process. —*

Unless otherwise prohibited by federal requirements or regulations, for any entity conducting a pharmacy audit all of the following audit items apply:

(1) The period covered by the audit may not exceed 24 months from the date that the claim was submitted to or adjudicated by the entity, unless a longer period is required under state or federal law.

(2) If an entity uses random sampling as a method for selecting a set of claims for examination, the sample size must be appropriate for a statistically reliable sample. The auditing entity shall provide the pharmacy a masked list that provides a prescription number or date range that the auditing entity is seeking to audit no less than 5 business days before an audit.

(3) An audit may not take place during the first 5 business days of the month or on a federal holiday unless consented to by the pharmacy.

(4) Auditors may not enter the pharmacy area unless escorted where patient-specific information is available and to the extent possible must be out of sight and hearing range of the pharmacy customers.

(5) Any recoupment will not be deducted against future remittances until after the appeals process and both parties have received the results of the final audit.

(6) A PBM may not require information to be written on a prescription unless the information is required to be written on the prescription by state or federal law. Recoupment may be assessed for items not written on the prescription if the required information is not readily available in print or electronic form for the auditor at the time of the audit and one or more of the following conditions applies:

a. Additional information is required in the provider manual.

b. The information is required by the Food and Drug Administration (FDA).

c. The information is required by the drug manufacturer's product safety program.

(7) The auditing company or agent may not receive payment based on a percentage of the amount recovered. This section does not prevent the entity conducting the audit from charging or assessing the responsible party, directly or indirectly, based on amounts recouped if both of the following conditions are met:

a. The plan sponsor and the entity conducting the audit have a contract that explicitly states the percentage charge or assessment to the plan sponsor; and

b. A commission to an agent or employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped.

(8) If an entity conducts a wholesale invoice audit, the audit must be limited to verification of purchased inventory specific to the pharmacy claims paid by the plan sponsor or pharmacy benefits manager conducting the audit. Redacted copies of supplier invoices in the pharmacy's or pharmacist's possession are acceptable to support the validity of a pharmacy claim.

(9) The cost of any audit subject to this subchapter shall be borne by the pharmacy benefits manager conducting the audit. The pharmacy benefits manager may not impose a fee or charge, other than a recoupment or chargeback, or pass costs along related to an audit to the audited pharmacy or pharmacist.

(80 Del. Laws, c. 65, § 1; 80 Del. Laws, c. 245, § 1; 85 Del. Laws, c. 481, § 1.)

§ 3305A. Requirements for recoupment or chargeback [For application of this section, see 80 Del. Laws, c. 245, § 2].

For recoupment or chargeback, the following criteria apply:

(1) Audit parameters must consider consumer-oriented parameters based on manufacturer listings.

(2) The reimbursable cost for a compounded medication shall be reflective of the ingredients, supplies and professional time reasonably required to create the finished product.

(3) A finding of overpayment or underpayment must be based on the actual overpayment or underpayment and not a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs.

(4) The entity conducting the audit shall not use extrapolation in calculating the recoupment or penalties for audits unless required by state or federal law or regulations.

(5) Calculations of overpayments must not include dispensing fees unless a prescription was not actually dispensed, the prescriber denied authorization, the prescription dispensed was a medication error by the pharmacy, or the identified overpayment is solely based on an extra dispensing fee.

(6) An entity may not consider any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error regarding a required document or record as fraud, however such errors may be subject to recoupment.

(7) In the case of errors that have no actual financial harm to the patient or plan, the PBM must not assess any chargebacks. Errors that are a result of the pharmacy failing to comply with a formal corrective action plan may be subject to recovery.

(8) Interest may not accrue during the audit period for either party, beginning with the notice of the audit and ending with the final audit report.

(9) Whenever it engages in recoupment or chargeback efforts, a PBM must provide written notice to the pharmacy that identifies the error made in the processing or payment of the claim and justifies the recoupment or chargeback efforts.

(80 Del. Laws, c. 65, § 1; 80 Del. Laws, c. 245, § 1; 85 Del. Laws, c. 201, § 2.)

§ 3306A. Documentation [For application of this section, see 80 Del. Laws, c. 245, § 2].

(a) To validate the pharmacy record and delivery, the pharmacy may use authentic and verifiable statements or records including medication administration records of a nursing home, assisted living facility, hospital, physician, or other authorized practitioner or additional audit documentation parameters located in the provider manual.

(b) Any legal prescription that meets the requirements in this subchapter may be used to validate claims in connection with prescriptions, refills, or changes in prescriptions, including medication administration records, faxes, e-prescriptions, or documented telephone calls from the prescriber or the prescriber's agents.

(80 Del. Laws, c. 65, § 1; 80 Del. Laws, c. 245, § 1.)

§ 3307A. Appeals process [For application of this section, see 80 Del. Laws, c. 245, § 2].

The entity conducting the audit must establish a written appeals process which must include appeals of preliminary reports and final reports.

(80 Del. Laws, c. 65, § 1; 80 Del. Laws, c. 245, § 1.)

§ 3308A. Audit information and reports [For application of this section, see 80 Del. Laws, c. 245, § 2].

(a) A preliminary audit report must be delivered to the pharmacy within 30 days after the conclusion of the audit. The preliminary audit report shall contain claim level information for any discrepancy and an estimated recovery amount.

(b) A pharmacy must be allowed at least 45 days following receipt of the preliminary audit to provide documentation to address any discrepancy found in the audit.

(c) A final audit report must be delivered to the pharmacy within 120 days after receipt of the preliminary audit report or final appeal, whichever is later.

(d) An entity shall remit any money due to a pharmacy or pharmacist as a result of an underpayment of a claim within 45 days after the appeals process has been exhausted and the final audit report has been issued.

(80 Del. Laws, c. 65, § 1; 80 Del. Laws, c. 245, § 1.)

§ 3309A. Disclosures to plan sponsor [For application of this section, see 80 Del. Laws, c. 245, § 2; 85 Del. Laws, c. 481, § 7].

Where contractually required, an auditing entity must provide a copy to the plan sponsor of all claims that were included in the audit, and any recouped money shall be returned to the plan sponsor.

(80 Del. Laws, c. 65, § 1; 80 Del. Laws, c. 245, § 1; 85 Del. Laws, c. 481, § 1.)

§ 3310A. Applicability of other laws and regulations [For application of this section, see 80 Del. Laws, c. 245, § 2; 85 Del. Laws, c. 481, § 7]

The provisions of this subchapter do not apply to an investigative audit of pharmacy records when any of the following apply:

(1) Fraud, waste, abuse, or intentional misconduct is indicated by physical review or review of claims data or statements.

(2) Other investigative methods indicate a pharmacy is or has been engaged in criminal wrongdoing, fraud, or other intentional or wilful misrepresentation.

(3) The audit is being conducted by the State.

(80 Del. Laws, c. 65, § 1; 80 Del. Laws, c. 245, § 1; 85 Del. Laws, c. 201, § 3; 85 Del. Laws, c. 481, § 1.)

Subchapter II

Maximum Allowable Cost Pricing for Prescription Drugs and Reimbursement for and Provision of Pharmacy Goods or Services [For application of this subchapter, see 80 Del. Laws, c. 245, § 2; and 83 Del. Laws, c. 256, § 15]

(80 Del. Laws, c. 245, § 1; 83 Del. Laws, c. 256, § 2, § 2.)

§ 3321A. Definitions [For application of this section, see 80 Del. Laws, c. 245, § 2; 85 Del. Laws, c. 481, § 7]

For purposes of this subchapter:

(1) "Claim" means a request from a pharmacy or pharmacist to be reimbursed for the cost of filling or refilling a prescription for a drug or for providing a medical supply or device.

(2) “Contracted pharmacy” means a pharmacy that participates in the network of a pharmacy benefits manager through a contract with a pharmacy benefits manager, a pharmacy services administration organization, or a group purchasing organization.

(3) “Drug shortage list” means a list of drug products listed on the federal Food and Drug Administration’s Drug Shortages website.

(4) “Insurer” means any entity that provides health insurance coverage in this State as defined in § 903 of this title.

(5) “Maximum allowable cost” means the maximum amount that a pharmacy benefits manager will reimburse a pharmacist or pharmacy for the cost of a multi-sourced drug, medical product, or device.

(6) “Maximum allowable cost list” means the multi-source generic drugs, medical products, and devices for which a maximum allowable cost has been established by a pharmacy benefits manager or a purchaser.

(7) “Net amount” means the dollar amount that is the result of the invoice price that the pharmacy paid to the supplier for the prescription drug modified as follows, as are attributable to the drug:

a. Increased by the dollar amount of all taxes, fees, and other costs.

b. Decreased by the dollar amount of all discounts and other cost reductions.

((8)) “Network providers” means those pharmacists and pharmacies who provide covered health-care services or supplies to an insured or a member pursuant to a contract with an insurer or pharmacy benefits manager.

(9) “Pharmacist” means as defined under § 2502 of Title 24.

(10) “Pharmacy” means as defined under § 2502 of Title 24.

(11) “Pharmacy benefits management services” means as defined under § 3351A of this title.

(12) “Pharmacy benefits manager” means as defined under § 3302A of this title.

(13) “Purchaser” means as defined under § 3351A of this title.

(14) “Similarly situated contracted pharmacy” means as defined in § 3302A of this title.

(80 Del. Laws, c. 245, § 1; 82 Del. Laws, c. 115, § 1; 85 Del. Laws, c. 481, § 2.)

§ 3322A. Exclusions [For application of this section, see 80 Del. Laws, c. 245, § 2].

This subchapter does not apply to the Department of Health and Human Services in the performance of its duties in administering fee-for-service Medicaid under Titles XIX and XXI of the Social Security Act [42 U.S.C. §§ 1396 et seq., 1397aa et seq.].

(80 Del. Laws, c. 245, § 1.)

§ 3323A. Requirements for maximum allowable cost pricing [For application of this section, see 80 Del. Laws, c. 245, § 2; and 83 Del. Laws, c. 256, § 15].

(a) To place a drug on a maximum allowable cost list, a pharmacy benefits manager must ensure that the drug meets all of the following requirements:

(1) It is listed as “A” or “B” rated in the most recent version of the United States Food and Drug Administration’s Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, or has an “NR” or “NA” rating or a similar rating by a nationally recognized reference.

(2) It is generally available for purchase by pharmacies in this State from national or regional wholesalers.

(3) It is not obsolete, temporarily unavailable, or listed on a drug shortage list as in shortage.

(4) If it is manufactured by more than 1 manufacturer, the drug is available for purchase by a contracted pharmacy, including a contracted retail pharmacy, in this State from a wholesale distributor with a permit in this State, with whom the pharmacy has an existing relationship.

(5) If it is manufactured by only 1 manufacturer, the drug is generally available for purchase by a contracted pharmacy, including a contracted retail pharmacy, in this State from at least 2 wholesale distributors with a permit in this State.

(b) A pharmacy benefits manager engaging in maximum allowable cost pricing must do all of the following:

(1) Make available to each network provider at the beginning of the term of the network provider’s contract, and upon renewal of the contract, the sources utilized to determine the maximum allowable cost pricing.

(2) Provide a process for a network pharmacy provider to readily access the most recent maximum allowable cost specific to that provider in an electronic format as updated in accordance with the requirements of this section.

(3) Review and update maximum allowable cost price information at least once every 7 business days and update the information when there is a modification of maximum allowable cost pricing.

(4) Ensure that dispensing fees are not included in the calculation of maximum allowable cost.

(5) On the next day after a pricing information update under paragraph (b)(3) of this section, use the updated pricing information in calculating the payments made to all contracted pharmacies.

(6) Maintain a procedure to eliminate products from the maximum allowable cost list as necessary to do all of the following:

a. Remain consistent with price changes.

b. Remove from the maximum allowable cost list a drug that no longer meets the requirements of subsection (a) of this section.

c. Reflect the most recent availability of drugs in the marketplace.

(80 Del. Laws, c. 245, § 1; 82 Del. Laws, c. 115, § 2; 83 Del. Laws, c. 256, § 3.)

§ 3324A. Appeals [For application of this section, see 80 Del. Laws, c. 245, § 2; 83 Del. Laws, c. 256, § 15; 85 Del. Laws, c. 481, § 7].

(a) (1) a. A pharmacy benefits manager must establish a process by which a contracted pharmacy can appeal the amount of the provider's reimbursement for a drug that was reimbursed by the pharmacy benefits manager.

b. A contracted pharmacy's representative may take actions and receive notices under this section on behalf of the contracted pharmacy.

(2) A contracted pharmacy has 40 calendar days after the applicable fill date to appeal a reimbursement if the reimbursement for the drug is less than any of the following:

a. The net amount that the network provider paid to the supplier of the drug.

b. The reimbursement amount required under § 3372A(7) of this title.

(3) A pharmacy benefits manager must respond with notice that the appeal has been denied or granted within 10 calendar days of the contracted pharmacy making the claim for which an appeal has been submitted.

(b) At the beginning of the term of a network provider's contract, and upon renewal, a pharmacy benefits manager must provide to network providers a telephone number and e-mail address at which a network provider can contact the pharmacy benefits manager to process an appeal under this section.

(c) (1) If an appeal is denied, the pharmacy benefits manager must provide a detailed reason for the denial. If the appeal is related to a maximum allowable cost reimbursement, the pharmacy benefits manager must also provide the name and national drug code number of the national or regional wholesalers operating in this State that have the drug in stock at a price below the maximum allowable cost at the time the pharmacy or pharmacist purchased the drug.

(2) At the time the pharmacy benefits manager provides the written notice of a final appeal determination under paragraph (c)(1) of this section, the pharmacy benefits manager shall provide notice to the pharmacy of the right to appeal an adverse determination to the Department.

(3) The notice under paragraph (c)(2) of this section may be separate from or a part of the written notice of the final determination under paragraph (c)(1) of this section and must, at a minimum, contain all of the following:

a. A statement that says "You have the right to appeal the final appeal determination through the Delaware Department of Insurance. All appeals must be filed with the Department within 10 calendar days from the date you receive the pharmacy benefits manager's final determination."

b. The Department website the pharmacy can use to file an appeal.

(d) If the appeal is granted the pharmacy benefits manger shall do the following:

(1) a. Adjust the reimbursement for the drug as of the date of the original claim for payment.

b. Without requiring the appealing pharmacy to reverse and rebill the claims, provide reimbursement for the claim and any subsequent and similar claims under similarly applicable contracts with the pharmacy benefits manager as follows:

1. For the original claim, in the first remittance to the pharmacy after the date the appeal was granted.

2. For subsequent and similar claims under similarly applicable contracts, in the second remittance to the pharmacy after the date the appeal was granted.

(2) For a similarly situated contracted pharmacy in this State, do all of the following:

a. Adjust the maximum allowable cost for the drug as of the date the appeal was granted.

b. Provide notice to the pharmacy or the pharmacy's contracted agent of all of the following:

1. That an appeal was granted.

2. That without filing a separate appeal, the pharmacy or the pharmacy's contracted agent may reverse and rebill a similar claim.

(e) A pharmacy benefits manager shall provide information on its website about the appeal process, including all of the following:

(1) A telephone number at which the contracted pharmacy may contact the department or office responsible for processing appeals for the pharmacy benefits manager to speak to an individual specifically or leave a message for an individual or office who is responsible for processing appeals.

(2) An email address of the department or office responsible for processing appeals to which an individual who responsible for processing appeals has access.

(3) The information required under paragraph (c)(3) of this section.

(f) A pharmacy benefits manager may not charge a contracted pharmacy a fee related to the re-adjudication of a claim resulting from a granted appeal under subsection (d) of this section or the granting of an appeal under subsection (h) of this section.

(g) A pharmacy benefits manager may not retaliate against a contracted pharmacy for exercising its right to appeal to the pharmacy benefits manager under subsection (a) of this section or to the Commissioner under subsection (h) of this section.

(h) (1) If a pharmacy benefits manager denies an appeal and a contracted pharmacy files an appeal with the Commissioner, the Commissioner shall do all of the following:

a. Review the pharmacy benefits manager's compensation program to ensure that the reimbursement for pharmacy benefits management services paid to the pharmacist or a pharmacy complies with the reimbursement requirements under § 3372A(7) of this title.

b. Based on a determination made by the Commissioner under paragraph (h)(1)a. of this section, do 1 of the following:

1. Deny the appeal.

2. Grant the appeal and order the pharmacy benefits manager to pay the claim in accordance with the Commissioner's findings.

(2) All pricing information and data collected by the Commissioner during a review required by paragraph (h)(1) of this section is confidential and not subject to subpoena or the Freedom of Information Act, Chapter 100 of Title 29.

(3) The non-prevailing party shall pay the costs incurred by the Department in processing an appeal under this subsection.

(4) On request, parties shall provide the Commissioner all mathematical calculations, accounts, records, documents, files, logs, correspondence, or other information necessary to complete the Commissioner's review of an appeal under this subsection.

(80 Del. Laws, c. 245, § 1; 82 Del. Laws, c. 115, § 3; 83 Del. Laws, c. 256, § 4; 85 Del. Laws, c. 481, § 2.)

§ 3325A. Reimbursement for and provision of pharmacy goods or services For application of this section, see 83 Del. Laws, c. 256, § 15].

(a) For purposes of this section:

(1) "Affiliate" means a pharmacy or pharmacist that directly or indirectly, through 1 or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership or control with, a pharmacy benefits manager.

(2) "Pharmaceutical wholesaler" means a person that sells and distributes a pharmaceutical product and offers regular and private delivery to a pharmacy.

(3) "Pharmacy acquisition cost" means the amount that a pharmaceutical wholesaler charges for a pharmaceutical product as listed on the pharmacy's billing invoice.

(4) "Pharmacy goods or services" means 1 or more of the following provided by a pharmacist or pharmacy:

a. A single-sourced drug, multi-sourced drug, or compounded drug.

b. A medical product.

c. A medical device.

d. A service.

(b) A pharmacy benefits manager may not reimburse a pharmacist or pharmacy for pharmacy goods or services in an amount less than the amount the pharmacy benefits manager reimburses itself or an affiliate for the same pharmacy goods or services.

(c) If the amount reimbursed by a pharmacy benefits manager for pharmacy goods or services is less than the pharmacy acquisition cost for the same pharmacy goods or services, a pharmacist or pharmacy may decline to provide the pharmacy goods or services to a patient.

(d) A pharmacist or pharmacy acting under subsection (c) of this section shall do all of the following:

(1) Inform the patient that the pharmacist or pharmacy has made the decision not to provide pharmacy goods or services to the patient under subsection (c) of this section because of the costs associated with providing the pharmacy goods or services.

(2) Provide the patient with a list of pharmacies in the area that may provide the pharmacy goods or services.

(83 Del. Laws, c. 256, § 5.)

Subchapter III

Permitted Disclosures Related to Prescription Drugs [For application of this subchapter, see 81 Del. Laws, c. 378, § 2].

(81 Del. Laws, c. 378, § 1.)

§ 3331A. Definitions For application of this section, see 80 Del. Laws, c. 245, § 2; 83 Del. Laws, c. 256, § 15; 85 Del. Laws, c. 481, § 7]

For purposes of this subchapter:

(1) "Pharmacist" means as defined in § 2502 of Title 24.

(2) "Pharmacy" means as defined in § 2502 of Title 24.

(3) "Pharmacy benefits manager" means as defined in § 3302A of this title.

(4) “Substitute” means as defined in § 2502 of Title 24.

(81 Del. Laws, c. 378, § 1; 83 Del. Laws, c. 256, § 6; 85 Del. Laws, c. 481, § 3.)

§ 3332A. Permitted disclosures related to prescription drugs [For application of this section, see 81 Del. Laws, c. 378, § 2; and 81 Del. Laws, c. 256, § 15].

A contract between a pharmacy benefits manager and a pharmacy may not prohibit a pharmacy or pharmacist from doing any of the following:

(1) Providing a patient with information regarding the retail price of a prescription drug or the amount of the cost share for which the patient is responsible for a prescription drug.

(2) Discussing with a patient information regarding the retail price of a prescription drug or the amount of the cost share for which the patient is responsible for a prescription drug.

(3) If a more affordable substitute is available, selling the more affordable substitute to the patient.

(81 Del. Laws, c. 378, § 1; 83 Del. Laws, c. 256, § 7.)

§ 3333A. Prohibited retaliation due to permitted disclosures [For application of this section, see 85 Del. Laws, c. 481, § 7].

(a) A pharmacy benefits manager may not retaliate against a pharmacist or pharmacy for disclosing information in any proceeding if the pharmacist or pharmacy has reasonable cause to believe that the disclosed information is evidence of a violation of a state or federal law, rule, or regulation. Proceedings under this subsection include information disclosed as follows:

(1) To a court.

(2) During an administrative investigation or hearing.

(3) To a legislative commission or committee.

(b) A pharmacy benefits manager may not retaliate against a pharmacist or pharmacy for disclosing information to a government, regulatory, or law-enforcement agency, if the pharmacist or pharmacy has reasonable cause to believe that the disclosed information is evidence of a violation of a state or federal law, rule, or regulation.

(c) A pharmacist or pharmacy shall, to the extent possible, limit the disclosure of confidential and proprietary information when making a disclosure under subsection (a) or (b) of this section.

(d) Retaliatory actions against a pharmacist or pharmacy include the cancellation or restriction of, the refusal to renew, or the refusal to offer a contract solely because the pharmacy or pharmacist has done 1 or more of the following:

(1) Disclosed information under subsection (a) or (b) of this section.

(2) Filed complaints with a pharmacy benefits manager.

(3) Filed complaints against an insurer or pharmacy benefits manager with the Department.

(4) Filed an appeal with the Commissioner under § 3324A(h) of this title.

(e) If a contract entered into, amended, extended, or renewed after December 31, 2026, includes a provision that prohibits a disclosure permitted under this section, that provision is against public policy and is void and unenforceable.

(85 Del. Laws, c. 481, § 3.)

Subchapter IV

Prior Authorization of Emergency Prescriptions and Prescriptions for Chronic or Long-Term Conditions

(81 Del. Laws, c. 379, § 1.)

§ 3335A. Definitions [For application of this section, see 85 Del. Laws, c. 481, § 7].

For purposes of this subchapter:

(1) “Chronic or long-term condition” means any of the following:

a. A “complex or chronic medical condition” as defined in § 3364(a) of this title.

b. A “rare medical condition” as defined in § 3364(a) of this title.

(2) “Emergency medical condition” means as defined in § 3349(e) of this title.

(3) “Pharmacy benefits manager” means as defined in § 3302A of this title.

(4) “Prior authorization” means a requirement by a carrier or health-insurance plan that providers submit a request or other prior notification to the carrier for evaluation of appropriateness of the request or if the prescription is medically necessary before treatment is rendered. Prior authorization lets the insured and provider know in advance which pharmaceuticals are considered by the insurer to be medically necessary.

(81 Del. Laws, c. 379, § 1; 85 Del. Laws, c. 481, § 4.)

§ 3336A. Prior authorization of emergency prescriptions [For application of this section, see 85 Del. Laws, c 481, § 7].

A pharmacy benefits manager may not require prior authorization for coverage of a 72-hour supply of medication that is for a noncontrolled substance prescribed for an emergency medical condition.

(81 Del. Laws, c. 379, § 1; 85 Del. Laws, c. 481, § 4.)

§ 3337A. Prior authorization of prescriptions for chronic or long-term conditions [For application of this section, see 85 Del. Laws, c. 481, § 7].

(a) A prior authorization form for a prescription medication must include a question regarding whether the prescription medication is for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient.

(b) If a prescriber indicates on a prior authorization form that the prescription medication is for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient, the pharmacy benefits manager may not request a reauthorization for the same prescription medication more frequently than every 12 months.

(c) In the same communication in which a pharmacy benefits manager or the pharmacy benefits manager's agent requests a prior authorization for a prescription medication that has therapeutically equivalent medications that do not require a prior authorization from a prescriber, the pharmacy benefits manager or the pharmacy benefits manager's agent shall provide the prescriber with a list of alternative prescription medications of the same class and family as the requested medication.

(d) Prescribers that utilize e-prescribing shall receive alternate medications from the pharmacy benefits manager for prescription medications that do not require a prior authorization before the completion of the e-prescribing transaction.

(e) A pharmacy benefits manager or the pharmacy benefit manager's agent shall provide alternative medications for therapeutically equivalent medications to the pharmacy that require prior authorization on the National Council for Prescription Drug Programs response transaction to a denied claim for prior authorization.

(81 Del. Laws, c. 379, § 1; 85 Del. Laws, c. 481, § 4.)

Subchapter V

Registration of Pharmacy Benefits Managers

(82 Del. Laws, c. 115, § 4.)

§ 3351A. Definitions [For application of this section, see 83 Del. Laws, c. 256, § 15].

For purposes of this subchapter:

(1) "Pharmacy benefits management services" means all of the following:

a. The procurement of prescription drugs at a negotiated rate for dispensation within this State to beneficiaries.

b. The administration or management of prescription drug coverage provided by a purchaser for beneficiaries.

c. Any of the following services provided with regard to the administration of prescription drug coverage:

1. Mail service pharmacy.

2. Claims processing, retail network management, and payment of claims to pharmacies for prescription drugs dispensed to beneficiaries.

3. Clinical formulary development and management services.

4. Rebate contracting and administration. For purposes of this paragraph (1)c.4., "rebate" means as defined in § 3361A of this title.

5. Patient compliance, therapeutic intervention, and generic substitution programs.

6. Disease management programs.

(2) "Pharmacy benefits manager" means as defined under § 3302A of this title.

(3) "Purchaser" means a person that does all of the following:

a. Provides prescription drug coverage or benefits in this State.

b. Enters into agreement with a pharmacy benefits manager for the provision of pharmacy benefits management services.

(82 Del. Laws, c. 115, § 4; 83 Del. Laws, c. 256, § 8.)

§ 3352A. Applicability.

This subchapter does not apply to plans of health insurance or health benefits designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act, 42 U.S.C. §§ 1395 et seq., 1396 et seq., and 1397aa et seq., known as Medicare, Medicaid, or any other similar coverage under a state or federal government plan.

(82 Del. Laws, c. 115, § 4.)

§ 3353A. Registration required [For application of this section, see 83 Del. Laws, c. 256, § 15].

(a) A pharmacy benefits manager shall register with the Commissioner as a pharmacy benefits manager before providing pharmacy benefits management services in this State to a purchaser.

(b) A purchaser may not enter into an agreement or contract with a pharmacy benefits manager that has not registered with the Commissioner.

(c) A pharmacy benefits manager applying for registration shall do all of the following:

(1) File with the Commissioner an application on the form that the Commissioner provides.

(2) Pay to the Commissioner a $1,000 nonrefundable registration fee.

(d) The Commissioner may require any additional information or submissions from a pharmacy benefits manager that may be reasonably necessary to verify the information contained in the application.

(e) Subject to § 3355A of this title, the Commissioner shall register each pharmacy benefits manager that meets the requirements of this section.

(f) Except where prohibited by state or federal law, a pharmacy benefits manager applying for registration is deemed to have appointed the Commissioner as agent for service of process in an action or proceeding arising in this State out of or in connection with the exercise of the registration. The appointment of the Commissioner as agent for service of process is irrevocable during the period within which a cause of action against the pharmacy benefits manager may arise out of transactions with respect to pharmacy benefits management services provided in this State. The process must be served on the Commissioner or a Deputy Insurance Commissioner or another person designated by the Commissioner by rule or regulation.

(82 Del. Laws, c. 115, § 4; 83 Del. Laws, c. 256, § 9.)

§ 3354A. Expiration and renewal of registration [For application of this section, see 83 Del. Laws, c. 256. § 15].

(a) A pharmacy benefits manager registration expires on May 1 after its effective date unless it is renewed as provided under this section.

(b) A pharmacy benefits manager may renew its registration for an additional 1-year term if the pharmacy benefits manager otherwise is entitled to be registered and does all of the following:

(1) Files with the Commissioner a registration renewal application on the form that the Commissioner requires.

(2) Pays to the Commissioner a $1,000 nonrefundable renewal fee.

(c) An application for renewal of a pharmacy benefits manager registration is to be considered made in a timely manner if it is postmarked on or before the date the pharmacy benefits manager's registration expires.

(d) The Commissioner may require additional information or submissions from a pharmacy benefits manager that may be reasonably necessary to verify the information contained in the registration renewal application.

(e) Subject to §§ 3355A of this title, the Commissioner shall renew the registration of each pharmacy benefits manager that meets the requirements of this section.

(82 Del. Laws, c. 115, § 4; 83 Del. Laws, c. 256, § 10.)

§ 3355A. Denial, suspension, or revocation of registration [For application of this section, see 83 Del. Laws, c. 256, § 15].

(a) The Commissioner may deny a registration to a pharmacy benefits manager applicant or refuse to renew, suspend, or revoke the registration of, or issue a cease and desist order to, a pharmacy benefits manager if the pharmacy benefits manager, or an officer, director, or employee of the pharmacy benefits manager, does any of the following:

(1) Makes a material misstatement, misrepresentation, or omission in a registration or registration renewal application.

(2) Fraudulently or deceptively obtains or attempts to obtain a registration or renewal of a registration.

(3) In connection with the administration of pharmacy benefits management services, commits fraud or engages in illegal or dishonest activities.

(4) Violates any provision of this chapter or a regulation adopted under this chapter.

(b) [Repealed.]

(c) If the action by the Commissioner is to deny or not renew a registration, the Commissioner shall notify the pharmacy benefits manager of the decision, in writing, including the reason for the denial or nonrenewal of the registration. The pharmacy benefits manager may, within 10 days after the Commissioner provides notice under this subsection, make written demand on the Commissioner for a hearing before the Commissioner to determine the reasonableness of the Commissioner's action. A hearing under this subsection must be held under §§ 323 through 328 of this title.

(d) This section does not limit any other regulatory authority of the Commissioner under this title.

(82 Del. Laws, c. 115, § 4; 83 Del. Laws, c. 256, § 11.)

§ 3356A. Recordkeeping requirements.

A pharmacy benefits manager shall maintain adequate books and records about each purchaser for which the pharmacy benefits manager provides pharmacy benefits management services as follows:

(1) In accordance with prudent standards of record keeping.

(2) For the duration of the agreement between the pharmacy benefits manager and the purchaser.

(3) For 3 years after the pharmacy benefits manager ceases to provide pharmacy benefits management services for the purchaser.

(82 Del. Laws, c. 115, § 4.)

§ 3357A. Examination of affairs, transactions, accounts, and records.

(a) Whenever the Commissioner considers it advisable, the Commissioner may examine the affairs, transactions, accounts, and records of a registered pharmacy benefits manager.

(b) The examination must be conducted under § 320 of this title.

(c) The expense of an examination is to be borne by the pharmacy benefits manager being examined. The expense includes the reasonable and proper expenses of the Commissioner, and the Commissioner's examiners and assistants, including expert assistance, and a reasonable per diem as to the examiners and assistants as necessarily incurred in the examination. The pharmacy benefits manager examined shall promptly pay the examination expense on presentation by the Commissioner or the Commissioner's examiner of a reasonably detailed written account of the examination expense.

(d) The Commissioner shall issue reports of the examination and investigation under § 321 of this title.

(82 Del. Laws, c. 115, § 4.)

§ 3358A. Permit required for nonresident pharmacy to deliver prescription drugs or devices.

A pharmacy benefits manager may not ship, mail, or deliver prescription drugs or devices to a person in this State through a nonresident pharmacy unless the nonresident pharmacy holds a permit issued under § 2535 of Title 24.

(82 Del. Laws, c. 115, § 4.)

§ 3359A. Penalties and enforcement [Transferred].

82 Del. Laws, c. 115, § 4Transferred to § 3373A of this title by 83 Del. Laws, c. 256, § 14, effective Oct. 26, 2021.

Subchapter VI

Pharmacy Benefits Manager Network Requirements [For application of this subchapter, see 83 Del. Laws, c. 256, § 15]

(83 Del. Laws, c. 256, § 12.)

§ 3361A. Definitions [For application of this section, see 83 Del. Laws, c. 256, § 15].

For purposes of this subchapter:

(1) "Claim" means as defined under § 3321A of this title.

(2) "Insured" means an individual covered by health insurance offered by an insurer.

(3) "Insurer" means as defined under § 3321A of this title.

(4) "Pharmacist" means as defined under § 2502 of Title 24.

(5) "Pharmacy" means as defined under § 2502 of Title 24.

(6) "Pharmacy benefits manager" means as defined under § 3302A of this title.

(7) "Pharmacy benefits manager network" means a network of pharmacists or pharmacies that are offered by an agreement or contract to provide pharmacy goods or services.

(8) "Pharmacy goods or services" means as defined under § 3325A of this title.

(9) a. "Rebate" means a discount or other price concession, or a payment that is both of the following:

1. Based on utilization of a prescription drug.

2. Paid by a manufacturer or third party, directly or indirectly, to the pharmacy benefits manager, pharmacy services administrative organization, or pharmacy after a claim has been processed and paid at a pharmacy.

b. "Rebate" includes incentives, disbursements, and reasonable estimates of a volume-based or category-based discount.

(83 Del. Laws, c. 256, § 12.)

§ 3362A. Pharmacy benefits manager network [For application of this section, see 83 Del. Laws, c. 256, § 15].

(a) A pharmacy benefits manager shall provide a reasonably adequate and accessible pharmacy benefits manager network for the provision of prescription drugs, which provides for convenient patient access to pharmacies within a reasonable distance from a patient's residence.

(b) A pharmacy benefits manager may not deny a pharmacy the opportunity to participate in a pharmacy benefits manager network at preferred participation status if the pharmacy is willing to accept the terms and conditions that the pharmacy benefits manager has established for other pharmacies as a condition of preferred network participation status.

(c) A mail-order pharmacy may not be included in the calculations for determining pharmacy benefits manager network adequacy under this section.

(83 Del. Laws, c. 256, § 12.)

§ 3363A. Reports [For application of this section, see 83 Del. Laws, c. 256, § 15; 85 Del. Laws, c. 481, § 7].

(a) A pharmacy benefits manager shall provide a pharmacy benefits manager network adequacy report describing the pharmacy benefits manager network and the pharmacy benefits manager network's accessibility in this State. The Commissioner shall adopt regulations setting the time and manner for providing the report.

(b) A pharmacy benefits manager shall report all of the following information to the Commissioner for each insurer:

(1) On an annual basis, no later than March 31, all of the following:

a. The itemized amount of pharmacy benefits manager revenue sources, including professional fees, administrative fees, processing fees, audits, direct and indirect renumeration fees, or any other fees.

b. The individual and aggregate amount the insurer paid to the pharmacy benefits manager for pharmacy goods or services provided in this State, itemized by all of the following:

1. Pharmacy.

2. Product.

3. Goods and services.

c. The individual and aggregate amount a pharmacy benefits manager paid for pharmacy goods or services provided in this State, itemized by all of the following:

1. Pharmacy.

2. Product.

3. Goods and services.

(2)-(5) [Repealed.]

(6) On an annual basis, all of the following:

a. The aggregate amount of the rebates distributed to the appropriate insurer.

b. The aggregate amount of the rebates passed on to insureds of each insurer at the point of sale that reduced the insureds' applicable deductible, copayment, coinsurance, or other cost-sharing amount.

(c) The information provided under this section is confidential and not subject to subpoena or the Freedom of Information Act, Chapter 100 of Title 29.

(83 Del. Laws, c. 256, § 12; 85 Del. Laws, c. 481, § 5.)

Subchapter VII

Prohibited Practices; Penalties; Enforcement [For application of this subchapter, see 83 Del. Laws, c. 256, § 15]

(83 Del. Laws, c. 256, § 13.)

§ 3371A. Definitions [For application of this section, see 83 Del. Laws, c. 256, § 15].

For purposes of this subchapter:

(1) "Board of Pharmacy" means the Delaware Board of Pharmacy.

(2) "Claim" means as defined under § 3321A of this title.

(3) "Insurer" means as defined under § 3321A of this title.

(4) "Pharmacist" means as defined under § 2502 of Title 24.

(5) "Pharmacy" means as defined under § 2502 of Title 24.

(6) "Pharmacy benefits manager" means as defined under § 3302A of this title.

(7) "Pharmacy benefits manager network" means a network of pharmacists or pharmacies that are offered by an agreement or contract to provide pharmacy goods or services.

(8) "Pharmacy goods or services" means as defined under § 3325A of this title.

(9) "Spread pricing" means the model of prescription drug pricing in which the pharmacy benefits manager charges a health benefit plan a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly pays the pharmacist or pharmacy for pharmacy goods or services.

(83 Del. Laws, c. 256, § 13; 85 Del. Laws, c. 49, § 1.)

§ 3372A. Prohibited practices [For application of this section, see 83 Del. Laws, c. 256, § 15].

A pharmacy benefits manager or representative of a pharmacy benefits manager may not do any of the following:

(1) Engage in spread pricing.

(2) Cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading.

(3) Unless reviewed and approved by the Commissioner, charge a pharmacist or pharmacy a fee related to the adjudication of a claim, including a fee for any of the following:

a. The receipt and processing of a pharmacy claim.

b. The development or management of claims processing services in a pharmacy benefits manager network.

c. Participation in a pharmacy benefits manager network.

(4) Unless reviewed and approved by the Commissioner in coordination with the Board of Pharmacy, require pharmacy accreditation standards or certification requirements inconsistent with, more stringent than, or in addition to requirements of the Board of Pharmacy.

(5) Violate § 3325A(b) of this title.

(6) Violate § 3362A of this title.

(7) Pay or reimburse a pharmacy or pharmacist for the ingredient drug product component of pharmacist services less than the national average drug acquisition cost that was in effect on the date of service. If the national average drug acquisition cost is unavailable, the wholesale acquisition cost should be applied. The wholesale acquisition cost price must be the price published in effect on the date of service for the drug claim.

(8) Make or permit any reduction of payment for pharmacy goods or services by a pharmacy benefits manager or an insurer directly or indirectly to a pharmacy under a reconciliation process to an effective rate of reimbursement, including generic effective rates, brand effective rates, direct and indirect remuneration fees, or any other reduction or aggregate reduction of payment.

(9) After adjudication of a claim for pharmacy goods or services, directly or indirectly retroactively deny or reduce the claim unless 1 or more of the following applies:

a. The original claim was intentionally submitted fraudulently.

b. The original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the pharmacy goods or services.

c. The pharmacy goods or services were not properly rendered by the pharmacy or pharmacist.

(10) Amend a contract between a pharmacy benefits manager and a pharmacy or pharmacist without providing at least 60 days' notice to the affected pharmacy or pharmacist.

(11) Require pharmacists to break open unit-of-use items beyond manufacturer recommendations if the only commercially available package size exceeds the minimum days' supply. Packaging labeled "for single-patient-use only" shall be deemed to be the smallest package size available.

(12) Require a pharmacy to dispense a therapeutically equivalent or therapeutically alternative drug that costs the enrollee more out-of-pocket than the prescribed drug, unless the substitution is made for medical reasons that benefit the enrollee.

(13) Transfer or share prescription information containing enrollee-identifiable or prescriber-identifiable data to an affiliated pharmacy for any commercial purpose other than the purposes of facilitating pharmacy reimbursement, formulary compliance, or utilization review.

(83 Del. Laws, c. 256, § 13; 85 Del. Laws, c. 481, § 6.)

§ 3373A. Penalties and enforcement [For application of this section, see 83 Del. Laws, c. 256, § 15].

(a) If the Commissioner determines that a pharmacy benefits manager has violated any provision of this chapter or any regulation adopted under this chapter, the Commissioner may, after notice and a hearing, issue an order that requires the pharmacy benefits manager to do 1 or more of the following:

(1) Cease and desist from the identified violation and further similar violations.

(2) Take specific affirmative action to correct the violation.

(3) Make restitution of money, property, or other assets to a person that has suffered financial injury because of the violation.

(4) Pay a fine in an amount determined by the Commissioner, not to exceed $10,000, for each violation of this chapter.

(5) Pay the costs, including applicable attorneys' fees, incurred by the Commissioner in bringing the action.

(b) A hearing under this section must be held under §§ 323 through 328 of this title and any regulations adopted by the Commissioner.

(c) The Commissioner may adopt regulations to enforce this chapter and to establish a complaint process and set associated fees to address grievances and appeals brought under this chapter.

(82 Del. Laws, c. 115, § 4; 83 Del. Laws, c. 256, § 14.)

§ 3374A. Prohibition of discrimination against 340B entities by pharmacy benefits managers.

(a) For purposes of this section:

(1) "340B drug" means a drug that is a covered outpatient drug under 42 U.S.C. § 256b.

(2) "340B drug program" means the federal drug pricing program under 42 U.S.C. § 256b that limits prices on drugs purchased by covered entities.

(3) "Claim" means a request from a covered entity or the covered entity's contracted pharmacy to be reimbursed for the cost of filling or refilling a prescription for a drug or for providing a medical supply or device.

(4) "Covered entity" means as defined in 42 U.S.C. § 256b(a)(4).

(5) "Pharmacy benefits manager" means as defined in § 3302A of this title.

(6) "Purchaser" means as defined in § 3351A of this title.

(b) A pharmacy benefits manager or purchaser may not discriminate, either directly or indirectly, against a covered entity or the covered entity's contracted pharmacy on the basis of its participation in the 340B program, including by doing any of the following:

(1) Providing a reimbursement rate for a 340B drug that is less than the national average drug acquisition cost rate for that drug as determined by the United States Centers for Medicare and Medicaid Services, measured at the time the drug is administered or dispensed, or if no such rate is available at that time, a reimbursement rate that is less than the wholesale acquisition cost of the drug, as contemplated under § 3372A of this title.

(2) Imposing a term or condition that differs from terms or conditions imposed on an entity that is not a covered entity or the covered entity's contracted pharmacy, including any of the following:

a. Imposing a fee, chargeback, clawback, or other adjustment to the covered entity or the covered entity's contracted pharmacy that is not imposed on or exceeds the amount imposed on an entity that is not a covered entity or the covered entity's contracted pharmacy.

b. Restricting or requiring participation in a pharmacy network.

c. Requiring more frequent auditing or a broader scope of audit for inventory management systems using generally accepted accounting principles, unless such audit is required under state or federal law.

d. Requiring a covered entity or the covered entity's contracted pharmacy to reverse, resubmit, identify, modify, or clarify a claim after the initial adjudication, unless these actions are the normal course of pharmacy business and not related to the 340B program or required under applicable state or federal law.

e. Requiring accreditation or recertification inconsistent with, more stringent than, or in addition to state or federal law.

f. Discriminating against a 340B entity or the entity's contracted pharmacy in a manner that prevents or interferes with an individual's choice to receive a prescription drug from a 340B covered entity or the covered entity's contracted pharmacy, including the administration of the drug.

g. Imposing any provision determined by the Insurance Commissioner to interfere with the ability of a covered entity or the covered entity's contracted pharmacy to maximize the value of discounts provided under the 340B program.

(c) A violation of subsection (b) of this section by any person constitutes an unfair practice in the insurance business under Chapter 23 of this title.

(d) Any contract that is entered into, amended, extended, or renewed after September 19, 2024 that includes a provision that violates subsection (b) of this section is against public policy and is void and unenforceable.

(84 Del. Laws, c. 408, § 2.)

Subchapter VIII

Fairness in Cost-Sharing for Pharmacy Benefits Managers [For application of this subchapter, see 83 Del. Laws, c. 522, § 4]

(83 Del. Laws, c. 522, § 3.)

§ 3381A. Definitions [For application of this subchapter, see 83 Del. Laws, c. 522, § 4].

For purposes of this subchapter:

(1) "Cost-sharing requirement" means any copayment, coinsurance, deductible, or annual limitation on cost-sharing (including a limitation subject to 42 U.S.C. §§ 18022(c) and 300gg-6(b)), required by or on behalf of an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health benefit plan.

(2) "Enrollee" means any individual entitled to health care services from an insurer.

(3) "Health benefit plan" means a policy, contract, certification, or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(4) "Health care service" means a policy, contract, certification, or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(5) “Insurer” means as defined under § 3321A of this title.

(6) “Person” means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, not-for-profit corporation, unincorporated organization, government or governmental subdivision or agency.

(7) “Pharmacy benefits manager” means as defined under § 3302A of this title, and shall include any person, business, or other entity that, pursuant to a contract or under an employment relationship with an insurer, either directly or through an intermediary, manages the prescription drug benefit provided by the insurer, including the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to the prescription drug benefit, contracting with network pharmacies, and/or controlling the cost of covered prescription drugs.

(83 Del. Laws, c. 522, § 3.)

§ 3382A. Fairness in cost-sharing [For application of this subchapter, see 83 Del. Laws, c. 522, § 4].

(a) *Cost-sharing calculation. —*

When calculating an enrollee’s contribution to any applicable cost-sharing requirement, a pharmacy benefits manager shall include any cost-sharing amounts paid by the enrollee or on behalf of the enrollee by another person. If under federal law, application of this requirement would result in health savings account ineligibility under § 223 of the federal Internal Revenue Code [26 U.S.C. § 223], this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under [26 U.S.C.] § 223, except with respect to items or services that are preventive care pursuant to [26 U.S.C.] § 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of this subsection shall apply regardless of whether the minimum deductible under [26 U.S.C.] § 223 has been satisfied.

(b) *Rule-making. —*

The Insurance Commissioner may promulgate rules and regulations as may be necessary or appropriate to implement and administer this section.

(83 Del. Laws, c. 522, § 3.)

Part I
Insurance

Chapter 33B
Health-Care Professional Access Act [Effective Jan. 1, 2028].

(85 Del. Laws, c. 487, § 1.)

§ 3301B. Short title [Effective Jan. 1, 2028].

This chapter is known and may be cited as the " Health-Care Professional Access Act."

(85 Del. Laws, c. 487, § 1.)

§ 3302B. Purpose and intent [Effective Jan. 1, 2028].

(a) This chapter requires carriers regulated by, or contracted with, this State and that require provider credentialing prior to the reimbursement or settlement of claims to participate in a comprehensive uniform health-care professional credentialing program to ensure that health-care professionals meet specific minimum standards of qualification for reimbursement and to ensure that the credentialing process is clearly defined and not limiting access to health-care services.

(b) Credentialing standards in this chapter are designed to promote uniformity and efficiencies among processes, set certain response standards to improve health-care professional speed-to-market, and reduce the administrative burden of completing multiple, complex, and different processes.

(c) Notwithstanding any other provision of law, this chapter establishes state standards for credentialing of health-care professionals and applies to all carriers that require provider credentialing prior to the reimbursement or settlement of claims and that contract with health-care professionals to provide health-care services under state-regulated plans or contracts delivered or issued under any of the following:

(1) Title 18.

(2) Title 19.

(3) Title 29.

(4) Title 31.

(85 Del. Laws, c. 487, § 1.)

§ 3303B. Definitions [Effective Jan. 1, 2028].

As used in this chapter:

(1) "Carrier" means any entity that provides or contracts for insurance or health benefits in this State. "Carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state regulation. "Carrier" also includes any dental plan organizations, pharmacy benefits managers, workers' compensation carrier, personal injury protection carriers, third-party administrators, credentialing intermediaries, or any other entities that adjust, administer, or settle claims in connection with such plans or benefits. For purposes of this chapter, "carrier" includes the State's employee health benefit plans and, to the extent permitted by federal law, the State's Medicaid managed care organizations.

(2) "Clean application" means an application for health-care professional credentialing submitted by a health-care professional to a carrier that is complete and includes all information and substantiation required.

(3) "Council for Affordable Quality Healthcare" or "CAQH" or its successor is an organization which offers a single, electronic uniform application for credentialing in all 50 states which simplifies data collection, primary source verification, and sanctions monitoring, to support carriers' credentialing needs.

(4) "Credentialing" means the process of assessing and verifying the qualifications of a health-care professional, including an evaluation of licensure status, education, training, and experience, to determine carrier eligibility to provide health-care services to a covered person and to receive reimbursement for health-care services.

(5) "Credentialing intermediary" means a person to whom a carrier has delegated credentialing or recredentialing authority and responsibility.

(6) "Health-care professional" means a person, corporation, facility, or institution licensed, certified, or otherwise authorized or permitted by law to provide health-care services in the ordinary course of business or practice of a profession and includes a "health-care provider" as that term is defined in § 2301 of Title 19.

(7) "Health-care services" means health-care-related services or products rendered or sold by a health-care professional within the scope of the professional's license or legal authorization, including hospital, medical, behavioral, surgical, dental, vision, and pharmaceutical services, products, or dispensing.

(8) "Participating provider" means a health-care professional who, under a contract with the carrier, has agreed to provide health-care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the carrier.

(9) “Pharmacy Profiles” is a National Committee for Quality Assurance (NCQA)-certified credentials verification organization that provides verified credentialing data for health-care professionals dispensing pharmaceuticals.

(10) “Provisional credentials” means the temporary credentials provided to certain health-care professionals under parameters required by this chapter and effective until a point at which credentialing determinations are rendered.

(11) “Recredentialing” means the process by which a carrier ensures that a health-care professional who is currently credentialed continues to meet credentialing criteria.

(12) “Uniform credentialing application” means the application created by CAQH or its successor, or the application created by Pharmacy Profiles, as applicable, for use by a carrier or its credentialing intermediary for credentialing and recredentialing a health-care professional.

(85 Del. Laws, c. 487, § 1.)

§ 3304B. General responsibilities of carriers [Effective Jan. 1, 2028].

(a) A carrier that requires provider credentialling prior to the reimbursement or settlement of claims shall do all of the following:

(1) Establish written policies and procedures for credentialing of health-care professionals and apply these standards consistently.

(2) Verify the credentials of a health-care professional before entering into a contract with that health-care professional to be a participating provider.

(3) Establish a credentialing committee consisting of health-care professionals to review credentialing information and supporting documents and make decisions regarding credentialing denials or terminations.

(4) Make available for review by health-care professional applicants upon request all credentialing policies and procedures.

(5) Retain all records and documents relating to a health-care professional’s provisional credentialing, initial credentialing, and recredentialing for at least 3 years from date of the record’s creation.

(6) Keep confidential all information obtained in the credentialing verification process, except as otherwise provided by law.

(b) Nothing in this chapter may be construed to require a carrier to select a health-care professional as a participating provider solely because the health-care professional meets the carrier’s credentialing standards, or to prevent a carrier from utilizing separate or additional criteria in selecting the health-care professionals with whom it contracts.

(85 Del. Laws, c. 487, § 1.)

§ 3305B. Application for credentialing, recredentialing [Effective Jan. 1, 2028].

(a) Beginning January 1, 2028, a carrier or its credentialing intermediary may not use any credentialing application other than the uniform credentialing application.

(b) A carrier shall do all of the following:

(1) Except as otherwise permitted in paragraph (b)(3) of this section, accept the uniform credentialing application as the sole application for a health-care professional to become credentialed or recredentialed.

(2) Make the uniform credentialing application available to any health-care professional to be credentialed or recredentialed by that carrier or credentialing intermediary.

(3) Accept the credentialing application of other states when a health-care professional practices outside this State and prefers to use the credentialing application required by their primary or home state.

(4) Accept applications through an online credentialing system.

(c) (1) A carrier may not require a health-care professional to complete recredentialing within 3 years of the health-care professional’s most recent successful credentialing application, except as necessary to address any activity that could disqualify a health-care professional from credentialing in accordance with NCQA standards.

(2) A carrier shall notify health-care professionals in writing not less than 90 days before recredentialing is required. The notices required therein must be delivered to the health-care professional electronically and by certified mail or by USPS Intelligent Mail barcode, or electronic delivery that meets the requirements of the Uniform Electronic Transactions Act (Chapter 12A of Title 6). Proof of mailing such notices are subject to the records retention requirements of this chapter.

(d) A carrier may not charge a fee to health-care professionals for processing a credentialing application.

(e) If a credentialed health-care professional changes employment or location, opens an additional location, or joins a new health-care facility, a carrier may only require submission of the new information as it is necessary to continue the health-care professional’s credentials and may not require a new credentialing application.

(85 Del. Laws, c. 487, § 1.)

§ 3306B. Health-care professional’s right to review credentialing information [Effective Jan. 1, 2028].

(a) Each health-care professional subject to credentialing has the right to review all information, including the source of that information, obtained by the carrier to satisfy the requirements of this chapter during the carrier’s credentialing process.

(b) A carrier shall notify a health-care professional of any information obtained during the credentialing process that does not meet the carrier's credentialing standards or that varies substantially from the information provided to the carrier by the health-care professional, except that the carrier is not required to reveal the source of the information if the information is not obtained to meet the requirements of this chapter, or if disclosure is prohibited by law.

(c) A health-care professional has the right to correct any erroneous information obtained by a carrier during the credentialing process. A carrier must have a formal process by which a health-care professional may submit supplemental or corrected information to the carrier's credentialing committee and request a reconsideration of the health-care professional's credentialing application if the health-care professional believes that the carrier's credentialing committee has received information that is incorrect or misleading. Supplemental information is subject to confirmation by the carrier.

(85 Del. Laws, c. 487, § 1.)

§ 3307B. Credentialing and recredentialing [Effective Jan. 1, 2028].

(a) Within 15 days of receipt of a uniform credentialing application, a carrier shall send to the health-care professional notice of either of the following:

(1) The carrier's confirmation that the submission was a clean application.

(2) Notice that the credentialing application is incomplete. Failure to provide notice within the required timeframe deems the application complete.

a. A carrier that receives an incomplete application shall return it to the health-care professional with a comprehensive list of all corrections needed.

b. If the requested information is not received within 30 days, the carrier may treat the application as withdrawn, and no further carrier action is required.

(b) If under subsection (a) of this section, a carrier provides confirmation of a clean application, the carrier will, within 30 days after the confirmation is provided, do 1 of the following:

(1) Accept the health-care professional's credentialing application and issue notice to the health-care professional.

(2) Provide notice that the carrier needs additional time to render the credentialing decision, with an explanation of the reasons for the delay, an estimate of the time necessary to complete the review, and notice of provisional credentialing information as required by this chapter.

(3) Deny the health-care professional's credentialing application.

(c) A carrier must provide each applicant notice of the outcome of the applicant's credentialing within 10 calendar days after the conclusion of the process.

(85 Del. Laws, c. 487, § 1.)

§ 3308B. Provisional credentialing [Effective Jan. 1, 2028].

(a) Carriers must provide provisional credentials to health-care professionals who have submitted the uniform credentialing application from the date of notice of a clean application, effective until the credentialing application is approved or denied, under any of the following circumstances:

(1) When the carrier fails to make a credentialing decision on a clean credentialing application within the period required by § 6207(b) of this title.

(2) When the health-care professional's primary employment is serving in a relevant health professional shortage area as designated by the U.S. Health Resources and Services Administration.

(3) When the health-care professional's primary employment is within a federally-qualified health center.

(4) When the health-care professional is actively credentialed by the carrier at a different facility or location within Delaware.

(5) When the health-care professional is actively credentialed by the carrier in a different state with reciprocity of licensure to Delaware and relocating to Delaware or providing multistate care including care in Delaware.

(b) The carrier may not issue provisional credentialing if the health-care professional disclosed a history of malpractice settlements within 5 calendar years of the application or licensing board disciplinary actions in its uniform credentialing application.

(c) If, on completion of the credentialing process, the carrier denies an application for a health-care professional that has received provisional credentialing, the carrier may recover an amount equal to the reimbursements collected by the health-care professional within 120 days of the denial.

(85 Del. Laws, c. 487, § 1.)

§ 3309B. Payments to health-care professionals for services rendered during pendency of credentialing [Effective Jan. 1, 2028].

(a) A carrier must pay claims for services rendered by a health-care professional prior to credentialing from the date a complete application for credentialing is submitted to the carrier as long as credentials are granted to that health-care professional by the carrier in accordance with the requirements of this chapter.

(b) A health-care professional intending to submit a claim pursuant to this subsection may not submit the claim until notified by the carrier of the effective date of any credentials.

(c) If a claim is submitted prior to the date credentials are granted, the carrier may process that claim in the same manner as a claim submitted by a nonnetwork health-care professional.

(85 Del. Laws, c. 487, § 1.)

§ 3310B. Denial, suspension, nonrenewal, and termination of credentialing [Effective Jan. 1, 2028].

(a) (1) A carrier may not deny, suspend, nonrenew, or terminate a health-care professional's credentials unless the carrier provides a written explanation prior to the termination or nonrenewal that include all of the following:

a. The reason or reasons for the proposed action in sufficient detail to permit the health-care professional to respond.

b. Reference to the evidence or documentation underlying the carrier's decision to pursue the proposed action.

c. Notice that the health-care professional has the right to request, within 30 days of receipt of the written explanation, a hearing before a panel appointed by the carrier.

(2) If the health-care professional requests a hearing pursuant to paragraph (a)(1)c. of this section, all of the following apply:

a. A hearing date must be within 30 days of the date of receipt of a request for a hearing.

b. A hearing panel must be composed of at least 3 health-care professionals appointed by the carrier, and 1 person on the hearing panel must be a clinical peer in the same discipline and the same or similar specialty as the health-care professional under review. A hearing panel may be composed of more than 3 health-care professionals if the number of clinical peers on the hearing panel constitutes # or more of the total membership of the panel. Any compensation paid to the panel may not be contingent upon the outcome of the review.

c. A hearing panel must render a decision on the proposed action in a timely manner. This decision must be either the reinstatement of the health-care professional by the carrier, the provisional reinstatement of the health-care professional subject to conditions established by the carrier, or uphold the termination or nonrenewal of the health-care professional's credentials.

d. A decision by a hearing panel to terminate or nonrenew a health-care professional's credentials may not become effective less than 60 days after the receipt by the health-care professional of the hearing panel's decision.

(b) Termination or nonrenewal of credentials may not be effective earlier than 60 days from the receipt of the notice of termination or nonrenewal.

(c) This section does not apply to termination cases involving imminent harm to patient care, a final determination of fraud by a governmental agency, or a final disciplinary action by a state licensing board or other governmental agency that impairs the ability of a health-care professional to practice.

(d) A carrier may deny, suspend, nonrenew, or terminate a health-care professional's credentials for any activity that could disqualify a health-care professional from credentialing in accordance with NCQA standards.

(e) A carrier may not deny, suspend, nonrenew, or terminate a health-care professional's credentialing based solely on the health-care professional's provision of legally protected health-care activity, or aiding and assisting with legally protected health-care activity, provided that the care provided by the health-care professional was consistent with the applicable professional standard of care and did not violate Delaware law.

(85 Del. Laws, c. 487, § 1.)

§ 3311B. Complaints and penalties [Effective Jan. 1, 2028].

(a) Complaints and allegations of violations of this chapter may be filed with the state agency regulating relevant carrier activities. If the agency to whom the complaint is addressed determines it to be more appropriate for another agency to process it, it may be referred to them.

(b) In addition to any other penalty authorized by law, an entity in violation of the provisions of this chapter may be subject to an award of damages to the health-care professional complainant that may not exceed $500 per day carrier action was delayed, or $5,000 in total per incident of noncompliance.

(85 Del. Laws, c. 487, § 1.)

§ 3312B. Certification of workers compensation health-care providers [Effective Jan. 1, 2028].

(a) Nothing in this chapter may be construed to supersede, limit, or otherwise interfere with the provisions set forth in §§ 2322A through 2322F of Title 19 relating to the certification of workers' compensation health-care providers.

(b) A health-care provider that has been certified under Chapter 23 of Title 19 may not be required by a carrier to also be credentialed pursuant to this chapter in order to be reimbursed for services provided pursuant to the workers' compensation laws.

(85 Del. Laws, c. 487, § 1.)

Part I
Insurance
Chapter 34
Medicare Supplement Insurance Minimum Standards

§ 3401. Definitions.

(a) "Applicant" means:

(1) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and

(2) In the case of a group Medicare supplement policy, the proposed certificate holder.

(b) "Certificate" means, for the purposes of this chapter, any certificate delivered or issued for delivery in this State under a group Medicare supplement policy.

(c) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(d) "Issuer" includes insurance companies, fraternal benefit societies, health-care service plans, health maintenance organizations and any other entity delivering or issuing for delivery in this State Medicare supplement policies or certificates.

(e) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965 [42 U.S.C. § 1395 et seq.], as then constituted or later amended.

(f) "Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. § 1395w-28(b)(1), and includes all of the following:

(1) Coordinated care plans that provide health-care services, including health maintenance organization plans, with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans.

(2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account.

(3) Medicare Advantage private fee-for-service plans.

(g) "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under § 1876 of the Federal Social Security Act (42 U.S.C. § 1395mm), or an issued policy under a demonstration project specified in the 42 U.S.C. § 1395(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

(h) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

(63 Del. Laws, c. 262, § 2; 67 Del. Laws, c. 45, § 1; 68 Del. Laws, c. 237, § 1; 70 Del. Laws, c. 156, § 1; 85 Del. Laws, c. 202, § 1.)

§ 3402. Applicability; scope.

(a) Except as otherwise specifically provided in this title, this chapter shall apply to:

(1) All Medicare supplement policies delivered or issued for delivery in this State on or after May 13, 1992; and

(2) All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this State.

(b) This chapter shall not apply to a policy of 1 or more employers or labor organizations, or of the trustees of a fund established by 1 or more employers or labor organizations, or combination thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

(c) Except as otherwise provided in § 3405(d) of this title, the provisions of this chapter are not intended to prohibit or apply to insurance policies or health-care benefit plans, including group conversion policies, provided to Medicare eligible persons which policies are not marketed or held to be Medicare supplement policies or benefit plans.

(67 Del. Laws, c. 45, § 1; 68 Del. Laws, c. 237, § 1; 70 Del. Laws, c. 156, §§ 2, 3.)

§ 3403. Standards for policy provisions and authority to promulgate regulations.

(a) No Medicare supplement policy or certificate in force in this State shall contain benefits that duplicate benefits provided by Medicare.

(b) Notwithstanding any other provision of law of this State, a Medicare supplement policy or certificate shall not exclude or limit benefits for loss incurred more than 6 months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define preexisting condition more restrictively than a condition for which medical advice was given or treatment recommended by or received from a physician within 6 months before the effective date of coverage.

(c) The Commissioner shall adopt reasonable regulations to establish specific standards for policy provisions of Medicare supplement policies and certificates. Such standards shall be in addition to and in accordance with applicable laws of this State. No requirement of the Insurance Code relating to minimum required policy benefits, other than the minimum standards contained in this chapter, shall apply to Medicare supplement policies and certificates. The standards may cover, but not be limited to:

(1) Terms of renewability;

(2) Initial and subsequent conditions of eligibility;

(3) Nonduplication of coverage;

(4) Probationary periods;

(5) Benefit limitations, exceptions and reductions;

(6) Elimination periods;

(7) Requirements for replacement;

(8) Recurrent conditions; and

(9) Definitions of terms.

(d) The Commissioner shall adopt reasonable regulations to establish minimum standards for benefits, claims payment, marketing practices and compensation arrangements and reporting practices, for Medicare supplement policies and certificates.

(e) The Commissioner may adopt from time to time, such reasonable regulations as are necessary to conform Medicare supplement policies and certificates to the requirements of federal law and regulations promulgated thereunder, including but not limited to:

(1) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements;

(2) Establishing a uniform methodology for calculating and reporting loss ratios;

(3) Assuring public access to policies, premiums and loss ratio information of issuers of Medicare supplement insurance;

(4) Establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases;

(5) Establishing a policy for holding public hearings prior to approval of premium increases; and

(6) Establishing standards for Medicare select policies and certificates.

(f) The Commissioner may adopt reasonable regulations that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the Commissioner, are unjust, unfair or unfairly discriminatory to any person insured or proposed to be insured under a Medicare supplement policy or certificate.

(63 Del. Laws, c. 262, § 2; 67 Del. Laws, c. 45, § 1; 68 Del. Laws, c. 237, § 1.)

§ 3404. Loss ratio standards.

Medicare supplement policies shall return to policyholders benefits which are reasonable in relation to the premium charged. The Commissioner shall issue reasonable regulations to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health-care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

(63 Del. Laws, c. 262, § 2; 67 Del. Laws, c. 45, § 1; 68 Del. Laws, c. 237, § 1.)

§ 3405. Disclosure standards.

(a) In order to provide for full and fair disclosure in the sale of Medicare supplement policies, no Medicare supplement policy or certificate shall be delivered in this State unless an outline of coverage is delivered to the applicant at the time application is made.

(b) The Commissioner shall prescribe the format and content of the outline of coverage required by subsection (a) of this section. For purposes of this section, “format” means style, arrangements and overall appearance, including such items as the size, color and prominence of type and arrangement of text and captions. Such outline of coverage shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the renewal provisions, including any reservation by the issuer of a right to change premiums; and disclosure of the existence of any automatic renewal premium increases based on the policyholder’s age;

(3) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(c) The Commissioner may prescribe by regulation a standard form and the contents of an informational brochure for persons eligible for Medicare, which is intended to improve the buyer’s ability to select the most appropriate coverage and improve the buyer’s understanding of Medicare. Except in the case of direct response insurance policies, the Commissioner may require by regulation that the information brochure be provided to any prospective insureds eligible for Medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the Commissioner may require by regulation that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

(d) The Commissioner may adopt regulations for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages, for all accident and sickness insurance policies sold to persons eligible for Medicare, other than:

(1) Medicare supplement policies;

(2) Disability income policies;

(3), (4) [Repealed.]

(e) The Commissioner may adopt reasonable regulations to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies, subscriber contracts or certificates by persons eligible for Medicare.

(63 Del. Laws, c. 262, § 2; 67 Del. Laws, c. 45, § 1; 68 Del. Laws, c. 237, § 1; 70 Del. Laws, c. 156, § 4.)

§ 3406. Notice of free examination.

Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner.

(63 Del. Laws, c. 262, § 2; 67 Del. Laws, c. 45, § 1; 68 Del. Laws, c. 237, § 1.)

§ 3407. Filing requirements for advertising.

Every issuer of Medicare supplement insurance policies or certificates in this State shall provide a copy of any Medicare supplement advertisement intended for use in this State whether through written, radio or television medium to the Commissioner of Insurance of this State for review or approval by the Commissioner to the extent it may be required under state law.

(67 Del. Laws, c. 45, § 1; 68 Del. Laws, c. 237, § 1.)

§ 3408. Administrative procedures.

Regulations adopted pursuant to this chapter shall be subject to the provisions of Chapter 101 of Title 29.

(68 Del. Laws, c. 237, § 1.)

§ 3409. Penalties.

In addition to any other applicable penalties for violations of the Insurance Code, the Commissioner may require issuers violating any provision of this chapter or regulations promulgated pursuant to this chapter to cease marketing any Medicare supplement policy or certificate in this State which is related directly or indirectly to a violation or may require such issuer to take such actions as are necessary to comply with the provisions of this chapter, or both.

(67 Del. Laws, c. 45, § 1; 68 Del. Laws, c. 237, § 1; 76 Del. Laws, c. 354, §§ 1, 2.)

§ 3410. Coverage for persons eligible for Medicare due to disability.

(a) Each Medicare supplement policy or applicable certificate that an issuer currently, or at any time hereafter, makes available in this State shall be made available to any applicant under the age of 65 who is eligible for Medicare due to a disability, including, without limitation, end-stage renal disease, provided that the applicant submits his or her application during the first 6 months immediately following such applicant's enrollment in Part B of Medicare or by January 15, 2014, whichever is later. The issuance or effectiveness of any Medicare supplement policy pursuant to this section shall not be conditioned on, nor shall the price of the policy be discriminatory based upon, the medical or health status or receipt of health care by the applicant; and no insurer shall perform individual medical underwriting on any applicant in connection with the issuance of a policy pursuant to this section.

(b) Premium rates for Medicare supplement policies and certificates issued pursuant to this section may differ between persons who qualify for Medicare who are 65 years of age or older and those who qualify for Medicare by reason of disability or end-stage renal disease and who are younger than 65 years of age. For those Medicare supplement policies and certificates that are issued to persons who are younger than 65 years of age and who qualify for Medicare by reason of disability or end-stage renal disease, insurers shall establish 2 separate rating pools for such persons, 1 pool specifically for end-stage renal disease and a separate pool for all other disabilities. For purposes of this section, any differences in premium rates shall be pursuant to rate schedules that are based on sound actuarial principles and shall be reasonable in relation to the benefits provided.

(c) Medicare supplement policies issued pursuant to this section shall be separately underwritten from other Medicare supplement policies, and risks assumed by issuers pursuant to subsection (a) of this section shall not be subsidized by purchasers of Medicare supplement policies that were not issued pursuant to subsection (a) of this section.

(79 Del. Laws, c. 101, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3411. Enrollment periods.

(a) A person enrolled in a Medicare supplement policy or certificate may cancel that person's existing Medicare supplement policy or certificate and purchase or select another Medicare supplement policy or certificate with the same or lesser benefits during an annual open enrollment period commencing 30 days prior to that person's birthday and remaining open for at least 30 days after that person's birthday.

(b) During the open enrollment period offered pursuant to subsection (a) of this section, an issuer of Medicare supplement policies or certificates in this State may not deny or condition the issuance or effectiveness of a Medicare supplement policy or certificate being offered or discriminate in the pricing of such a Medicare supplement policy or certificate because of health status, claims experience,

receipt of health care, or medical condition, and may not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy or certificate.

(c) A person enrolled in a Medicare Advantage plan or certificate may cancel that person's existing Medicare Advantage plan or certificate and enroll in a Medicare supplement policy or certificate during Medicare open enrollment periods.

(d) With respect to any individual applying for a Medicare supplement policy or certificate pursuant to subsection (c) of this section, except as otherwise set forth in this subsection, an issuer of Medicare supplement policies or certificates in this State may not deny or condition the effectiveness of a Medicare supplement policy or certificate being offered. Nothing in this subsection prevents an issuer from individually rating each applicant applying for a policy or certificate pursuant to subsection (c) of this section or applying a preexisting condition limitation in accordance with § 3403 of this title.

(e) At least 30 days before the beginning of the open enrollment period offered pursuant to subsection (a) of this section, but not more than 60 days before the beginning of that period, an issuer that issues a Medicare supplement policy or certificate must notify each person to whom the open enrollment period applies of all of the following:

(1) The dates on which the open enrollment period begins and ends and the rights of the person established by the provisions of this section.

(2) Any modification to the benefits provided by the policy or certificate under which the person is currently insured or adjustment to the premiums charged for that policy or certificate.

(f) The open enrollment periods created pursuant to this section are in addition to, and independent of, any other open enrollment periods established by federal or state law or regulation.

(85 Del. Laws, c. 202, § 2.)

Part I
Insurance

Chapter 35
Group and Blanket Health Insurance

Subchapter I
Group Health Insurance

§ 3501. Group policies must meet group requirements.

Except as provided in § 3509 of this title, no policy of group health insurance shall be delivered in this State unless it conforms to one of the descriptions contained in §§ 3502-3508 of this title.

(66 Del. Laws, c. 175, § 1.)

§ 3502. Employee groups.

A policy may be issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(1) The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of 1 or more subsidiary corporations, and the employees, individual proprietors and partners of 1 or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials. The policy may provide that the term "employee" does not include farm laborers employed in agriculture.

(2) The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees, or from both. Except as provided in paragraph (3) of this section, a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject such coverage in writing.

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(66 Del. Laws, c. 175, § 1.)

§ 3503. Debtor groups.

A policy may be issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by 2 or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditors with respect to their indebtedness, subject to the following requirements:

(1) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes thereof. The policy may provide that the term "debtors" shall include:

a. Borrowers of money or purchasers or lessees of goods, services or property for which payment is arranged through a lease or credit transaction;

b. The debtors of 1 or more subsidiary corporations; and

c. The debtors of 1 or more affiliated corporations, proprietorships or partnerships if the business of the policyholder and of such affiliated corporations, proprietorships or partnerships is under common control.

(2) The premium for the policy shall be paid either from the creditor's funds, or from charges collected from the insured debtors, or from both. Except as provided in paragraph (3) of this section, a policy on which no part of the premium is to be derived from funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

(3) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

(4) The total amount of insurance payable with respect to an indebtedness shall not exceed the greater of the total of scheduled payments or actual amount of unpaid indebtedness as to the creditor. The insurer may exclude any payments which are delinquent on the date the debtor becomes disabled as defined in the policy.

(5) The insurance may be payable to the creditor or any successor to the right, title and interest of the creditor. Such payment or payments shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of each such payment and any excess of the insurance shall be payable to the insured or the estate of the insured.

(6) Notwithstanding the preceding provisions of this section, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

(66 Del. Laws, c. 175, § 1.)

§ 3504. Labor union or employee organization groups.

A policy may be issued to a labor union, or similar employee organization which shall be deemed to be the policyholder, to insure members of such union or organization for the benefit of persons other than the union or organization or any of its officials, representatives or agents, subject to the following requirements:

(1) The members eligible for insurance under the policy shall be all of the members of the union or organization, or all of any class or classes thereof.

(2) The premium for the policy shall be paid either from funds of the union or organization, or from funds contributed by the insured members specifically for their insurance, or from both. Except as provided in paragraph (3) of this section, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for the insurance must insure all eligible members, except those who reject such coverage in writing.

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(66 Del. Laws, c. 175, § 1.)

§ 3505. Trustee groups.

A policy may be issued to a trust, or to the trustee or trustees of a fund, established or adopted by 2 or more employers, or by 1 or more labor unions or similar employee organizations, or by 1 or more employers and 1 or more labor unions or similar employee organizations, which trust or trustee or trustees shall be deemed the policyholder, to insure employee of the employer or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(1) The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof. The policy may provide that the term “employees” shall include the employees of 1 or more subsidiary corporations, and the employees, individual proprietors and partners of 1 or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term “employees” shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term “employees” shall include retired employees, former employees and directors of a corporate employer. The policy may provide that the term “employees” shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

(2) The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons, or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons from both the insured persons and the employer(s) or union(s) or similar employee organization(s). Except as provided in paragraph (3) of this section, a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing.

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(66 Del. Laws, c. 175, § 1.)

§ 3506. Association groups.

(a) “Bona fide association” means, with respect to health insurance coverage offered in Delaware, an association which:

(1) Has been actively in existence for at least 5 years;

(2) Has been formed and maintained in good faith for purposes other than obtaining insurance and does not condition membership on the purchase of association-sponsored insurance;

(3) Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee) and clearly so states in all membership and application materials;

(4) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member) and clearly so states in all marketing and application materials;

(5) Does not make health insurance coverage offered through the association available other than in connection with a member of the association and clearly so states in all marketing and application materials; and

(6) Provides and annually updates information necessary for the Commissioner to determine whether or not an association meets the definition of a bona fide association before qualifying as a bona fide association for the purposes of this chapter.

(b) An association policy shall be subject to the following requirements:

(1) The policy may insure members of such association or associations, employees thereof or employees of members or 1 or more of the preceding or all of any class or classes thereof for the benefit of persons other than the employer.

(2) The premium for the policy shall be paid from funds contributed by the association or associations or by the employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations or employer members.

(3) A policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing.

(66 Del. Laws, c. 175, § 1; 71 Del. Laws, c. 143, § 15.)

§ 3507. Credit union groups.

A policy may be issued to a credit union or to a trustee or trustees or agent designated by 2 or more credit unions, which credit union, trustee, trustees or agent shall be deemed the policyholder, to insure members of such credit unions for the benefit of persons other than the credit unit or credit unions, trustee or trustees, or agent or any of their officials, subject to the following requirements:

(1) The members eligible for insurance shall be all of the members of the credit union or credit unions, or all of any class or classes thereof.

(2) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in paragraph (3) of this section, must insure all eligible members.

(3) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

(66 Del. Laws, c. 175, § 1.)

§ 3508. Discretionary groups.

A policy may be issued to any other substantially similar group which, in the discretion of the Commissioner, may be subject to the issuance of a group health policy or contract.

(66 Del. Laws, c. 175, § 1.)

§ 3509. Requirements for other groups; out-of-state groups.

(a) Group health insurance offered to a resident of this State under a group health insurance policy issued to a group other than those described in §§ 3502-3508 of this title shall be subject, where applicable, to the requirements of subsections (b)-(e) of this section.

(b) No such group health insurance policy shall be delivered or coverage offered in this State unless the Commissioner finds that:

(1) The issuance of such group policy is not contrary to the best interest of the public;

(2) The issuance of the group policy would result in economies of acquisition or administration;

(3) The benefits are reasonable in relation to the premiums charged; and

(4) The group is not affiliated with or controlled by (as those terms are defined in Chapter 50 of this title) an insurer unless approved by the Commissioner.

(c) No such group health insurance coverage may be offered in this State by an insurer under a policy issued in another state unless this State or another state having requirements substantially similar to those contained in paragraphs (b)(1)-(4) of this section has made a determination that such requirements have been met.

(d) The premium for the policy shall be paid either from the policyholders' funds or from funds contributed by the covered persons or from both.

(e) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(66 Del. Laws, c. 175, § 1; 70 Del. Laws, c. 104, §§ 1-4.)

§ 3510. Disclosure requirements for other groups.

(a) With respect to a program of insurance which if issued on a group basis would not qualify under §§ 3502-3508 of this title, if compensation of any kind will or may be paid to:

(1) A policyholder or sponsoring or endorsing entity in the case of a group policy; or

(2) A sponsoring or endorsing entity in the case of individual blanket or franchise polices marketed by means of direct response solicitation,

then in such cases the insurer shall cause to be distributed to prospective insureds a written notice that compensation will or may be paid.

(b) The written notice required by subsection (a) of this section shall be distributed:

(1) Whether compensation is direct or indirect; and

(2) Whether such compensation is paid to or retained by the policyholder or sponsoring or endorsing entity, or paid to or retained by a third party at the direction of the policyholder or sponsoring or endorsing entity, or any entity affiliated therewith by way of ownership, contract or employment.

(c) The notice required by subsection (a) of this section shall be placed on or accompany any application or enrollment form provided prospective insureds.

(d) As used in this section, the following terms shall have the meanings indicated:

(1) "Direct response solicitation" means a solicitation through a sponsoring or endorsing entity through the mails, telephone or other mass communications media;

(2) "Sponsoring or endorsing entity" means an organization which has arranged for the offering of a program of insurance in a manner which communicates that eligibility for participation in the program is dependent upon affiliation with such organization or that it encourages participation in the program.

(66 Del. Laws, c. 175, § 1.)

§ 3511. Dependents' coverage.

Except for a policy issued under § 3503 of this title, a group health insurance policy may be extended to insure the employees or members with respect to their family members or dependents, or any class or classes thereof, subject to the following:

(1) The premium for the insurance shall be paid either from funds contributed by the employer, union, association or other person to whom the policy has been issued, or from funds contributed by the covered person, or from both. Except as provided in paragraph (2) of this section, a policy on which no part of the premium for the family members' or dependents' coverage is to be derived from funds contributed by the covered persons must insure all eligible employees or members with respect to their family members or dependents, or any class or classes thereof.

(2) An insurer may exclude or limit the coverage on any family member or dependent as to whom evidence of individual insurability is not satisfactory to the insurer.

(66 Del. Laws, c. 175, § 1.)

§ 3512. Group health insurance standard provisions generally.

No policy of group health insurance shall be delivered in this State unless it contains in substance the provisions set forth in §§ 3513-3527 of this title or provisions which in the opinion of the Commissioner are more favorable to persons insured, or at least a favorable to the persons insured and more favorable to the policyholder; provided, however,

(1) That §§ 3517, 3519, 3524, 3528 and 3529 of this title shall not apply to policies insuring persons under § 3503 of this title;

(2) That the standard provisions required for individual health insurance policies shall not apply to group health insurance policies; and

(3) That if any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the Commissioner, shall omit from such policy any inapplicable provision or part of a provision and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(66 Del. Laws, c. 175, § 1.)

§ 3513. Grace period.

A group health insurance policy shall contain a provision that the policyholder is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the policy shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period.

(66 Del. Laws, c. 175, § 1.)

§ 3514. Incontestability.

A group health insurance policy shall contain a provision that the validity of the policy shall not be contested except for nonpayment of premiums, after it has been in force for 2 years from its date of issue; and that no statement made by any person covered under the policy relating to insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of 2 years during such person's lifetime nor unless it is contained in a written instrument signed by the person making such statement; provided, however, that no such provision shall preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy or upon other provisions in the policy.

(66 Del. Laws, c. 175, § 1.)

§ 3515. Application; statements deemed representations.

A group health insurance policy shall contain a provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the person insured shall be deemed representations and not

warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative.

(66 Del. Laws, c. 175, § 1.)

§ 3516. Insurability.

A group health insurance policy shall contain a provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the individual's coverage.

(66 Del. Laws, c. 175, § 1.)

§ 3517. Preexisting conditions; limits [For application of this section, see 79 Del. Laws, c. 99, § 19].

(a) A group health insurance policy shall not include a provision that excludes coverage, and a health insurer shall not deny a claim under the policy, as a result of a disease or physical condition of a person effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy. This subsection shall not apply to accident only; credit; dental; vision; Medicare supplement; benefits for long-term care, home health care, community-based care or any combination thereof; disability income insurance; liability insurance including general liability insurance and automobile liability insurance; coverage for on-site medical clinics; coverage issued as a supplement to liability insurance, worker's compensation or similar insurance; specified disease, hospital indemnity or other limited benefit health insurance policies; or automobile medical payment insurance.

(b) For those policies not subject to subsection (a) of this section, a group health insurance policy shall contain a provision specifying the additional exclusion or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy. Any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the 12 months prior to the effective date of the person's coverage. In no event shall such exclusion or limitation apply to loss incurred or disability commencing after the earlier of:

(1) The end of a continuous period of 12 months commencing on or after the effective date of the person's coverage during all of which the person has received no medical advice or treatment in connection with such disease or physical condition; and

(2) The end of the 2-year period commencing on the effective date of the person's coverage.

(c) Notwithstanding subsection (a) or (b) of this section, a group health insurance policy issued by a health insurer, health service corporation or health maintenance organization shall contain a provision which extends coverage for an insured who is hospitalized on the date coverage terminates for a period of 10 consecutive days during a single period of continuous hospitalization, if coverage terminates for any reason except nonpayment of premium. Benefits shall continue at the same level as provided in the terminated policy for the 10-day period.

(d) Following the termination of the 10-day period set forth in subsection (c) of this section, the succeeding insurer, if any, shall provide benefits for an insured who is hospitalized on the effective date of coverage at the level provided in the policy then in force, notwithstanding any preexisting conditions or other similar exclusions contained in the new policy. This provision applies only to a continuing single period of hospitalization.

(66 Del. Laws, c. 175, § 1; 68 Del. Laws, c. 323, § 2; 79 Del. Laws, c. 99, § 5.)

§ 3518. Misstatement of age.

If the premiums or benefits vary by age, there shall be a provision specifying an equitable adjustment of premiums or of benefits, or both, to be made in the event the age of a covered person has been misstated, such provision to contain a clear statement of the method of adjustment to be used.

(66 Del. Laws, c. 175, § 1.)

§ 3519. Certificate.

A group health insurance policy shall contain a provision that the insurer will issue to the policyholder for delivery to each person insured a certificate setting forth a statement as to the insurance protection to which that person is entitled, to whom the insurance benefits are payable, and a statement as to any family members' or dependents' coverage.

(66 Del. Laws, c. 175, § 1.)

§ 3520. Notice of claim.

A group health insurance policy shall contain a provision that written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

(66 Del. Laws, c. 175, § 1.)

§ 3521. Claim forms.

A group health insurance policy shall contain a provision that the insurer will furnish to the person making claim, or to the policyholder for delivery to such person, such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 15 days after the insurer receives notice of any claim under the policy, the person making such claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

The nonhospital claim form to be used under this provision is the Health Care Financing Administration Form-1500 or its successor. This form requirement shall not apply to medical payments made by the federal government, prescription drug claims, dental claims or claims using an electronic paperless submission process.

(66 Del. Laws, c. 175, § 1; 68 Del. Laws, c. 416, § 2.)

§ 3522. Proofs of loss; disability.

When applicable, a group health insurance policy shall contain a provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within 90 days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within 90 days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than 1 year from the time proof is otherwise required.

(66 Del. Laws, c. 175, § 1.)

§ 3523. Time for payment of benefits.

A group health insurance policy shall contain a provision that all benefits payable under the policy other than benefits for loss of time will be payable not more than 60 days after receipt of proof, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid as soon as possible after receipt of such proof.

(66 Del. Laws, c. 175, § 1.)

§ 3524. Payment of benefits.

A group health insurance policy shall contain a provision that benefits for loss of life of the person insured shall be payable to the beneficiary designated by the person insured. However, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of these benefits is subject to the provisions of the policy in the event no such designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy shall be payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay such benefit, up to an amount not exceeding $5,000, to any relative by blood or connection by marriage of such person who is deemed by the insurer to be equitably entitled thereto.

(66 Del. Laws, c. 175, § 1.)

§ 3525. Physical examinations.

A group health insurance policy shall contain a provision that the insurer shall have the right and opportunity to examine the person or the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy in the case of death where it is not prohibited by law.

(66 Del. Laws, c. 175, § 1.)

§ 3526. Legal actions.

A group health insurance policy shall contain a provision that no action at law or in equity shall be brought to recover on the policy prior to the expiration of 90 days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought at all unless brought within 3 years from the expiration of the time within which proof of loss is required by the policy.

(66 Del. Laws, c. 175, § 1.)

§ 3527. Information to debtors.

In the case of a policy insuring debtors, a group health insurance policy shall contain a provision that the insurer will furnish to the policyholder for delivery to each debtor insured under the policy a certificate of insurance describing the coverage and specifying that the benefits payable shall first be applied to reduce or extinguish the indebtedness.

(66 Del. Laws, c. 175, § 1.)

§ 3528. Direct payment of hospital or medical services.

Any group health policy may provide that all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services may, at the insurer’s option, be paid directly to the hospital or person rendering such services, but

the policy may not require that the service be rendered by a particular hospital or person. Payments so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

(18 Del. C. 1953, § 3504; 56 Del. Laws, c. 380, § 1; 66 Del. Laws, c. 175, § 1.)

§ 3529. Readjustment of premiums; dividends.

Any contract of group health insurance may provide for the readjustment of the rate of premium based upon the experience thereunder. If a policy dividend is hereafter declared or a reduction in rate is hereafter made or continued for the first or any subsequent year of insurance under any policy of group health insurance heretofore or hereafter issued to any policyholder, the excess, if any, of the aggregate dividends or rate reductions under such policy and all other group insurance policies of the policyholder over the aggregate expenditure for insurance under such policies made from funds contributed by the policyholder, or by an employer of insured persons, or by a union or associations which the insured persons belong, including expenditures made in connection with administration of such policies, shall be applied by the policyholder for the sole benefit of insured employees or members.

(18 Del. C. 1953, § 3505; 56 Del. Laws, c. 380, § 1; 66 Del. Laws, c. 175, § 1.)

§ 3530. Limitations on preexisting condition limitations for minor children [Repealed].

(78 Del. Laws, c. 141, § 2; repealed by 82 Del. Laws, c. 186, § 3, effective Aug. 6, 2019.)

Subchapter II

Blanket Health Insurance

§ 3540. "Blanket health insurance" defined.

Blanket health insurance is hereby declared to be that form of health insurance covering groups of persons as enumerated in 1 of the following paragraphs:

(1) Under a policy or contract issued to any common carrier or to any operator, owner or lessee of a means of transportation, who or which shall be deemed the policyholder, covering a group of persons who may become passengers defined by reference to their travel status on such common carrier or such means of transportation;

(2) Under a policy or contract issued to an employer, who shall be deemed the policyholder, covering any group of employees, dependents or guests, defined by reference to specified hazards incident to an activity or activities or operations of the policyholder;

(3) Under a policy or contract issued to a college, school or other institution of learning, a school district or districts or school jurisdictional unit, or to the head, principal or governing board of any such educational unit, who or which shall be deemed the policyholder, covering students, teachers or employees;

(4) Under a policy or contract issued to any religious, charitable, recreational, educational or civic organization, or branch thereof, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to any activity or activities or operations sponsored or supervised by such policyholder;

(5) Under a policy or contract issued to a sports team, camp or sponsor thereof, which shall be deemed the policyholder, covering members, campers, employees, officials or supervisors;

(6) Under a policy or contract issued to any volunteer fire department, first aid, civil defense or other such volunteer organization, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder;

(7) Under a policy or contract issued to a newspaper or other publisher, which shall be deemed the policyholder, covering its carriers;

(8) Under a policy or contract issued to an association, including a labor union, which has a constitution and bylaws, statement of organization or substantially similar document and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder;

(9) Under a policy or contract issued to cover any other risk or class of risks which, in the discretion of the Commissioner, may be properly eligible for blanket health insurance. The discretion of the Commissioner may be exercised on an individual risk basis or class of risks, or both.

(18 Del. C. 1953, § 3506; 56 Del. Laws, c. 380; 66 Del. Laws, c. 175, § 1.)

§ 3541. Filing and required provisions in blanket policies.

Any insurer authorized to write health insurance in this State shall have the power to issue blanket health insurance. No such blanket policy, except as provided in § 2712 of this title, may be issued or delivered in this State unless a copy of the form thereof shall have been filed in accordance with such § 2712 of this title. Every such blanket policy shall contain provisions which in the opinion of the Commissioner are not less favorable to the policyholder and the individual insured than the following:

(1) A provision that the policy, including endorsements, copies of the applications, if any, of the policyholder and the persons insured shall constitute the entire contract between the parties, and that any statement made by the policyholder or by a person insured shall,

in absence of fraud, be deemed a representation and not a warranty and that no such statements shall be used in defense to a claim under the policy, unless contained in a written application. Such person, his or her beneficiary, or assignee, shall have the right to make written request to the insurer for a copy of such application and the insurer shall, within 15 days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request a copy of such application. Such written request shall provide the insurer with the full name and address of the insured, the policyowner and the policy number if known, or the written request shall contain such information that the insurer can reasonably be expected to locate the application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action based upon or involving any statements contained therein.

(2) A provision that written notice of sickness or of injury must be given to the insurer within 20 days after the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

(3) A provision that the insurer will furnish either to the claimant or to the policyholder for delivery to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 15 days after giving of such notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

(4) A provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within 90 days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within 90 days after the date of such loss. Failure to furnish such proof within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

(5) A provision that all benefits payable under the policy other than benefits for loss of time will be payable immediately upon receipt of due written proof of such loss, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable and that any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

(6) A provision that the insurer at its own expense shall have the right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy where it is not prohibited by law.

(7) A provision that no action at law or in equity shall be brought to recover under the policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the policy and that no such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

(18 Del. C. 1953, § 3507; 56 Del. Laws, c. 380, § 1; 66 Del. Laws, c. 175, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3542. Application and certificates not required.

An individual application need not be required from a person covered under a blanket health policy or contract nor shall it be necessary for the insurer to furnish each person a certificate.

(18 Del. C. 1953, § 3508; 56 Del. Laws, c. 380, § 1; 66 Del. Laws, c. 175, § 1.)

§ 3543. Payment of benefits under blanket policy.

All benefits under any blanket health policy or contract shall be payable to the person insured, or to his or her designated beneficiary or beneficiaries, or to his or her estate, except that if the person insured be a minor or otherwise not competent to give a valid release, such benefits may be made payable to his or her parent, guardian or other person actually supporting him or her. Except, however, that the policy may provide that all or a portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services may, at the option of the insurer, and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services, but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the obligation of the insurer with respect to the amount of insurance so paid.

(18 Del. C. 1953, § 3509; 56 Del. Laws, c. 380, § 1; 66 Del. Laws, c. 175, § 1; 70 Del. Laws, c. 186, § 1.)

Subchapter III

Provisions Applicable to Group and Blanket Health Insurance

§ 3550. Newborn children.

All group and blanket health insurance policies providing coverage for a family member of the insured or a subscriber shall, as to such family member's coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly-born child of the insured or subscriber from the moment of birth in accordance with § 3335 of this title.

(59 Del. Laws, c. 529, § 2; 66 Del. Laws, c. 175, § 1.)

§ 3551. Filing of rates.

Except for credit health insurance, the rates of group health insurance and blanket health insurance shall be filed pursuant to and be subject to the requirements of Chapter 25 of this title. Rates for credit health insurance shall be filed pursuant to the requirements of Chapter 37 of this title.

(60 Del. Laws, c. 388, § 4; 66 Del. Laws, c. 175, § 1.)

§ 3552. Cancer screening tests [For application of this section, see 84 Del. Laws, c. 511, § 4].

(a) All group and blanket health insurance policies, which are delivered or issued for delivery in this State by any health insurer or health service corporation, and which provide benefits for outpatient services, shall provide to covered persons residing or having their principal place of employment in this State a benefit for cervical and endometrial cancer screening, commonly known as a "PAP smear." Such screening shall be deemed a covered service, notwithstanding policy exclusions for services which are part of or related to annual or routine examinations.

(b) [Repealed]

(c) All group and blanket health insurance policies which are delivered or issued for delivery in this State by any health insurer or health service corporation and which provide benefits for outpatient services shall provide to covered persons residing or having their principal place of employment in this State a benefit for:

(1) Periodic mammographic examinations on the following schedule:

a. A base line mammogram for asymptomatic women at least age 35, or as otherwise declared appropriate by the Director of the Division of Public Health or the Director's designee from time to time.

b. An annual mammogram for women age 40 and older, regardless of whether a referral is provided by a woman's healthcare provider.

c. [Repealed.]

(2) A mammographic examination prescribed by a physician for any woman based on such physician's evaluation of the woman's physical conditions, symptoms or risk factors indicating a probability of breast cancer higher than the general population.

Such screening shall be deemed a covered service, notwithstanding policy exclusions for services which are part of or related to annual or routine examinations.

The benefit paid for a mammogram as a covered service under this subsection (c) shall not exceed the least expensive cost of a mammogram at a qualified imaging facility located at a fixed location in the county in this State in which the woman resides or in the county in this State where the principal place of employment of the woman, or the employee under whose group or blanket health insurance the woman is covered, is located, or the county in this State in which the woman actually has the mammogram. The cost of the benefit shall include both the facility and radiologist's fees. The least expensive cost for a mammogram determining the maximum benefit under this subsection during each calendar year shall be the least expensive cost as of the first day of such calendar year in each county of the State.

For the purposes of this subsection, "qualified imaging facility" shall mean a diagnostic facility having a certificate or provisional certificate issued by any state agency (of this State or any other state) approved by the Secretary of the Department of Health and Human Services to accredit facilities and issue certificates and provisional certificates for the purposes of the Mammography Quality Standards Act of 1992, 42 U.S.C. § 263b, or having an application for certification filed and pending with such state agency; provided, however, that in the event no such state agency certification program or procedure is in effect under the Mammography Quality Standards Act of 1992 in the state in which the woman has the mammogram performed, "qualified imaging facility" shall mean a diagnostic facility having equipment certified by the American College of Radiology, and being certified by the American College of Radiology or having an application for certification filed and pending with the American College of Radiology.

(d) Nothing in this section shall prevent the operation of such policy provisions as deductibles, coinsurance, allowable charge limitations, coordination of benefits or provisions restricting coverage to services by licensed, certified or carrier-approved providers or facilities.

(66 Del. Laws, c. 281, § 1; 68 Del. Laws, c. 432, § 1; 69 Del. Laws, c. 166, §§ 1, 2; 70 Del. Laws, c. 147, § 26; 70 Del. Laws, c. 186, § 1; 71 Del. Laws, c. 425, § 1; 84 Del. Laws, c. 483, § 2; 84 Del. Laws, c. 511, § 2.)

§ 3552A. Supplemental and diagnostic breast examinations [For application of this section, see 84 Del. Laws, c. 121, § 5].

(a) As used in this section:

(1) "Breast magnetic resonance imaging" or "breast MRI" means a diagnostic tool, including standard and abbreviated breast MRI, that uses radio waves and magnets to produce detailed images of structures within the breast. A breast MRI may be used as a screening tool when clinically indicated, including after indeterminant results from a mammogram that requires additional evaluation and for those at high risk for breast cancer.

(2) "Breast ultrasound" means a noninvasive diagnostic tool that uses high-frequency sound waves and their echoes to produce detailed images of structures within the breast. A breast ultrasound may be used as a screening tool when clinically indicated, including after indeterminant results from a mammogram that requires additional evaluation and for those at high risk for breast cancer.

(3) “Cost-sharing requirement” means a deductible, coinsurance, or copayment and any maximum limitation on the application of such a deductible, coinsurance, copayment, or similar out-of-pocket expense.

(4) “Diagnostic breast examination” means a medically-necessary and clinically-appropriate examination of the breast, including such examination using breast MRI, breast ultrasound, or mammogram, that is used for either of the following:

a. To evaluate an abnormality seen or suspected from a screening examination for breast cancer.

b. To evaluate an abnormality detected by another means of examination.

(5) “Mammogram” means a diagnostic or screening mammography exam using a low-dose X-ray to produce an image of the breast.

(6) “Supplemental breast screening examination” means a medically-necessary and clinically-appropriate examination of the breast, including such examination using breast MRI, breast ultrasound, or mammogram, that is used for either of the following:

a. To screen for breast cancer when there is no abnormality seen or suspected in the breast.

b. Based on personal or family medical history or additional factors that may increase the individual’s risk of breast cancer.

(b) All group and blanket health insurance policies which are delivered or issued for delivery in this State by any health insurer or health service corporation and which provide benefits for outpatient services shall provide coverage for diagnostic breast examinations and supplemental breast screening examinations. The terms of such coverage, including cost-sharing requirements, shall be no less favorable than the cost-sharing requirements applicable to screening mammography for breast cancer.

(c) This section does not apply to any of the following:

(1) A high deductible health plan if providing coverage under subsection (b) of this section would cause the plan to fail to be treated as a high deductible health plan under § 223(c)(2) of the Internal Revenue Code [26 U.S.C. § 223(c)(2)].

(2) A specified accident, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit health insurance policy.

(84 Del. Laws, c. 121, § 1.)

§ 3552B. Prostate cancer screening [For application of this section, see 84 Del. Laws, c. 511, § 4].

(a) For purposes of this section, “prostate screening” means a medically-necessary and clinically-appropriate method for the detection and diagnosis of prostate cancer, including a digital rectal exam and prostate specific antigen test, and associated laboratory work.

(b) All group and blanket health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State shall provide coverage for prostate screenings at no cost to a covered individual, including deductible payments and cost-sharing amounts charged once a deductible is met. In accordance with the American Cancer Society guidelines, coverage shall begin at:

(1) Age 50 for men at average risk of developing prostate cancer.

(2) Age 45 for men at high risk for developing prostate cancer, including African American men and men who have a first-degree relative diagnosed with prostate cancer.

(3) Age 40 for men at even higher risk for prostate cancer, including men who have more than 1 first-degree relative diagnosed with prostate cancer.

(c) Except as provided under subsection (b) of this section, nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(d) (1) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.

(2) a. The cost-sharing limitation under subsection (b) of this section does not apply to a high deductible health plan to the extent this cost-sharing limitation would cause the plan to fail to be treated as a high deductible health plan under § 223(c)(2) of the Internal Revenue Code [26 U.S.C. § 223(c)(2)].

b. If the cost-sharing limitation under subsection (b) of this section would result in an enrollee becoming ineligible for a health savings account under federal law, this cost-sharing limitation only applies to a qualified high deductible health plan after the enrollee’s deductible has been met.

(84 Del. Laws, c. 511, § 3.)

§ 3553. Midwife services reimbursement.

(a) This section shall apply to every group or blanket policy, contract or certificate issued thereunder, of health or sickness or accident insurance delivered or issued for delivery within the State which meets the requirements of subsection (d) of this section.

(b) This section shall apply to all such policies, contracts, certificates or programs issued, renewed, modified, altered, amended or reissued on or after September 9, 1988.

(c) The section shall apply to all private and public programs for health services and facilities reimbursement, including but not limited to any such reimbursement programs operated by the State.

(d) Whenever an insurance policy, contract or certificate or health services reimbursement program provides for reimbursement for any health-care service which is within those areas of practice for which a midwife may be licensed pursuant to § 122 of Title 16 or pursuant to statute in the state where the service is delivered, or for the cost of birthing facilities, the insured or any other person covered by the policy, contract or certificate, or health services or facilities reimbursement program shall be entitled to reimbursement for such service or use of the facilities performed by a duly licensed certified nurse midwife practicing within those areas for which the certified nurse midwife is licensed in the state where the licensed certified nurse midwife is practicing. Whenever such service is performed by a licensed certified nurse midwife and reimbursed by a professional health services plan corporation, the licensed certified nurse midwife shall be granted such rights of participation, plan admission and registration as may be granted by the professional health services plan corporation, to a physician or osteopath performing such a service. When payment is made for health-care services performed by a licensed certified nurse midwife, no payment or reimbursement shall be payable to a physician or osteopath for the services performed by the licensed certified nurse midwife.

(e) For the purposes of this section, "midwifery" shall only include those having the following qualifications:

(1) Age of 21 years or older;

(2) Licensed as a registered professional nurse in the State;

(3) Possesses a valid certification by the American College of Nurse Midwives;

(4) Submits a sworn statement that he or she has not been convicted of a felony; been professionally penalized or convicted of substance addiction; had a professional nursing license suspended or revoked in this or another state; been professionally penalized or convicted of fraud; is physically and mentally capable of engaging in the practice of midwifery; and

(5) Has formed an alliance which is defined as a relationship between a midwife and a physician or physicians licensed to practice medicine or osteopathy in Delaware whereby medical consultation and referral, available on a 24-hour basis, is agreed upon in writing, signed by both parties, and filed with the Department of Health and Social Services.

(66 Del. Laws, c. 331, § 2; 70 Del. Laws, c. 149, § 204.)

§ 3553A. Coverage for doula services.

(a) "Doula services" means services provided by a trained doula and designed to provide physical, emotional, and educational support to pregnant and birthing persons, before, during, and after childbirth. "Doula services" include the following:

(1) Support and assistance during labor and childbirth.

(2) Prenatal and postpartum support and education.

(3) Breastfeeding assistance and lactation support.

(4) Parenting education.

(5) Support for a birthing person following loss of pregnancy.

(b) All group and blanket health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State after December 31, 2025, shall provide coverage for doula services, when provided by a doula who is certified by the Delaware Certification Board, that includes all of the following:

(1) Three prenatal visits of up to 90 minutes.

(2) Three postpartum visits of up to 90 minutes.

(3) Attendance through labor and birth.

(c) Coverage must be provided for additional postpartum doula visits with a recommendation from a practitioner or clinician licensed under Title 24 acting within their scope of practice.

(d) (1) Nothing in this section prevents the operation of policy provisions such as deductibles, coinsurance, allowable charge limitations, or coordination of benefits.

(2) Carriers may require doulas to be certified or registered in the same manner required by the Division of Medicaid and Medical Assistance under § 530 of Title 31.

(e) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.

(84 Del. Laws, c. 420, § 2.)

§ 3554. Lead poison screening reimbursement [For application of this section, see 83 Del. Laws, c. 75, § 9].

(a) All group and blanket insurance policies, which are delivered or issued for delivery in this State by any health insurer, health service corporation, health maintenance organization, or any health services and facilities reimbursement program operated by the State which provide a benefit for outpatient services shall provide a benefit for a baseline lead poisoning screening or testing, as defined in § 2601 of Title 16.

(b) Benefits must also be provided for lead poisoning screening, testing, diagnostic evaluations, screening and testing supplies, and home visits for children who are at high risk for lead poisoning under guidelines and criteria established by the Division of Public Health.

(c) The benefits required under subsections (a) and (b) of this section are a covered service, notwithstanding any policy exclusions for services which are part of, or related to, annual or routine examinations.

(d) Nothing in this section prevents the operation of policy provisions such as deductibles, coinsurance allowable charge limitations, coordination of benefits, or provision restricting coverage to services rendered by licensed, certified, or carrier-approved providers or facilities.

(e) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, or other limited health insurance policies.

(69 Del. Laws, c. 310, § 3; 83 Del. Laws, c. 75, § 7.)

§ 3555. Coverage of cancer monitoring and screening tests [For application of this section, see 84 Del. Laws, c. 254, § 4].

(a) All group and blanket health insurance policies, which are delivered or issued for delivery in this State by any health insurer, health service corporation or health maintenance organization, and which provide benefits for outpatient services, shall provide to covered persons residing or having their principal place of employment in this State, a benefit for monitoring tests for ovarian cancer subsequent to treatment and annual screening tests for women at risk for ovarian cancer. Such monitoring or screening tests shall be deemed a covered service. The terms of such coverage, including cost-sharing requirements, shall be no less favorable than the terms of coverage, including cost-sharing requirements, applicable to screening mammography for breast cancer.

(b) This section does not apply to a high deductible health plan if providing coverage under subsection (a) of this section would cause the plan to fail to be treated as a high deductible health plan under § 223(c)(2) of the Internal Revenue Code [26 U.S.C. § 223(c)(2)].

(c) If, at any time, the State is required under federal law to defray the cost of any coverage required under this section, the requirements under this section are inoperative and the State does not assume any obligation for the cost of coverage.

(d) For purposes of this section:

(1) "At risk for ovarian cancer" means any of the following:

a. Having a family history of any of the following:

1. One or more first- or second-degree relatives with ovarian cancer.
2. Clusters of women relatives with breast cancer.
3. Nonpolyposis colorectal cancer.
4. Breast cancer in a male relative.

b. Testing positive for any of the following genetic mutations:

1. BRCA1 or BRCA2.
2. Lynch syndrome.

c. Having a personal history of any of the following:

1. Ovarian cancer.
2. Endometriosis.
3. Unexplained infertility.
4. Uterine fibroids.
5. Polycystic ovarian syndrome.

(2) "Cost-sharing requirement" means a deductible, coinsurance, or copayment and any maximum limitation on the application of such a deductible, coinsurance, payment, or similar out-of-pocket expense.

(3) "Monitoring tests" and "screening tests" mean tests or examinations for ovarian cancer using any of the following methods that are recommended by a patient's physician:

a. Tumor marker tests supported by national clinical guidelines, national standards of care, or peer-reviewed medical literature.

b. Transvaginal ultrasound.

c. Pelvic examination.

d. Other screening tests supported by national clinical guidelines, national standards of care, or peer reviewed medical literature.

(69 Del. Laws, c. 405, § 2; 84 Del. Laws, c. 254, § 2.)

§ 3555A. Equal reimbursement for oral and intravenous anticancer medication.

(a) Every group or blanket policy or contract of health insurance, or certificate issued thereunder, which is delivered, issued for delivery, renewed, modified, altered, or amended in this State on or after January 1, 2013, and which provides medical, major medical, or similar comprehensive-type coverage, and provides coverage for prescription drugs, and which also provides coverage for anticancer medication, must provide coverage for a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells, and must apply the lower cost sharing of either:

(1) Anticancer medication under the prescription drug benefit, or

(2) Intravenous or injected anticancer medications.

For purposes of this section, the term "cost sharing" may include co-pays, coinsurance, and deductibles, as considered appropriate by the Commissioner.

(b) An insurer who provides coverage under this section and any participating entity through which the insurer offers health services may not:

(1) Vary the terms of the policy for the purpose of or with the effect of avoiding compliance with this section;

(2) Provide incentives, monetary or otherwise, to encourage a covered person to accept less than the minimum protections available under this section;

(3) Penalize in any way or reduce or limit the compensation of a healthcare practitioner for recommending or providing care to a covered person in accordance with this section;

(4) Provide incentives, monetary or otherwise, to a healthcare practitioner relating to the services provided pursuant to this section, intended to induce or have the effect of inducing the practitioner to provide care to a covered person in a manner inconsistent with this section; or

(5) Achieve compliance with this section by imposing an increase in cost sharing for an oral, intravenous, or injected anticancer medication covered under the policy on and following May 1, 2012.

(c) Nothing in this section may be interpreted to prohibit an insurer from requiring prior authorization for any anticancer treatment.

(d) Nothing in this section may be interpreted to require coverage for anticancer medication.

(78 Del. Laws, c. 233, § 2.)

§ 3555B. Coverage of drugs approved for treatment of certain cancers [For application of this section, see 81 Del. Laws, c. 180, §§ 3 and 4; 84 Del. Laws, c. 338, 3].

(a) No group or blanket policy or contract of health insurance, or certificate issued thereunder, which is delivered, issued for delivery, renewed, modified, altered, or amended in this State that directly or indirectly covers the treatment of cancer shall limit or exclude coverage for a drug approved by the United States Food and Drug Administration by mandating that the insured shall first be required to fail to successfully respond to a different drug or drugs or prove a history of failure of a different drug or drugs; provided, however that the use of such drug or drugs is consistent with best practices for the treatment of stage 4 advanced, metastatic cancer or in the case of other cancers, the use of the drug is supported by national clinical guidelines, national standards of care, or for the treatment of the cancer, or in the case of targeted therapy, the target at issue.

(b) No group or blanket policy or contract of health insurance, or certificate issued thereunder, which is delivered, issued for delivery, renewed, modified, altered, or amended in this State that directly or indirectly cover the associated conditions of metastatic cancer shall limit or exclude coverage for drugs approved by the United States Food and Drug Administration by mandating that the insured shall first be required to fail to successfully respond to a different drug or drugs or prove a history of failure of a different drug or drugs; provided, however that the use of such drug is consistent with best practices for the treatment of the associated conditions of metastatic cancer and is supported by national clinical guidelines, national standards of care, or peer reviewed medical literature.

(c) For purposes of this section, “associated conditions” mean the symptoms or side effects associated with metastatic cancer or its treatment and which, in the judgment of the health-care practitioner, further jeopardizes the health of a patient if left untreated.

(81 Del. Laws, c. 180, § 2; 84 Del. Laws, c. 338, § 2.)

§ 3556. Obstetrical and gynecological coverage.

(a) This section applies to every group or blanket policy or contract of health insurance, or certificate issued thereunder, which is delivered or issued for delivery in this State that requires an insured, participant, policyholder, subscriber or beneficiary to designate a participating primary care provider.

(b) Any such policy or contract shall permit each female enrolled insured, participant, policyholder, subscriber or beneficiary to designate a participating, in-network, obstetrician-gynecologist as the enrollee’s primary care provider if:

(1) The obstetrician-gynecologist meets the standards established by the insurance plan for primary care providers;

(2) The obstetrician-gynecologist requests that the insurer makes the obstetrician-gynecologist available for designation as a primary care provider;

(3) The obstetrician-gynecologist agrees to accept the payment terms applicable under the plan to primary care providers for services other than obstetrician-gynecological services; and

(4) The obstetrician-gynecologist agrees to abide by all other terms and conditions applicable to primary care physicians under the plan generally.

(c) If a female enrolled insured, participant, policyholder, subscriber or beneficiary has designated a primary care provider who is not an obstetrician-gynecologist, then the policy or contract shall not require as a condition to the coverage of the services of a participating in-network obstetrician-gynecologist that a female enrollee first obtain a referral from another primary care physician, and shall permit the female enrolled insured, participant, policyholder, subscriber or beneficiary to have direct access to the health-care services of an in-network obstetrician-gynecologist participating in the plan, within the benefits provided under that plan. In such cases the obstetrician-gynecologist shall consult with the primary care physician with respect to the care given and any follow-up care, and the plan may require a visit to the primary care physician, if necessary, before the patient may be directed to another specialty provider, or for inpatient hospitalization or outpatient surgical procedures.

(d) For purposes of this section, “health-care services” means the full scope of medically necessary services provided by the participating obstetrician-gynecologist within the benefits provided under that plan.

(e) This section shall not be construed to require an individual obstetrician-gynecologist to accept primary care physician status if the obstetrician-gynecologist does not wish to be designated as a primary care physician, nor to interfere with the credentialing and other selection criteria usually applied by a health benefit plan with respect to other physicians within its network.

(f) Any such policy or contract may not impose a copayment, coinsurance requirement or deductible for directly accessed obstetric and gynecologic services as required in this section, unless such additional cost sharing is imposed for access to health-care practitioners for other types of health-care services.

(g) If a policy or contract limits an insured’s access to a network of participating providers for other health-care services, then it may limit access for obstetric and gynecologic services, but the policy or contract shall include in all its provider networks sufficient numbers of obstetrician-gynecologists to accommodate the direct access needs of their female enrollees.

(h) Each such policy or contract shall provide notice to female enrolled participants, policyholders, subscribers and beneficiaries regarding the coverage required by this chapter. The notice shall be in writing, printed in type not less than 8 points, and prominently positioned in any literature or correspondence, including benefit handbooks and enrollment materials. Policies or contracts shall include an explanation of any voluntary process of preauthorization of services available to female enrollees and obstetrician-gynecologists. The enrollee handbook explanation shall include information regarding any limitation to direct access, including, but not limited to, a closed network of providers, or any limitation on access to an obstetrician-gynecologist based on a female’s choice of primary care provider.

(i) (1) For purposes of this subsection:

a. “Iatrogenic infertility” means an impairment of fertility due to surgery, radiation, chemotherapy, or other medical treatment.

b. “Infertility” means a disease or condition that results in impaired function of the reproductive system whereby an individual is unable to procreate or to carry a pregnancy to live birth, including the following:

1. Absent or incompetent uterus.

2. Damaged, blocked, or absent fallopian tubes.

3. Damaged, blocked, or absent male reproductive tract.

4. Damaged, diminished, or absent sperm.

5. Damaged, diminished, or absent oocytes.

6. Damaged, diminished, or absent ovarian function.

7. Endometriosis.

8. Hereditary genetic disease or condition that would be passed to offspring.

9. Adhesions.

10. Uterine fibroids.

11. Sexual dysfunction impeding intercourse.

12. Teratogens or idiopathic causes.

13. Polycystic ovarian syndrome.

14. Inability to become pregnant or cause pregnancy of unknown etiology.

15. Two or more pregnancy losses, including ectopic pregnancies.

16. Uterine congenital anomalies, including those caused by diethylstilbestrol (“DES”).

c. “Standard fertility preservation services” means procedures consistent with established medical practices and professional guidelines published by professional medical organizations, including the American Society for Clinical Oncology and the American Society for Reproductive Medicine.

(2) All group and blanket health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State by any health insurer, health service corporation, or health maintenance organization and that provide for medical or hospital expenses shall include coverage for fertility care services, including in vitro fertilization services for individuals who suffer from a disease or condition that results in the inability to procreate or to carry a pregnancy to live birth and standard fertility preservation services for individuals who must undergo medically necessary treatment that may cause iatrogenic infertility. Such benefits must be provided to covered individuals, including covered spouses and covered nonspouse dependents, to the same extent as other pregnancy-related benefits and include the following:

a. Intrauterine insemination.

b. Assisted hatching.

c. Cryopreservation and thawing of eggs, sperm, and embryos.

d. Cryopreservation of ovarian tissue.

e. Cryopreservation of testicular tissue.

f. Embryo biopsy.

g. Consultation and diagnostic testing.

h. Fresh and frozen embryo transfers.

i. Six completed egg retrievals per lifetime, with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine, using single embryo transfer ("SET") when recommended and medically appropriate.

j. In vitro fertilization ("IVF"), including IVF using donor eggs, sperm, or embryos, and IVF where the embryo is transferred to a gestational carrier or surrogate.

k. Intra-cytoplasmic sperm injection ("ICSI").

l. Medications.

m. Ovulation induction.

n. Storage of oocytes, sperm, embryos, and tissue.

o. Surgery, including microsurgical sperm aspiration.

p. Medical and laboratory services that reduce excess embryo creation through egg cryopreservation and thawing in accordance with an individual's religious or ethical beliefs.

(3) An individual qualifies for coverage under this subsection if all of the following requirements are met:

a. A board-certified or board-eligible obstetrician-gynecologist, subspecialist in reproductive endocrinology, oncologist, urologist, or andrologist verifies that the covered individual is diagnosed with infertility or is at risk of iatrogenic infertility.

b. When the covered individual is diagnosed with infertility, the covered individual has not been able to obtain a successful pregnancy through reasonable effort with less costly infertility treatments covered by the policy, contract, or certificate, except as follows:

1. No more than 3 treatment cycles of ovulation induction or intrauterine inseminations may be required before in vitro fertilization services are covered.

2. If IVF is medically necessary, no cycles of ovulation induction or intrauterine inseminations may be required before in vitro fertilization services are covered.

3. IVF procedure must be performed at a practice that conforms to American Society for Reproductive Medicine and American Congress of Obstetricians and Gynecologists guidelines.

c. For IVF services, retrievals are completed before the individual is 45 years old and transfers are completed before the individual is 50 years old.

(4) A policy, contract, or certificate may not impose any exclusions, limitations, or other restrictions on coverage of fertility medications that are different from those imposed on any other prescription medications, nor may it impose deductibles, copayments, coinsurance, benefit maximums, waiting periods, or any other limitations on coverage for required fertility care services, which are different from those imposed upon benefits for services not related to infertility.

(5) A religious employer may request and an entity subject to this subsection shall grant an exclusion from coverage for the coverage required under this subsection in a policy, contract, or certificate if the required coverage conflicts with the religious organization's bona fide religious beliefs and practices. A religious employer that obtains an exclusion under this subsection shall provide its employees reasonable and timely notice of the exclusion.

(6) Employers who self-insure or who have fewer than 50 employees are exempt from the requirements of this subsection.

(7) A policy, contract, or certificate is not required to cover experimental fertility care services, monetary payments to gestational carriers or surrogates, or the reversal of voluntary sterilization undergone after the covered individual successfully procreated with the covered individual's partner at the time the reversal is desired.

(71 Del. Laws, c. 178, § 2; 70 Del. Laws, c. 186, § 1; 81 Del. Laws, c. 284, § 2.)

§ 3556A. Primary care coverage [For applicability of section, see 84 Del. Laws, c. 25, § 2].

(a) For purposes of this section:

(1) a. "Carrier" means any entity that provides health insurance in this State. "Carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

b. "Carrier" does not mean a plan of health insurance or health benefits designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act (42 U.S.C. §§ 1395 et seq., 1396 et seq. and 1397aa. et seq.), known as Medicare, Medicaid, or any other similar coverage under state or federal governmental plans.

(2) "Chronic care management" means the services in the Chronic Care Management Services Program, as administered by the Centers for Medicare and Medicaid Services, and includes Current Procedural Terminology ("CPT") codes 99487, 99489, and 99490.

(3) "Medicare" means the federal Medicare Program (U.S. Public Law 89-87, as amended) (42 U.S.C. § 1395 et seq.).

(4) "Primary care" means health care provided by a physician or an individual licensed under Title 24 to provide health care, with whom the patient has initial contact and by whom the patient may be referred to a specialist and includes family practice, pediatrics, internal medicine, and geriatrics.

(b) (1) A carrier shall provide coverage for chronic care management and primary care at a reimbursement rate that is not less than the Medicare reimbursement for comparable services.

(2) This subsection applies to a group health insurance policy, plan, or contract that is delivered, issued for delivery, or renewed by a carrier on or after January 1, 2019.

(3) A carrier shall do the following:

a. By 2022, spend at least 7% of its total cost of medical care on primary care.

b. By 2023, spend at least 8.5% of its total cost of medical care on primary care.

c. By 2024, spend at least 10% of its total cost of medical care on primary care.

d. By 2025, spend at least 11.5% of its total cost of medical care on primary care.

e. By 2026 and each year thereafter, spend at least 11.5%, 5% of which must be via prospective primary care management payments, of its total cost of medical care on primary care.

(c) If a comparable Medicare reimbursement rate is not available, a carrier shall reimburse for services at the rates generally available under Medicare for services such as office visits and prolonged preventive services, which may be further delineated by regulation.

(d) (1) The Department shall arbitrate disagreements regarding rates under this section. The parties must pay the cost of the arbitration.

(2) The Department shall adopt regulations to implement the requirements of this subsection no later than March 31, 2019.

(e) The provisions of this section may not be waived by contract. Any contractual arrangement in conflict with the provisions of this section or that purports to waive any requirements of this section is void.

(f) Coverage for chronic care management must not be subject to patient deductibles, copayments, or fees.

(g) (1) A carrier shall offer value-based care programs that meet the program design element requirements issued by the Department by the first full plan year following the Department's promulgation of regulations pursuant to § 334 of this title.

(2) A carrier may not deny a contracted provider the opportunity to participate in an offered value-based care program if the provider is willing to accept the terms and conditions established for other providers as a condition of program participation.

(h) In calculating total cost of medical care for purposes of this section, the Commissioner shall, by regulation, authorize the exclusion of high-cost claims and may authorize the exclusion of other costs actually incurred by carriers.

(81 Del. Laws, c. 392, § 6; 82 Del. Laws, c. 141, § 24; 83 Del. Laws, c. 237, §§ 6, 14; 84 Del. Laws, c. 25, § 1; 85 Del. Laws, c. 348, §§ 7, 8.)

§ 3557. Child abuse or neglect — Group coverage.

No group or blanket policy, contract or certificate issued thereunder, of health insurance which provides medical coverage for a child and which:

(1) Covers a child who resides in this State; or

(2) Is delivered or issued for delivery within the State

shall limit medical insurance coverage for any child referred by the Division of Family Services or law enforcement agency for suspected child abuse or neglect, including requiring referral by a primary physician.

(71 Del. Laws, c. 199, § 17.)

§ 3558. Immunizations and preventive services.

(a) This section applies to any health carrier providing coverage under an individual or group health benefit plan.

(1) This section does not apply to grandfathered plan coverage.

(2) For purposes of this section, "grandfathered plan coverage" means coverage provided by a health carrier in which an individual was enrolled on March 23, 2010, for as long as it maintains that status in accordance with federal regulations.

(3) This section shall not apply to accident-only, specified diseases, hospital, indemnity, disability income or other fixed indemnity policies.

(b) A health carrier shall provide coverage for the following items and services. A health carrier shall not impose any costs, such as a copayment, coinsurance or deductible with respect to the following items and services:

(1) Except as otherwise provided in this section, evidence-based items or services that had a rating of A or B in the recommendations of the United States Preventive Services Task Force that were in effect on January 1, 2025, with respect to the individual involved.

(2) Immunizations for routine use in children, adolescents and adults that were recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention in effect on January 1, 2025, or other immunizations that were supported by national clinical guidelines or national standards of care in effect on January 1, 2025, with respect to the individual involved. For purposes of this paragraph, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention.

(3) With respect to infants, children and adolescents, evidence-informed preventive care, and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration in effect on January 1, 2025.

(4) With respect to women, to the extent not described in paragraph (b)(1) of this section, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration in effect on January 1, 2025.

(c) [Repealed.]

(d) Other provisions of state or federal law may apply in connection with a health carrier's ceasing to provide coverage for any such items or services including § 2715(d)(4) of the Public Health Service Act [42 U.S.C. § 300gg-15(d)(4)], which requires a health carrier to give 60 days' advance notice to a covered person before any material modification will become effective.

(e), (f) [Repealed.]

(g) A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in this section is billed separately or is tracked as individual encounter data separately from the office visit.

(h) A health carrier shall not impose cost-sharing requirements with respect to an office visit if an item or service described in this section is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the item or service.

(i) A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in this section is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service.

(j) Nothing in this section requires a health carrier that has a network of providers to provide benefits for items and services described herein that are delivered by an out-of-network provider.

(k) Nothing in this section precludes a health carrier that has a network of providers from imposing cost-sharing requirements for items or services described herein that are delivered by an out-of-network provider.

(l) Nothing in this section prohibits a health carrier from using reasonable medical management techniques to determine the frequency, method, treatment or setting for an item or service described herein to the extent not specified in the recommendation or guideline.

(m) Nothing in this section prohibits a health carrier from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided by guidelines supported by the Health Resources and Services Administration. A health carrier may impose cost-sharing requirements for a treatment not described in this section even if the treatment results from an item or service described herein.

(78 Del. Laws, c. 194, § 2; 70 Del. Laws, c. 186, § 1; 85 Del. Laws, c. 419, § 2.)

§ 3559. Contraceptive coverage.

(a) For purposes of this section:

(1) "Carrier" means any entity that provides health insurance in this State. "Carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(2) "FDA" means the Food and Drug Administration.

(3) a. "Health benefit plan" means any hospital or medical policy or certificate, major medical expense insurance, health service corporation subscriber contract, or health maintenance organization subscriber contract. "Health benefit plan" does not include accident-only, credit, dental, vision, Medicaid plans, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical payment insurance.

b. "Health benefit plan" does not include policies or certificates of specified disease, hospital confinement indemnity, or limited benefit health insurance, if the carrier offering such policies or certificates has done the following:

1. Filed on or before March 1 of each year a certification with the Commissioner that contains the following statement:

A. A statement from the carrier certifying that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance.

B. A summary description of each policy or certificate described in this paragraph, including the average annual premium rates or range of premium rates in cases where premiums vary by age, gender, or other factors charged for such policies and certificates in this State.

2. In the case of a policy or certificate that is described in this paragraph (a)(3)b. and that is offered for the first time in this State on or after January 1, 1999, the carrier files with the Commissioner the information and statement required in this paragraph (a)(3)b. at least 30 days prior to the date such a policy or certificate is issued or delivered in this State.

(4) "Therapeutic equivalent" means a contraceptive drug, device, or product that is all of the following:

a. Approved as safe and effective.

b. Pharmaceutically equivalent to another contraceptive drug, device, or product in that it contains an identical amount of the same active drug ingredient in the same dosage form and route of administration and meets compendial or other applicable standards of strength, quality, purity, and identity.

c. Assigned, by the FDA, the same therapeutic equivalence code as another contraceptive drug, device, or product.

(b) Carriers shall provide coverage for contraceptive methods in all health benefit plans delivered or issued for delivery in this State. Coverage for contraceptive methods must include all of the following:

(1) All FDA-approved contraceptive drugs, devices, and other products as follows:

a. If the FDA has approved 1 or more therapeutic equivalents of a contraceptive drug, device, or product, the health benefit plan is not required to include all such therapeutically equivalent versions in its formulary as long as at least 1 is included and covered without cost-sharing and in accordance with this section.

b. If there is a therapeutic equivalent of a drug, device, or other product for an FDA-approved contraceptive method, the health benefit plan may provide coverage for more than 1 drug, device, or other product and may impose cost-sharing requirements as long as at least 1 drug, device, or other product for that method is available without cost-sharing. If, however, an individual's attending provider recommends a particular FDA-approved contraceptive based on a medical determination with respect to that individual, regardless of whether the contraceptive has a therapeutic equivalent, the health benefit plan shall provide coverage for the prescribed contraceptive drug, device, or product without cost-sharing.

c. The health benefit plan is not required to provide coverage for male condoms.

(2) FDA-approved contraception available over-the-counter, including emergency contraception, whether with or without a prescription, or dispensed consistent with the requirements of Chapter 25 of Title 24.

(3) A prescription for contraceptives intended to last for no more than a 12-month period which may be dispensed all at once or over the course of the 12-month period, regardless of whether the covered individual was enrolled in the health benefit plan under this chapter at the time the prescription contraceptive was first dispensed.

(4) Voluntary female sterilization procedures.

(5) Patient education and counseling on contraception.

(6) Follow-up services related to the drugs, devices, products, and procedures covered under this subsection, including management of side effects, counseling for continued adherence, and device insertion and removal.

(7) Immediate postpartum insertion of long-acting reversible contraception.

(c) (1) Coverage provided under this section is not subject to any deductible, coinsurance, copayment, or any other cost-sharing requirement, except under paragraph (b)(1) of this section or as otherwise required under federal law. Coverage offered under this section may not impose unreasonable restrictions or delays in the coverage, except that reasonable medical management techniques may be applied to coverage within a method category, as defined by the FDA, but not across types of methods.

(2) Coverage provided to a covered individual under this section shall be the same for the covered individual's covered spouse and covered dependents.

(d) This section does not preclude coverage for contraceptive drugs, devices, products, and procedures as prescribed by a provider for reasons other than contraceptive purposes, including decreasing the risk of ovarian cancer, eliminating symptoms of menopause, or providing contraception that is necessary to preserve the life or health of the covered individual.

(e) The plan is not required under this section to cover experimental or investigational treatments.

(f) A religious employer may request and an entity subject to this section shall grant an exclusion from coverage under the policy, plan, or contract for the coverage required under this section for the insertion and removal and medically necessary examination associated with the use of FDA-approved drugs or devices if the required coverage conflicts with the religious organization's bona fide religious beliefs and practices. A religious employer that obtains an exclusion under this subsection shall provide its employees reasonable and timely notice of the exclusion.

(72 Del. Laws, c. 311, § 1; 70 Del. Laws, c. 186, § 1; 73 Del. Laws, c. 89, § 5; 81 Del. Laws, c. 323, § 2; 84 Del. Laws, c. 374, § 2.)

§§ 3559A-3559C. Insurance coverage for diabetes; annual pap smear coverage reimbursement; colorectal cancer screening.

Transferred to present §§ 3560 to 3562 by 73 Del. Laws, c. 89, § 5, effective June 30, 2001.

§ 3560. Insurance coverage for diabetes.

(a) Every individual or group hospital service corporation contract, individual or group medical service corporation contract, individual or group health service corporation contract, individual health insurance policy, group health insurance policy, and contract for health-care services that provides hospital services, outpatient services, or medical expense benefits and provides coverage for prescription drugs, and is delivered, issued, executed or renewed in this State pursuant to this title or is approved for issuance or renewal in this State by

the Insurance Commissioner shall provide benefits to any subscriber or other person covered thereunder for expenses incurred for the following equipment and supplies for the treatment of diabetes if recommended in writing or prescribed by a physician: insulin pumps, blood glucose meters and strips, urine testing strips, insulin, syringes, and pharmacological agents for controlling blood sugar strips, insulin, syringes, and pharmacological agents for controlling blood sugar.

(b) The benefits required by this section shall be provided to the same extent as for any other sickness under the contract.

(c) This section shall apply to all hospital service corporation contracts in which the hospital service corporation has reserved the right to change the premium.

(d) The Insurance Commissioner may promulgate and periodically update a list of additional diabetes equipment and related supplies that are medically necessary for the treatment of diabetes and for which benefits shall be provided according to the provisions of this section.

(e) This section shall apply to all contracts and policies issued, renewed, modified, altered, amended or reissued 90 days and thereafter from June 30, 2000.

(f) Nothing in this section shall apply to accident-only, specified disease, hospital indemnity, Medicare supplement long-term care, disability income or other limited benefit health insurance policies.

(72 Del. Laws, c. 376, § 1; 73 Del. Laws, c. 89, § 5.)

§ 3560A. Cost sharing in prescription insulin drugs.

(a) For purposes of this section, "prescription insulin drug" means a drug containing insulin that is dispensed under Chapter 47 of Title 16 for the treatment of diabetes.

(b) A group or blanket health insurance policy, contract, or certificate that is delivered, issued for delivery, renewed, extended, or modified in this State that provides coverage for prescription insulin drugs must do all of the following:

(1) Cap the total amount that a covered individual is required to pay for covered prescription insulin drugs at no more than $100 per month for each enrolled individual, regardless of the amount or types of insulin needed to fill the covered individual's prescriptions. The $100 per month cap includes deductible payments and cost-sharing amounts charged once a deductible is met.

(2) Include at least 1 formulation of each of the following types of prescription insulin drugs on the lowest tier of the drug formulary developed and maintained by the carrier:

a. Rapid-acting.

b. Short-acting.

c. Intermediate-acting.

d. Long-acting.

(3) For purposes of paragraph (b)(2) of this section, the "lowest tier of the drug formulary" means either of the following:

a. If the prescription insulin drug is a generic drug, the lowest tier for generic drugs.

b. If the prescription insulin drug is a brand-name drug, the lowest tier for brand-name drugs.

(c) Except as provided under paragraph (b)(1) of this section, nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(d) This section applies to all policies, contracts, or certificates issued, renewed, modified, altered, amended, or reissued after December 31, 2020.

(82 Del. Laws, c. 250, § 2.)

§ 3560B. Coverage for insulin pumps.

(a) For purposes of this section, "insulin pump" means a small, portable medical device that is approved by the U.S. Food and Drug Administration to provide continuous subcutaneous insulin infusion.

(b) All group and blanket health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State shall provide coverage for a medically-necessary insulin pump at no cost to a covered individual, including deductible payments and cost-sharing amounts charged once a deductible is met.

(c) Except as provided under subsection (b) of this section, nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(d) This section does not apply to any of the following:

(1) Accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.

(2) A high deductible health plan if providing coverage under subsection (b) of this section would cause the plan to fail to be treated as a high deductible health plan under § 223(c)(2) of the Internal Revenue Code [26 U.S.C. § 223(c)(2)].

(e) This section applies to all policies, contracts, or certificates issued, renewed, modified, altered, amended, or reissued after December 31, 2021.

(83 Del. Laws, c. 241, § 2.)

§ 3560C. Cost sharing in diabetes equipment and supplies.

(a) For purposes of this section, "diabetes equipment and supplies" means blood glucose meters and strips, urine testing strips, syringes, continuous glucose monitors and supplies, and insulin pump supplies.

(b) A health insurance policy, contract, or certificate that is delivered, issued for delivery, renewed, extended, or modified in this State that provides coverage for any diabetes equipment or supplies must cap the total amount that a covered individual is required to pay for diabetes equipment and supplies at no more than $35 per month for each enrolled individual, regardless of the amount or types of diabetes equipment or supplies needed to fill the individual's prescriptions. The $35 per month cap includes deductible payments and cost-sharing amounts charged once a deductible is met, except that the $35 cap does not apply to deductible payments charged by high deductible health plans or catastrophic health plans.

(c) Except as provided under subsection (b) of this section, nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(d) This section does not apply to any of the following:

(1) Accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.

(2) A high deductible health plan if providing coverage under subsection (b) of this section would cause the plan to fail to be treated as a high deductible health plan under § 223(c)(2) of the Internal Revenue Code (26 U.S.C. § 223(c)(2)).

(3) A catastrophic health plan if providing coverage under subsection (b) of this section would cause the plan to fail to be treated as a catastrophic plan under § 1302(e) of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18022(e).

(e) This section applies to all policies, contracts, or certificates issued, renewed, modified, altered, amended, or reissued after December 31, 2023.

(83 Del. Laws, c. 521, § 2.)

§ 3561. Annual pap smear coverage reimbursement.

All group and blanket health insurance policies which are delivered or issued for delivery in this State by any health insurer, health service corporation, health maintenance organization or any health services and facilities reimbursement program operated by the State and which provide a benefit for outpatient services shall also provide a benefit for an annual benefit for 1 cervical cancer screening, known as a "pap smear," for all females aged 18 and over.

This section shall apply to all policies, contracts, certificates or programs issued, renewed, modified, altered, amended or reissued on or after January 1, 2001.

(72 Del. Laws, c. 408, § 2; 73 Del. Laws, c. 61, § 2; 73 Del. Laws, c. 89, § 5.)

§ 3562. Colorectal cancer screening.

(a) All group and blanket health insurance policies which are delivered or issued for delivery or renewed in this State on or after January 1, 2001, by any health insurer or health service corporation shall provide coverage for colorectal cancer screening.

(b) Colorectal cancer screening covered by this section shall include:

(1) For persons 50 years of age or older screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging or other screening modalities, shall be provided as determined by the Secretary of Health and Social Services of this State after consideration of recommendations of the Delaware Cancer Consortium and the most recently published recommendations established by the American College of Gastroenterology, the American Cancer Society, the United States Preventive Task Force Services for the ages, family histories and frequencies referenced in such recommendations and deemed appropriate by the attending physician.

(2) For persons who are deemed at high risk for colon cancer because of:

a. Family history of familial adenomatous polyposis;

b. Family history of hereditary nonpolyposis colon cancer;

c. Chronic inflammatory bowel disease;

d. Family history of breast, ovarian, endometrial, colon cancer or polyps; or

e. A background, ethnicity or lifestyle such that the health-care provider treating the participant or beneficiary believes he or she is at elevated risk;

screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging or other screening modalities, or other screening modalities, shall be provided as determined by the Secretary of Health

and Social Services of this State after consideration of recommendations of the Delaware Cancer Consortium and the most recently published recommendations established by the American College of Gastroenterology, the American Cancer Society, the United States Preventive Task Force Services for the ages, family histories and frequencies referenced in such recommendations and deemed appropriate by the attending physician.

(3) For all persons covered pursuant to paragraph (b)(1) or (b)(2) of this section, colorectal cancer screening shall include the use of anesthetic agents, including general anesthesia, in connection with colonoscopies and endoscopies performed in accordance with generally-accepted standards of medical practice and all applicable patient safety laws and regulations, if the use of such anesthetic agents is medically necessary in the judgment of the treating physician.

(72 Del. Laws, c. 416, § 2; 70 Del. Laws, c. 186, § 1; 73 Del. Laws, c. 89, § 5; 76 Del. Laws, c. 338, §§ 3, 4; 76 Del. Laws, c. 406, § 2.)

§ 3563. Required coverage for reconstructive surgery following mastectomy.

(a) All group and blanket health insurance policies, contracts or certificates that are delivered or issued for delivery in this State by any health insurer, health service corporation or managed care organization which provide medical and surgical benefits with respect to a mastectomy shall provide, in a case of an insured, participant, policyholder, subscriber and beneficiary who is receiving benefits in connection with such mastectomy, in a manner determined in consultation with the attending physician and the patient, coverage for:

(1) All stages of reconstruction of the breast on which the mastectomy has been performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) Prostheses and physical complications of mastectomy, including lymphedemas.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan of coverage. Written notice of the availability of such coverage shall be delivered to the insured, participant, policyholder, subscriber and beneficiary upon enrollment and annually thereafter.

(b) All group and blanket health benefit plans shall provide notice to each insured, participant, policyholder, subscriber and beneficiary under such plan regarding the coverage required by this section in accordance herewith. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan and shall be transmitted:

(1) In the next mailing made by the plan to the insured, participant, policyholder, subscriber and beneficiary;

(2) As part of any yearly informational packet sent to the insured, participant, policyholder, subscriber and beneficiary;

(3) Not later than June 30, 2001, whichever is earliest.

(c) A group or blanket health benefit plan may not deny to a patient eligibility or continued eligibility to enroll or to renew coverage under the terms of the plan solely for the purpose of avoiding the requirements of this section, and may not penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, or induce such provider to provide care to an individual insured, participant, policyholder, subscriber and beneficiary in a manner inconsistent with this section.

(d) Nothing in this section shall be construed to prevent a group health benefit plan from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

(73 Del. Laws, c. 89, § 1.)

§ 3564. Referrals.

(a) This section applies to every group or blanket policy or contract of health insurance, including each policy or contract issued by a health service corporation, which is delivered or issued for delivery in this State and which designates network physicians or providers or preferred physicians or providers (hereinafter referred to collectively as “network providers”).

(b) All individual and group health insurance policies shall provide that if medically necessary covered services are not available through network providers, or the network providers are not available within a reasonable period of time, the insurer, on the request of a network provider, within a reasonable period, shall allow referral to a non-network physician or provider and shall reimburse the non-network physician or provider at a previously agreed-upon or negotiated rate. In such circumstances, the non-network physician or provider may not balance bill the insured. Such a referral shall not be refused by the insurer absent a decision by a physician in the same or a similar specialty as the physician to whom a referral is sought that the referral is not reasonably related to the provision of medically necessary services.

(c) All individual and group health insurance policies which do not allow insureds to have direct access to health-care specialists shall establish and implement a procedure by which insureds can obtain a standing referral to a health-care specialist.

(d) The procedure established under subsection (c) of this section:

(1) Shall provide for a standing referral to a specialist if the insured’s network provider determines that the insured needs continuing care from the specialist; and

(2) May require the insurer’s approval of an initial treatment plan designed by the specialist containing:

a. A limit on the number of visits to the specialist;

b. A time limit on the duration of the referral; and

c. Mandatory updates on the insured's condition.

Such approval shall not be withheld absent a decision by a qualified physician that the treatment sought in the treatment plan is not reasonably related to the appropriate treatment of the insured's condition.

Within the treatment period referred to in paragraph (d)(2) of this section, the specialist shall be permitted to treat the insured without a further referral from the insured's network provider and may authorize such further referrals, procedures, tests and other medical services as the individual's network provider would otherwise be permitted to provide or authorize, provided that such further referrals, procedures, tests and other medical services are part of treating the patient for the condition for which the patient was referred to the specialist. Referrals, procedures, tests and other medical services referred to in this subsection shall be provided by network providers unless such services are not available through network providers, or the network providers are not available within a reasonable period of time. If services are not available through network providers, or the network providers are not available within a reasonable period of time, the out-of-network provider shall be reimbursed at an agreed-upon or negotiated rate. In such circumstances, the non-network provider may not balance bill the insured.

(e) Nothing in this section shall prevent the operation of policy provisions involving deductibles or copayments.

(73 Del. Laws, c. 96, § 8; 73 Del. Laws, c. 315, § 8.)

§ 3565. Emergency care.

(a) This section applies to every group or blanket policy or contract of health insurance, including each policy or contract issued by a health service corporation, which is delivered or issued for delivery in this State and which designates network physicians or providers or preferred physicians or providers (hereinafter referred to collectively as "network providers"). However, this section applies only to conditions for which coverage is provided by those policies or contracts.

(b) All individual and group health insurance policies shall provide that persons covered under those policies will be insured for emergency care services performed by non-network providers at an agreed-upon or negotiated rate, regardless of whether the physician or provider furnishing the services has a contractual or other arrangement with the insurer to provide items or services to persons covered under the policies. In the event that the provider of emergency services and the insurer cannot agree upon the appropriate rate, the provider shall be entitled to those charges and rates allowed by the Insurance Commissioner or the Commissioner's designee following an arbitration of the dispute. The Insurance Commissioner shall adopt regulations concerning the arbitration of such disputes. In such circumstances, the non-network provider may not balance bill the insured.

(c) Prior to a determination by the Insurance Commissioner's (or the Commissioner's designee) of those charges and rates allowed by the providers of emergency services pursuant to subsection (b) of this section, the insurer will pay directly to the non-network emergency care provider the highest allowable charge for each emergency care service allowed by the insurer for any other network or non-network emergency care provider during the full 12-month period immediately prior to the date of each emergency care service performed by the non-network provider. The Insurance Commissioner is authorized to adopt regulations concerning the provisions of this subsection (c).

(d) Plans described in subsections (a) and (b) of this section shall cover:

(1) Any medical screening examination or other evaluation medically required to determine whether an emergency medical condition exists;

(2) Necessary emergency care services, including treatment and stabilization of an emergency medical condition; and

(3) Services originated in a hospital emergency facility or comparable facility following treatment or stabilization of an emergency medical condition as approved by the insurer with respect to services performed by non-network providers, provided that the insurer is required to approve or disapprove coverage of poststabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of services and the condition of the patient, but in no case to exceed 1 hour from the time of the request.

(e) Nothing in this section shall prevent the operation of policy provisions involving deductibles or copayments. As used in this section "emergency medical condition" means a medical or behavioral condition the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

(2) Serious impairment to such person's bodily functions;

(3) Serious impairment or dysfunction of any bodily organ or part of such person; or

(4) Serious disfigurement of such person.

(f) This section shall not apply to services provided by a volunteer fire department recognized as such by the State Fire Prevention Commission.

(g) The Insurance Commissioner shall establish a schedule of fees for arbitration. The nonprevailing party at arbitration shall reimburse the Commissioner for the expenses related to the arbitration process. Funds paid to the Insurance Commissioner under this subsection shall

be placed in the arbitration fund and shall be used exclusively for the payment of appointed arbitrators. The Insurance Commissioner may, in the Commissioner's discretion, impose a schedule of maximum fees that can be charged by an arbitrator for a given type of arbitration.

(73 Del. Laws, c. 96, § 9; 70 Del. Laws, c. 186, § 1; 73 Del. Laws, c. 315, §§ 3, 12; 78 Del. Laws, c. 111, § 2.)

§ 3565A. Required coverage for volunteer ambulance company services.

(a) For the purpose of this section:

(1) "Ambulance run" means a volunteer ambulance company response to dispatched calls for service.

(2) "Basic life support (BLS)" shall have the same meaning as set forth in § 9702 of Title 16.

(3) "Volunteer ambulance company" means a nonprofit ambulance company that is certified by the State Fire Prevention Commission and is providing basic life support (BLS) services.

(b) Every individual health insurance policy, contract, certificate, or plan which is delivered or issued for delivery in this State by any health insurer, health service corporation, health maintenance organization, or managed care organization shall include coverage of not less than the cost of every ambulance run and associated basic life support (BLS) services provided by a volunteer ambulance company, inclusive of an allowance for uncompensated service, whether in the form of:

(1) An allowable charge;

(2) Through 100% payment; or

(3) Any combination of the foregoing.

(c) In the event that the volunteer ambulance company and the health insurer, health service corporation, health maintenance organization, or managed care organization cannot agree upon the allowable charge or the amount of payment to be made for an ambulance run and associated basic life support (BLS) services, then the volunteer ambulance company shall be entitled to those charges and rates allowed by the Insurance Commissioner or the Commissioner's designee following an arbitration of the dispute.

(1) The Insurance Commissioner shall adopt regulations concerning the arbitration of such disputes.

(2) The Insurance Commissioner shall establish a schedule of fees for arbitration. The nonprevailing party at arbitration shall reimburse the Commissioner for the expenses related to the arbitration process. Funds paid to the Insurance Commissioner under this subsection shall be placed in the arbitration fund and shall be used exclusively for the payment of appointed arbitrators. The Insurance Commissioner may, in the Commissioner's discretion, impose a schedule of maximum fees that can be charged by an arbitrator for a given type of arbitration.

(d) Prior to the determination by the Insurance Commissioner, or the Commissioner's designee, of the allowable charge or the amount of payment to be made for an ambulance run and associated basic life support (BLS) services, the health insurer, health service corporation, health maintenance organization, or managed care organization will pay directly to the volunteer ambulance company the charge assessed by the volunteer ambulance company for the run and basic life support (BLS) services provided, which shall not be subject to reimbursement after the Commissioner's determination. The Insurance Commissioner is authorized to adopt regulations concerning the provisions of this subsection.

(e) Nothing in this section shall prevent the operation of policy provisions involving deductibles or copayments.

(f) This section shall not apply to policies that exclusively cover the following, and do not provide expense or reimbursement coverage for ambulance runs and associated basic life support (BLS) services provided by a volunteer ambulance company:

(1) Hospital confinement indemnity;

(2) Disability income;

(3) Long-term care;

(4) Medicare supplement;

(5) Specified disease indemnity;

(6) Individual and group supplemental health insurance; or

(7) Other limited benefit policies, to the extent the policies do not cover ambulance runs and associated basic life support (BLS) services provided by a volunteer ambulance company.

(g) Notwithstanding subsections (a)-(e) of this section, managed care organizations that contract with the State shall be exempt from this section with regard to that portion of their plans that serve Medicaid and Delaware Healthy Children Program recipients.

(h) This section shall apply to all policies, contracts, certificates, or plans issued, renewed, modified, altered, amended, or reissued on or after January 1, 2015.

(79 Del. Laws, c. 435, § 2.)

§ 3566. Prescription medication.

(a) This section applies to every group or blanket policy or contract of health insurance, including each policy or contract issued by a health service corporation, which is delivered or issued for delivery in this State and which provides coverage for outpatient prescription drugs.

(b) Every group or blanket policy or contract of health insurance described in subsection (a) of this section shall provide coverage for any outpatient drug prescribed to treat a covered person for a covered chronic, disabling or life-threatening illness if the drug:

(1) Has been approved by the Food and Drug administration for at least 1 indication; and

(2) Is recognized for treatment of the indication for which the drug is prescribed in:

a. A prescription drug reference compendium approved by the Insurance Commissioner for purposes of this section; or

b. Substantially accepted peer reviewed medical literature.

(c) Coverage of a drug required by this section shall include coverage of medically necessary services associated with administration of the drug.

(d) This section does not require coverage for:

(1) Medication that may be obtained without a physician's prescription;

(2) Experimental drugs not otherwise approved for the proposed use or indication by the Food and Drug Administration; or

(3) Any disease, condition, service or treatment that is excluded from coverage under the policy.

(e) Nothing in this section shall prevent the operation of policy provisions involving deductibles, coinsurance, allowable charge limitations, maximum dollar policy limitations or coordination of benefits.

(73 Del. Laws, c. 96, § 10; 73 Del. Laws, c. 315, § 5.)

§ 3566A. Copayment or coinsurance for prescription drugs limited [For application of this section, see 82 Del. Laws, c. 57, § 3; and 83 Del. Laws, c. 522, § 4].

(a) *Definitions.* — (1) "Carrier" means any entity that provides health insurance in this State. "Carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(2) "Contract price" means the lowest price a pharmacy is paid for the acquisition of a prescription drug based on a contract that a pharmacy has with a carrier or pharmacy benefits manager. "Contract price" includes a dispensing fee set by a contract between a pharmacy and a carrier or pharmacy benefits manager.

(3) "Cost-sharing requirement" means any copayment, coinsurance, deductible, or annual limitation on cost-sharing (including a limitation subject to 42 U.S.C. §§ 18022(c) and 300gg-6(b)), required by or on behalf of an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health benefit plan.

(4) "Health benefit plan" means as defined in § 3343 of this title.

(5) "Health care service" means an item or service furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

(6) "Person" means as defined in § 102 of this Title.

(7) "Pharmacy" means as defined in § 2502 of Title 24.

(8) "Pharmacy benefit manager" means as defined under § 3302A of this title.

(b) *Application.* —

This section applies to a carrier that provides coverage, either directly or through a pharmacy benefits manager, for prescription drugs under a health insurance policy, health benefit plan, or contract that is issued or delivered in this State.

(c) A carrier subject to this section may not impose a copayment or coinsurance requirement for a covered prescription drug that exceeds the lesser of one of the following:

(1) The applicable copayment or coinsurance that would apply for the prescription drug in the absence of this section.

(2) The amount an individual would pay for the prescription drug if the individual were paying the usual and customary price.

(3) The contract price for the prescription drug.

(d) *Cost-sharing calculation.* —

When calculating an enrollee contribution to any applicable cost-sharing requirement, a carrier shall include any cost-sharing amounts paid by the enrollee or on behalf of the enrollee by another person. If under federal law, application of this requirement would result in health savings account ineligibility under § 223 of the federal Internal Revenue Code [26 U.S.C. § 223], this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under [26 U.S.C.] § 223, except with respect to items or services that are preventive care pursuant to [26 U.S.C.] § 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of this subsection shall apply regardless of whether the minimum deductible under [26 U.S.C.] § 223 has been satisfied.

(e) *Rule-making.* —

The Insurance Commissioner may promulgate rules and regulations as may be necessary or appropriate to implement and administer this section.

(82 Del. Laws, c. 57, § 2; 83 Del. Laws, c. 522, § 2.)

§ 3567. Clinical trials.

(a) *Definitions.* — (1) "Clinical trials" for purposes of this section include clinical trials that are approved or funded by use of the following entities:

a. One of the National Institutes of Health (NIH);

b. An NIH Cooperative Group or center which is a formal network of facilities that collaborate or research projects and have an established NIH-approval peer review program operating within the group. This includes, but is not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;

c. The federal Departments of Veterans' Affairs or Defense;

d. An institutional review board of an institution in this State that has a multiple project assurance contract approval by the Office of Protection for the Research Risks of the NIH; and

e. A qualified research entity that meets the criteria for NIH Center Support grant eligibility.

(2) "Routine patient care costs," as used in this section, include all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

a. The investigational items or service itself;

b. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patients; and

c. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

(3) Any clinical trial receiving coverage for routine costs under the provisions of this act must meet the following requirements:

a. The subject or purpose of the trial must be the evaluation of an item or service that falls within the covered benefits of the policy and is not specifically excluded from coverage.

b. The trial must not be designed exclusively to test toxicity or disease pathophysiology.

c. The trial must have therapeutic intent.

d. Trials of therapeutic interventions must enroll patients with diagnosed disease.

e. The principal purpose of the trial is to test whether the intervention potentially improves the participant's health outcomes.

f. The trial is well supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use.

g. The trial does not unjustifiably duplicate existing studies.

h. The trial is in compliance with federal regulations relating to the protection of human subjects.

(b) Every group or blanket policy of health insurance which is delivered or issued for delivery in this State, including each policy or contract issued by a health service corporation, shall provide coverage for routine patient care costs as defined in paragraph (a)(2) of this section for covered persons engaging in clinical trials for treatment of life threatening diseases. Nothing in this section, however, independently requires coverage for expense of such clinical trials which are otherwise not covered under the policy or contract.

(73 Del. Laws, c. 96, § 11.)

§ 3567B. Experimental treatment coverage.

(a) No group or blanket policy or contract of health insurance or certificate issued thereunder which is delivered, issued for deliver, or renewed in this State shall deny coverage, payment, or reimbursement for a National Coverage Determination Service on the basis that the service, item, test, or treatment is experimental or investigational.

(b) "National Coverage Determination Service" as used in this section shall mean a service, item, test, or treatment which has been determined to be covered nationally by the Secretary of the U.S. Department of Health and Human Services pursuant to the Social Security Act, § 1869 (f) [42 U.S.C. § 1395ff].

(81 Del. Laws, c. 266, § 2.)

§ 3568. Newborn and infant hearing screening; coverage and reimbursement.

(a) Any group or blanket insurance health insurance policy which is delivered, issued for delivery, renewed, extended, or modified in this State by any health-care insurer and which provides coverage for a child shall be deemed to provide coverage for hearing loss screening tests of newborns and infants provided by a hospital before discharge.

(b) The amount of reimbursement for newborn or infant hearing screening provided under such a policy shall be consistent with reimbursement of other medical expenses under the policy, including the imposition of co-payment, coinsurance, deductible, or any dollar limit or other cost-sharing provisions otherwise applicable under the policy.

(75 Del. Laws, c. 116, § 3.)

§ 3569. Use of Social Security numbers on insurance cards.

(a) As used in this section, "insurance card" means a card that a person or entity provides to an individual so that the individual may present the card to establish the eligibility of the individual or the individual's dependents to receive health, dental, optical, or

accident insurance benefits, prescription drug benefits, or benefits under a managed care plan or a plan provided by a health maintenance organization, a health services plan corporation, or a similar entity.

(b) No person or entity which provides an insurance card shall use an individual's Social Security number as the identification number on that insurance card.

(75 Del. Laws, c. 179, § 2; 70 Del. Laws, c. 186, § 1.)

§ 3570. Supplemental coverage for children of insureds [For application of this section, see 79 Del. Laws, c. 99, § 19].

(a) *Definitions.* — As used in this section:

(1) "Carrier" means any entity that provides health insurance in this State. For the purposes of this section, "carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(2) "Covered person" means a person who claims to be entitled to receive benefits from a carrier.

(3) "Dependent" means a covered person's child by blood or by law who is less than 26 years of age.

(b) If a carrier's contract with a subscriber provides coverage for a covered person's dependent under which coverage of the dependent terminates at a specific age before the dependent's twenty-sixth birthday, the contract must nevertheless provide coverage to the dependent after that specific age until the dependent's twenty-sixth birthday.

(c) Subsection (b) of this section may not be construed to require:

(1) Coverage for services provided to a dependent prior to May 30, 2007;

(2) That an employer pay all or part of the cost of coverage for a dependent as provided pursuant to this section; or

(3) Coverage for services rendered prior to a dependent's election pursuant to subsection (e) of this section and payment of premium required under subsection (g) of this section.

(d) A dependent covered by a covered person's contract, where coverage under the contract's language would terminate at a specific age before the dependent's twenty-sixth birthday, may make a written election for coverage as a dependent pursuant to this section, until the dependent's twenty-sixth birthday. The election must be made:

(1) Within 30 days prior to the termination of coverage at the specific age provided in the contract's language;

(2) Within 30 days after meeting the requirements for dependent status as set forth in subsection (a) of this section, when coverage for the dependent under the contract's language had previously terminated; or

(3) During an open enrollment period, as provided pursuant to the contract, if the dependent meets the requirements for dependent status as set forth in subsection (a) of this section during the open enrollment period.

Coverage for a dependent who makes a written election for coverage may not be conditioned upon or discriminate on the basis of lack of evidence of insurability.

(e) Notwithstanding the time limitations imposed by subsection (d) of this section, until May 30, 2008, a dependent who qualifies for dependent status as set forth in subsection (a) of this section, but whose coverage as a dependent under a covered person's contract terminated under the terms of the contract prior to May 30, 2007, may make a written election to reinstate coverage under that contract as a dependent pursuant to this section.

(f) Coverage for a dependent who makes a written election for coverage pursuant to subsection (d) of this section consists of coverage which is identical to the coverage that would have been provided to that dependent had that dependent not been terminated from the contract due to the dependent's age.

(g) A covered person's contract may require payment of a premium by the covered person or dependent, subject to any approvals required by Delaware law, for any period of coverage relating to a dependent's written election for coverage pursuant to subsection (d) of this section. The payment may not exceed 102% of the applicable portion of the premium previously paid for that dependent's coverage under the contract prior to the termination of coverage at the specific age provided in the contract.

(h) The applicable portion of the premium previously paid for a dependent's coverage under subsection (g) of this section is determined pursuant to regulations promulgated by the Department of Insurance, based upon the difference between the contract's rating tiers for adult and dependent coverage or family coverage, as appropriate, and single coverage, or based upon any other formula or dependent rating tier which provides a substantially similar result and is considered appropriate by the Department of Insurance.

(i) Coverage for a dependent provided pursuant to this section must be provided until the earlier of the following:

(1) The dependent is no longer a dependent as defined in subsection (a) of this section;

(2) The date on which coverage ceases under the contract by reason of a failure to make a timely payment of any premium required under the contract by the covered person or dependent for coverage provided pursuant to this section. The payment of any premium is considered to be timely if made within 30 days after the due date or within a longer period as provided for by the contract; or

(3) The date upon which the employer under whose contract coverage is provided to a dependent ceases to provide coverage to the covered person.

(j) Prominent notice regarding coverage for a dependent as provided pursuant to this section must be provided to a covered person by the carrier:

(1) In the certificate of coverage prepared for covered persons by the carrier on or about the date of commencement of coverage; and

(2) Upon each renewal, but at least once annually; and

(3) By June 29, 2007.

(75 Del. Laws, c. 419, § 2; 70 Del. Laws, c. 186, § 1; 78 Del. Laws, c. 159, § 2; 79 Del. Laws, c. 99, §§ 6, 7.)

§ 3570A. Autism spectrum disorders coverage.

(a) All group and blanket health benefit plans as defined in § 3578(a) of this title shall provide coverage for the screening and diagnosis of autism spectrum disorders and the treatment of autism spectrum disorders in individuals less than 21 years of age. To the extent that the diagnosis of autism spectrum disorders and the treatment of autism spectrum disorders are not already covered by a health benefit plan, coverage under this section shall be included in health benefit plans that are delivered, issued, executed or renewed in this State pursuant to this title after December 11, 2012. No insurer shall terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to a group solely because an individual in that group or a family member of an individual in that group is diagnosed with 1 of the autism spectrum disorders or has received treatment for autism spectrum disorders. Coverage under this section shall not be denied on the basis that the treatment is habilitative or nonrestorative in nature.

(b) Coverage for applied behavior analysis services under this section by an insurer shall be subject to a maximum benefit of $36,000 per 12-month period per person, but shall not be subject to any limits on the number of visits an individual may make to an autism services provider, or that a provider may make to an individual, regardless of the locations in which services are provided. After December 31, 2012, the Insurance Commissioner shall, on or before April 1 of each calendar year, publish in the Delaware Register of Regulations an adjustment to the maximum benefit equal to the change in the United States Department of Labor Consumer Price Index for all Urban Consumers (CPI-U) in the preceding year and the published adjusted maximum benefit shall be applicable to all health insurance policies issued or renewed thereafter. Payments made by an insurer on behalf of a covered individual for treatment unrelated to applied behavior analysis shall not be applied toward any maximum benefit established under this subsection.

(c) The coverage required under this section shall not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally under the health benefit plan, except as otherwise provided in subsection (b) of this section.

(d) This section shall not be construed as limiting benefits that are otherwise available to an individual or family member under their health benefit plan.

(e) As used in this section:

(1) “Applied behavior analysis” means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(2) “Autism services provider” means any person, entity, or group authorized by this section that provides treatment of autism spectrum disorders. This includes licensed physicians, psychologists or their assistants, psychiatrists, speech therapists or their aides, occupational therapists or their aides, physical therapists or their assistants, practitioners with the national certification of board-certified behavior analyst or those working under their supervision, licensed professional counselors of mental health, licensed clinical social workers, advanced practice nurses, or any person, entity, or group meeting the standards set by the Department of Health and Social Services as authorized by subsection (f) of this section.

(3) “Autism spectrum disorders” means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including Autistic Disorder, Asperger’s Disorder and Pervasive Developmental Disorder Not Otherwise Specified, as such may be amended hereafter from time to time.

(4) “Behavioral health treatment” means professional counseling, guidance services or treatment programs, including applied behavior analysis, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. This definition also applies to treatment or counseling to improve social skills and function.

(5) “Medically necessary” means reasonably expected to do the following:

a. Prevent the onset of an illness, condition, injury, or disability;

b. Reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or

c. Assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individuals of the same age.

(6) “Pharmacy care” means medications prescribed by a licensed practitioner and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

(7) “Psychiatric care” means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

(8) “Psychological care” means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices or by a psychological assistant acting under the supervision of a psychologist.

(9) “Screening and diagnosis of autism spectrum disorders” means medically necessary assessments, evaluations, or tests to diagnose whether an individual has or is at risk for 1 of the autism spectrum disorders.

(10) “Therapeutic care” means services provided by speech, occupational, or physical therapists or an aide or assistant under their supervision.

(11) “Treatment for autism spectrum disorders” shall include the following care prescribed or ordered for an individual diagnosed with 1 of the autism spectrum disorders by a licensed physician or licensed psychologist who determines the care to be medically necessary:

a. Behavioral health treatment;

b. Pharmacy care;

c. Psychiatric care;

d. Psychological care;

e. Therapeutic care;

f. Items and equipment necessary to provide, receive, or advance in the above-listed services, including those necessary for applied behavioral analysis; and

g. Any care for individuals with autism spectrum disorders that is determined by the Secretary of the Department of Health and Social Services, based upon their review of best practices and/or evidence-based research, to be medically necessary. The Secretary shall inform the Insurance Commissioner of such determination, and upon receiving notice the Insurance Commissioner shall issue a bulletin stating that any such care, treatment, intervention, service, or item that was not previously covered shall be included in any health benefit plan delivered, executed, issued, amended, adjusted, or renewed on or after 120 days following the date of such bulletin.

(f) The Department of Health and Social Services shall promulgate regulations establishing standards for certifying qualified autism services providers by June 11, 2013. If an autism services provider meets recognized national certification as a board-certified behavior analyst, such autism services provider shall be deemed to have met the standards to be established under this section to provide applied behavioral analysis services. Once the regulations are promulgated, payment for the treatment of autism spectrum disorders covered under this section shall only be required to be made to autism services providers who meet the standards.

(g) Except for inpatient services, if an individual is receiving treatment for autism spectrum disorders, an insurer will have the right to request a review of that treatment not more than once every 12 months unless the insurer and the licensed physician or licensed psychologist agree that a more frequent review is necessary. The cost of obtaining any review shall be borne by the insurer.

(h) This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan (IFSP); an individualized education program (IEP); an individual plan for employment (IPE); a 504 plan; or an individualized service plan, including an essential lifestyle plan (ELP).

(i) The Insurance Commissioner may promulgate rules and regulations as may be necessary or appropriate to implement and administer this section, except for subsection (f) of this section.

(78 Del. Laws, c. 398, § 3; 81 Del. Laws, c. 29, § 2.)

§ 3571. Phenylketonuria (PKU) and other inherited metabolic diseases.

(a) *Definitions.* — In this section the following words shall have the meanings indicated:

(1) “Inherited metabolic diseases” shall mean diseases caused by an inherited abnormality of biochemistry. The words “inherited metabolic diseases” shall also include any diseases for which the State screens newborn babies.

(2) a. “Low protein modified formula or food product” means a formula or food product that is:

1. Specially formulated to have less than 1 gram of protein per serving; and

2. Intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease.

b. “Low protein modified food product” does not include a natural food that is naturally low in protein.

(3) “Medical formula or food” means a formula or food that is:

a. Intended for the dietary treatment of an inherited metabolic disease for which nutritional requirements and restrictions have been established by medical research; and

b. Formulated to be consumed or administrated enterally under the direction of a physician.

(b) *Application of this section.* — The provisions of this section shall apply to any health insurance contract that:

(1) Provides coverage for a family member of the insured; and

(2) Is delivered or issued for delivery in the State.

(c) A health insurance contract shall, under the family member coverage, include coverage for medical formulas and foods and low protein modified formulas and modified food products for the treatment of inherited metabolic diseases, if such medical formulas and foods or low protein modified formulas and food products are:

(1) Prescribed as medically necessary for the therapeutic treatment of inherited metabolic diseases, and

(2) Administered under the direction of a physician.

(76 Del. Laws, c. 176, § 2.)

§ 3571A. Hearing aid coverage.

(a) For purposes of this section, the term "hearing aid" means any nonexperimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, but excluding batteries, cords, and other assistive listening devices such as FM systems.

(b) Every group and blanket health insurance contract, including each policy or contract issued by a health service corporation, which is delivered, issued for delivery, or renewed in this State on or after January 1, 2009, shall provide coverage of up to $1000 per individual hearing aid, per ear, every 3 years, for children less than 24 years of age, covered as a dependent by the policy holder.

(c) The insured may choose a hearing aid exceeding $1,000 and pay the difference in cost above the amount of coverage required by this section. Reimbursement shall be provided according to the respective principles and policies of the insurer. The insurer may require the policyholder to provide a prescription or show proof through other suitable documentation of the need for a hearing aid and nothing contained in this section shall preclude the insurer from conducting managed care, medical necessity, or utilization review or prevent the operation of such policy provisions as deductibles, coinsurance, allowable charge limitations, coordination of benefits or provisions restricting coverage to services by licensed, certified or carrier-approved providers or facilities.

(d) This section does not apply to insurance coverage providing benefits for:

(1) Hospital confinement indemnity;

(2) Disability income;

(3) Accident only;

(4) Long-term care;

(5) Medicare supplement;

(6) Limited benefit health;

(7) Specified diseased indemnity;

(8) Sickness or bodily injury or death by accident or both; and

(9) Other limited benefit policies.

(76 Del. Laws, c. 244, § 2.)

§ 3571B. Required coverage for scalp hair prosthesis.

(a) All group and blanket health insurance policies, contracts or certificates that are delivered or issued for delivery in this State by any health insurer, health service corporation or managed care organization which provide for medical or hospital expenses and also provide coverage for other prostheses, shall provide coverage for expenses for a scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata, resulting from an autoimmune disease. Such coverage shall be subject to the same limitations and guidelines as other prostheses, provided that such coverage for alopecia areata shall not exceed $500 per year.

(b) For purposes of this section:

(1) "Prostheses" means artificial appliances used to replace lost natural structures. Prostheses include, but are not limited to, artificial arms, legs, breasts, or glass eyes.

(2) "Scalp hair prosthesis" means artificial substitutes for scalp hair that are made specifically for a specific individual.

(c) Such coverage may be subject to annual deductibles and co-insurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan of coverage. Written notice of the availability of such coverage shall be delivered to the insured, participant, policyholder, subscriber and beneficiary upon enrollment and annually thereafter.

(d) All group and blanket health benefit plans shall provide notice to each insured, participant, policyholder, subscriber and beneficiary under such plan regarding the coverage required by this section in accordance herewith. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan and shall be transmitted as part of any yearly informational packet sent to the insured, participant, policyholder, subscriber and beneficiary.

(76 Del. Laws, c. 314, § 2.)

§ 3571C. Dental services for children with a severe disability.

(a) *Definitions.* — As used in this section:

(1) "Child with a severe disability" means a person under the age of 21 who, due to a significant mental or physical condition, illness, or disease, is likely to require specialized treatment or supports to secure effective access to dental care. The written certification of a child's treating physician, advanced practice nurse, or licensed psychologist shall be sufficient to qualify a person as a "child with a severe disability."

(2) "Dental services" means the full range of diagnostic and treatment services within the scope of benefits available under the health insurance contract or policy.

(b) *Application of section.* — This section applies to every group or blanket health insurance contract, including each policy or contract issued by a health service corporation, which is delivered, issued for delivery, or renewed in this State which provides coverage for dental services for a child.

(c) *Payment authorization.* — Every contract or policy described in subsection (b) of this section shall authorize payment to a licensed practitioner for dental services to a child with a severe disability irrespective of lack of contractual or network status. Unless otherwise negotiated with the practitioner in advance, such payment shall be in an amount at least equal to the insurer's reasonable and customary compensation for the same or similar services in the same geographical area. A nonnetwork practitioner accepting payment under this section may not balance bill the insured.

(d) *Preservation of contract limits.* — Nothing in this section shall prevent the application of contract or policy provisions involving deductibles, coinsurance, maximum dollar limitations or coordination of benefits, provided that such limits shall be applied using in-network standards.

(e) *Waiver.* — The Commissioner may establish, by regulation, standards authorizing the issuance of a waiver to an insurer from application of this section. At a minimum, such waiver standards shall only permit a time-limited, renewable waiver upon submission of clear and convincing documentation of the numerical and geographical availability of in-network practitioners willing and able to effectively treat a child with a severe disability.

(77 Del. Laws, c. 54, § 2.)

§ 3571D. Screening of infants and toddlers for developmental delays.

(a) *Definitions.* — As used in this section:

(1) "Carrier" means any entity that provides health insurance in this State. For the purposes of this section, "carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(2) "Developmental screening" shall mean any developmental screening tool favorably mentioned by the American Academy of Pediatrics Committee on Children with Disabilities in its position paper on "Developmental Surveillance and Screening of Infants and Young Children," or any program judged by the Department of Health and Social Services to be an equivalent program.

(b) This section shall apply to any health insurance contract that provides coverage for a family member of the insured and is delivered by a carrier or issued by a carrier for delivery in the State.

(c) This section shall not apply to policies that exclusively cover:

(1) Hospital confinement indemnity;

(2) Disability income;

(3) Accident only;

(4) Long-term care;

(5) Medicare supplement;

(6) Specified disease indemnity; or

(7) Sickness or bodily injury or death by accident, or both.

(d) Every health insurance policy covered by this section shall entitle children covered by the policy to receive developmental screenings at ages 9 months, 18 months, and 30 months.

(77 Del. Laws, c. 207, § 2.)

§ 3571E. Reimbursement for orthotic and prosthetic services.

(a) *Definitions.* — For purposes of this section:

(1) "Federal reimbursement rates" means the current listed fee schedule from the Centers for Medicare and Medicaid Services, listing the current Healthcare Common Procedure Coding System (HCPCS) and the corresponding reimbursement rates.

(2) "Orthosis" means a custom fabricated brace or support that is designed based on medical necessity. Orthosis does not include prefabricated or direct-formed orthotic devices or any of the following assistive technology devices: commercially available knee orthoses used following injury or surgery; spastic muscle-tone inhibiting orthoses; upper extremity adaptive equipment; finger splints; hand splints; wrist gauntlets; face masks used following burns; wheelchair seating that is an integral part of the wheelchair and not worn by the patient independent of the wheelchair; fabric or elastic supports; corsets; low-temperature formed plastic splints; trusses; elastic hose; canes; crutches; cervical collars; dental appliances; and any other similar devices as determined Secretary of the Department of Health and Social Services, commonly carried in stock by a pharmacy, department store, or surgical supply facility.

(3) "Orthotics" means the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, adjusting, or servicing, as well as providing the initial training necessary to accomplish the fitting of, an orthosis for the support, correction, or alleviation of neuromuscular or musculoskeletal dysfunction, disease, injury, or deformity. The practice of orthotics encompasses evaluation, treatment, and consultation; with basic observational gait and postural analysis, orthotists assess and design orthoses to

maximize function and provide not only the support but also the alignment necessary to either prevent or correct a deformity or to improve the safety and efficiency of mobility, locomotion, or both. Orthotic practice includes providing continuing patient care in order to assess its effect on the patient's tissues and to assure proper fit and function of the orthotic device through periodic evaluation.

(4) "Prosthesis" means an artificial limb that is alignable or, in lower-extremity applications, capable of weight bearing. Prosthesis means an artificial medical device that is not surgically implanted and that is used to replace a missing limb, appendage, or other external human body part including an artificial limb, hand, or foot. The term does not include artificial eyes, ears, noses, dental appliances, ostomy products, or devices such as eyelashes or wigs.

(5) "Prosthetics" means the science and practice of evaluation, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing, as well as providing the initial training necessary to accomplish the fitting of, a prosthesis through the replacement of external parts of a human body lost due to amputation, congenital deformities, or abscesses. The practice of prosthetics also includes the generation of an image, form, or mold that replicates the patient's body or body segment and that requires rectification of dimensions, contours, and volumes for use in the design and fabrication of a socket to accept a residual anatomic limb to, in turn, create an artificial appendage that is designed either to support body weight or to improve or restore function or cosmesis, or both. Involved in the practice of prosthetics is observational gait analysis and clinical assessment of the requirements necessary to refine and mechanically fix the relative position of various parts of the prosthesis to maximize function, stability, and safety of the patient. The practice of prosthetics includes providing and continuing patient care in order to assess the prosthetic device's effect on the patient's tissues and to assure proper fit and function of the prosthetic device through periodic evaluation.

(b) Every group and blanket health insurance contract, plan, or policy which is delivered, issued for delivery, or renewed in this State on or after January 1, 2012, and which provides medical coverage that includes coverage for physician services in a physician's office, and every policy which provides major medical or similar comprehensive type coverage, shall provide reimbursement for orthotic and prosthetic devices at least equal to federal reimbursements rates provided for under federal laws for health insurance for the aged and disabled pursuant to 42 U.S.C. §§ 1395k, 1395l, and 1395m and 42 C.F.R. §§ 414.202, 414.210, 414.228, and 410.100, as applicable to this section.

(c) A health insurance contract, plan, or policy may require prior authorization for orthotic and prosthetic devices in the same manner that prior authorization is required for any other covered benefit.

(d) Covered benefits for orthotic or prosthetic devices shall be limited to the most appropriate model that adequately meets the medical needs of the patient.

(e) The repair and replacement of orthotic or prosthetic devices also shall be covered subject to co-payments and deductibles, unless necessitated by misuse or loss.

(f) An insurer may require, if coverage is provided through a managed care plan, that benefits mandated pursuant to this section be covered benefits only if the orthotic or prosthetic devices are provided by a vendor, and orthotic or prosthetic services are rendered by a provider, who is licensed by the State to provide orthotics and prosthetics.

(g) This section shall not apply to policies that exclusively cover:

(1) Hospital confinement indemnity;

(2) Disability income;

(3) Accident only;

(4) Long-term care;

(5) Medicare supplement;

(6) Limited benefit health;

(7) Specified disease indemnity;

(8) Sickness or bodily injury or death by accident, or both; or

(9) Other limited benefit policies.

(78 Del. Laws, c. 171, § 2.)

§ 3571F. Mini-COBRA small employer group health policies [For application of this section, see 79 Del. Laws, c. 99, § 19].

A group policy renewed or delivered or issued for delivery in this State on or after June 21, 2012, by an insurer that insures employees and their eligible dependents for hospital, surgical or major medical insurance shall provide that covered employees or eligible dependents whose coverage under the group policy would otherwise terminate because of a qualifying event shall be entitled to continue their hospital, surgical or major medical coverage under that group policy subject to the following terms and conditions:

(1) Continuation shall only be available to a covered employee or eligible dependent who has been continuously insured under a group policy or for similar benefits under any group policy that it replaced, during the entire 3-month period ending with such termination. If employment is reinstated during the continuation period, then coverage under the group policy must be reinstated for the covered employee and any eligible dependents who were covered under continuation.

(2) Continuation shall not be available for any person covered under the group policy when such person:

a. Is covered or eligible for coverage under Medicare;

b. Fails to verify that such person is ineligible for employer-based group health insurance as an eligible dependent; or

c. Is or could be covered by any other insured or uninsured arrangement which provides hospital, surgical or major medical coverage for individuals in a group and under which the person was not covered immediately prior to such termination, excluding the medical assistance program established under the Delaware Code.

(3) Continuation must include any benefits provided under the group policy.

(4) a. The group policy shall provide notice to the policyholder of the rights provided under this section. Unless already provided in the group policy, an insurer who has issued a group policy in effect as of June 21, 2012, shall provide such notice to the policyholder by August 5, 2012.

b. The employer of a covered employee under a group policy must notify the administrator or its designee, the covered employee and the insurer of a qualifying event within 30 days of the qualifying event. Notice to the covered employee shall include notice of the rights set forth in this section.

c. Each covered employee or eligible dependent shall notify the administrator or its designee of its election of continuation coverage under this section within 30 days of notice under paragraph (4)b. of this section. The coverage shall be effective as of the date of the qualifying event and shall be the same as the coverage in effect at the time of the qualifying event or any replacement coverage.

d. An administrator or its designee notified under paragraph (4)c. of this section of an election of continuation coverage shall notify the insurer within 14 days of the covered employee's or eligible dependent's election.

e. Except as otherwise specified in an election, any election of continuation coverage by an eligible dependent shall be deemed to include an election of continuation coverage on behalf of any other eligible dependent who would lose coverage under the plan by reason of the qualifying event.

(5) a. The covered employee or eligible dependent requesting the continuation of coverage must pay to the administrator or its designee, on a monthly basis, the amount of contribution required to be paid by the covered employee or eligible dependent to continue the coverage.

b. The premium contribution may not be more than 102% of the group rate of the insurance being continued on the due date of each payment.

c. Nothing in this section shall require the employer to contribute to the deductible of an employee holding a health savings account as defined in the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 223(d)) or other medical spending account as a component of the group policy after the termination date as long as scheduled payments have been made.

(6) a. Continuation of coverage under the group policy for any covered employee or eligible dependent shall terminate upon failure to satisfy paragraph (2) of this section or, if earlier, at the first to occur of the following:

1. The date 9 months after the date the covered employee's or eligible dependent's coverage under the group would have terminated because of a qualifying event;

2. If the employee or member fails to make timely payment of a required premium contribution by the end of the period for which contributions were made;

3. The date on which the group policy is terminated.

b. A covered employee or eligible dependent shall provide written notice to the administrator or its designee within 14 days if, pursuant to paragraph (2) of this section, coverage should not occur.

1. Coverage, as required by this section, may not be conditioned or discriminated on the basis of lack of evidence of insurability.

2. This section shall apply to only those persons who satisfy both of the following criteria:

A. A person who is not subject to the continuation and conversion provisions set forth in Title 1, subtitle b, part 6 of the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 29 U.S.C. § 1161 et seq.) or Title XX of the Public Health Service Act, Public Law 99-272, 42 U.S.C. § 300bb-1 et seq.; and

B. A person and the eligible dependents of such person, who is employed by an employer that normally employed between 1 and 19 employees on a typical business day during the preceding year.

3. The Department of Insurance may promulgate regulations as necessary for the implementation and administration of this section.

4. For purposes of this section, the following words and phrases shall have the following meanings unless the context clearly indicates otherwise:

A. "Administrator" means the person specifically designated by an employer by written agreement to manage the administration of a group policy issued to an employer or, if an administrator is not so designated, the employer.

B. "Covered employee" means an individual who is or was provided coverage under a group policy by virtue of the performance of services by the individual for 1 or more persons maintaining the policy, including as an employee defined in § 401(c)(1) of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 401(c)(1)).

C. "Eligible dependent" means:

I. With respect to a covered employee under a group health plan, any other individual who on the day before the qualifying event for that employee is a beneficiary under the plan:

(A) As the spouse of the covered employee; or

(B) As the dependent child of the employee.

II. In the case of a "qualifying event" described in paragraph (6)b.4.F.II. of this section, the term includes a covered employee.

III. In the case of a "qualifying event" described in paragraph (6)b.4.F.VI. of this section, the term includes a covered employee who had retired on or before the date of substantial elimination of coverage and any other individual who, on the day before such qualifying event, is a beneficiary under the plan:

(A) As the spouse of the covered employee;

(B) As the dependent child of the employee; or

(C) As the surviving spouse of the covered employee, the term shall also include a child who is born to or placed for adoption with a covered employee during the period of continuation coverage under this section.

D. "Group policy" means any group health insurance policy, subscriber contract, certificate or plan which provides health or sickness and accident coverage which is offered by an insurer. The term shall not include any of the following:

I. An accident-only policy.

II. A credit-only policy.

III. A long-term care or disability income policy.

IV. A specified disease policy.

V. A Medicare supplement policy.

VI. A Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement policy.

VII. A fixed indemnity policy.

VIII. A dental-only policy.

IX. A vision-only policy.

X. A workers' compensation policy.

XI. An automobile medical payment policy under Chapter 21 of this title.

XII. Any other similar policies providing for limited benefits.

E. "Insurer" means any entity that provides health insurance in this State. For purposes of this section, "insurer" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

F. "Qualifying event" means, with respect to any covered employee, any of the following events which, but for the continuation of coverage required under this section, would result in the loss of coverage of an eligible dependent:

I. The death of a covered employee.

II. The termination, other than by reason of such employee's gross misconduct, or reduction of hours of the covered employee's employment.

III. The divorce or legal separation of the covered employee from an eligible dependent.

IV. The covered employee becoming entitled to benefits under Title XVIII of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395 et seq.).

V. A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

VI. A proceeding in a case under Chapter 11 of Title 11 of the United States Code with respect to the employer from whose employment the covered employee retired at any time. In the case of an event described in this paragraph (6)b.4.F.VI of this section, a loss of coverage includes a substantial elimination of coverage with respect to an eligible dependent within 1 year before or after the date of commencement of the proceeding.

(78 Del. Laws, c. 246, § 1; 79 Del. Laws, c. 99, § 16.)

§ 3571G. School-based health centers.

(a) For purposes of this section, a school-based health center (SBHC) is a health clinic that:

(1) Is located in or near a school facility;

(2) Is organized through school and health provider relationships;

(3) Except as provided by subsection (h) of this section, provides through licensed professionals primary health services to children, including comprehensive health assessments, diagnosis, and treatment of minor, acute, and chronic medical conditions, referrals to and follow-up for specialty care and oral and vision health services, mental health and substance use disorder assessments, crisis intervention, counseling, treatment, and referral to a continuum of mental health and substance abuse services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs; and

(4) Is recognized by the State pursuant to relevant regulations and law.

(b) The Delaware Division of Public Health (DPH) shall have sole authority to determine whether a facility is an SBHC as defined in subsection (a) of this section.

(c) Except as noted herein, benefits provided under any group or blanket health insurance policy which is delivered, issued for delivery, or renewed in this State shall reimburse SBHCs for covered services provided by SBHCs as if those services were provided by a network provider under the relevant contract of insurance. In the absence of an agreement between a carrier and an SBHC on reimbursement, reimbursement for such services shall be at the rate established by the Division of Medicaid and Medical Assistance for those services. Any insurance contract term purporting to exclude otherwise covered services on the basis that they are performed by an SBHC shall be void except as specifically permitted under this chapter.

(d) If DPH has approved an SBHC, that approval shall be deemed sufficient to meet the carrier's standards for inclusion in its network or for being eligible for payment by the carrier.

(e) SBHCs shall not charge co-pays or any other out-of-pocket fees to students for use of SBHC services. Insurance carriers shall not incur any additional financial liability by virtue of this subsection.

(f) The Delaware DPH, in coordination with the State's SBHCs, insurance carriers, and the Department of Insurance, shall issue regulations to ensure that SBHCs are properly integrated into the State's spectrum of health-care providers that provide covered services to youth. These regulations shall include, but are not limited to:

(1) Regulations governing reporting to and interaction with students' primary care providers; and

(2) Regulations regarding promotion of vaccinations among student users of SBHCs.

(g) Nothing in this chapter shall prevent the enforceability of an agreement negotiated between an SBHC and an insurance carrier governing claims submission, reimbursement, quality standards, credentialing and similar matters, provided, however, that in the absence of such agreement the terms of this chapter shall govern.

(h) DPH shall have the authority to approve supervised clinical training rotations for mental health providers at SBHCs.

(78 Del. Laws, c. 276, § 2; 85 Del. Laws, c. 196, § 2.)

§ 3571H. Payment for emergency medical services.

(a) As used in this section:

(1) "Ambulance" shall have the same definition set forth in § 9702 of Title 16.

(2) "Basic life support" shall have the same definition set forth in § 9702 of Title 16.

(3) "Emergency medical services provider agency" shall have the same definition set forth in § 9802 of Title 16.

(4) "Volunteer fire company" shall mean the duly organized volunteer fire companies in the State.

(b) Notwithstanding any provision precluding an assignment of benefits in any group or blanket health insurance policy, contract, certificate or plan, delivered or issued for delivery in this State by any insurer, health service corporation, or health maintenance organization, when a volunteer fire company or other emergency medical services provider agency certified by the Delaware State Fire Prevention Commission renders covered emergency medical services or supplies, including but not limited to basic life support and ambulance service, any payment or reimbursement made by an insurer, health service corporation or health maintenance organization for such covered emergency medical services or supplies shall be paid directly to the volunteer fire company or other certified emergency medical services provider agency, or their designee, without regard to whether a contract exists between the volunteer fire company or certified emergency medical services provider agency and the insurer, health service corporation or health maintenance organization, and otherwise without regard to whether the volunteer fire company or emergency medical services provider agency is a part of any network maintained by the insurer, health service corporation or health maintenance organization.

(c) The limitations on balance billing provided in § 3348 of this title shall not apply to billing for emergency medical services within the scope of this section provided by volunteer fire companies or emergency medical services provider agencies certified by the Delaware State Fire Prevention Commission.

(d) This section shall apply to all policies, contracts, certificates or plans issued, renewed, modified, altered, amended or reissued on or after July 1, 2013.

(e) Nothing in this section should apply to supplemental health insurance policies that do not provide expense or reimbursement coverage for emergency medical services, basic life support or ambulance services.

(79 Del. Laws, c. 76, § 2.)

§ 3571I. No lifetime or annual limits [For application of this section, see 79 Del. Laws, c. 9, § 19].

(a) (1) Except as provided in subsection (b) of this section, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, may not establish any lifetime limit on the dollar amount of benefits for any individual.

(2) a. Except as provided in paragraph (a)(2)b., subsections (b) and (d) of this section, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, may not establish any annual limit on the dollar amount of benefits for any individual.

b. A health flexible spending arrangement (as defined in § 106(c)(2) of the Internal Revenue Code) [26 U.S.C. § 106(c)(2)] is not subject to the requirement in paragraph (a)(2)a. of this section.

(b) (1) The rules of this section do not prevent a group health plan, or a health insurance issuer offering group or individual health insurance coverage, from placing annual or lifetime dollar limits with respect to any individual on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable federal or state law.

(2) The rules of this section do not prevent a group health plan, or a health insurance issuer offering group or individual health insurance coverage, from excluding all benefits for a condition. However, if any benefits are provided for a condition, then the requirements of this section apply. Other requirements of federal or state law may require coverage of certain benefits.

(c) The term "essential health benefits" as used in this section means essential health benefits under § 1302(b) of the Patient Protection and Affordable Care Act [42 U.S.C. § 18022(b)], as the law and its implementing regulations were in effect on January 1, 2025; Delaware law; and applicable state regulations.

(d) (1) With respect to plan years beginning prior to January 1, 2014, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, may establish, for any individual, an annual limit on the dollar amount of benefits that are essential health benefits, provided the limit is no less than the following amounts:

a. For a plan year beginning on or after September 23, 2010, but before September 23, 2011, $750,000.

b. For a plan year beginning on or after September 23, 2011, but before September 23, 2012, $1,250,000.

c. For plan years beginning on or after September 23, 2012, but before January 1, 2014, $2,000,000.

(2) In determining whether an individual has received benefits that meet or exceed the applicable amount described in paragraph (d)(1) of this section, a plan or issuer must take into account only essential health benefits.

(79 Del. Laws, c. 99, § 8; 82 Del. Laws, c. 186, § 4; 85 Del. Laws, c. 89, § 2.)

§ 3571J. Guaranteed availability of coverage [For application of this section, see 79 Del. Laws, c. 99, § 19].

(a) *Guaranteed availability of coverage in the group market.* — Subject to subsections (b)-(d) of this section, a health insurer that offers health insurance coverage in the group market in this State must offer to any employer in this State all products that are approved for sale in the group market, and must accept any employer that applies for any of those products.

(b) *Enrollment periods.* — A health insurer may restrict enrollment in health insurance coverage to open or special enrollment periods.

(1) a. *Open enrollment periods in the group market.* —

A health insurer in the group market must permit an employer to purchase health insurance coverage for a group health plan at any point during the year. In the case of health insurance coverage offered in the small group market, a health insurer may decline to offer coverage to a plan sponsor that is unable to comply with a material plan provision relating to employer contribution or group participation rules under applicable state law and, in the case of a qualified health plan offered in the Small Business Health Options Program (SHOP), as permitted by 45 C.F.R. § 156.285(c). For purposes of this paragraph (b)(1):

1. "Employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries.

2. "Group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specific percentage or number of eligible individuals or employees of an employer.

b. With respect to coverage in the small group market, and in the large group market if such coverage is offered in a SHOP in the State, coverage for a group enrollment received from a qualified employer at the time of an initial group enrollment or renewal becomes effective as follows:

1. Between the first and fifteenth day of any month, the health insurer or SHOP must ensure a coverage effective date of the first day of the following month unless the employer opts for a later effective date within a quarter for which small group market rates are available.

2. Between the sixteenth and last day of any month, the health insurer or SHOP must ensure a coverage effective date of the first day of the second following month unless the employer opts for a later effective date within a quarter for which small group market rates are available.

(2) Special enrollment periods. —

A health insurer in the group market shall establish special enrollment periods for qualifying events as defined under § 603 of the Employee Retirement Income Security Act of 1974 [29 U.S.C. § 1163], as amended. Enrollees must be provided 30 calendar days after the date of the qualifying event to elect coverage, with such coverage becoming effective consistent with the dates described in 45 C.F.R. § 155.420(b), as in effect on January 1, 2025. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law.

(c) *Special rules for network plans.* — (1) In the case of a health insurer that offers health insurance coverage in the group market through a network plan, the health insurer may do the following:

a. Limit the employers that may apply for the coverage to those with eligible individuals in the group market who live, work or reside in the service area for the network plan.

b. Within the service area of the plan, deny coverage to employers if the carrier has demonstrated to the Commissioner the following:

1. It will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees.

2. It is applying paragraph (c)(1) of this section uniformly to all employers without regard to the claims experience of those employers and their employees (and their dependents) or any health-status related factor relating to such employees and dependents.

(2) A health insurer that denies health insurance coverage to an employer in any service area, in accordance with paragraph (c)(1)b. of this section, may not offer coverage in the group market within the service area to any employer for a period of 180 calendar days after the date the coverage is denied. This paragraph (c)(2) does not limit the health insurer's ability to renew coverage already in force or relieve the carrier of the responsibility to renew that coverage.

(3) Coverage offered within a service area after the 180-day period specified in paragraph (c)(2) of this section is subject to the requirements of this section.

(d) *Application of financial capacity limits.* — (1) A health insurer may deny health insurance coverage in the group market if the health insurer has demonstrated to the Commissioner the following:

a. It does not have the financial reserves necessary to underwrite additional coverage.

b. It is applying this paragraph (d)(1) uniformly to all employers in the group market in this State consistent with applicable state law and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such employees and dependents.

(2) A health insurer that denies health insurance coverage to any employer in this State under paragraph (d)(1) of this section may not offer coverage in the group market in this State before the later of either of the following dates:

a. The one hundred and eighty-first day after the date the health insurer denies coverage;

b. The date the health insurer demonstrates to the Commissioner that the carrier has sufficient reserves to underwrite additional coverage.

(3) Paragraph (d)(2) of this section does not limit the carrier's ability to renew coverage already in force or relieve the carrier of the responsibility to renew that coverage.

(4) Coverage offered after the 180-day period specified in paragraph (d)(2) of this section is subject to the requirements of this section.

(5) The Commissioner may provide for the application of this subsection (d) on service-area-specific basis.

(e) *Marketing.* — A health insurer and its officials, employees, agents and representatives must comply with any applicable state laws and regulations regarding marketing by health insurers and cannot employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage.

(f) *Grandfathered health plans.* — This section does not apply to grandfathered health plans. For purposes of this section, "grandfathered health plans" means plans provided by a health insurer in which an individual was enrolled on March 23, 2010, for as long as it maintains that status in accordance with federal regulations.

(79 Del. Laws, c. 99, § 8; 82 Del. Laws, c. 186, § 5; 85 Del. Laws, c. 89, § 3.)

§ 3571K. Prohibition on excessive waiting periods [For application of this section, see 79 Del. Laws, c. 99, § 19].

A group health plan and a health insurer offering group health insurance coverage shall not apply any waiting period that exceeds 90 days. As used in this section, "waiting period" means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective.

(79 Del. Laws, c. 99, § 8.)

§ 3571L. Nondiscrimination in health care [For application of this section, see 79 Del. Laws, c. 99, § 19].

(a) *Providers.* — A group health plan and a health insurer offering group health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health-care provider who is acting within the scope of that provider's license or certification under applicable state law. This section shall not require that a group health plan or health insurer contract with any health-care provider willing to abide by the terms and conditions for participation established by the plan or insurer. Nothing in this section shall be construed as preventing a group health plan, a health insurer or the Commissioner from establishing varying reimbursement rates based on quality or performance measures.

(b) *Individuals.* — The provisions of § 1557 of the Patient Protection and Affordable Care Act (relating to nondiscrimination) [42 U.S.C. § 18116], as the law and its implementing regulations were in effect on January 1, 2025, apply with respect to a group health plan or health insurer offering group health insurance coverage.

(79 Del. Laws, c. 99, § 8; 82 Del. Laws, c. 186, § 6; 85 Del. Laws, c. 89, § 4.)

§ 3571M. Comprehensive health insurance coverage [For application of this section, see 79 Del. Laws, c. 99, § 19].

(a) *Coverage for essential health benefits package. —*

A health insurer that offers health insurance coverage in the small group market shall ensure that such coverage includes the essential health benefits package in conformity with § 1302 of the Patient Protection and Affordable Care Act [42 U.S.C. § 18022], as the law and its implementing regulations were in effect on January 1, 2025, and state law. The Commissioner shall issue a regulation setting forth what constitutes "essential health benefits" for purposes of this section.

(b) *Cost-sharing under group health plans. —*

A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under § 1302(c)(1) and (2) of the Patient Protection and Affordable Care Act [42 U.S.C. § 18022(c)(1) and (2)], as the law and its implementing regulations were in effect on January 1, 2025, and state law.

(c) *Child-only plans. —*

If a health insurer offers health insurance coverage in any level of coverage specified under § 1302(d) of the Patient Protection and Affordable Care Act [42 U.S.C. § 18022(d)], as the law and its implementing regulations were in effect on January 1, 2025, or state law, the health insurer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of the plan year, are under the age of 21.

(d) *Dental only. —*

This section shall not apply to a plan described in § 1311(d)(2)(B)(ii) of the Patient Protection and Affordable Care Act [42 U.S.C. § 18031(d)(2)(B)(ii)], as the law and its implementing regulations were in effect on January 1, 2025.

(79 Del. Laws, c. 99, § 8; 81 Del. Laws, c. 79, § 30; 82 Del. Laws, c. 186, § 7; 85 Del. Laws, c. 89, § 5.)

§ 3571N. Prohibiting discrimination against individual participants and beneficiaries based on health status [For application of this section, see 79 Del. Laws, c. 99, § 19].

(a) *In general. —* A group health plan and a health insurer offering group health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(1) Health status.

(2) Medical condition (including both physical and mental illnesses).

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

(8) Disability.

(9) Any other health status-related factor determined appropriate by the Commissioner.

(b) *Programs of health promotion or disease prevention. —* (1) *General provisions. —* a. *General rule. —* For purposes of paragraph (b)(2)b. of this section, a program of health promotion or disease prevention (referred to in this subsection as a "wellness program") shall be a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.

b. *No conditions based on health status factor. —* If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (b)(2) of this section are complied with.

c. *Conditions based on health status factor. —* If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of paragraph (b)(3) of this section are complied with.

(2) *Wellness programs not subject to requirements. —* If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (b)(1)b. of this section are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (b)(3) of this section if participation in the program is made available to all similarly situated individuals:

a. A program that reimburses all or part of the cost for membership in a fitness center.

b. A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

c. A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under a group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

d. A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

e. A program that provides a reward to individuals for attending a periodic health education seminar.

(3) *Wellness programs subject to requirements.* — If any of the conditions for obtaining a premium discount, rebate or reward under a wellness program as described in paragraph (b)(1)c. of this section is based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:

a. The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30% of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30% of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Commissioner may increase the reward available under this paragraph to up to 50% of the cost of coverage if the Commissioner determines that such an increase is appropriate.

b. The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.

c. The plan shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year.

d. The full reward under the wellness program shall be made available to all similarly situated individuals. For such purpose, among other things:

1. The reward is not available to all similarly situated individuals for a period unless the wellness program allows:

A. For a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

B. For a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

2. If reasonable under the circumstances, the plan or health insurer may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

e. The plan or health insurer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under paragraph (b)(3)d. of this section. If plan materials disclose that such a program is available, without describing its terms, the disclosure under this paragraph shall not be required.

(4) Nothing in this section shall prohibit a program of health promotion or disease prevention that was established prior to July 15, 2013, and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.

(79 Del. Laws, c. 99, § 8.)

§ 3571O. Insurance offered through the state health insurance exchange [For application of this section, see 79 Del. Laws, c. 99, § 19].

(a) A health insurer that offers health insurance coverage in the small group market through the state health insurance exchange program established pursuant to the Patient Protection and Affordable Care Act [P.L. 111-148] shall first satisfy all certification standards required by federal and state law, and the health insurer shall offer only those plans that are "qualified health plans" as required by federal and state law.

(b) The Commissioner shall adopt regulations, in accordance with the Administrative Procedures Act [Chapter 101 of Title 29], that set forth the certification and compliance standards and requirements for health insurers operating within the state health exchange.

(79 Del. Laws, c. 99, § 8.)

§ 3571P. Rating factors [For application of this section, see 79 Del. Laws, c. 99, § 19].

(a) In establishing rates for health insurance coverage offered in the small group market, the rate may vary with respect to the particular plan or coverage involved only by determining the following:

(1) Whether the plan or coverage covers an individual or family.

(2) Rating area, as established in accordance with subsection (d) of this section.

(3) Age, except that the rate may not vary by more than 3 to 1 for like individuals of different age who are age 21 and older and that the variation in rate must be actuarially justified for individuals under age 21, consistent with the uniform age rating curve under subsection (e) of this section. For purposes of identifying the appropriate age adjustment under this paragraph (a)(3) and the age band under subsection (e) of this section applicable to a specific enrollee, the enrollee's age as of the date of policy issuance or renewal must be used.

(4) Subject to § 3571N of this title, tobacco use, except that such rate may not vary by more than 1.5 to 1 and may only be applied with respect to individuals who may legally use tobacco under federal and state law. For purposes of this paragraph (a)(4), tobacco use means use of tobacco on average 4 or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used.

(b) The rate established under this section must not vary with respect to the particular plan or coverage involved by any other factor not described in subsection (a) of this section.

(c) A health insurer must consider the claims experience of all enrollees in all health plans, other than grandfathered health plans, offered by such insurer in the small group market in this State, including those enrollees who do not enroll in such plans through the state health exchange, to be members of a single risk pool. A health insurer must charge the same premium rate without regard to whether the plan is offered through the state health exchange or whether the plan is offered directly from the health insurer or through an agent.

(d) In establishing rates, all health insurers offering health plans in the small group market shall use a single rating area that applies to the entire State.

(e) The following uniform age bands apply for rating purposes under paragraph (a)(3) of this section:

(1) *Child age bands. —*

a. A single age band for individuals age 0 through 14.

b. One-year age bands for individuals age 15 through 20.

(2) *Adult age bands. —*

One-year age bands for individuals age 21 through 63.

(3) *Older adult age bands. —*

A single age band for individuals age 64 and older.

(f) *Application of variations based on age or tobacco use. —*

With respect to family coverage under health insurance coverage, the rating variations permitted under paragraphs (a)(3) and (a)(4) of this section must be applied based on the portion of the premium attributable to each family member covered under the coverage.

(1) The total premium for family coverage must be determined by summing the premiums for each individual family member. With respect to family members under age 21, the premiums for no more than the 3 oldest covered children must be taken into account in determining the total family premium.

(2) If the State does not permit any rating variation for the factors described in paragraphs (a)(3) and (a)(4) of this section, as determined by the Insurance Commissioner by regulation, the State may require that premiums for family coverage be determined by using uniform family tiers and the corresponding multipliers established by the State. If the State does not establish uniform family tiers and the corresponding multipliers, the per-member-rating methodology under paragraph (f)(1) of this section applies in this State.

(3) a. In the case of the small group market, the total premium charged to a group health plan is determined by summing the premiums of covered participants and beneficiaries in accordance with paragraph (f)(1) or (f)(2) of this section, as applicable.

b. Subject to paragraph (f)(3)c. of this section, nothing in this section prevents the State from requiring health insurers to offer to a group health plan, or a health insurer from voluntarily offering to a group health plan, premiums that are based on average enrollee premium amounts, if the total group premium established at the time of applicable enrollment at the beginning of the plan year is the same total amount derived under paragraph (f)(1) or (f)(2) of this section, as applicable.

c. A health insurer that, in connection with a group health plan in the small group market, offers premiums that are based on average enrollee premium amounts under paragraph (f)(3)b. of this section must:

1. Ensure an average enrollee premium amount calculated based on applicable enrollment of participants and beneficiaries at the beginning of the plan year that does not vary during the plan year.

2. Unless the State establishes and, if applicable, CMS approves an alternate rating methodology, calculate an average enrollee premium amount for covered individuals age 21 and older, and calculate an average enrollee premium amount for covered individuals under age 21. The premium for a given family composition is determined by summing the average enrollee premium

amount applicable to each family member covered under the plan, taking into account no more than 3 covered children under age 21.

3. Under applicable state law, ensure that the average enrollee premium amount calculated for any individual covered under the plan does not include any rating variation for tobacco use permitted under paragraph (a)(4) of this section. The rating variation for tobacco use permitted under paragraph (a)(4) of this section is determined based on the premium rate that would be applied on a per-member basis with respect to an individual who uses tobacco and then included in the premium charged for that individual.

4. To the extent permitted by applicable state law and, in the case of coverage offered through a federally-facilitated SHOP, as permitted by 45 C.F.R. § 156.285(a)(4), apply this paragraph (f)(3)c. uniformly among group health plans enrolling in that product, giving those group health plans the option to pay premiums based on average enrollee premium amounts.

(g) The Commissioner may adopt regulations, in accordance with the Administrative Procedures Act (Chapter 101 of Title 29), that are consistent with Chapter 25 of this title and set forth more specifically the rating standards and requirements for health insurers operating within this State.

(79 Del. Laws, c. 99, § 8; 82 Del. Laws, c. 186, § 8.)

§ 3571Q. Notification and reasons for cancellation or nonrenewal [For application of this section, see 79 Del. Laws, c. 390, § 8].

A notice of cancellation or nonrenewal of group health insurance coverage by an insurer due to nonpayment of premiums shall be in writing, shall be delivered to the policyholder or mailed to the policyholder at the last known address of the policyholder, shall state the effective date of the cancellation or nonrenewal and shall be accompanied by a written explanation of the specific reasons for the cancellation or nonrenewal. Proof of mailing of such cancellation or nonrenewal notice shall be retained by the insurer for a period of not less than 1 year. This section shall not apply to any long-term care policy where notice provisions regarding cancellations or nonrenewals are specifically addressed elsewhere in this title or in regulations promulgated thereunder.

(79 Del. Laws, c. 390, § 4.)

§ 3571R. Telehealth and telemedicine.

(a) For purposes of this section:

(1) “Distant site” means a site at which a health-care provider legally allowed to practice in Delaware is located while providing health-care services by means of telemedicine or telehealth.

(2) “Originating site” means a site in Delaware at which a patient is located at the time health-care services are provided to the patient by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used. Notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

(3) “Store and forward transfer” means the transmission of a patient’s medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

(4) “Telehealth” means the use of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which support clinical health-care provider consultation, patient and professional health-related education, public health, health administration, and other services as authorized in Chapter 60 of Title 24.

(5) “Telemedicine” means a form of telehealth which is the delivery of clinical health-care services, and other services, as authorized in Chapter 60 of Title 24, by means of real time 2-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support health-care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care by a health-care provider legally allowed to practice in Delaware and practicing within the health-care provider’s scope of practice as would be practiced in-person with a patient, while such patient is at an originating site and the health-care provider is at a distant site.

(b) Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health-care plan for health-care services shall provide coverage for the cost of such health-care services provided through telemedicine.

(c) Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health-care plan for health-care services shall provide coverage for the cost of such health-care services provided through telehealth as directed through regulations promulgated by the Department.

(d) An insurer, health service corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through in-person consultation or contact between a health-care provider and a patient for services appropriately provided through telemedicine services.

(e) An insurer, health service corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis and at least at the rate that the insurer, health service corporation, or health maintenance organization is responsible for coverage for the provision of the same service through in-person consultation or contact. Payment for telemedicine interactions shall include reasonable compensation to the originating or distant site for the transmission cost incurred during the delivery of health-care services.

(f) No insurer, health service corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

(g) The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended on and after January 1, 2016, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

(h) This section shall not apply to short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts, nor shall it contravene any telehealth requirements made in policies or contracts designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act [42 U.S.C. §§ 1395 et seq., 1396 et seq., and 1397aa et seq.], known as Medicare and Medicaid, or any other similar coverage under state or federal governmental plans.

(80 Del. Laws, c. 80, § 21; 70 Del. Laws, c. 186, § 1; 82 Del. Laws, c. 261, § 3, 16; 83 Del. Laws, c. 52, § 3; 83 Del. Laws, c. 283, § 28.)

§ 3571S. Network disclosure and transparency.

(a) This section applies to every policy or contract of health insurance which is delivered or issued for delivery in this State, including each policy or contract issued by a health-service corporation, which provides medical, major medical, or similar comprehensive-type coverage, and which designates network physicians or providers (hereinafter referred to collectively as "network providers"). However, this section applies only to items, services or conditions for which coverage is provided by those policies or contracts (hereinafter referred to as "covered services").

(b) For purposes of this section "facility-based provider" means a provider who provides health-care services to patients who are in an in-patient or ambulatory facility, including services such as pathology, anesthesiology, or radiology.

(c) For purposes of this section "health-care provider" means any provider who provides health-care services to patients who are not in a facility-based setting and includes a provider who provides health-care services to a covered person based upon a referral from another provider without the knowledge of or input from the covered person.

(d) *Nonemergency out-of-network services. —*

(1) When a facility-based provider schedules a procedure or seeks prior authorization from a health carrier for the provision of nonemergency covered services to a covered person, the facility shall ensure that the covered person has received a timely written out-of-network disclosure that states the following:

a. That discloses whether the facility is a participating or out-of-network facility;

b. That certain facility-based providers may be called upon to render care to the covered person during the course of treatment;

c. That those facility-based providers may not have a contract with the covered person's health carrier and are therefore considered to be out-of-network;

d. That the services therefore will be provided on an out-of-network basis, which may result in additional charges for which the covered person may be responsible, and a statement that these charges are in addition to any coinsurance, deductibles and copayments applicable under the covered person's health insurance policy;

e. A listing, including name and contact information, of those facility-based providers who may be called upon to render care to the covered person during the course of treatment, and a statement that the covered person should contact their health insurer to determine the network status of those facility-based providers;

f. Notification that an estimate of the range of charges for any out-of-networks services charged by the out-of-network provider for which the covered person may be responsible may be requested from, and will be timely provided by, the out-of-network provider; and

g. That the covered person may contact the covered person's health insurer for additional assistance or may rely on whatever other rights and remedies may be available under state or federal law.

h. The written out-of-network disclosure required by this paragraph (d)(1) shall include a written consent form which would enable a covered person who wishes to utilize the services of an out-of-network provider to: (i) acknowledge a provider may be a non-network provider; (ii) acknowledge that the services provided by the non-network provider may not be covered by the covered person's policy; (iii) acknowledge receipt of the notification that an estimate of the range of charges for any out-of-network services for which the covered person may be responsible may be obtained from the out-of-network providers; and (iv) affirmatively elect to obtain the services and agree to accept and pay the charges for the out-of-network services.

i. If a covered person requests from an out-of-network provider an estimate of the range of charges for any out-of-network services for which the covered person may be responsible, the out-of-network provider shall provide the estimate in writing to the covered person within 3 business days of the request.

j. If the facility and all facility-based providers participate in the covered person's network, this disclosure shall not be required.

(2) Prior to the delivery of nonemergency covered services to a covered person, an out-of-network health-care provider shall provide the covered person with a timely, written out-of-network disclosure that states the following:

a. That the health-care provider is an out-of-network provider and the services therefore will be provided on an out-of-network basis;

b. That out-of-network services may result in additional charges for which the covered person may be responsible, and a statement that these charges are in addition to any coinsurance, deductibles and copayments applicable under the person's health insurance policy;

c. Identification of the range of charges for any out-of-network services charged by the out-of-network provider for which the covered person may be responsible; and

d. That the covered person may contact the covered person's health insurer for additional assistance or may rely on whatever other rights and remedies may be available under state or federal law.

e. The written out-of-network disclosure required by this paragraph (d)(2) shall contain a written consent form which would enable a covered person who wishes to utilize the services of an out-of-network provider to: (i) acknowledge a provider may be a non-network provider; (ii) acknowledge that the services provided by the non-network provider may not be covered by the insured's policy; (iii) acknowledge receipt of the identification of the range of charges for any out-of-network services for which the covered person may be responsible; and (iv) affirmatively elect to obtain the services and agree to accept and pay the charges for the out-of-network services.

(3) A facility-based provider or a health-care provider may not balance bill a covered person for health-care services not covered by an insured's health insurance contract, if the facility-based provider or health-care provider:

a. Fails to provide the covered person the written out-of-network disclosure required by paragraph (d)(1) or (2) of this section.

b. Fails to obtain from the covered person in a timely manner, before the health-care services are provided, a copy of the consent form required by paragraph (d)(3) of this section that has been signed by the covered person.

(4) Nothing in paragraph (d)(3) of this section shall prevent the operation of policy provisions involving coinsurance, deductibles and copayments payable under the covered person's health insurance policy.

(5) In the event a facility-based provider or a health-care provider fails to comply with the requirements of paragraph (d)(3)a. or (3)b. of this section, and the provider of services and insurer cannot agree on the appropriate rate of reimbursement, the provider shall be entitled to those charges and rates allowed by the Insurance Commissioner or the Commissioner's designee following arbitration of the dispute pursuant to the procedures set forth in § 333 of this title and any regulation promulgated thereunder.

(6) This section shall not apply to those out-of-network services provided pursuant to §§ 3564 and 3565 of this chapter.

(e) Health insurers shall be required to maintain accurate and complete provider directories, to update provider directories frequently, to audit the accuracy and completeness of such directories and make the directories easily accessible to the covered person in a variety of formats.

(f) The Insurance Commissioner shall adopt regulations to implement the requirements of this section, including:

(1) Regulations concerning the form and content of the written out-of-network disclosures and written consent form required by paragraphs (d)(1) and (2) of this section.

(2) Regulations requiring health insurers and out-of-network providers to inform covered persons of their rights with respect to payment of balance bills.

(3) *Regulations concerning the provisions of subsection (e) of this section. —*

The regulations adopted and arbitrations authorized pursuant to this section shall reflect the objectives of protecting consumers from surprise bills and not creating incentives for providers to be out-of-network.

(80 Del. Laws, c. 339, § 2.)

§ 3571T. Coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome.

(a) All group and blanket health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State by any health insurer, health service corporation, or health maintenance organization shall provide coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy.

(b) At any time that the State determines it is required under federal law to defray the cost of any coverage for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome required under

subsection (a) of this section, the requirements under subsection (a) of this section are inoperative and the State may not assume any obligation for the cost of coverage for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome.

(81 Del. Laws, c. 400, § 2; 84 Del. Laws, c. 233, § 39.)

§ 3571U. Mental Health Parity and Addiction Equity Act reporting requirements [Effective until Jan. 1, 2028].

Each health insurer offering group health insurance coverage that provides mental illness and drug and alcohol dependencies benefits must submit a report to the Delaware Health Information Network and Commissioner on or before July 1 2019, and any year thereafter during which the insurer makes significant changes to how it designs and applies its medical management protocols; the report must contain the following information:

(1) A description of the process used to develop or select the medical necessity criteria for mental illness and drug and alcohol dependencies benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits.

(2) Identification of all nonquantitative treatment limitations (NQTLs) that are applied to mental illness and drug and alcohol dependencies benefits and medical and surgical benefits within each classification of benefits; there may be no separate NQTLs that apply to mental illness and drug and alcohol dependencies benefits that do not also apply to medical and surgical benefits within any classification of benefits.

(3) The results of an analysis that demonstrates that for the medical necessity criteria described in paragraph (1) of this section and for each NQTL identified in paragraph (2) of this section, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to mental illness and drug and alcohol dependencies benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to medical and surgical benefits within the corresponding classification of benefits; at a minimum, the results of the analysis shall:

a. Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected.

b. Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each NQTL.

c. Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written, for mental illness and drug and alcohol dependencies benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each NQTL, as written, for medical and surgical benefits.

d. Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each NQTL, in operation, for mental illness and drug and alcohol dependencies benefits are comparable to, and applied no more stringently than, the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits.

e. Disclose the specific findings and conclusions reached by the insurer that the results of the analyses above indicate that the carrier is in compliance with this section and the Mental Health Parity and Addiction Equity Act of 2008 [P.L. 104-204] and its implementing regulations, which includes 45 C.F.R. 146.136 and any other related federal regulations found in the Code of Federal Regulations.

(4) Any information submitted to the Delaware Health Information Network and Commissioner by a carrier that is considered proprietary by the carrier shall not be made public record.

(5) The Insurance Commissioner shall retain the authority to enforce the provisions of this section. The provisions of this section shall not give rise to a private cause of action.

§ 3571U. Mental Health Parity and Addiction Equity Act requirements [Effective Jan. 1, 2028].

(a) Each health insurer offering group health insurance coverage that provides mental health disorder or substance use disorder benefits must submit a report to the Delaware Health Information Network and Commissioner on or before July 1 2019, and any year thereafter during which the insurer makes significant changes to how it designs and applies its medical management protocols; the report must contain the following information:

(1) A description of the process used to develop or select the utilization review criteria for mental health disorder and substance use disorder benefits and the process used to develop or select the utilization review criteria for medical and surgical benefits.

(2) Identification of all nonquantitative treatment limitations (NQTLs) that are applied to mental health disorder or substance use disorder benefits and medical and surgical benefits within each classification of benefits; there may be no separate NQTLs that apply to mental health disorder or substance use disorder benefits that do not also apply to medical and surgical benefits within any classification of benefits.

(3) The results of an analysis that demonstrates that for the utilization review criteria described in paragraph (a)(1) of this section and for each NQTL identified in paragraph (a)(2) of this section, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to mental health disorder or substance use disorder benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies,

evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to medical and surgical benefits within the corresponding classification of benefits; at a minimum, the results of the analysis shall:

a. Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected.

b. Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each NQTL.

c. Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written, for mental health disorder or substance use disorder benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each NQTL, as written, for medical and surgical benefits.

d. Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each NQTL, in operation, for mental health disorder or substance use disorder benefits are comparable to, and applied no more stringently than, the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits.

e. Disclose the specific findings and conclusions reached by the insurer that the results of the analyses above indicate that the carrier is in compliance with this section and the Mental Health Parity and Addiction Equity Act of 2008 [P.L. 104-204] and its implementing regulations, which includes 45 C.F.R. 146.136 and any other related federal regulations found in the Code of Federal Regulations.

(4) Any information submitted to the Delaware Health Information Network and Commissioner by a carrier that is a trade secret or confidential or privileged commercial or financial information shall not be made public record.

(5) The Insurance Commissioner shall retain the authority to enforce the provisions of this section. The provisions of this section shall not give rise to a private cause of action.

(b) *Disclosure of nonquantitative treatment limitation parity compliance analyses. —*

(1) A health-care provider, a current covered person, or a prospective covered person may request of a carrier any nonquantitative treatment limitation parity compliance analysis (NQTL parity compliance analysis) that a carrier is required to have completed by 29 U.S.C. § 1185a or 42 U.S.C. § 37 300gg-26.

(2) Within 30 days of receiving a request pursuant to paragraph (b)(1) of this section, a carrier must provide a copy of the requested NQTL parity compliance analysis to the requesting person, free of charge.

(3) Every health benefit plan policy and mental health disorder and substance use disorder provider contract must disclose the following information:

a. A notification of the right to request an NQTL parity compliance analysis.

b. Instructions for how to request an NQTL parity compliance analysis.

(c) The provisions published at 89 Federal Register 77586 et seq. on September 23, 2024, are incorporated into this section in their entirety and apply as state law. This incorporation remains in effect notwithstanding any subsequent amendment, repeal, or nonenforcement of the referenced federal provisions.

(d) Under all health benefit plans delivered or issued for delivery in this State, if a carrier provides any benefits for a mental health disorder or substance use disorder in any classification of benefits, it must provide meaningful benefits for that mental health disorder or substance use disorder in every classification in which medical or surgical benefits are provided. For purposes of this subsection, “core treatments” means standard treatments or courses of treatment, therapy, service, or intervention indicated by generally accepted standards of mental health disorder or substance use disorder care. For purposes of this subsection, whether the benefits provided are considered “meaningful benefits” is determined in comparison to the benefits provided for medical conditions and surgical procedures in the classification and requires, at a minimum, coverage of benefits for that condition or disorder in each classification in which the carrier provides benefits for 1 or more medical conditions or surgical procedures. A carrier does not provide meaningful benefits under this subsection unless it provides benefits for core treatments for that condition or disorder in each classification in which the carrier provides benefits for core treatments for 1 or more medical conditions or surgical procedures. If there is no core treatment for a covered mental health disorder or substance use disorder with respect to a classification, the carrier is not required to provide benefits for core treatments for such condition or disorder in that classification, but must provide benefits for such condition or disorder in every classification in which medical or surgical benefits are provided.

(e) For the purposes of determining comparability and stringency for nonquantitative treatment limitations, a carrier may not rely upon discriminatory factors or evidentiary standards to design a nonquantitative treatment limitation to be imposed on mental health disorder or substance use disorder benefits. A factor or evidentiary standard is discriminatory if the information, evidence, sources, or standards on which the factor or evidentiary standard are based are biased or not objective in a manner that discriminates against mental health disorder or substance use disorder benefits as compared to medical or surgical benefits.

(f) A nonquantitative treatment limitation applicable to mental health disorder or substance use disorder benefits in a classification may not be more restrictive than the predominant nonquantitative treatment limitation applied to substantially all medical or surgical benefits in the classification. To test compliance with this subsection, a carrier shall collect and evaluate relevant data in a manner reasonably designed to assess the impact of the nonquantitative treatment limitation on relevant outcomes related to access to mental health disorder or substance use disorder benefits and medical or surgical benefits and carefully consider the impact as part of the plan’s evaluation.

As part of its evaluation, the carrier may not disregard relevant outcomes data that it knows or reasonably should know suggest that a nonquantitative treatment limitation is associated with material differences in access to mental health disorder or substance use disorder benefits as compared to medical or surgical benefits. To the extent the relevant data evaluated suggest that the nonquantitative treatment limitation contributes to material differences in access to mental health disorder or substance use disorder benefits as compared to medical or surgical benefits in a classification, those differences will be considered a strong indicator of a noncompliant nonquantitative treatment limitation. Where the relevant data suggest that the nonquantitative treatment limitation contributes to material differences in access to mental health disorder or substance use disorder benefits as compared to medical or surgical benefits in a classification, the carrier must take reasonable action to address the material differences to ensure compliance and must document the actions that have been or are being taken by the carrier to address material differences in access to mental health disorder or substance use disorder benefits, as compared to medical or surgical benefits.

(85 Del. Laws, c. 480, § 2.)

§ 3571V. Time of submitting claim for reimbursement.

(a) For purposes of this section:

(1) "Carrier" means any entity that provides health insurance in this State. "Carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(2) "Carrier" does not mean an entity that provides a plan of health insurance or health benefits designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act (42 U.S.C. §§ 1395 et seq., 1396 et seq. and 1397 et seq.), known as Medicare, Medicaid, or any other similar coverage under state or federal governmental plans.

(b) Regardless of network status, a carrier shall permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement. Any contract between a carrier and provider that prohibits a provider from submitting a claim beyond the minimum time limit required under this section shall not be deemed a violation of this section.

(82 Del. Laws, c. 111, § 4.)

§ 3571W. Electronic medical claims.

(a) This section shall apply to all claims for healthcare services that are submitted as part of group or blanket health insurance contracts.

(b) For purposes of this section:

(1) "Carrier" means any entity that provides health insurance in this State. "Carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(2) "Carrier" does not mean an entity that provides a plan of health insurance or health benefits designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act (42 U.S.C. §§ 1395 et seq., 1396 et seq. and 1397 et seq.), known as Medicare, Medicaid, or any other similar coverage under state or federal governmental plans.

(c) A carrier shall accept primary and secondary claims electronically from providers regardless of network status.

(d) A carrier shall permit a provider to receive electronic remittance advice (ERA/835) files for claims payments upon the completion of the necessary agreements required by the carrier.

(e) Any electronic claim shall be acknowledged by the carrier electronically no later than 2 business days following receipt of the claim to the entity submitting the claim.

(82 Del. Laws, c. 111, § 4.)

§ 3571X. Medication assisted treatment for drug and alcohol dependencies [Effective until Jan. 1, 2028].

(a) For purposes of this section, "medication-assisted treatment" means the use of U.S. Food and Drug Administration-approved medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of drug and alcohol dependencies.

(b) If group health insurance coverage provides prescription medication benefits for the treatment of mental illness and drug and alcohol dependencies, a health insurer must place at least 1 formulation of a medication-assisted treatment on the lowest tier of the drug formulary developed and maintained by the carrier, including each of the following:

(1) Buprenorphine.

(2) Naltrexone.

(3) Naloxone.

(4) A product containing both buprenorphine and naloxone.

(c) A health insurer that provides coverage for prescription drugs must cover the fees associated with the administration or dispensing of methadone dispensed at an opioid treatment program as defined under 42 C.F.R. § 8.2.

(d) A health insurer shall provide benefits under this section as follows:

(1) Not impose a prior authorization requirement.

(2) Must authorize coverage of prescription medicine without imposing a step therapy requirement for at least 1 formulation of each prescription medication for medication-assisted treatment that is on each tier of the drug formulary developed and maintained by the health insurer.

(82 Del. Laws, c. 199, § 2.)

§ 3571X. Medications for mental health disorders and substance use disorders [Effective Jan. 1, 2028].

(a) [Repealed.]

(b) If group health insurance coverage provides prescription medication benefits for the treatment of a mental health disorder or substance use disorder, as defined by § 3578 of this title, a health insurer must place at least 1 formulation of each FDA-approved medication to treat 1 or more substance use disorders, regardless of whether the prescription drug is formulary, nonformulary, or excluded, on the lowest tier of the drug formulary developed and maintained by the carrier, including each of the following:

(1) Buprenorphine.

(2) Naltrexone.

(3) Naloxone.

(4) A product containing both buprenorphine and naloxone.

(5) Disulfiram.

(6) Acamprosate.

(c) A health insurer that provides coverage for prescription drugs must cover the fees associated with the administration or dispensing of methadone dispensed at an "opioid treatment program" as defined under 42 C.F.R. § 8.2.

(d) A health insurer shall provide benefits under this section as follows:

(1) Not impose a prior authorization requirement.

(2) Must authorize coverage of prescription medicine without imposing a step therapy requirement for at least 1 formulation of each FDA-approved medication to treat 1 or more substance use disorders that is on each tier of the drug formulary developed and maintained by the health insurer. A health insurer may impose a step therapy requirement for a prescription medication only to require use of a therapeutically equivalent generic drug that is rated as therapeutically equivalent (AB-rated) by the United States Food and Drug Administration and has the same active ingredient, dosage form, and strength as the prescribed medication. Notwithstanding any step therapy requirement permitted under this subsection, a health insurer shall authorize coverage of the prescribed dosage form or formulation of the prescribed medication when the prescribed formulation is reasonably expected to provide clinical benefit for the covered person.

(82 Del. Laws, c. 199, § 2; 85 Del. Laws, c. 480, § 2.)

§ 3571Y. Coverage for epinephrine autoinjectors.

(a) For purposes of this section, "epinephrine autoinjector" means a single-use device used for the automatic injection of a premeasured dose of epinephrine into the human body.

(b) All group and blanket health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State shall provide coverage for medically-necessary epinephrine autoinjectors by including at least 1 formulation of epinephrine autoinjectors on the lowest tier of the drug formulary developed and maintained by the carrier.

(c) Nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(d) (1) For individuals who are 18 years of age or under, this section applies to all policies, contracts, or certificates issued, renewed, modified, altered, amended, or reissued after December 31, 2021.

(2) For individuals who are more than 18 years of age, this section applies to all policies, contracts, or certificates issued, renewed, modified, altered, amended, or reissued after December 31, 2024.

(e) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.

(83 Del. Laws, c. 42, § 2; 84 Del. Laws, c. 36, § 2.)

§ 3571Z. Annual behavioral health well check.

(a) As used in this section:

(1) "Behavioral health well check" means a predeductible annual visit with a licensed mental health clinician with at minimum a masters level degree. The well check must include but is not limited to a review of medical history, evaluation of adverse childhood

experiences, use of a group of developmentally-appropriate mental health screening tools, and may include anticipatory behavioral health guidance congruent with stage of life using the diagnosis of "annual behavioral health well check."

(2) "Carrier" means any entity that provides health insurance in this State that is subject to this subchapter. "Carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(b) All carriers shall provide coverage of an annual behavioral health well check, which, except as provided in subsection (d) of this section, shall be reimbursed through the following common procedural terminology (CPT) codes at the same rate that such CPT codes are reimbursed for the provision of other medical care, provided that reimbursement may be adjusted for payment of claims that are billed by a nonphysician clinician so long as the methodology to determine such adjustments is comparable to and applied no more stringently than the methodology for adjustments made for reimbursement of claims billed by nonphysician clinicians for other medical care, in accordance with 45 CFR § 146.136(c)(4):

(1) 99381.

(2) 99382.

(3) 99383.

(4) 99384.

(5) 99385.

(6) 99386.

(7) 99387.

(8) 99391.

(9) 99392.

(10) 99393.

(11) 99394.

(12) 99395.

(13) 99396.

(14) 99397.

(c) (1) The Commissioner shall update this list of codes through the promulgation of rules if the CPT codes listed in subsection (b) of this section are altered, amended, changed, deleted, or supplemented.

(2) Reimbursement of any of the CPT codes listed in subsection (b) of this section or promulgated under paragraph (c)(1) of this section for the purpose of covering an annual behavioral health well check may not be denied because such CPT code was already reimbursed for the purpose of covering a service other than an annual behavioral health well check.

(3) Reimbursement of any of the CPT codes listed in subsection (b) of this section or promulgated under paragraph (c)(1) of this section for the purpose of covering a service other than an annual behavioral health well check may not be denied because such CPT code was already reimbursed for the purpose of covering an annual behavioral health well check.

(d) An annual behavioral health well check may be reimbursed through a value-based arrangement, a capitated arrangement, a bundled payment arrangement, or any other alternative payment arrangement that is not a traditional fee-for-service arrangement, provided that a carrier must have documentation demonstrating that within such payment arrangement the annual behavioral health well check is valued commensurate to the value established under subsection (b) of this section.

(e) An annual behavioral health well check may be incorporated into and reimbursed within any type of integrated primary care service delivery method including, but not limited to, the psychiatric collaborative care model, the primary care behavioral health model or behavioral health consultant model, any model that involves co-location of mental health professionals within general medical settings, or any other integrated care model that focuses on the delivery of primary care.

(f) Nothing in this section prevents the operation of policy provisions such as copayments, coinsurance, allowable charge limitations, coordination of benefits, or provisions restricting coverage to services rendered by licensed, certified, or carrier-approved providers or facilities.

(83 Del. Laws, c. 388, § 2.)

§ 3571AA. Coverage for allergenic protein dietary supplements [For application of this section, see 84 Del. Laws, c. 376, § 5].

(a) For purposes of this section:

(1) "Dietary supplement" means as defined in the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 321.

(2) "Early egg allergen introduction dietary supplement" means a dietary supplement that is prescribed to an infant by a health-care practitioner and contains sufficient infant-safe, well-cooked egg protein to reduce the risk of food allergies.

(3) "Early peanut allergen introduction dietary supplement" means a dietary supplement that is prescribed to an infant by a health-care practitioner and contains sufficient infant-safe peanut protein to reduce the risk of food allergies.

(4) "Health-care practitioner" means an individual licensed and authorized to write medical orders for an individual under Title 24.

(5) "Infant" means a child who has not attained the age of 1 year.

(b) (1) All group and blanket health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State shall provide coverage for at least 1 of each of the following:

a. An early egg allergen introduction dietary supplement.

b. An early peanut allergen introduction dietary supplement.

(2) The coverage required under paragraph (b)(1) of this section shall be provided at no cost to a covered individual, including deductible payments and cost-sharing amounts charged once a deductible is met.

(c) Except as provided under paragraph (b)(2) of this section, nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(d) (1) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.

(2) a. The cost-sharing limitation under paragraph (b)(2) of this section does not apply to a high deductible health plan to the extent this cost-sharing limitation would cause the plan to fail to be treated as a high deductible health plan under § 223(c)(2) of the Internal Revenue Code [26 U.S.C. § 223(c)(2)].

b. If the cost-sharing limitation under paragraph (b)(2) of this section would result in an enrollee becoming ineligible for a health savings account under federal law, this cost-sharing limitation only applies to a qualified high deductible health plan after the enrollee's deductible has been met.

(84 Del. Laws, c. 376, § 2.)

§ 3571BB. Services related to termination of pregnancy.

(a) As used in this section:

(1) "Carrier" means any entity that provides health insurance in this State that is subject to the provisions of this chapter. "Carrier" includes an insurance company, health service corporation, managed care organization, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(2) "Health benefit plan" means as defined in § 3342A of this title.

(b) A carrier subject to this section shall cover services related to the termination of pregnancy for enrollees.

(1) a. Except as provided in paragraphs (b)(1)b. and (b)(1)c. of this section, coverage provided under this section may not be subject to any deductible, coinsurance, copayment, or any other cost-sharing requirement.

b. The limitations on cost-sharing in paragraph (b)(1)a. of this section do not apply to a high deductible health plan if the limitations would cause the plan to lose its status as a high deductible health plan. under § 223(c)(2) of the Internal Revenue Code [26 U.S.C. § 223(c)(2)].

c. Coverage under this section may be limited to $750 per covered individual per year.

(2) A carrier must provide coverage for the full scope of services permissible under the law.

(3) Coverage provided under this section may not require a referral or prior authorization as a condition of coverage.

(4) If a policy or contract limits an insured's access to a network of participating providers for other health-care services, then it may limit access for services related to termination of pregnancy, but the policy or contract must include in all its provider networks a sufficient number of providers of termination of pregnancy services to accommodate the direct access needs of their enrollees.

(c) (1) A religious employer may request, and the plan must grant, an exclusion from the coverage requirement if the coverage requirement conflicts with the religious organization's bona fide religious beliefs and practices. If such employer obtains an exclusion, it must provide its employees reasonable and timely notice of the exclusion.

(2) An exclusion under this subsection does not authorize the exclusion of coverage for services related to the termination of pregnancy that are necessary to preserve the life or health of a covered individual.

(d) This section applies to all policies, contracts, or certificates issued, renewed, modified, altered, amended, or reissued after December 31, 2025.

(84 Del. Laws, c. 402, § 4.)

§ 3571CC. Pharmacist services reimbursement [For application of this section, see 85 Del. Laws, c. 253, § 23].

(a) For purposes of this section, "carrier" means any entity that provides health insurance in this State. "Carrier" includes any insurance company, managed care organization, health service corporation, health maintenance organization, and any other entity providing a plan

of health insurance or health benefits subject to state insurance regulation. “Carrier” also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(b) For all group and blanket insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State after January, 1, 2025, a carrier must provide reimbursement to a pharmacist for a service or procedure at a rate not less than that provided to other nonphysician practitioners if the service or procedure is all of the following:

(1) Within the scope of practice of a pharmacist.

(2) Would otherwise be covered under the policy, plan, or contract if the service or procedure is provided by any health-care service provider or practitioner, including a physician, advance practice registered nurse, or physician associate.

(c) Whenever a service is performed by a licensed pharmacist and reimbursed by a carrier, the licensed pharmacist must be granted such rights of participation, plan admission, and registration as may be granted by the carrier to any health-care service provider or practitioner, including a physician, advance practice registered nurse, or physician associate performing such a service.

(84 Del. Laws, c. 421, § 3; 85 Del. Laws, c. 253, § 15.)

§ 3571DD. Developmentally-delayed speech coverage [For application of this section, see 84 Del. Laws, c. 520, § 3].

(a) For the purpose of this section “child” means a child from birth to age 18.

(b) All group and blanket health insurance policies or contracts which are delivered, issued for delivery, or renewed in this State after December 31, 2024, shall provide coverage for any therapy or services to treat a child diagnosed with any of the following speech-language disorders classified in the International Classification of Diseases (ICD-10):

(1) Childhood onset fluency disorder.

(2) Developmental disorder of speech and language, unspecified.

(3) Expressive language disorder.

(4) Mixed receptive-expressive disorder.

(5) Phonological disorder.

(6) Receptive language disorder.

(7) Social pragmatic communication disorder.

(c) This section does not apply to insurance coverage providing benefits exclusively for:

(1) Hospital confinement indemnity.

(2) Disability income.

(3) Accident only.

(4) Long-term care.

(5) Medicare supplement.

(6) Limited benefit health.

(7) Specified disease indemnity.

(8) Sickness or bodily injury or death by accident, or both.

(9) Other limited benefit policies.

(d) Nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(84 Del. Laws, c. 520, § 2.)

§ 3571EE. Coverage for removal of excess skin and subcutaneous tissue [For application of this section, see 85 Del. Laws, c. 88, § 5].

(a) For purposes of this section:

(1) “Medically necessary” means as defined in § 3581 of this title.

(2) “Panniculectomy” means an operative procedure used to contour the abdominal wall by removing significant excess skin and subcutaneous adipose tissue.

(b) All group and blanket health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State must provide coverage for medically necessary removal of excess skin and subcutaneous tissue, including a panniculectomy.

(c) Nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(d) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.

(85 Del. Laws, c. 88, § 2.)

§ 3571FF. Coverage for pre-exposure prophylaxis treatment and post-exposure prophylaxis treatment.

(a) As used in this section:

(1) "Cost-sharing requirement" includes a deductible, coinsurance, copayment, and out-of-pocket expense.

(2) "Essential support services" include all of the following:

a. HIV testing.

b. Hepatitis B and C testing.

c. Kidney function assessment through creatinine testing and calculated estimated creatinine clearance or glomerular filtration rate.

d. Pregnancy testing.

e. Sexually transmitted infection screening and counseling.

f. Adherence counseling.

(3) "FDA" means the United States Food and Drug Administration.

(4) "HIV" means the human immunodeficiency virus.

(5) "Medically necessary" means as defined in § 3581 of this title.

(6) "PEP" means post-exposure prophylaxis medication for preventing HIV infection after possible HIV exposure.

(7) "PrEP" means pre-exposure prophylaxis medication for preventing HIV infection before possible HIV exposure.

(8) "Therapeutic equivalent" means a PrEP or a PEP that is all of the following:

a. Approved as safe and effective.

b. Pharmaceutically equivalent to another PrEP or another PEP because it contains an identical amount of the same active drug ingredient in the same dosage form and route of administration and meets compendial or other applicable standards of strength, quality, purity, and identity.

c. Assigned, by the FDA, the same therapeutic equivalence code as another PrEP or another PEP.

(b) (1) All group and blanket health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State must provide coverage for all of the following:

a. Medically necessary PrEP.

b. Medically necessary PEP.

c. Medically necessary essential support services.

(2) Except as otherwise provided in paragraph (b)(3) of this section, the coverage required under paragraph (b)(1) of this section must be provided without any of the following:

a. Cost-sharing requirements.

b. Prior authorization or step therapy requirements.

c. Unreasonable delay in coverage determination.

(3) a. If the FDA has approved 1 or more therapeutic equivalents of a PrEP or a PEP, a health benefit plan is not required to cover all of the therapeutic equivalent versions of that PrEP or that PEP, so long as at least 1 therapeutic equivalent version of that PrEP and at least 1 therapeutic equivalent version of that PEP are covered without cost-sharing, prior authorization, or step therapy requirements. For purposes of this section, a long-acting version of a PrEP or a PEP is not therapeutically equivalent to another long-acting version of a PrEP or a PEP with a different duration.

b. If there is a therapeutic equivalent of a PrEP or a PEP, a health benefit plan may provide coverage for more than 1 version of that PrEP or that PEP and may impose cost-sharing, prior authorization, or step therapy requirements, so long as at least 1 version of that PrEP and at least 1 version of that PEP in the same method of administration is covered without cost-sharing, prior authorization, or step therapy requirements. But a health benefit plan must provide coverage for a particular PrEP or a particular PEP without cost-sharing, prior authorization, or step therapy requirements, regardless of whether the PrEP or the PEP has a therapeutic equivalent, if a covered individual's treating health-care provider recommends that particular PrEP or that particular PEP based on a medical determination regarding that covered individual.

(c) Except as otherwise provided in subsection (b) of this section, nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(d) (1) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited health insurance policies.

(2) a. The cost-sharing limitation under paragraph (b)(2) of this section does not apply to a high deductible health plan to the extent this cost-sharing limitation would cause the plan to fail to be treated as a high deductible health plan under § 223(c)(2) of the Internal Revenue Code[26 U.S.C. § 223(c)(2)].

b. If the cost-sharing limitation under paragraph (b)(2) of this section would result in an enrollee becoming ineligible for a health savings account under federal law, the cost-sharing limitation only applies to a qualified high deductible plan after the enrollee's deductible has been met.

(85 Del. Laws, c. 452, § 2.)

§ 3571GG. Coverage for diagnostic services and treatment for menopause and perimenopause [For application of this section, see 85 Del. Laws, c. 482, § 5].

(a) As used in this section:

(1) "Hormone replacement therapy" means medical treatment, approved by the United States Food and Drug Administration, that replaces a hormone that an individual's body is no longer making or no longer making enough of, as determined by a licensed health-care professional. "Hormone replacement therapy" includes prescribing any of the following:

a. A cream.

b. An oral medication.

c. A vaginal device.

d. Another method approved by the United States Food and Drug Administration.

(2) "Medically necessary" means providing of health-care services or products that a prudent licensed health-care professional would provide to a patient for the purpose of diagnosing or treating an illness, injury, disease or its symptoms in a manner that is all of the following:

a. In accordance with generally accepted standards of medical practice.

b. Consistent with the symptoms or treatment of the condition.

c. Not solely for anyone's convenience.

d. Not including investigational or experimental health-care services.

(3) "Menopause" means the permanent end of menstruation due to loss of ovarian follicular function, characterized by the end of ovulation and a decline in estrogen and progesterone production.

(4) "Menopause and perimenopause symptoms" include any of the following:

a. Irregular menstrual periods.

b. Hot flashes.

c. Vaginal or bladder changes, including genitourinary syndrome of menopause.

d. Decreased fertility.

e. Loss of bone density, including osteoporosis.

f. Elevated low-density lipoprotein cholesterol levels.

g. Sleep disturbances, including night sweats.

(5) "Perimenopause" means the transitional period leading to menopause, marked by fluctuating hormone levels and changes in the menstrual cycle.

(b) (1) All group and blanket health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State must provide coverage for medically necessary diagnostic services and treatment for menopause, perimenopause, and menopause and perimenopause symptoms, including all of the following:

a. Consultation and diagnostic testing.

b. Hormonal therapies, including hormone replacement therapy and bioidentical hormone treatments, that are approved by the United States Food and Drug Administration.

c. Nonhormonal treatments, including selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, neurokinin B antagonists, and other medications to manage menopause and perimenopause symptoms.

d. All drugs, devices, and combination products approved by the United States Food and Drug Administration for the treatment of menopause and perimenopause symptoms.

e. Therapy to treat menopause induced by a hysterectomy.

f. Behavioral health care services.

g. Pelvic floor physical therapy.

h. Bone health treatments due to hormonal changes related to menopause and perimenopause, including screenings and medications.

i. Preventative services for early detection and treatment of health conditions related to menopause and perimenopause, including osteoporosis and cancer.

j. Counseling and education regarding menopause management.

(2) An insurer shall provide clear and accessible information to each covered individual regarding covered diagnostic services and treatment for menopause, perimenopause, and menopause and perimenopause symptoms.

(3) Coverage for medically necessary hormone replacement therapy provided under this section may not be any of the following:

a. Denied or limited, if the use of the hormone replacement therapy is supported by national clinical guidelines, national standards of care, or peer-reviewed medical literature for the treatment of menopause, perimenopause, or menopause and perimenopause symptoms.

b. Subject to prior authorization or step therapy requirements.

(4) Except as otherwise provided in paragraph (b)(3) of this section, benefits provided under this section must be provided to covered individuals to the same extent as other benefits for any other medical condition covered under the group or blanket health insurance policy, contract, or certificate.

(c) Nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(d) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long- term care, disability income, or other limited health insurance policies.

(e) (1) If the coverage required under this section conflicts with a religious employer's bona fide religious beliefs and practices, the religious employer may request that a policy, contract, or certificate include a coverage exclusion for the coverage required under this section. An insurer shall grant a coverage exclusion requested under this subsection.

(2) A religious employer that obtains an exclusion under this subsection shall give its employees reasonable and timely notice of the exclusion.

(85 Del. Laws, c. 482, § 2.)

§ 3571HH. Biomarker testing [For application of this section, see 85 Del. Laws, c. 484, § 5].

(a) For purposes of this section:

(1) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered. Biomarkers include gene mutations, characteristics of genes, and protein expression. A biomarker is not an assessment of how a covered person or enrollee feels, functions or survives.

(2) "Biomarker testing" means the analysis of an individual's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes single-analyte tests, multi-plex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing.

(3) "Investigatory and experimental biomarker tests" means biomarker tests that are subject to the United States food and drug administration's investigational device exemption (C.F.R. Part 812).

(4) "Medically necessary" means as defined in § 3581 of this title.

(5) "Nationally recognized clinical practice guideline" means an evidence-based clinical practice guideline developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and with a conflict-of-interest policy. A clinical practice guideline establishes a standard of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options and includes recommendations intended to optimize patient care.

(6) "Screening" means a medical procedure or test for a covered person who has yet to display symptoms of a particular disease or condition for the purpose of determining the person's likelihood of having the disease or condition.

(b) All individual health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State shall provide coverage for biomarker testing to guide or inform treatment decisions for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a covered person's disease or condition when the test is medically necessary as demonstrated by medical and scientific evidence, including any of the following:

(1) Labeled indications for an FDA-approved or FDA-cleared test.

(2) Indicated tests for an FDA-approved drug.

(3) Warnings and precautions on FDA-approved drug labels.

(4) Centers for Medicare and Medicaid Services (CMS) national coverage determinations or Medicare administrative contractor (MAC) local coverage determinations.

(5) Nationally recognized clinical practice guidelines.

(c) A biomarker test that meets 1 of the medical and scientific evidence outlined in paragraphs (b)(1) through (b)(5) of this section shall not be considered an investigational or experimental health-care service.

(d) Insurers, health-benefit plans, and health-service corporations must ensure that coverage for biomarker testing, as required by subsection (b) of this section, is provided in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples.

(e) Nothing in this section prevents the operation of a policy provision required by this section as a deductible, coinsurance, allowable charge limitation, coordination of benefits, or a provision restricting coverage to services by a licensed, certified, or carrier-approved provider or facility.

(f) Nothing in this section restricts the use of utilization management.

(g) Nothing in this section shall be construed to require coverage of biomarker testing for screening or coverage of investigatory and experimental biomarker tests.

(h) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.

(85 Del. Laws, c. 484, § 2.)

Subchapter IV

Large Employer Health Insurance Standards

§ 3572. Definitions.

As used in this subchapter:

(1) "Affiliation period" means a period of time not to exceed 2 months (3 months for late enrollees) during which a health maintenance organization does not collect premium and coverage issued is not effective.

(2) "Bona fide association" means, with respect to health insurance coverage offered in Delaware, an association which:

a. Has been actively in existence for at least 5 years;

b. Has been formed and maintained in good faith for purposes other than obtaining insurance and does not condition membership on the purchase of association-sponsored insurance;

c. Does not condition membership in the association on any health status-related factor relating to an employee of an employer or a dependent of an employee and clearly so states in all membership and application materials;

d. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member) and clearly so states in all marketing and application materials;

e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association and clearly so states in all marketing and application materials; and

f. Provides and annually updates information necessary for the Commissioner to determine whether or not an association meets the definition of a bona fide association before qualifying as a bona fide association for the purposes of this chapter.

(3) "Creditable coverage" means, with respect to an individual, health benefits or coverage provided under any of the following:

a. A group health benefit plan;

b. A health benefit plan;

c. Part A or Part B of Title XVIII of the Social Security Act [42 U.S.C. § 1395 et seq. or 42 U.S.C. § 1395j et seq.];

d. Title XIX of the Social Security Act [42 U.S.C. § 1396 et seq.], other than coverage consisting solely of benefits under § 1928 [42 U.S.C. § 1396s];

e. Chapter 55 of Title 10, United States Code [10 U.S.C. § 1071 et seq.];

f. A medical care program of the Indian Health Service or of a tribal organization;

g. A state health benefits risk pool;

h. A health plan offered under Chapter 89 of Title 5, United States Code [5 U.S.C. § 8901 et seq.];

i. A public health plan as defined in federal regulations;

j. A health benefit plan under § 5(e) of the Peace Corps Act [22 U.S.C. § 2504(e)].

(4) "Health benefit plan" means any hospital or medical policy or certificate, major medical expense insurance policy or certificate, any hospital or medical service plan contract, health maintenance organization or health service corporation subscriber contract or any other similar health contract subject to the jurisdiction of the Commissioner.

"Health benefit plan" does not include: accident only; credit; dental; vision; Medicare supplement; benefits for long-term care, home health care, community-based care or any combination thereof; disability income insurance; liability insurance including general liability insurance and automobile liability insurance; coverage for on-site medical clinics; coverage issued as a supplement to liability insurance, worker's compensation or similar insurance; or automobile medical payment insurance. The term also excludes specified disease, hospital confinement indemnity or limited benefit health insurance if such types of coverage do not provide coordination of benefits and are provided under separate policies or certificates; provided, that the carrier offering such policies or certificates complies with the following:

a. The carrier files, on or before March 1 of each year, a certification with the Commissioner that contains the statement and information described in paragraph (4)b. of this section.

b. The certification shall contain the following:

1. A statement from the carrier certifying that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance.

2. A summary description of each policy or certificate described in this paragraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age or other factors) charged for these policies and certificates in this State.

c. In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this State on or after July 1, 1997, the carrier files with the Commissioner the information and statement required in paragraph (4)b. of this section at least 30 days prior to the date the policy or certificate is issued or delivered in this State.

(5) "Health status-related factor" means any of the following factors:

a. Health status;

b. Medical condition, including both physical and mental illnesses;

c. Claims experience;

d. Receipt of health care;

e. Medical history;

f. Genetic information, as defined in § 2317 of this title;

g. Evidence of insurability, including conditions arising out of acts of domestic violence;

h. Disability.

(6) "Large employer" means any person, firm, corporation, partnership or association that is actively engaged in business that, on at least 50 percent of its working days during the preceding calendar quarter, employed more than 50 eligible employees, as defined in § 7202 of this title, the majority of whom were employed within this State. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation shall be considered 1 employer. In the case of an employer that was not in existence throughout the preceding calendar quarter, the determination of whether such employer is a small or large employer shall be based on the average number of employees that is reasonably expected such employer will employ on business days in the current calendar year.

(7) "Late enrollee" means an eligible employee or dependent who requests enrollment in a group health benefit plan following the initial enrollment period during which such individual is entitled to enroll under the terms of the health benefit plan, if such initial enrollment period is a period of at least 30 days. An eligible employee or dependent shall not be considered a late enrollee if:

a. The individual:

1. Was covered under other creditable coverage at the time of the initial enrollment period and, if required by the carrier or issuer, the employee stated at the time of initial enrollment that this was the reason for declining enrollment;

2. Lost coverage under the other creditable coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the creditable coverage, death of a spouse, legal separation or divorce or employer contributions towards such coverage was terminated; and

3. Requests enrollment within 30 days after termination of the other creditable coverage; or

b. The individual is employed by an employer that offers multiple health benefit plans and elects a different plan during an open enrollment period; or

c. A court has ordered that coverage be provided for a dependent under a covered employee's health benefit plan and the request for enrollment is made within 30 days after issuance of such court order; or

d. A person becomes a dependent of a covered person through marriage, birth, adoption or placement for adoption and requests enrollment no later than 30 days after becoming such a dependent. In such case, coverage shall commence on the date the person becomes a dependent if a request for enrollment is received in a timely fashion before such date.

(8) "Medical care" means amounts paid for:

a. The diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

b. Transportation primarily for and essential to medical care referred to in paragraph (8)a. of this section; and

c. Insurance covering medical care referred to in paragraphs (8)a. and (8)b. of this section.

(9) "Waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible for benefits under the terms of the plan. For purposes of calculating periods of creditable coverage, a waiting period shall not be considered a gap in coverage.

(71 Del. Laws, c. 143, § 14; 72 Del. Laws, c. 383, § 4; 73 Del. Laws, c. 89, § 1; 76 Del. Laws, c. 176, § 3.)

§ 3573. Limitations on preexisting condition limitations [For application of this section, see 79 Del. Laws, c. 99, § 19].

A health benefit plan that covers a large group in this State:

(1) Shall not deny, exclude or limit benefits for a covered individual because of a preexisting condition;

(2) May impose an affiliation period. An affiliation period shall run concurrently with any waiting period. A health maintenance organization may, in lieu of an affiliation period, use an alternative method to address adverse selection with the prior approval of the Commissioner;

(3) Shall waive an affiliation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than 63 days prior to the effective date of the new coverage. For purposes of calculating continuous coverage, a waiting period shall not be considered a gap in coverage. This paragraph shall not preclude application of any waiting period applicable to all new enrollees under the plan. The method of crediting and certifying coverage shall be determined by the Commissioner by regulation; and

(4) May not exclude coverage for late enrollees for a preexisting condition.

A health benefit plan shall not establish rules for eligibility for any individual to enroll under the plan based on any health status-related factors in relation to the individual or a dependent of the individual.

(71 Del. Laws, c. 143, § 14; 73 Del. Laws, c. 89, § 1; 76 Del. Laws, c. 176, § 3; 79 Del. Laws, c. 99, § 9.)

§ 3574. Renewability of coverage.

(a) A health benefit plan shall be renewable with respect to an enrollee or dependents at the option of the enrollee, except in any of the following cases:

(1) The policyholder fails to comply with participation or contribution rules;

(2) With respect to a network plan, there is no longer any enrollee in connection with such plan that lives, resides or works in the service area of the carrier;

(3) With respect to a coverage that is made available only through 1 or more bona fide associations, the membership of the employer ceases;

(4) The policyholder has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the health carrier has not received timely premium payments;

(5) The policyholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(6) A decision by the carrier to discontinue offering a particular type of group health benefit plan in the state's large group insurance market. A type of health benefit plan may be discontinued by the carrier in the large group market only if the carrier:

a. Provides notice of the decision not to renew coverage to all affected enrollees and to the Commissioner in each state in which an affected enrollee is known to reside at least 90 days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the Commissioner under this subparagraph shall be provided at least 3 working days prior to the notice to the affected individuals;

b. Offers to each large employer provided the particular type of health benefit plan the option to purchase any other health benefit plans currently being offered by the carrier to large employers in the state; and

c. In exercising the option to discontinue the particular type of health benefit plan and in offering the option of coverage under paragraph (a)(6)b. of this section, the carrier acts uniformly without regard to the claims experience of any affected individual or any health status-related factor relating to any covered individuals or beneficiaries who may become eligible for the coverage;

(7) The carrier elects to discontinue offering and to nonrenew all its health benefit plans delivered or issued for delivery in the state. In that case, the carrier shall provide notice of the decision not to renew coverage to all enrollees and to the Commissioner in each state in which an enrollee is known to reside at least 180 days prior to the nonrenewal of the health benefit plan by the carrier. Notice to the Commissioner under this paragraph shall be provided at least 3 working days prior to the notice of the enrollees.

(b) A carrier that elects not to renew all its health benefit plans under paragraph (a)(7) of this section shall be prohibited from writing new business in the large group market in this State for a period of 5 years from the date of the discontinuation of the last health benefit plan not so renewed.

(c) A carrier may modify a large group health benefit plan if all those large groups covered by the same policy form are uniformly modified.

(71 Del. Laws, c. 143, § 14; 73 Del. Laws, c. 89, § 1; 76 Del. Laws, c. 176, § 3; 79 Del. Laws, c. 102, § 3.)

§ 3575. Rate regulation.

A carrier offering a large group health benefit plan may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution that is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual. This prohibition shall not be construed to restrict the amount that an employer may be charged

for coverage under a large group health benefit plan or to prevent a carrier from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention, if not otherwise prohibited by law.

(71 Del. Laws, c. 143, § 14; 73 Del. Laws, c. 89, § 1; 76 Del. Laws, c. 176, § 3.)

§ 3576. Mental health parity.

A carrier offering a large group health plan shall comply with the provisions of 42 U.S.C. § 300gg-5, Public Law 104-204 and any subsequent changes in federal law.

(71 Del. Laws, c. 143, § 14; 73 Del. Laws, c. 89, § 1; 76 Del. Laws, c. 176, § 3.)

§ 3577. Newborns and mothers health protection.

A carrier offering a health benefit plan shall comply with the provisions of 42 U.S.C. § 300gg-4 and any subsequent changes in federal law.

(71 Del. Laws, c. 143, § 14; 73 Del. Laws, c. 89, § 1; 76 Del. Laws, c. 176, § 3.)

§ 3578. Insurance coverage for serious mental illness [For application of this section, see 81 Del. Laws, c. 29, § 3] [Effective until Jan. 1, 2028].

(a) *Definitions.* — For the purposes of this section, the following words and phrases shall have the following meanings:

(1) "ASAM criteria" means the comprehensive set of guidelines for placement, continued stay, and transfer or discharge of patients with addiction established by the American Society of Addiction Medicine ("ASAM") for use in determining medically necessary treatment.

(2) "Carrier" means any entity that provides health insurance in this State. For the purposes of this section, "carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(3) "Drug and alcohol dependencies" means substance abuse disorder or the chronic, habitual, regular, or recurrent use of alcohol, inhalants, or controlled substances as identified in Chapter 47 of Title 16.

(4) "Health benefit plan" means any hospital or medical policy or certificate, major medical expense insurance, health service corporation subscriber contract, or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, credit, dental, vision, Medicaid plans, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical payment insurance.

"Health benefit plan" shall not include policies or certificates or specified disease, hospital confinement indemnity, or limited benefit health insurance, provided that the carrier offering such policies or certificates complies with the following:

a. The carrier files on or before March 1 of each year a certification with the Commissioner that contains the statement and information described in paragraph (a)(4)b. of this section.

b. The certification required in paragraph (a)(4)a. of this section shall contain the following:

1. A statement from the carrier certifying that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance.

2. A summary description of each policy or certificate described in this paragraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age, gender or other factors) charged for such policies and certificates in this State.

c. In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this State on or after January 1, 1999, the carrier files with the Commissioner the information and statement required in paragraph (a)(4)b. of this section at least 30 days prior to the date such a policy or certificate is issued or delivered in this State.

(5) "Serious mental illness" means any of the following biologically based mental illnesses: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo affective disorder, and delusional disorder. The diagnostic criteria set out in the most recent edition of the Diagnostic and Statistical Manual shall be utilized to determine whether a beneficiary of a health benefit plan is suffering from a serious mental illness.

(b) *Coverage of serious mental illness and drug and alcohol dependency.* — (1) a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide:

1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.

2. Unlimited medically necessary treatment for drug and alcohol dependencies as required by the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a) and determined by the use of the full set of ASAM criteria, in all of the following:

A. Treatment provided in residential setting.

B. Intensive outpatient programs.

C. Inpatient withdrawal management.

b. Subject to subsections (a) and (c) through (g) of this section, no carrier may issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan. By way of example, such terms include deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits or limits in the coverage of prescription medicines.

(2) a. A health benefit plan that provides coverage for prescription drugs must provide coverage for the treatment of serious mental illnesses and drug and alcohol dependencies that include immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications covered under the health benefit plan for the medically necessary treatment of serious mental illnesses and drug and alcohol dependencies where an emergency medical condition, as defined in § 3565(e) of this title, exists, including a prescribed drug or medication associated with the management of opioid withdrawal or stabilization, except where otherwise prohibited by law.

b. Coverage of an emergency supply of prescribed medications must include medication for opioid overdose reversal otherwise covered under the health benefit plan prescribed to a covered person.

c. Coverage provided under this paragraph (b)(2) may be subject to copayments, coinsurance, and annual deductibles that are consistent with those imposed on other benefits within the health benefit plan; provided, however, a health benefit plan must not impose an additional copayment or coinsurance on a covered person who received an emergency supply of the same medication in the same 30-day period in which the emergency supply of medication was dispensed.

d. This paragraph (b)(2) does not preclude the imposition of a copayment or coinsurance on the initial emergency supply of medication in an amount that is less than the copayment or coinsurance otherwise applicable to a 30-day supply of such medication, provided that the total sum of copayments or coinsurance for an entire 30-day supply of the medication does not exceed the copayment or coinsurance otherwise applicable to a 30-day supply of such medication.

(c) *Eligibility for coverage.* — Subject to the limitations set forth in subsection (d) of this section, a health benefit plan may condition coverage of services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency on the further requirements that the service or services:

(1) Must be rendered by a mental health professional licensed or certified by the State Board of Licensing including, but not limited to, psychologists, psychiatrists, social workers and such other mental health professionals, or a drug and alcohol counselor who has been certified by the Delaware Certified Alcohol and Drug Counselors Certification Board, or in a mental health facility licensed by the State or in a treatment facility approved by the Department of Health and Social Services or the Bureau of Alcoholism and Drug Abuse as set forth in Chapter 22 of Title 16 or substantially similar licensing entities in other states;

(2) Must be medically necessary; and

(3) Must be covered services subject to any administrative requirements of the health benefit plan.

A health benefit plan may further condition coverage of services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency in the same manner and to the same extent as coverage for all other illnesses and diseases is conditioned. Such conditions may include, by way of example and not by way of limitation, precertification and referral requirements.

(d) *Benefit management.* — (1) A carrier may, directly or by contract with another qualified entity, manage the benefit prescribed by subsection (b) of this section in order to limit coverage of services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency to those services that are deemed medically necessary as follows:

a. The management of benefits for serious mental illnesses and drug and alcohol dependencies may be by methods used for the management of benefits provided for other medical conditions, or may be by management methods unique to mental health benefits. Such may include, by way of example and not limitation, pre-admission screening, prior authorization of services, utilization review and the development and monitoring of treatment plans.

b. A carrier may not impose precertification, prior authorization, pre-admission screening, or referral requirements for the diagnosis and medically necessary treatment, including in-patient treatment, of drug and alcohol dependencies.

c. The benefit prescribed by paragraph (b)(1) of this section may not be subject to concurrent utilization review during the first 14 days of any inpatient admission to a facility approved by a nationally recognized health-care accrediting organization or the Division of Substance Abuse and Mental Health, 30 days of intensive outpatient program treatment, or 5 days of inpatient withdrawal management, provided that the facility notifies the carrier of both the admission and the initial treatment plan within 48 hours of the admission. The facility shall perform daily clinical review of the patient, including the periodic consultation with the carrier to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the carrier which is designated by the American Society of Addiction Medicine ("ASAM") or, if applicable, any state-specific ASAM criteria, and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient.

d. Any utilization review of treatment provided under paragraph (b)(1) of this section may include a review of all services provided during such inpatient treatment, including all services provided during the first 14 days of such inpatient treatment, 30 days of

intensive outpatient program treatment, or 5 days of inpatient withdrawal management;provided, however, the carrier may only deny coverage for any portion of the initial 14-day inpatient treatment on the basis that such treatment was not medically necessary if such inpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the carrier which is designated by ASAM or, if applicable, any state-specific ASAM criteria.

e. A covered person does not have any financial obligation to the facility for any treatment under paragraph (b)(1) of this section other than any copayment, coinsurance, or deductible otherwise required under the health benefit plan.

(2) This section shall not be interpreted to require a carrier to employ the same benefit management procedures for serious mental illnesses and drug and alcohol dependencies that are employed for the management of other illnesses or diseases covered by the health benefit plan or to require parity or equivalence in the rate, or dollar value of, claims denied.

(e) *Exclusions.* — This section shall not apply to plans or policies not within the definition of health benefit plan, as set out in subsection (a) of this section.

(f) *Out of network services.* — Where a health benefit plan provides benefits for the diagnosis and treatment of serious mental illnesses and drug and alcohol dependencies within a network of providers and where a beneficiary of the health benefit plan obtains services consisting of diagnosis and treatment of a serious mental illness and drug and alcohol dependency outside of the network of providers, the provisions of this section shall not apply. The health benefit plan may contain terms and conditions applicable to out of network services without reference to the provisions of this section.

(g) Nothing in this section shall be construed to limit or reduce any benefit, entitlement, or coverage conferred by § 3570A of this title including, but not limited to, provider and service eligibility.

(71 Del. Laws, c. 275, § 2; 73 Del. Laws, c. 89, § 1; 73 Del. Laws, c. 199, §§ 7-10, 12; 74 Del. Laws, c. 157, § 2; 76 Del. Laws, c. 176, § 3; 78 Del. Laws, c. 398, § 4; 81 Del. Laws, c. 29, § 2; 81 Del. Laws, c. 190, §§ 4–6.)

§ 3578. Insurance coverage for mental health disorders and substance use disorders [For application of this section, see 81 Del. Laws, c. 29, § 3] [Effective Jan. 1, 2028].

(a) *Definitions.* —

For the purposes of this section, the following words and phrases shall have the following meanings:

(1) “ASAM criteria” means the latest version of comprehensive set of guidelines for placement, continued stay, and transfer or discharge of individuals with a primary diagnosis of a substance use disorder established by the American Society of Addiction Medicine (“ASAM”).

(2) “Carrier” means any entity that provides health insurance in this State. For the purposes of this section, “carrier” includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. “Carrier” also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(3) “Child and Adolescent Level of Care Utilization System / Service Intensity Instrument” or “CALOCUS-CASII” means the latest version of comprehensive set of guidelines for placement, continued stay, and transfer or discharge of children and adolescents aged 6 to 18 with a primary diagnosis of a mental health disorder established by the American Association for Community Psychiatry (“AACP”) and the American Academy of Child and Adolescent Psychiatry (“AACAP”).

(4) “Early Childhood Service Intensity Instrument” or “ECSII” means the latest version of the service planning tool established by AACAP for determination of the intensity of services for children and families with emotional, behavioral, or developmental needs, including those who are experiencing environmental stressors that may put them at risk for such problems.

(5) “Emergency care” means care provided to treat a mental health disorder or substance use disorder that meets the definition of an “emergency medical condition” as defined in § 3349 of this title.

(6) “Generally accepted standards of mental health disorder and substance use disorder care” means standards of care and clinical practice that are generally recognized by health-care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical social work, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental health disorder and substance use disorder care include published peer-reviewed scientific studies and medical literature and clinical practice guidelines and other recommendations of nonprofit health-care professional associations.

(7) “Health benefit plan” means any hospital or medical policy or certificate, major medical expense insurance, health service corporation subscriber contract, or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, credit, dental, vision, Medicaid plans, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, worker’s compensation or similar insurance, or automobile medical payment insurance.

“Health benefit plan” shall not include policies or certificates or specified disease, hospital confinement indemnity, or limited benefit health insurance, provided that the carrier offering such policies or certificates complies with the following:

a. The carrier files on or before March 1 of each year a certification with the Commissioner that contains the statement and information described in paragraph (a)(7)b. of this section.

b. The certification required in paragraph (a)(7)a. of this section shall contain the following:

1. A statement from the carrier certifying that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance.

2. A summary description of each policy or certificate described in this paragraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age, gender or other factors) charged for such policies and certificates in this State.

c. In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this State on or after January 1, 1999, the carrier files with the Commissioner the information and statement required in paragraph (a)(7)b. of this section at least 30 days prior to the date such a policy or certificate is issued or delivered in this State.

(8) "Level of Care Utilization System" or "LOCUS" means the latest version of comprehensive set of guidelines for placement, continued stay, and transfer or discharge of adults over 18 years of age with a primary diagnosis of a mental health disorder established by AACP.

(9) "Medically necessary" means a service or product addressing the specific needs of a covered person, for the purpose of screening, preventing, diagnosing, managing, or treating a mental health disorder or substance use disorder, including minimizing the progression of a disorder or its symptoms, in a manner that is all of the following:

a. In accordance with the generally accepted standards of mental health disorder and substance use disorder care.

b. Clinically appropriate in terms of type, frequency, extent, site, and duration.

c. Not primarily for the economic benefit of the carrier, purchaser, or for the convenience of the covered person, treating physician, or other health-care provider.

(10) "Mental health disorders and substance use disorders" means a mental health disorder or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, or the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood.

(11) "Nonprofit health-care professional association" means a not-for-profit health-care provider professional association or specialty society that is generally recognized by clinicians practicing in the relevant clinical specialty and that issues peer-reviewed guidelines, criteria, or other clinical recommendations developed through a transparent process, including the American Psychiatric Association, American Psychological Association, American Society of Addiction Medicine, American Academy of Child and Adolescent Psychiatry, and American Association for Community Psychiatry.

(12) "Serious mental illness" means any of the following mental health disorders: neurodevelopmental disorders; schizophrenia spectrum and other psychotic disorders; bipolar and related disorders; depressive disorders; anxiety disorders; obsessive-compulsive and related disorders; trauma- and stressor-related disorders; dissociative disorders; somatic symptom and related disorders; feeding and eating disorders; personality disorders; and disruptive, impulse-control, and conduct disorders. The diagnostic criteria set out in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders must be utilized to determine whether a beneficiary of a health benefit plan has a serious mental illness.

(13) "Urgent mental health disorder and substance use disorder care" means care that is delivered on an expedited basis for the treatment of an acute mental health disorder or substance use disorder with symptoms of sufficient severity pursuant to a determination by a licensed treating health-care provider, operating within the health-care provider's scope of practice and professional expertise, that the failure to provide the service is likely to result in serious, long-term health complications or a material deterioration in the covered person's or enrollee's condition and prognosis.

(14) "Utilization review" means reviewing and approving, modifying, delaying, or denying, requests by health-care providers, covered persons, or their authorized representatives for coverage of health-care services, based in whole or in part on medical necessity, or for out-of-network services required pursuant to subsection (g) of this section.

(15) "Utilization review criteria" means any criteria, standards, protocols, or guidelines used by a carrier to conduct utilization review.

(b) *Coverage of mental health disorders and substance use disorders.* — (1) a. Carriers shall provide coverage for all medically necessary services for mental health disorders or substance use disorders under all health benefit plans delivered or issued for delivery in this State. Coverage for mental health disorders and substance use disorders must provide all of the following:

1. The levels of care described in the ASAM criteria, LOCUS, CALOCUS-CASII, and ECSII.

2. Unlimited medically necessary services for mental health disorders and substance use disorders as required by the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a) and determined by the use of the full set of ASAM criteria, LOCUS, CALOCUS-CASII, and ECSII, including all of the following levels of care:

A. Treatment provided in residential settings.

B. Intensive outpatient programs.

C. Inpatient settings, including withdrawal management.

3. Emergency services to treat mental health disorders and substance use disorders, including emergency transportation to an appropriate provider or facility for the purposes of stabilization, mobile crisis response teams, crisis receiving and stabilization services, and other services necessary to screen, evaluate, and stabilize an individual experiencing a mental health or substance use disorder emergency.

4. For purposes of paragraph (b)(1)a.3. of this section, mobile crisis response services provided by a state-operated program or by a program authorized by the Division of Substance Abuse and Mental Health are considered emergency services. A carrier shall reimburse a state-operated or state-authorized mobile crisis program that submits claims for covered services consistent with this section. Nothing in this section requires a carrier to establish or duplicate a mobile crisis delivery system where this State operates or authorizes such services.

5. Nothing in this subsection requires a carrier to cover nonclinical placements or supports, including foster care or recovery residences that are not licensed or certified as behavioral health treatment programs under Delaware law; provided, however, that if a carrier provides coverage for such services or settings, the carrier shall apply the requirements of this section to that coverage and shall cover medically necessary clinical services, including services delivered in residential treatment settings, as required under paragraph (b)(1)a.2. of this section.

b. Subject to subsections (a), (c) through (e), (g), and (h) of this section, no carrier may issue for delivery, or deliver, in this State any health benefit plan that does any of the following:

1. Contains terms that place a greater financial burden on a covered person for covered services provided in the diagnosis and treatment of a mental health disorder or substance use disorder than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan. By way of example, such terms include deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits or limits in the coverage of prescription medicines.

2. Discriminates, in its benefit design or implementation of its benefit design, against covered persons because of their history of, present, or predicted mental health disorder or substance use disorder.

(2) a. A health benefit plan that provides coverage for prescription drugs must provide coverage for the treatment of mental health disorders and substance use disorders that includes immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications covered under the health benefit plan for the medically necessary services of mental health disorders and substance use disorders where an "emergency medical condition," as defined in § 3565(e) of this title, exists, including a prescribed drug or medication associated with the management of opioid withdrawal or stabilization, except where otherwise prohibited by law.

b. Coverage of an emergency supply of prescribed medications must include medication for opioid overdose reversal otherwise covered under the health benefit plan prescribed to a covered person.

c. Coverage provided under this paragraph (b)(2) may be subject to copayments, coinsurance, and annual deductibles that are consistent with those imposed on other benefits within the health benefit plan and in compliance with the Mental Health Parity and Addiction Equity Act of 2008's [29 U.S.C. § 1185a] financial requirements; provided, however, a health benefit plan must not impose an additional copayment or coinsurance on a covered person who received an emergency supply of the same medication in the same 30-day period in which the emergency supply of medication was dispensed.

d. This paragraph (b)(2) does not preclude the imposition of a copayment or coinsurance on the initial emergency supply of medication in an amount that is less than the copayment or coinsurance otherwise applicable to a 30-day supply of such medication, provided that the total sum of copayments or coinsurance for an entire 30-day supply of the medication does not exceed the copayment or coinsurance otherwise applicable to a 30-day supply of such medication.

(c) *Eligibility for coverage.* — Subject to the limitations set forth in subsection (d) of this section, a health benefit plan may condition coverage of services provided in the diagnosis and treatment of a mental health disorder or substance use disorder on any of the further requirements that the service or services:

(1) Must be rendered by a mental health disorder or substance use disorder professional licensed or certified by the State Board of Licensing, including psychologists, psychiatrists, social workers and such other mental health professionals, or a drug and alcohol counselor who has been certified by the Delaware Certified Alcohol and Drug Counselors Certification Board, or in a mental health disorder or substance use disorder facility licensed by this State or in a treatment facility approved by the Department of Health and Social Services or the Bureau of Alcoholism and Drug Abuse as set forth in Chapter 22 of Title 16 or substantially similar licensing entities in other states. Nothing in this paragraph (c)(1) affects a health benefit plan's obligation to cover medically necessary team-based services, including coordinated specialty care and assertive community treatment, of a mental health disorder or substance use disorder so long as such services are supervised by a licensed or certified professional.

(2) Must be medically necessary.

(3) Must be covered services subject to any administrative requirements of the health benefit plan.

A health benefit plan may further condition coverage of services provided in the diagnosis and treatment of a mental health disorder or substance abuse disorder in the same manner and to the same extent as coverage for all other illnesses and diseases is conditioned. Such conditions may include, by way of example and not by way of limitation, precertification and referral requirements.

(d) *Benefit management.* — (1) A carrier may, directly or by contract with another qualified entity, manage the benefit prescribed by subsection (b) of this section in order to limit coverage of services provided in the diagnosis and treatment of a mental health disorder or substance use disorder as follows:

a. The management of benefits for mental health disorders or substance use disorders may be by methods used for the management of benefits provided for other medical conditions, including utilization review and the development and monitoring of treatment plans.

b. A carrier may not impose precertification, prior authorization, pre-admission screening, or referral requirements for the diagnosis and medically necessary services of serious mental illnesses or substance use disorders, including in-patient treatment. Nothing in § 3571U of this title may be construed to expand the prohibition in this paragraph (d)(1)b. to mental health disorder benefits not subject to this paragraph (d)(1)b.

c. The benefit prescribed by paragraph (b)(1) of this section may not be subject to concurrent utilization review during the first 14 days of any inpatient admission to a facility approved by a nationally recognized health-care accrediting organization or the Division of Substance Abuse and Mental Health, 30 days of intensive outpatient program treatment, or 5 days of inpatient withdrawal management, provided that the facility notifies the carrier of both the admission and the initial treatment plan within 48 hours of the admission. The facility shall perform daily clinical review of the patient and conduct periodic assessments using ASAM, LOCUS, CALOCUS-CASII, or ECSII, as appropriate to the covered person's age and primary diagnosis, to determine continued stay, transfer, or discharge to ensure that the inpatient treatment is medically necessary for the covered person.

d. Any utilization review of treatment provided under paragraph (b)(1) of this section may include a review of all nonemergency care provided during such inpatient treatment, including all services provided during the first 14 days of such inpatient treatment, 30 days of intensive outpatient program treatment, or 5 days of inpatient withdrawal management; provided, however, the carrier may only deny coverage for any portion of the initial 14-day inpatient treatment on the basis that such nonemergency care was not medically necessary if such inpatient treatment was contrary to ASAM criteria, LOCUS, CALOCUS-CASII, or ECSII.

e. A carrier must ensure that a covered person does not have any financial obligation to an in-network provider for any treatment under paragraph (b)(1) of this section other than any copayment, coinsurance, or deductible otherwise required under the health benefit plan.

f. Utilization review and utilization review criteria may not deviate from current generally accepted standards of mental health disorder and substance use disorder care. In conducting utilization review, a carrier shall apply the relevant, age-appropriate criteria or guidelines set forth in the most recent versions of treatment criteria or guidelines developed by the nonprofit professional association for the relevant clinical specialty and shall not apply different, additional, conflicting, or more restrictive utilization review criteria. In conducting utilization review permitted by this subsection relating to service intensity or level of care placement, continued stay, or transfer or discharge, the carrier shall apply the ASAM criteria, LOCUS, CALOCUS-CASII, or ECSII, as applicable, and shall authorize placement at the service intensity and level of care consistent with that criteria. If the carrier's application of the applicable patient placement criteria is not consistent with the service intensity or level of care placement requested by the covered person or the covered person's provider, any adverse benefit determination notice must include full details of the carrier's assessment under the applicable criteria to the provider and the covered person.

g. Notwithstanding paragraph (d)(1)f. of this section, the Commissioner, in consultation with the Division of Substance Abuse and Mental Health, may designate a specific edition or version of the ASAM criteria, LOCUS, CALOCUS-CASII, ECSII, or other nonprofit health-care professional association treatment criteria or guidelines required under paragraph (d)(1)f. of this section during a transition from 1 edition or version to a subsequent edition or version to ensure alignment with state licensure standards.

(2) [Repealed.]

(e) *Exclusions.* —

This section does not apply to plans or policies not within the definition of health benefit plan, as set out in subsection (a) of this section.

(f) [Repealed.]

(g) *Availability of in-network services.* —

(1) A carrier shall maintain an adequate network in each of its health benefit plans to ensure timely access to nonurgent mental health disorder and substance use disorder services within 10 business days and to urgent mental health disorder and substance use disorder services within 24 hours. If a covered person requests assistance from the carrier to obtain medically necessary services and the carrier fails to secure the delivery of those services from an appropriate in-network provider within applicable network adequacy standards established under state or federal law, the carrier shall, in a timely manner, execute a single-case agreement that allows the covered person to receive medically necessary services, including any follow-up services to complete a course of treatment, from an appropriate out-of-network provider. If the carrier identifies an appropriate in-network provider who can deliver medically necessary services within the applicable network adequacy standards and the covered person declines those services, the carrier has satisfied its obligation under this subsection. For purposes of this subsection, "appropriate provider" includes providers who have the training and experience necessary to provide age- and condition-appropriate services to treat the covered person under the requirements of this section.

(2) The single-case agreement executed pursuant to this subsection shall do all of the following:

a. Reimburse the out-of-network provider for covered services at a rate negotiated by the provider and the carrier.

b. Apply no greater cost-sharing requirements than would apply if the services were provided by an in-network provider, with such cost-sharing amounts accruing toward the in-network deductible and out-of-pocket maximum.

c. Specify the duration, scope, and services covered under the agreement.

d. Treat services provided pursuant to the agreement as covered services under the health benefit plan for the duration of the agreement.

e. Specify that the provider shall accept payment from the carrier and the covered person's in-network cost sharing as payment in full.

(3) If the Commissioner determines that the carrier failed to execute a single-case agreement under this section in a timely manner, the Commissioner may order the carrier to hold the covered person harmless for any costs in excess of in-network cost-sharing that the covered person incurred to obtain medically necessary services from an out-of-network provider.

(4) A carrier shall disclose, in the health benefit plan policy and on the carrier's publicly accessible website, a covered person's rights under this subsection and the process by which a covered person may request assistance from the carrier in obtaining medically necessary services from an appropriate in-network provider within applicable network adequacy standards, including a telephone number and a dedicated webpage or electronic submission mechanism to make such requests, and the circumstances under which the carrier must enter into a single-case agreement with an out-of-network provider, with no greater cost-sharing than would apply if the services were provided by an in-network provider.

(h) Nothing in this section shall be construed to:

(1) Limit or reduce any benefit, entitlement, or coverage conferred by § 3570A of this title including provider and service eligibility.

(2) Prohibit exclusions for experimental or investigational services that comply with the parity requirements of § 3571U of this title.

(3) Require a carrier to switch to the latest version of the ASAM criteria, LOCUS, CALOCUS-CASII, or ECSII criteria, or diagnostic manuals or classifications during a plan year when a new version of the criteria or manuals is released after a plan year has begun.

(71 Del. Laws, c. 275, § 2; 73 Del. Laws, c. 89, § 1; 73 Del. Laws, c. 199, §§ 7-10, 12; 74 Del. Laws, c. 157, § 2; 76 Del. Laws, c. 176, § 3; 78 Del. Laws, c. 398, § 4; 81 Del. Laws, c. 29, § 2; 81 Del. Laws, c. 190, §§ 4–6; 85 Del. Laws, c. 480, § 2.)

§ 3579. Health insurance; pharmacies; electronic reimbursement.

(a) This section shall apply to:

(1) Insurers and nonprofit health service plans that provide, directly or through a pharmacy benefit manager, coverage for prescription drugs under health insurance policies or contracts that are issued or delivered in this State; and

(2) Health maintenance organizations that provide, directly or through a pharmacy benefit manager, coverage for prescription drugs under contracts that are issued or delivered in this State.

(b) If an entity subject to this section requires a pharmacy to submit a request for payment electronically, then the pharmacy or its designated agent may choose to be reimbursed electronically, and in that event the entity shall electronically reimburse such pharmacy and shall provide the appropriate payment data electronically.

(c) An entity subject to this section may not impose on a pharmacy a processing fee for the electronic reimbursement or for providing payment data electronically, provided that the electing pharmacy agrees to, and can accept claims details for the payments electronically and provide accurate electronic funds transfer information to the entity making payments.

(d) Subsequent to January 6, 2010, any pharmacy that requires electronic reimbursement under this section shall allow an entity 45 days to become compliant herewith from the date of the pharmacy's initial request to commence electronic reimbursement between the parties.

(77 Del. Laws, c. 116, § 2.)

§ 3580. Specialty tier prescription coverage.

(a) Unless otherwise specifically provided, the definitions herein apply throughout this section.

(1) "Class of drugs" means a group of medications having similar actions designed to treat a particular disease process.

(2) "Coinsurance" means a cost-sharing amount set as a percentage of the total cost of the drug.

(3) "Commissioner" means the Insurance Commissioner of this State.

(4) "Copayment" means a cost-sharing amount set as a dollar value.

(5) "Nonpreferred drug" means a specialty drug formulary classification for certain specialty drugs deemed nonpreferred and therefore subject to limits on eligibility for coverage or to higher cost-sharing amounts than preferred specialty drugs.

(6) "Preferred drug" means a specialty drug formulary classification for certain specialty drugs deemed preferred and therefore not subject to limits on eligibility for coverage or not subject to higher cost-sharing amounts than nonpreferred specialty drugs.

(7) "Specialty drug" means a prescription drug that:

a. Is prescribed for a person with:

1. A complex or chronic medical condition, defined as a physical, behavioral, or developmental condition that may have no known cure and/or is progressive and/or can be debilitating or fatal if left untreated or under-treated, such as multiple sclerosis, hepatitis C, and rheumatoid arthritis; or

2. A rare medical condition, defined as any disease or condition that affects fewer than 200,000 persons in the United States, or about 1 in 1,500 people, such as cystic fibrosis, hemophilia, and multiple myeloma; and

b. The total monthly cost of the prescription is $600 or more; and

c. The drug is not stocked at a majority of retail pharmacies; and

d. The drug has 1 or more of the following characteristics:

1. It is an oral, injectable, or infusible drug product.

2. It has unique storage or shipment requirements, such as refrigeration.

3. Patients receiving the drug require education and support beyond traditional dispensing activities.

(8) "Specialty drug formulary" means a specialty drug benefit design that distinguishes for purposes of eligibility for coverage or for cost sharing between preferred drugs and nonpreferred drugs.

(9) "Specialty drug tier" means a tier of cost sharing designed for specialty drugs that imposes a cost-sharing obligation for specialty drugs that exceeds the amount for nonspecialty drugs and such a cost-sharing amount is based on a coinsurance.

(b) A health plan that provides coverage for prescription drugs and utilizes a specialty drug tier shall ensure that any required copayment or coinsurance applicable to specialty drugs on a specialty tier does not exceed $150 per month for each specialty drug up to a 30-day supply of any single drug.

(c) A health plan that provides coverage for prescription drugs and utilizes a specialty drug formulary shall implement an exceptions process that allows enrollees to request an exception to the formulary. Under such an exception, a nonformulary specialty drug could be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the individual, or would have adverse effects for the individual, or both. In the event an enrollee is denied an exception, such denial shall be considered an adverse event and will be subject to the health plan internal review process set forth in § 332 of this title and the state external review process set forth in § 6416 of this title.

(d) A health plan that provides coverage for prescription drugs shall be prohibited from placing all drugs in a given class of drugs on a specialty tier.

(e) Nothing in this section shall be construed to require a health plan to:

(1) Provide coverage for any additional drugs not otherwise required by law;

(2) Implement specific utilization management techniques, such as prior authorization or step therapy; or

(3) Cease utilization of tiered cost-sharing structures, including those strategies used to incent use of preventive services, disease management, and low-cost treatment options.

(f) Nothing in this section shall be construed to require a pharmacist to substitute a drug without the consent of the prescribing physician.

(g) Nothing contained in any other provision of Delaware law or regulation shall preclude a health plan or other entity subject to this chapter from requiring specialty drugs to be obtained through a designated pharmacy or other source of such drugs.

(79 Del. Laws, c. 133, § 2.)

Subchapter V

Pre-Authorization Transparency

(80 Del. Laws, c. 310, § 2.)

§ 3581. Definitions [For application of this section, see 82 Del. Laws, c. 44, § 3; 85 Del. Laws, c. 176, § 4].

For purposes of this subchapter, the following definitions apply:

(1) "Adverse determination" means a benefit denial, reduction or termination, or determination that an admission or continued stay, or course of treatment, or other covered health service does not satisfy the insurance policy's clinical requirements for appropriateness, necessity, health-care setting and/or level of care.

(2) "Clean pre-authorization" means when a submission is made to satisfy any pre-authorization in which the relevant data is provided as called for by the utilization review entity. Any request submitted by a provider or covered person that includes an unspecified, unclassified or miscellaneous code or data element to constitute a clean request shall also include appropriate supporting documentation or narrative which explains the unspecified, unclassified or miscellaneous code and describes the diagnosis and treatment rendered.

(3) "Clinical criteria" means the written policies, written screening procedures, drug formularies or lists of covered drugs, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols and any other criteria or rationale used by the utilization review entity to determine the necessity and appropriateness of health-care services.

(4) "Covered person" means an individual or family, or both, who has entered into a contractual arrangement, or on whose behalf a contractual arrangement has been entered into, with a carrier, pursuant to which the carrier provides health insurance for such person.

(5) "Electronic pre-authorization" [ePA] is a submission of information via a website, the Delaware Health Information Network, or other method via the Internet as delineated by regulation and as accepted by the utilization review entity. Electronic pre-authorization does not include any form of request that is transmitted to the utilization review entity through facsimile.

(6) “Emergency health-care services” means those services identified in §§ 3349 and 3565 of this title.

(7) “Episode of care” means care that meets all of the following:

a. Is for a specific medical problem, condition, or illness being managed by a health-care provider, including tests, procedures, and rehabilitation initially requested by the health-care provider.

b. Is performed at the site of service.

c. Is not out-of-network care.

(8) “Health-care service” means any services or supplies included in the furnishing to any individual of medical care, or hospitalization or incidental to the furnishing of such care or hospitalization, as well as the furnishing to any individual of any and all other services for the purpose of preventing, alleviating, curing or healing human illness, injury, disability or disease.

(9) “Medically necessary” or “medical necessity” means providing of health-care services or products that a prudent physician would provide to a patient for the purpose of diagnosing or treating an illness, injury, disease or its symptoms in a manner that is all of the following:

a. In accordance with generally accepted standards of medical practice;

b. Consistent with the symptoms or treatment of the condition;

c. Not solely for anyone’s convenience; and

d. Not including investigational or experimental health-care services.

(10) “NCPDP SCRIPT standard” means the most recent standard adopted of the National Council for Prescription Drug Programs SCRIPT adopted by the United States Department of Health and Human Services. To fall within this definition, any version released subsequent to passage of this section must be compatible to the current version adopted by the United States Department of Health and Human Services.

(11) “Pre-authorization” means a requirement by a carrier or health-insurance plan that providers submit a treatment plan, service request, or other prior notification to the carrier for evaluation of appropriateness of the plan or if the service is medically necessary before treatment is rendered. Pre-authorization lets the insured and provider know in advance which procedures and pharmaceuticals are considered by the insurer to be medically necessary.

(12) “Step therapy exception determination” means a determination as to whether a step therapy protocol should apply in a particular situation, or whether the step therapy protocol should be overridden in favor of immediate coverage of the health care provider’s selected prescription drug. This determination is based on a review of the request for an override, along with supporting rationale and documentation.

(13) “Step therapy protocol” means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition and medically appropriate for a particular patient are covered by an insurer or health plan.

(14) “Urgent health-care service” means a covered health-care service subject to prior authorization that is delivered on an expedited basis for the treatment of an acute condition with symptoms of sufficient severity pursuant to a determination by a licensed treating health-care provider, operating within the health-care provider’s scope of practice and professional expertise, that the failure to provide the service is likely to result in serious, long-term health complications or a material deterioration in the covered person’s or enrollee’s condition and prognosis.

(15) “Utilization review entity” means an individual or entity which performs pre-authorization or step therapy protocol review for 1 or more of the following entities:

a. An employer with employees who are covered under a health-benefit plan or health-insurance policy or contract issued for delivery in this State or delivered in this State which does not fall under the Employee Retirement Income Security Act (ERISA) [29 U.S.C. § 1001 et seq.];

b. An insurer, health-benefit plan, or health-service corporation that writes health-insurance policies, performs pre-authorization, performs step therapy protocol review or an entity to which these capabilities have been delegated;

c. A preferred-provider organization, managed-care organization, or health-maintenance organization;

d. Any other individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits to a person treated by a health-care provider in Delaware under a policy, plan, or contract;

e. This definition does not include accident-only, credit, dental, vision, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, worker’s compensation or similar insurance or automobile medical payment insurance, or any coverage under state or federal governmental plans.

(80 Del. Laws, c. 310, § 2; 82 Del. Laws, c. 44, § 2; 85 Del. Laws, c. 176, § 2.)

§ 3582. Disclosure and review of pre-authorization requirements; adverse determinations. [For application of this section, see 85 Del. Laws, c. 176, § 4].

(a) A utilization review entity shall make any current pre-authorization requirements and restrictions readily accessible on its website and in written or electronic form upon request for covered persons, health-care providers, and others with access to the website. Information

from a utilization review entity that is not an insurer, health-benefit plan, or health-service corporation shall make this information available at an electronic pre-authorization portal that is accessible in real time. Requirements shall be described in detail but also in clear, easily-understandable language. Clinical criteria shall be described in language easily understandable by a health-care provider practicing in the same clinical area.

(b) If an insurer, health-benefit plan, or health-service corporation intends either to implement a new pre-authorization requirement or restriction, or amend an existing requirement or restriction, they shall ensure that the new or amended requirement is not implemented unless their website has been updated to reflect the new or amended requirement or restriction. This shall not extend to expansion of coverage for new health-care services.

(c) (1) If an insurer, health-benefit plan, or health-service corporation, or utilization review entity intends either to implement a new pre-authorization requirement or restriction, or amend an existing requirement or restriction, they shall provide covered persons who are currently authorized by the utilization review entity for coverage of the affected health-care service and all contracted health-care providers who provide the affected health-care service or services of written notice of the new or amended requirement or amendment no less than 60 days before the requirement or restriction is implemented. Such notice may be delivered electronically or by other means.

(2) Notwithstanding the provisions of paragraph (c)(1) of this section, if an insurer, health-benefit plan, health-service corporation, or utilization review entity changes utilization review terms, such as clinical criteria, for a health-care service, the change in utilization review terms does not apply to covered persons with an existing authorization for the health-care service, and will apply only upon re-authorization of the health-care service. An insurer, health-benefit plan, health-service corporation, or utilization review entity must provide notice to covered persons at least 6 months before any changes to utilization review terms for a health-care service, unless those changes were due to clinical guideline status changes, recalls, market withdrawals or relevant FDA published safety information.

(d) Insurers, health-benefit plans, and health-service corporations utilizing pre-authorization shall report de-identified statistics regarding pre-authorization approvals, denials, and appeals to the Delaware Health Information Network in a format and frequency, no less than twice annually, of the Delaware Health Information Network's request. The Department may also request this data at any time. The statistics shall include, but may be expanded upon or further delineated by regulation, categories for all of the following:

(1) For denials, the aggregated reasons for denials such as medical necessity or incomplete pre-authorization submission.

(2) For appeals:

a. Practitioner specialty.

b. Medication, diagnostic test, or diagnostic procedure.

c. Indication offered.

d. Reason for underlying denial.

e. Number of denials overturned upon appeal.

(e) *Utilization review; specific requirements related to adverse determinations. —*

(1) When a clean pre-authorization request is submitted by a physician or representative of a physician, an insurer, health-benefit plan, health-service corporation, or utilization review entity must ensure that any adverse determination is made by a physician who meets all of the following requirements:

a. Any compensation paid to the physician is not contingent upon the outcome of the review.

b. At least 1 of the following requirements is satisfied:

1. The physician is licensed in any United States jurisdiction with appropriate training, knowledge, or experience in the same or similar specialty that typically manages or consults on the health-care service in question.

2. The physician is licensed in any United States jurisdiction, in consultation with an appropriately qualified third-party health-care provider licensed in the same or similar medical specialty as the requesting physician, or a health-care provider with experience related to the covered person's associated condition. Any compensation paid to the consulting health-care provider may not be contingent upon the outcome of the review.

(2) An insurer, health-benefit plan, health-service corporation, or utilization review entity must ensure that all appeals of an adverse determination related to a clean pre-authorization request submitted by a physician or representative of a physician are reviewed and determined by a physician who meets all the following requirements, in addition to the requirements set forth in paragraph (e)(1) of this section:

a. Possesses a current, unrestricted license in good standing to practice medicine in any United States jurisdiction.

b. Was not directly involved in making the adverse determination under appeal.

c. Reviews and considers all clinical aspects of the health-care service under appeal, including all medical records of the covered person submitted as part of the pre-authorization process.

(3) When a clean pre-authorization request is submitted by a health-care provider other than a physician, an adverse determination or review in an appeal from an adverse determination must be made by a health-care provider licensed in the same or similar profession as the health-care provider submitting the request for pre-authorization, or a licensed health-care provider in consultation with an appropriately qualified third-party health-care provider licensed in the same or similar medical specialty as the requesting health-care

provider. Any compensation paid to the health-care provider or consulting health-care provider may not be contingent upon the outcome of the review of the clean pre-authorization request or appeal from an adverse determination.

(4) A utilization review entity must, within 15 days of the receipt of an appeal of an adverse determination, notify the covered person and health-care provider submitting the request for pre-authorization of the determination on the appeal. If the utilization review entity cannot make a determination within the 15-day period because additional information, documentation, or medical records are required to complete a review of the health-care service under appeal, the utilization review entity must notify the covered person and health-care provider submitting the request for pre-authorization in writing within the 15-day period specifying the additional information, documents, or medical records required to complete the determination on appeal and shall have 15 days from the receipt thereof to make a determination on the appeal and notify the covered person and health-care provider. The written notification required by this paragraph (e)(4) must include all of the following:

a. A summary of the findings supporting the determination made in the appeal.

b. The qualifications of any reviewer involved in making the determination in the appeal, including any license, certification, or specialty designation of any reviewer.

c. The relationship between the covered person's diagnosis or disease being treated and the review criteria used as the basis for the determination in the appeal, including the specific basis for the determination made.

(5) An insurer, health-benefit plan, or health-service corporation must ensure then that any utilization review entity used to perform utilization review complies with all of the following:

a. Performs utilization review on weekends.

b. Provides access to a medical director or other clinical decision-maker Monday through Friday between the hours of 7:00 a.m. to 7:00 p.m. and during reasonable business hours Saturday through Sunday.

c. Has established procedures for the submission of appeals in writing, electronically, or by telephone.

d. Provides a minimum of 30 days from the date of an adverse determination for the submission of an appeal.

(80 Del. Laws, c. 310, § 2; 85 Del. Laws, c. 176, § 2.)

§ 3583. Utilization review entity's obligations with respect to pre-authorizations [For application of this section, see 85 Del. Laws, c. 176, § 4].

(a) If a utilization review entity requires pre-authorization of a pharmaceutical, the utilization review entity must complete its process or render an adverse determination and notify the covered person's health-care provider within 2 business days of obtaining a clean pre-authorization or of using services described in § 3587 of this title.

(b) If a utilization review entity requires pre-authorization of a health-care service, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 5 business days of receipt of a clean pre-authorization not submitted using services described in § 3587 of this title. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(c) If a utilization review entity requires pre-authorization of a health-care service, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 3 business days of receipt of a clean pre-authorization submitted using services described in § 3587 of this title. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(d) If a utilization review entity requires pre-authorization of an urgent health-care service, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 24 hours of receipt of a clean pre-authorization submitted using services described in § 3587 of this title. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(e) (1) If a utilization review entity requires pre-authorization of a patient transfer, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 24 hours of receipt of a clean pre-authorization submitted using services described in § 3587 of this title. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(2) Notwithstanding the provisions in paragraph (e)(1) of this section, when an insurer, health-benefit plan or health-service corporation has determined that a lower level of care at a health-care facility is clinically appropriate, the insurer, health-benefit plan, or health-service corporation may not require pre-authorization for medically necessary interfacility transport of the covered person.

(f) If a utilization review entity requires pre-authorization of an urgent health-care service, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 48 hours of receipt of a clean pre-authorization submitted not using services described in § 3587 of this title. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(g) If a utilization review entity requires pre-authorization of a patient transfer, the review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 48 hours of receipt of a clean

pre-authorization not submitted using services described in § 3387 of this title. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(80 Del. Laws, c. 310, § 2; 85 Del. Laws, c. 176, § 2.)

§ 3584. Utilization review entity's obligations with respect to pre-authorization concerning emergency health-care services.

A utilization review entity must follow all emergency procedures and mandates as delineated in §§ 3349 and 3565 of this title.

(80 Del. Laws, c. 310, § 2.)

§ 3585. Retrospective denial.

The utilization review entity may not revoke, limit, condition or restrict a pre-authorization on ground of medical necessity after the date the health-care provider received the pre-authorization. Any language attempting to disclaim payment for services on the basis of changes to medical necessity that have been pre-authorized and delivered while under coverage shall be null and void. A proper notification of policy changes validly delivered as per § 3372 of this title may void a pre-authorization if received after pre-authorization but before delivery of the service.

(80 Del. Laws, c. 310, § 2.)

§ 3586. Effect and length of pre-authorization; limitation per episode of care [For application of this section, see 85 Del. Laws, c. 176, § 4].

(a) A pre-authorization for pharmaceuticals shall be valid for 1 year from the date the health-care provider receives the pre-authorization, subject to confirmation of continued coverage and eligibility and to policy changes validly delivered as per § 3582 of this title and except as otherwise set by evidence-based treatment protocol.

(b) A pre-authorization for a health-care service shall be valid for a period of time that is reasonable and customary for the specific service, but no less than 90 days, from the date the health-care provider receives the pre-authorization, subject to confirmation of continued coverage and eligibility and to policy changes validly delivered as per § 3582 of this title.

(c) *Limitation per episode of care. —*

An insurer, health-benefit plan, or health-service corporation may not require more than 1 pre-authorization for an episode of care. Any new treatment or additional testing or procedures related or unrelated to the specific medical problem, condition, or illness being managed may require a separate pre-authorization.

(d) *Pre-authorization of other covered services in-network. —*

If a utilization review entity gives pre-authorization of a health-care service as part of a group of services for which a bundled payment is charged, pre-authorization of all other covered health-care services provided by in-network providers included in the group is deemed to be approved.

(80 Del. Laws, c. 310, § 2; 85 Del. Laws, c. 176, § 2.)

§ 3587. Electronic standards for pre-authorization [For application of this section, see 85 Del. Laws, c. 176, § 4].

(a) No later than January 1, 2018, the insurer must accept and respond to pre-authorization requests under the pharmacy benefit through a secure electronic transmission using the NCPDP SCRIPT standard ePA transactions. Facsimile, proprietary payer portals, and electronic forms shall not be considered electronic transmission.

(b) No later than January 1, 2027, an insurer, health-benefit plan, health-service corporation, or utilization review entity must allow for and accept electronic pre-authorization requests and must respond to electronic pre-authorization requests through the same website, mobile application, digital platform, or other method as the electronic pre-authorization request was submitted.

(c) No later than January 1, 2027, an insurer, health-benefit plan, health-service corporation, or utilization review entity must establish a provider portal that includes all of the following features:

(1) Electronic submission of pre-authorization requests.

(2) Access to the insurer's, health-benefit plan's, health-service corporation's, or utilization review entity's applicable medical policies.

(3) Information necessary to request a peer-to-peer review.

(4) Contact information for the insurer's, health-benefit plan's, health-service corporation's, or utilization review entity's relevant clinical or administrative staff.

(5) For any health-care service that requires pre-authorization that is not subject to electronic submission via the provider portal, copies of applicable forms.

(6) Instructions for the submission of pre-authorization requests if the insurer's, health-benefit plan's, health-service corporation's, or utilization review entity's provider portal is unavailable for any reason.

(d) Within 12 months following establishment of a provider portal under subsection (c) of this section, the insurer, health-benefit plan, health-service corporation, or utilization review entity may require a health-care provider seeking pre-authorization to submit the request via the provider portal unless 1 of the following exemptions applies:

(1) The portal is not available and operational at the time of attempted submission.

(2) The health-care provider does not have access to the insurer's, health-benefit plan's, health service corporation's, or utilization review entity's operational provider portal.

(3) The health-care provider satisfies an allowance by the insurer, health-benefit plan, health service corporation, or utilization review entity for submission other than through the provider portal.

(80 Del. Laws, c. 310, § 2; 85 Del. Laws, c. 176, § 2.)

§ 3588. Health-care services deemed preauthorized if a utilization review entity fails to comply with the requirements of this subchapter.

Any failure by a utilization review entity to comply with the deadlines and other requirements specified in this subchapter will result in any health-care services subject to review to be automatically deemed preauthorized.

(80 Del. Laws, c. 310, § 2.)

§ 3589. Waiver prohibited.

The provisions of this subchapter cannot be waived by contract issued or renewed after January 1, 2017. Any contractual arrangement in conflict with the provisions of this subchapter or that purports to waive any requirements of this subchapter is null and void.

(80 Del. Laws, c. 310, § 2.)

§ 3590. Exemptions.

This subchapter shall not apply to policies or contracts designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act [42 U.S.C. § 1395 et seq., § 1396 et seq. and § 1397aa. et seq.], known as Medicare, Medicaid, or any other similar coverage under state or federal governmental plans.

(80 Del. Laws, c. 310, § 2.)

§ 3591. Step therapy exception process [For application of this section, see 82 Del. Laws, c. 44, § 3].

(a) When coverage of a prescription drug for the treatment of any medical condition is restricted for use by an insurer, health plan, or utilization review entity through the use of a step therapy protocol, the patient and prescribing practitioner shall have access to a clear, readily accessible and convenient process to request a step therapy exception determination. An insurer, health service corporation, health plan, or utilization review entity may use its existing medical exceptions process to satisfy this requirement. The process shall be made easily accessible via the insurer's, health plan's, or utilization review entity's website. A step therapy exception determination shall be expeditiously granted in any one of the following circumstances:

(1) The required prescription drug is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient.

(2) The required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;.

(3) The patient has tried the required prescription drug while under the patient's current or previous health insurance or health benefit plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

(4) The required prescription drug is not in the best interest of the patient, based on medical necessity.

(5) The patient is stable, for the medical condition under consideration, on a prescription drug selected by the patient's health-care provider or while the patient was insured by the patient's current or a previous insurance or health benefit plan.

(b)(1) The insurer, health services corporation, health plan, or utilization review entity shall grant or deny a step therapy exception request within 2 business days of receipt of such request, which shall be from a health-care provider, and which shall state the circumstance which qualifies the patient for a step therapy exception pursuant to subsection (a) of this section. A step therapy exception determination not granted or denied in writing at the end of 2 days shall be deemed granted.

(2) During a step therapy exception determination under paragraph (a)(5) of this section, a determination will be deemed granted until the insurer, health services corporation, health plan, or utilization review entity issues a step therapy exception determination.

(c) In cases where emergency circumstances exist, as outlined in § 3565 of this title, an insurer, health plan, or utilization review entity shall grant or deny a step therapy exception request within 24 hours of receipt of a request, which shall be from a health care provider, and which shall state the circumstance which qualifies the patient for a step therapy exception pursuant to subsection (a) of this section. A request shall be deemed granted if the required response is not received by the requesting or appealing party within the times set forth in this subsection.

(d) Upon the granting of a step therapy exception determination, the insurer, health plan, or utilization review entity shall authorize coverage for the prescription drug prescribed by the patient's treating health-care provider.

(e) This section shall not be construed to prevent:

(1) An insurer, health plan, or utilization review entity from requiring a patient to try either of the following:

a. An AB-rated generic equivalent or an "interchangeable" biological product as defined in 42 U.S.C. § 262 prior to providing coverage for the equivalent branded prescription drug.

b. A "biosimilar" as defined in 42 U.S.C. § 262 prior to providing coverage for the brand name prescription reference product drug or drugs.

(2) A health-care provider from prescribing a prescription drug that is determined to be medically necessary.

(f) Clinical criteria used to establish a step therapy protocol shall be based on clinical criteria that:

(1) Recommend that the prescription drugs be taken in the specific sequence required by the step therapy protocol.

(2) Developed and endorsed by a multidisciplinary panel of experts that manages conflicts of interest among the members of the writing and review groups by:

a. Requiring members to disclose any potential conflict of interests with entities, including insurers, health plans, and pharmaceutical manufacturers and recuse themselves of voting if they have a conflict of interest.

b. Using a methodologist to work with writing groups to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus.

(3) Offer opportunities for public review and comments.

(4) Based on peer reviewed studies, research, and medical practice.

(5) Created by an explicit and transparent process that:

a. Minimizes biases and conflicts of interest.

b. Explains the relationship between treatment options and outcomes.

c. Rates the quality of the evidence supporting recommendations.

d. Considers relevant patient subgroups and preferences.

e. Continually updated through a review of new evidence, research and newly developed treatments.

(6) When establishing a step therapy protocol, a utilization review entity shall also take into account the needs of atypical patient populations and diagnoses when establishing clinical criteria.

(7) This section shall not be construed to require insurers, health plans or the state to set up a new entity to develop clinical review criteria used for step therapy protocols.

(g) Any step therapy exception determination as defined by this subsection shall be eligible for appeal by an insured or their authorized representative, as outlined in Chapter 3 and Chapter 64 of this title.

(82 Del. Laws, c. 44, § 2; 85 Del. Laws, c. 401, § 2.)

Part I
Insurance
Chapter 36
Individual Health Insurance Minimum Standards

§ 3601. Purpose and scope.

(a) The purpose of this chapter shall be to provide reasonable standardization and simplification of terms and coverages of individual health insurance policies and subscriber contracts of health service corporations to facilitate public understanding and comparison, to eliminate provisions contained in individual health insurance policies and subscriber contracts of health service corporations which may be misleading or unreasonably confusing in connection either with the purchase of such coverages or with the settlement of claims, and to provide for full disclosure in the sale of health insurance coverages. Additionally, the purpose of this chapter is to promote the availability of health insurance coverage to recently uninsured individuals, regardless of their health status or claims experience, and to improve the overall fairness and efficiency of the individual health insurance market.

(b) This chapter notwithstanding, Medicare supplement coverage shall be governed by Chapter 34, Medicare Supplement Insurance Minimum Standards, of this title.

(64 Del. Laws, c. 142, § 1; 71 Del. Laws, c. 143, § 1.)

§ 3602. Definitions [For application of this section, see 79 Del. Laws, c. 99, § 19].

As used in this chapter:

(1) "Affiliation period" means a period of time not to exceed 2 months (3 months for late enrollees) during which a health maintenance organization does not collect premiums and coverage issued is not effective.

(2) "Bona fide association" means, with respect to health insurance coverage offered in Delaware, an association which:

a. Has been actively in existence for at least 5 years;

b. Has been formed and maintained in good faith for purposes other than obtaining insurance and does not condition membership on the purchase of association-sponsored insurance;

c. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee) and clearly so states in all membership and application materials;

d. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member) and clearly so states in all marketing and application materials;

e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association and clearly so states in all marketing and application materials; and

f. Provides and annually updates information necessary for the Commissioner to determine whether or not an association meets the definition of a bona fide association before qualifying as a bona fide association for the purposes of this chapter.

(3) "Carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health-care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation or any other entity providing a plan of health insurance, health benefits or health services. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(4) "Church plan" has the meaning given such term under § 3(33) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. § 1002(33)].

(5) "Creditable coverage" means, with respect to an individual, health benefits or coverage provided under any of the following:

a. A group health benefit plan;

b. An individual health benefit plan or individual insurance coverage;

c. Part A or Part B of Title XVIII of the Social Security Act [42 U.S.C. § 1395 et seq. or 42 U.S.C. § 1395j et seq.];

d. Title XIX of the Social Security Act [42 U.S.C. § 1396 et seq.], other than coverage consisting solely of benefits under § 1928 [42 U.S.C. § 1396s];

e. Chapter 55 of Title 10, United States Code [10 U.S.C. § 1071 et seq.];

f. A medical care program of the Indian Health Service or of a tribal organization;

g. A state health benefits risk pool;

h. A health plan offered under Chapter 89 of Title 5, United States Code [5 U.S.C. § 8901 et seq.];

i. A public health plan as defined in federal regulations;

j. A health benefit plan under § 5(e) of the Peace Corps Act [22 U.S.C. § 2504(e)]. Such term does not include coverage consisting solely of coverage of excepted benefits as defined in paragraph (10)b. of this section.

(6) “Dependent” means a spouse, an enrollee’s child by blood or law who is less than 26 years of age and an unmarried child of any age who is medically certified as totally disabled and dependent upon the enrollee.

(7) “Federally eligible individual” means an individual:

a. For whom, as of the date on which the individual seeks coverage under this chapter, the aggregate of the periods of creditable coverage, as defined in this section, is 18 or more months;

b. Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in connection with any such plan;

c. Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act or a state plan under Title XIX of such act or any successor program, and who does not have other health insurance coverage;

d. With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

e. Who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected such coverage; and

f. Who has exhausted such continuation coverage under such provision or program, if the individual elected the continuation coverage described in subparagraph e. of this paragraph.

(8) “Form” means policies, contracts, riders, endorsements and applications required to be filed with the Commissioner pursuant to §§ 2712 and 6306 of this title.

(9) “Governmental plan” has the meaning given such term under § 3(32) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. § 1002(32) et seq.] and any federal governmental plan.

(10) a. “Health benefit plan” means any hospital or medical expense policy or certificate, major medical expense insurance policy or certificate, any hospital or medical service plan contract, health maintenance organization or health service corporation subscriber contract or any other similar health contract subject to the jurisdiction of the Commissioner.

b. “Health benefit plan” does not include: accident only; credit; dental; vision; Medicare supplement; benefits for long-term care, home health care, community-based care or any combination thereof; disability income insurance; liability insurance including general liability insurance and automobile liability insurance; coverage for on-site medical clinics; coverage issued as a supplement to liability insurance, worker’s compensation or similar insurance; or automobile medical payment insurance. The term also excludes specified disease, hospital confinement indemnity or limited benefit health insurance if such types of coverage do not provide coordination of benefits and are provided under separate policies or certificates; provided, that the carrier offering such policies or certificates complies with the following:

1. The carrier files, on or before March 1 of each year, a certification with the Commissioner that contains the statement and information described in paragraph (10)b.2. of this section.

2. The certification shall contain the following:

A. A statement from the carrier certifying that policies or certificates described in this subparagraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance.

B. A summary description of each policy or certificate described in this paragraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age or other factors) charged for these policies and certificates in this State.

3. In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this State on or after July 1, 1997, the carrier files with the Commissioner the information and statement required in paragraph (10)b.2. of this section at least 30 days prior to the date the policy or certificate is issued or delivered in this State.

(11) “Health insurance” means insurance permitted to be written in accordance with § 903 of this title, other than credit health insurance, and coverages written under Chapter 63 of this title, Health Service Corporations. For purposes of this chapter, health service corporations shall be deemed to be engaged in the business of insurance.

(12) “Health status-related factor” means any of the following factors:

a. Health status;

b. Medical condition, including both physical and mental illnesses;

c. Claims experience;

d. Receipt of health care;

e. Medical history;

f. Genetic information, as defined in § 2317 of this title;

g. Evidence of insurability, including conditions arising out of acts of domestic violence;

h. Disability.

(13) “Medical care” means amounts paid for:

a. The diagnosis, cure, mitigation, treatment or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

b. Transportation primarily for and essential to medical care referred to in subparagraph a. of this paragraph; and

c. Insurance covering medical care referred to in paragraphs (13)a. and b. of this section.

(14) "Network plan" means health insurance coverage offered by a health carrier under which the financing and delivery of medical care including items and services paid for as medical care are provided, in whole or in part, through a defined set of providers under contract with the carrier.

(15) "Policy" means the entire contract between the insurer and the insured, including the policy riders, endorsements and the application, if attached, and also includes subscriber contracts issued by health service corporations.

(16) "Waiting period" means, with respect to an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible for benefits under the terms of the plan. For purposes of calculating periods of creditable coverage, a waiting period shall not be considered a gap in coverage.

(64 Del. Laws, c. 142, § 1; 71 Del. Laws, c. 143, § 2; 72 Del. Laws, c. 383, § 6; 74 Del. Laws, c. 157, § 3; 79 Del. Laws, c. 99, § 10.)

§ 3603. Standards for policy provisions.

(a) The Commissioner shall issue reasonable regulations to establish specific standards, including standards of full and fair disclosure, that set forth the manner, content and required disclosure for the sale of individual policies of health insurance and subscriber contracts of health service corporations, other than conversion policies issued pursuant to a contractual conversion privilege under a group or individual policy of health insurance, when such group or individual contract contains provisions which are inconsistent with the requirements of this chapter or any regulation issued pursuant to this chapter, or to policies being issued to employees or members being added to franchise plans in existence on January 12, 1984, or any regulation issued pursuant to this chapter which shall be in addition to and in accordance with applicable laws of this State including the applicable statutory provisions set forth in §§ 3303-3336 of this title which may cover but shall not be limited to:

(1) Terms of renewability;

(2) Initial and subsequent conditions of eligibility;

(3) Nonduplication of coverage provisions;

(4) Coverage of dependents;

(5) Preexisting conditions;

(6) Termination of insurance;

(7) Probationary periods;

(8) Limitations;

(9) Exceptions;

(10) Reductions;

(11) Elimination periods;

(12) Requirements for replacement;

(13) Recurrent conditions; and

(14) The definition of terms including but not limited to the following: Hospital, accident, sickness, injury, physician, accidental means, total disability, partial disability, nervous disorder, guaranteed renewable and noncancellable.

(b) Subsection (a) of this section authorizes the Commissioner to establish specific standards for policy provisions which will facilitate public understanding of such provisions. The subsection does not alter the requirements of §§ 3303-3336 (Uniform Health Policy Provisions Law), or other specifically applicable state laws dealing with individual policy provisions. Regulations adopted under the subsection should be consistent with §§ 3303-3336, and other applicable state laws relating to the subject matter.

(c) The Commissioner may issue reasonable regulations that specify prohibited policies or policy provisions not otherwise specifically authorized by statute which in the opinion of the Commissioner, are unjust, unfair or unfairly discriminatory to the policyholder, any person insured under the policy or beneficiary.

(64 Del. Laws, c. 142, § 1.)

§ 3604. Minimum standards for benefits.

(a) The Commissioner may issue regulations to establish minimum standards for benefits under each of the following categories of coverage in individual policies, other than conversion policies issued pursuant to a contractual conversion privilege under group or individual policy, when such group or individual contract contains provisions which are inconsistent with the requirements of this chapter or any regulation issued pursuant to this chapter or to policies being issued to employees or members being added to franchise plans in existence on January 12, 1984, or any regulation issued pursuant to this chapter, of health insurance and subscriber contracts of health service corporations:

(1) Basic hospital expense coverage;

(2) Basic medical-surgical expense coverage;

(3) Hospital confinement indemnity coverage;

(4) Major medical expense coverage;

(5) Disability income protection coverage;

(6) Accident only coverage;

(7) Specified disease or specified accident coverage; and

(8) Limited benefit health coverage.

(b) Nothing in this section shall preclude the issuance of any policy or contract which combines 2 or more of the categories of coverage enumerated in paragraphs (a)(1)-(6) of this section.

(c) No policy or contract shall be delivered or issued for delivery in this State which does not meet the prescribed minimum standards for the categories of coverage listed in paragraphs (a)(1)-(8) of this section, or which does not meet the other applicable requirements for such coverages as prescribed by this title.

(d) The Commissioner shall prescribe the method of identification of policies and contracts based upon coverages provided.

(64 Del. Laws, c. 142, § 1.)

§ 3605. Disclosure requirements.

(a) In order to provide for full and fair disclosure in the sale of individual health insurance policies or subscriber contracts of a health service corporation, no such policy or contract shall be delivered or issued for delivery in this State unless the outline of coverage described in subsection (b) of this section either accompanies the policy or is delivered to the applicant at the time the application is made and an acknowledgement of receipt or certificate of delivery of such outlines is provided the insurer. In the event the policy is issued on a basis other than that applied for, the outline of coverage properly describing the policy or contract must accompany the policy or contract when it is not the policy or contract for which application was made.

(b) The Commissioner shall prescribe by regulation the format and content of the outline of coverage required by subsection (a) of this section. “Format” means style, arrangement and overall appearance, including such items as the size, color and prominence of type and the arrangement of text and captions. Such outline of coverage shall include:

(1) A statement identifying the applicable category or categories of coverage provided by the policy or contract as prescribed in § 3604 of this title;

(2) A description of the principal benefits and coverage provided in the policy or contract;

(3) A statement of the exceptions, reductions and limitations contained in the policy or contract;

(4) A statement of the renewal provisions including any reservation by the insurer or health service corporation of a right to change premiums;

(5) A statement that the outline is a summary of the policy or contract issued or applied for and that the policy or contract should be consulted to determine governing contractual provisions.

(c) The outline of coverage shall not be considered to be part of the policy or subscriber contract for insurance.

(d) Every insurer or health service corporation electing to refuse coverage of an applicant or decline coverage of an insured who is not included within the coverage of Chapter 23 of Title 19 shall disclose to such applicant or insured in writing the fact of such noncoverage or declination of coverage. Any insurer or health insurer failing to disclose in writing such noncoverage or declination of coverage shall be deemed to cover the applicant or insured under the health insurance policy then in effect.

(64 Del. Laws, c. 142, § 1; 64 Del. Laws, c. 378, § 1.)

§ 3606. Preexisting conditions [For application of this section, see 79 Del. Laws, c. 99, § 19].

(a) Notwithstanding § 3306 of this title, a policy or contract must not deny, exclude, or limit benefits for a covered individual for losses due to a preexisting condition, and the policy or contract must not include wording that would permit a defense based upon preexisting conditions.

(b) Notwithstanding subsection (a) of this section and § 3306 of this title, an insurer or a health service corporation which issues a specified disease policy, regardless of whether such policy is issued on the basis of a detailed application form, a simplified application for or an enrollment form, may not deny a claim for any covered loss that begins after the policy has been in force. Except for rescission for misrepresentation, no other defenses based upon preexisting conditions are permitted.

(64 Del. Laws, c. 142, § 1; 79 Del. Laws, c. 99, § 11; 82 Del. Laws, c. 186, § 9.)

§ 3607. Guaranteed availability of coverage [For application of this section, see 79 Del. Laws, c. 99, § 19].

(a) *Guaranteed availability of coverage in the individual market.* — Subject to subsections (b)-(d) of this section, a carrier that offers health insurance coverage in the individual market in this State must offer to any individual in this State all products that are approved for sale in the individual market, and must accept any individual that applies for any of those products.

(b) *Enrollment periods.* — A carrier may restrict enrollment in health insurance coverage to open or special enrollment periods.

(1) *Open enrollment periods in the individual market.* —

A carrier in the individual market must permit an individual to purchase health insurance coverage during an annual open enrollment period. For benefit years beginning on or after January 1, 2018, the annual open enrollment period begins on November 1 and extends through December 15 of the calendar year preceding the benefit year. A carrier must ensure that coverage is effective January 1 for enrollments received by the carrier on or before December 15 of the calendar year preceding the benefit year.

(2) *Special enrollment periods.* —

A carrier in the individual market shall establish special enrollment periods for qualifying events as defined under § 603 of the Employee Retirement Income Security Act of 1974, as amended [29 USC § 1163]. Enrollees must be provided 30 calendar days after the date of the qualifying event to elect coverage, with such coverage becoming effective consistent with the dates described in 45 C.F.R. § 155.420(b), as in effect on January 1, 2025. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law.

(c) *Special rules for network plans.* — (1) In the case of a carrier that offers health insurance coverage in the individual market through a network plan, the carrier may do the following:

a. Limit the individuals who may apply for the coverage in the individual market to those who live or reside in the service area for the network plan.

b. Within the service area of the plan, deny coverage to individuals if the carrier has demonstrated to the Commissioner the following:

1. It will not have the capacity to deliver services adequately to enrollees of any additional individuals because of its obligations to existing contract holders and enrollees.

2. It is applying paragraph (c)(1) of this section uniformly to all individuals without regard to the claims experience of those individuals (and their dependents) or any health-status related factor relating to such individuals and dependents.

(2) A carrier that denies health insurance coverage to an individual in any service area, in accordance with paragraph (c)(1)b. of this section, may not offer coverage in the individual market within the service area to any individual for a period of 180 calendar days after the date the coverage is denied. This paragraph (c)(2) does not limit the carrier's ability to renew coverage already in force or relieve the carrier of the responsibility to renew that coverage.

(3) Coverage offered within a service area after the 180-day period specified in paragraph (c)(2) of this section is subject to the requirements of this section.

(d) *Application of financial capacity limits.* — (1) A carrier may deny health insurance coverage in the individual market if the carrier has demonstrated to the Commissioner the following:

a. It does not have the financial reserves necessary to underwrite additional coverage.

b. It is applying this paragraph (d)(1) uniformly to all individuals in the individual market in this State consistent with applicable state law and without regard to the claims experience of those individuals (and their dependents) or any health status-related factor relating to such individuals and dependents.

(2) A carrier that denies health insurance coverage to any individual in this State under paragraph (d)(1) of this section may not offer coverage in the individual market in this State before the later of either of the following dates:

a. The one hundred and eighty-first day after the date the carrier denies coverage;

b. The date the carrier demonstrates to the Commissioner that the carrier has sufficient reserves to underwrite additional coverage.

(3) Paragraph (d)(2) of this section does not limit the carrier's ability to renew coverage already in force or relieve the carrier of the responsibility to renew that coverage.

(4) Coverage offered after the 180-day period specified in paragraph (d)(2) of this section is subject to the requirements of this section.

(5) The Commissioner may provide for the application of this subsection (d) on service-area-specific basis.

(e) *Marketing.* — A carrier and its officials, employees, agents and representatives must comply with any applicable state laws and regulations regarding marketing by carriers and cannot employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage.

(f) *Grandfathered health plans.* — This section does not apply to grandfathered health plans. For purposes of this section, "grandfathered health plans" means plans provided by a health insurer in which an individual was enrolled on March 23, 2010, for as long as it maintains that status in accordance with federal regulations.

(79 Del. Laws, c. 99, § 12; 82 Del. Laws, c. 186, § 10; 85 Del. Laws, c. 89, § 6.)

§ 3608. Renewability of coverage.

(a) An individual health benefit plan shall be renewable with respect to an enrollee or dependents at the option of the enrollee, except in any of the following cases:

(1) The individual has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the health carrier has not received timely premium payments;

(2) The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(3) A decision by the individual carrier to discontinue offering a particular type of health benefit plan in the state's individual insurance market. A type of health benefit plan may be discontinued by the carrier in the individual market only if the carrier:

a. Provides notice of the decision not to renew coverage to all affected individuals and to the Commissioner in each state in which an affected insured individual is known to reside at least 90 days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the Commissioner under this subparagraph shall be provided at least 3 working days prior to the notice to the affected individuals;

b. Offers to each individual provided the particular type of health benefit plan the option to purchase all other health benefit plans currently being offered by the carrier to individuals in the state; and

c. In exercising the option to discontinue the particular type of health benefit plan and, in offering the option of coverage under paragraph (a)(3) of this section, the carrier acts uniformly without regard to the claims experience of any affected individual or any health status-related factor relating to any covered individuals or beneficiaries who may become eligible for the coverage;

(4) The carrier elects to discontinue offering and to nonrenew all its individual health benefit plans delivered or issued for delivery in the state. In that case, the carrier shall provide notice of its decision not to renew coverage to all enrollees and to the Commissioner in each state in which an enrollee is known to reside at least 180 days prior to the nonrenewal of the health benefit plan by the carrier. Notice to the Commissioner under this paragraph shall be provided at least 3 working days prior to the notice of the enrollees;

(5) The Commissioner finds that the continuation of the coverage would not be in the best interests of the enrollees, the plan is obsolete or would impair the carrier's ability to meet its contractual obligations. Once the Commissioner has made such a finding, the carrier shall provide notice to each affected covered individual provided coverage of this type of such discontinuation and shall provide each affected covered individual the opportunity to purchase any other individual health insurance coverage being offered by the carrier. In exercising this option, the carrier shall act uniformly without regard for any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage;

(6) The Commissioner finds that the product form is being uniformly modified and is being replaced with comparable coverage.

(b) An individual carrier that elects not to renew all its health benefit plans under paragraph (a)(4) of this section shall be prohibited from writing new business in the individual market in this State for a period of 5 years from the date of the discontinuation of the last health benefit plan not so renewed.

(c) In the case of an individual carrier doing business in 1 established geographic service area of the state, the rules set forth in this section shall apply only to the carrier's operations in that service area.

(d) An individual carrier offering coverage through a network plan shall not be required to renew, offer coverage or accept applications pursuant to subsection (a) of this section to an eligible person who no longer resides, lives or works in the service area or in an area for which the carrier is not authorized to do business, but only if coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals.

(e) In applying this section in the case of a health benefit plan that is made available in the individual market to individuals only through 1 or more bona fide associations, a reference to an "individual" is deemed to include a reference to such an association (of which the individual is a member).

(71 Del. Laws, c. 143, § 3.)

§ 3609. Nondiscrimination in health care [For application of this section, see 79 Del. Laws, c. 99, § 19].

(a) *Providers.* — A health insurer offering individual health insurance coverage shall not discriminate with respect to participation under the coverage against any health-care provider who is acting within the scope of that provider's license or certification under applicable state law. This section shall not require that a health insurer contract with any health-care provider willing to abide by the terms and conditions for participation established by the insurer. Nothing in this section shall be construed as preventing a health insurer or the Commissioner from establishing varying reimbursement rates based on quality or performance measures.

(b) *Individuals.* — The provisions of § 1557 of the Patient Protection and Affordable Care Act (relating to nondiscrimination) [42 U.S.C. § 18116], as the law and its implementing regulations were in effect on January 1, 2025, apply with respect to a health insurer offering individual health insurance coverage.

(79 Del. Laws, c. 99, § 13; 82 Del. Laws, c. 186, § 11; 85 Del. Laws, c. 89, § 7.)

§ 3610. Comprehensive health insurance coverage [For application of this section, see 79 Del. Laws, c. 99, § 19].

(a) *Coverage for essential health benefits package. —*

A health insurer that offers health insurance coverage in the individual market shall ensure that such coverage includes the essential health benefits package in conformity with § 1302 of the Patient Protection and Affordable Care Act [42 U.S.C. § 18022], as the law and its implementing regulations were in effect on January 1, 2025, and state law. The Commissioner shall issue a regulation setting forth what constitutes "essential health benefits" for purposes of this section.

(b) *Cost-sharing under individual health insurance policies. —*

An individual health insurance policy shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under § 1302(c)(1) of the Patient Protection and Affordable Care Act [42 U.S.C. § 18022(c)(1)], as the law and its implementing regulations were in effect on January 1, 2025, and state law.

(c) *Child-only plans. —*

If a health insurer offers health insurance coverage in any level of coverage specified under § 1302(d) of the Patient Protection and Affordable Care Act [42 U.S.C. § 18022(d)], as the law and its implementing regulations were in effect on January 1, 2025, or state law, the health insurer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of the plan year, are under age 21.

(d) *Dental only. —*

This section does not apply to a plan described in § 1311(d)(2)(B)(ii) of the Patient Protection and Affordable Care Act [42 U.S.C. § 18031(d)(2)(B)(ii)], as the law and its implementing regulations were in effect on January 1, 2025.

(79 Del. Laws, c. 99, § 13; 81 Del. Laws, c. 79, § 31; 82 Del. Laws, c. 186, § 12; 85 Del. Laws, c. 89, § 8.)

§ 3611. Prohibiting discrimination against individual participants and beneficiaries based on health status [For application of this section, see 79 Del. Laws, c. 99, § 19].

In general. — A health insurer offering individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(1) Health status.

(2) Medical condition (including both physical and mental illnesses).

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

(8) Disability.

(9) Any other health status-related factor determined appropriate by the Commissioner.

(79 Del. Laws, c. 99, § 13.)

§ 3612. Insurance offered through the state health insurance exchange [For application of this section, see 79 Del. Laws, c. 99, § 19].

(a) A health insurer that offers health insurance coverage in the individual market through the state health insurance exchange program established pursuant to the Patient Protection and Affordable Care Act [P.L. 111-148] shall first satisfy all certification standards required by federal and state law, and the health insurer shall offer only those policies that are "qualified health plans" as required by federal and state law.

(b) The Commissioner shall adopt regulations, in accordance with the Administrative Procedures Act [Chapter 101 of Title 29], that set forth the certification and compliance standards and requirements for health insurers operating within the state health exchange.

(79 Del. Laws, c. 99, § 13.)

§ 3613. Rating factors [For application of this section, see 79 Del. Laws, c. 99, § 19].

(a) In establishing rates for health insurance coverage offered in the individual market, the rate may vary with respect to the particular plan or coverage involved only by determining the following:

(1) Whether the plan or coverage covers an individual or family.

(2) Rating area, as established in accordance with subsection (d) of this section.

(3) Age, except that the rate may not vary by more than 3 to 1 for like individuals of different age who are age 21 and older and that the variation in rate must be actuarially justified for individuals under age 21, consistent with the uniform age rating curve under subsection (e) of this section. For purposes of identifying the appropriate age adjustment under this paragraph (a)(3) and the age band under subsection (e) of this section applicable to a specific enrollee, the enrollee's age as of the date of policy issuance or renewal must be used.

(4) Subject to § 3611 of this title, tobacco use, except that such rate may not vary by more than 1.5 to 1 and may only be applied with respect to individuals who may legally use tobacco under federal and state law. For purposes of this paragraph (a)(4), tobacco use means use of tobacco on average 4 or more times per week within no longer than the past 6 months. This includes all tobacco

products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used.

(b) The rate established under this section must not vary with respect to the particular plan or coverage involved by any other factor not described in subsection (a) of this section.

(c) A health insurer must consider the claims experience of all enrollees in all health plans, other than grandfathered health plans, offered by such insurer in individual market in this State, including those enrollees who do not enroll in such plans through the state health exchange, to be members of a single risk pool. A health insurer must charge the same premium rate without regard to whether the plan is offered through the state health exchange or whether the plan is offered directly from the health insurer or through an agent.

(d) In establishing rates, all health insurers offering health plans in the individual market shall use a single rating area that applies to the entire State.

(e) The following uniform age bands apply for rating purposes under paragraph (a)(3) of this section:

(1) *Child age bands. —*

a. A single age band for individuals age 0 through 14.

b. One-year age bands for individuals age 15 through 20.

(2) *Adult age bands. —*

One-year age bands for individuals age 21 through 63.

(3) *Older adult age bands. —*

A single age band for individuals age 64 and older.

(f) *Application of variations based on age or tobacco use. —*

With respect to family coverage under health insurance coverage, the rating variations permitted under paragraphs (a)(3) and (a)(4) of this section must be applied based on the portion of the premium attributable to each family member covered under the coverage.

(1) The total premium for family coverage must be determined by summing the premiums for each individual family member. With respect to family members under age 21, the premiums for no more than the 3 oldest covered children must be taken into account in determining the total family premium.

(2) If the State does not permit any rating variation for the factors described in paragraphs (a)(3) and (a)(4) of this section, as determined by the Insurance Commissioner by regulation, the State may require that premiums for family coverage be determined by using uniform family tiers and the corresponding multipliers established by the State. If the State does not establish uniform family tiers and the corresponding multipliers, the per-member-rating methodology under paragraph (f)(1) of this section applies in this State.

(g) The Commissioner may adopt regulations, in accordance with the Administrative Procedures Act (Chapter 101 of Title 29), that are consistent with Chapter 25 of this title and set forth more specifically the rating standards and requirements for health insurers operating within this State.

(79 Del. Laws, c. 99, § 13; 82 Del. Laws, c. 186, § 13.)

Part I
Insurance

Chapter 37
Delaware Consumer Credit Insurance Model Act

§ 3701. Purpose.

The purpose of this chapter is to promote the public welfare by regulating consumer credit insurance. Nothing in this chapter is intended to prohibit or discourage reasonable competition. The provisions of this chapter shall be liberally construed.

(70 Del. Laws, c. 576, § 1.)

§ 3702. Scope and definitions.

(a) *Citation and scope.* — (1) This chapter may be cited as the "Delaware Consumer Credit Insurance Model Act."

(2) All consumer credit insurance issued or sold in connection with loans or other credit transactions for personal, family or household purposes shall be subject to the provisions of this chapter, except:

a. Insurance written in connection with a credit transaction that is:

1. Secured by a first mortgage or deed of trust; and

2. Made to finance the purchase of real property or the construction of a dwelling thereon or to refinance a prior credit transaction made for such a purpose.

b. Insurance sold as an isolated transaction on the part of the insurer and not related to an agreement or a plan for insuring debtors of the creditor.

c. Insurance for which no identifiable charge is made to the debtor.

d. Insurance written in connection with a credit transaction where the initial term exceeds 10 years. Consumer credit insurance forms and premium rates approved for use with credit transactions of 10 years or less may be used for long term transactions, if the term of the insurance does not exceed 10 years.

(b) *Definitions.* — For the purpose of this chapter:

(1) "Commissioner" means the insurance supervisory authority of the State;

(2) "Consumer credit insurance" is a general term used in this chapter to refer to any or all of credit life insurance credit accident and health insurance or any other insurance specifically defined in this chapter;

(3) "Credit accident and health insurance" means insurance on a debtor or debtors to provide indemnity for payments or debt becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy;

(4) "Credit life insurance" means insurance on a debtor or debtors, pursuant to or in connection with a specific loan or other credit transaction, to provide for satisfaction of a debt, in whole or in part, upon the death of an insured debtor;

(5) "Credit transaction" means any transaction by the terms of which the repayment of money loaned or loan commitment made or payment for goods, services or properties sold or leased is to be made at a future date or dates;

(6) "Creditor" means the lender of money or vendor or lessor of goods, services or property, rights or privileges for which payment is arranged through a credit transaction or any successor to the right, title or interest of any such lender, vendor or lessor and an affiliate, associate or subsidiary of any of them or any director, officer or employee of any of them or any other person in any way associated with any of them;

(7) "Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction;

(8) "Gross debt" means the sum of the remaining payments owed to the creditor by the debtor;

(9) "Identifiable charge" means a charge for a type of consumer credit insurance that is made to debtors having such insurance and not made to debtors not having such insurance; it includes a charge for insurance that is disclosed in the credit or other instrument furnished to the debtor which sets out the financial elements of the credit transaction and any difference in the finance, interest, service or other similar charge made to debtors who are in like circumstances except for the insured or noninsured status of the debtor or of the property used as security for the credit transaction; and

(10) "Open-end credit" means credit extended by a creditor under an agreement in which:

a. The creditor reasonably contemplates repeated transactions;

b. The creditor imposes a finance charge from time to time on an outstanding unpaid balance; and

c. The amount of credit that may be extended to the debtor during the term of the agreement (up to any limit set by the creditor) is generally made available to the extent that any outstanding balance is repaid.

(70 Del. Laws, c. 576, § 1.)

§ 3703. Types of consumer credit insurance.

The types of consumer credit insurance defined in § 3702 of this title may be written separately or in combination with other types of consumer credit insurance on an individual policy or group policy basis.

(70 Del. Laws, c. 576, § 1.)

§ 3704. Amount of consumer credit insurance.

(a) *Credit life insurance.* — (1) The initial amount of credit life insurance shall not exceed the total amount repayable under the credit transaction, which is the gross debt.

(2) In cases where an indebtedness is repayable in substantially equal installments, the amount of insurance shall at no time exceed the scheduled or actual amount of unpaid indebtedness, whichever is greater.

(3) Notwithstanding paragraph (a)(1) or (2) of this section, insurance on agricultural credit transactions not exceeding 2 years in duration may be written up to the amount of the loan commitment on a nondecreasing or level term plan.

(4) Notwithstanding paragraphs (a)(1) and (2) of this section, or any other subsection, insurance on educational credit transaction commitments may be written for the amount of the portion of such commitment that has not been advanced by the creditor.

(b) *Credit accident and health insurance.* — (1) The total amount of periodic indemnity payable by credit accident and health insurance in the event of disability as defined in the policy shall not exceed the aggregate of the periodic scheduled unpaid installments of the gross debt and the amount of each periodic indemnity payment shall not exceed the original gross debt divided by the number of periodic installments.

(2) Notwithstanding paragraph (b)(1) of this section, for credit accident and health insurance written in connection with an open-end credit agreement, the amount of insurance shall not exceed the gross debt which would accrue on that amount using the periodic indemnity. Subject to any policy maximums, the periodic indemnity must not be less than the creditor's minimum repayment schedule.

(70 Del. Laws, c. 576, § 1.)

§ 3705. Term of consumer credit insurance.

(a) *Effective date of coverage.* — (1) For consumer credit insurance made available to and elected by the debtor before or contemporaneous with a credit transaction to which the insurance relates, the term of the insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor, except that when evidence of individual insurability is required and such evidence is furnished more than 30 days after the date when the debtor becomes obligated to the creditor, the term of the credit insurance may commence on the date on which the insurance company determines the evidence to be satisfactory.

(2) For insurance coverage made available to and elected by the debtor on a date subsequent to the date of the consumer credit transaction to which the insurance relates, the insurance shall, subject to acceptance by the insurer, commence on a date not earlier than the date the election is made by the debtor not later than 30 days following the date on which the insurance company accepts the risk for coverage, according to an objective method such as one related to a particular date within a billing or repayment cycle or a calendar month.

(3) Notwithstanding paragraphs (a)(1) and (2) of this section, when a group policy provides coverage with respect to debts existing on the policy effective date, the insurance relating to the debt shall not commence before the effective date of the group policy.

(4) In no event shall a charge for insurance be made to the debtor and retained by the creditor or insurer for any time prior to commencement of the consumer credit insurance to which the charge is related.

(b) *Termination date of coverage.* — (1) The term of any consumer credit insurance shall not extend beyond the termination date specified in the policy. The termination date of insurance may precede, coincide with or follow the scheduled maturity date of the debt to which it relates, subject to any other requirements and restrictions of this chapter.

(2) The term of any consumer credit insurance shall not extend more than 15 days beyond the scheduled maturity date of the debt, except when extended without additional cost to the debtor or except when extended pursuant to a written agreement, signed by the debtor, in connection with a variable interest rate credit transaction or a deferral, renewal, refinancing or consolidation of debt.

(3) If the debt is discharged due to renewal, refinancing or consolidation prior to the scheduled termination date of the insurance, any insurance in force shall be terminated before any new insurance may be written in connection with the renewed, refinanced or consolidated debt.

(4) In all cases of termination of insurance prior to the scheduled termination of the insurance, an appropriate refund or credit to the debtor shall be made of any unearned insurance charge paid by the debtor for a term of insurance after the date of the termination, except that no refund is required of a charge made for insurance if the insurance is terminated by performance of the insurer's obligation with respect to the insurance.

(5) An insured debtor may terminate consumer credit insurance at any time by providing advance request to the insurer. The individual policy or group certificate may require that the request be in writing or that the debtor surrender the individual policy or group certificate, or both. The debtor's right to terminate coverage may also be subject to the terms of the credit transaction contract.

(70 Del. Laws, c. 576, § 1.)

§ 3706. Disclosure to debtors and provisions of policies and certificates of insurance.

(a) *Pre-purchase disclosure.* — Before the debtor elects to purchase consumer credit insurance in connection with a credit transaction, the following shall be disclosed to the debtor in writing or as provided for in subsection (b) of this section:

(1) That the purchase of consumer credit insurance is optional and not a condition of obtaining credit approval;

(2) If more than 1 kind of consumer credit insurance is being made available to the debtor, whether the debtor can purchase each kind separately or the multiple coverage only as a package;

(3) The conditions of eligibility;

(4) That within the first 30 days after receiving the individual policy or group certificate, the debtor may cancel the coverage and have all premium paid by the debtor refunded or credited. Thereafter, the debtor may cancel the policy at any time during the term of the loan and receive a refund of any of the unearned premium. However, only in those instances where insurance is a requirement for the extension of credit, the debtor may be required to offer evidence of alternative insurance acceptable to the creditor at the time of cancellation; and

(5) A brief description of the coverage.

(b) The disclosure required in subsection (a) of this section shall be provided in the following manner:

(1) In connection with consumer credit insurance offered contemporaneously with the extension of credit or offered through direct mail advertisements, disclosure shall be made in writing and presented to the consumer in a clear or conspicuous manner;

(2) In conjunction with the offer of credit insurance subsequent to the extension of credit by other than direct mail advertisements, disclosure may be provided orally so long as written disclosures are provided to the debtor no later than the earlier of:

a. Ten days after the offer; or

b. The date any other written material is provided to the debtor.

(c) All consumer credit insurance shall be evidenced by an individual policy or a group certificate of insurance which shall be delivered to the debtor.

(d) The individual policy or group certificate shall, in addition to other requirements of law, set forth the following:

(1) The name and home office address of the insurer;

(2) The name or names of the debtor or debtors, or in the case of a group certificate, the identity by name or otherwise of the debtor or debtors;

(3) The premium or amount of payment by the debtor separately for each kind of coverage or for all coverages in a package, except that for open-end loans, the premium rate and the basis of premium calculation (e.g., average daily balance, prior monthly balance) shall be specified;

(4) A full description of the coverage or coverages, including the amount of term thereof and any exceptions, limitation and exclusions; and

(5) A statement that the benefits shall be paid to the creditor to reduce or extinguish the unpaid debt and, whenever the amount of insurance benefit exceeds the unpaid debt, that any such excess shall be payable to a beneficiary other than the creditor, named by the debtor or the debtor's estate.

(e) Unless the individual policy or group certificate of insurance is delivered to the debtor at the time the debt is incurred or at such other time that the debtor elects to purchase coverage, a copy of the application for the policy or a notice of proposed insurance, signed by the debtor and setting forth the name and home office address of the insurer, the name or names of the debtor, the premium rate or amount of payment by the debtor for the insurance, the amount of payment by the debtor for the insurance and the amount, term and a brief description of the coverage provided, shall be delivered at the time the debt is incurred or the election to purchase coverage is made. The copy of the application for or notice of proposed insurance shall also refer exclusively to insurance coverage and shall be separate and apart from the loan, sale or other credit statement of account, instrument or agreement, unless the information required by this subsection is prominently set forth therein. Upon acceptance of the insurance by the insurer and within 30 days of the date upon which the debt is incurred or the election to purchase coverage is made, the insurer shall cause the individual policy or group certificate of insurance to be delivered to the debtor. The application or notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective as provided in § 3705 of this title.

(f) The application, notice of proposed insurance or certificate may be used to fulfill all of the requirements of subsections (a) and (d) of this section if it contains all of the information required by those subsections.

(g) The debtor has 30 days from the date that he or she receives either the individual policy or the group certificate to review the coverage purchased. At any time within the 30-day period, the debtor may contact the creditor or insurer issuing the policy or certificate and request that the coverage be canceled. The individual policy or group certificate may require the request to be in writing or that the policy or certificate be returned to the insurer or both. The debtor shall, within 30 days of the request, receive a full refund or credit of all premiums or insurance charges paid by the debtor, provided no loss has occurred and no claim has been made.

(h) If the named insurer does not accept the risk, the debtor shall receive a policy or certificate of insurance setting forth the name and home office address of the substituted insurer and the amount of the premium to be charged, and, if the amount of premium is less than

that set forth in the notice or proposed insurance, an appropriate refund shall be made within 30 days. If no insurer accepts the risk, then all premiums paid shall be refunded or credited within 30 days of application to the person entitled thereto.

(i) For the purpose of subsection (e) of this section, an individual policy or group certificate delivered in conjunction with an open-end consumer credit agreement or any consumer credit insurance requested by the debtor after that date of the debt shall be deemed to be delivered at the time the debt is incurred or election to purchase coverage is made if the delivery occurs within 30 days of the date the insurance is effective.

(j) An individual policy or group certificate delivered in conjunction with an open-end credit agreement shall continue from its effective date through the term of the agreement unless the individual policy or group certificate is terminated in accordance with its terms at an earlier date.

(70 Del. Laws, c. 576, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3707. Filing, approval and withdrawal of forms.

(a) All policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders delivered or issued for delivery in this State and the schedules of premium rates pertaining thereto shall be filed with the Commissioner before being used.

(b) The Commissioner shall, within 30 days after the filing of any such policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders, disapprove any such form if the benefits provided are not reasonable in relation to the premium charged or if it contains provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the coverage or are contrary to any provision of the Insurance Code or of any rule or regulation promulgated thereunder. If the Commissioner does not disapprove a filing within 30 days, it may be deemed approved.

(c) If the Commissioner disapproves the form in accordance with subsection (b) of this section, the Commissioner shall promptly notify the insurer in writing of the disapproval, and it is unlawful for the insurer to issue or use the form. In the notice, the Commissioner shall specify the reasons for disapproval and state that a hearing will be granted upon written request by the insurer.

(d) The Commissioner may withdraw approval of any approved form when the Commissioner would be required to disapprove the form if it were filed at the time of the action of withdrawal. The withdrawal shall be in writing and shall specify the reasons for the withdrawal and the effective date of the withdrawal. Any insurer adversely affected by such withdrawal may, within 30 days after receiving the written notification of the withdrawal, request a hearing to determine whether the withdrawal should be annulled, modified or confirmed. Unless the Commissioner, in writing, in the withdrawal or subsequent thereto grants an extension, the withdrawal shall, in the absence of a request for a hearing, become effective, prospectively and not retroactively, on the ninety-first day following the delivery of the notice of withdrawal, and, if request for hearing is filed, on the 91st day following delivery of written notice of the Commissioner's determination.

(e) Any hearing requested pursuant to subsections (c) and (d) of this section shall be noticed and conducted in accordance with the Delaware Administrative Procedures Act, Chapter 101 of Title 29.

(f) If a group policy of consumer credit insurance:

(1) Has been delivered in this State before November 20, 1996; or

(2) Has been or is delivered in another state before or after November 20, 1996,

then the insurer shall be required to file only the group certificate and notice of proposed insurance delivered or issued for delivery in this State as specified in § 3706(c) and (e) of this title and such forms shall be approved by the Commissioner if they conform with the requirements specified in these subsections and if the schedules of premium rates applicable to the insurance evidenced by such certificate or notice are not in excess of the insurer's schedules of premium rates filed with the Commissioner; provided however, that the premium rate in effect on existing group policies may be continued until the first policy anniversary date following November 22, 1996, as provided in § 3713 of this title. However, all other forms specified in subsection (a) of this section shall also be filed as specified in this section unless the group policy has been or is delivered in another state which has adopted statutes, regulations or other provisions similar to this section. In that event, the forms should be filed for informational purposes. However, the insurer shall be prohibited from using any form filed for informational purposes if the Commissioner subsequently determines that the form is not in substantive compliance with the requirements of this section.

(70 Del. Laws, c. 576, § 1.)

§ 3708. Premiums and refunds.

(a) Any insurer may revise its schedules of premium rates from time to time and shall file the revised schedules with the Commissioner. No insurer shall issue any consumer credit insurance policy for which the premium rate exceeds that determined by the schedules of the insurer as then on file with the Commissioner. The Commissioner shall have the authority to promulgate regulations to assure that the premium rates are reasonable in relation to the benefits provided. In determining whether the premium rates are reasonable in relation to the benefits provided, the Commissioner shall consider and provide for: actual and expected loss experience, general and administrative expenses, loss settlement and adjustment expenses, reasonable creditor compensation, investment income, the manner in which premiums are charged and other acquisition costs, reserves, taxes, regulatory license fees and fund assessments, reasonable insurer profit and other relevant data, consistent with generally accepted actuarial standards.

(b) Each individual policy or group certificate shall provide for a refund in the event of termination of the insurance prior to the scheduled maturity date of the insurance and upon notice to the insurer. The refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled thereto; provided however, that the Commissioner shall prescribe a minimum refund and no refund which would be less than such minimum need be made. The formula to be used in computing such refund shall be filed with and approved by the Commissioner.

(c) If a creditor requires a debtor to make any payment for consumer credit insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to the debtor and shall promptly make an appropriate credit to the account or issue a refund.

(d) The amount charged to a debtor for any consumer credit insurance shall not exceed the premiums charged by the insurer, as computed at the time the charge to the debtor is determined.

(e) The insurance premium or other identifiable charge for credit life or credit accident and health insurance may be collected from the insured or included in the principal of any loan or other transaction at the time such transaction is completed.

(f) The premium or cost of credit life or credit accident and health insurance when issued through any creditor shall not be deemed interest or charges, consideration or an amount in excess of permitted charges in connection with the loan or other credit transaction, and any gain or advantage to the creditor arising out of the premium or commission or dividend from the issuance of such insurance shall not be deemed a violation of any other law, general or special, civil or criminal, of the State.

(70 Del. Laws, c. 576, § 1.)

§ 3709. Issuance of policies.

All policies of consumer credit insurance shall be delivered or issued for delivery in this State only by an insurer authorized to engage in the business of insurance therein and shall be issued only through holders of licenses or authorizations issued by the Commissioner.

(70 Del. Laws, c. 576, § 1.)

§ 3710. Claims.

(a) All claims shall be promptly reported to the insurer or its designated claim representative and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.

(b) All claims shall be paid either by draft drawn upon the insurer, by electronic funds transfer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions or upon direction of such claimant to one specified.

(c) No plan or arrangement shall be used whereby any person, firm or corporation other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims; provided, that a group policyholder may, by arrangement with the group insurer, draw drafts, checks or electronic transfers in payment of claims due to the group policyholder subject to audit and review by the insurer.

(70 Del. Laws, c. 576, § 1.)

§ 3711. Existing insurance — Choice of insurer.

When consumer credit insurance is required as additional security for any debt, the debtor shall, upon request to the creditor, have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by the debtor or of procuring and furnishing the required coverage through any insurer authorized to transact any insurance business within this State.

(70 Del. Laws, c. 576, § 1.)

§ 3712. Duties of an insurer.

Except as otherwise prohibited by law, duties imposed upon an insurer within this chapter may be carried out by a creditor if the creditor is acting as a common law or statutory agent on behalf of the insurer.

(70 Del. Laws, c. 576, § 1.)

§ 3713. Enforcement; penalties.

(a) The Commissioner may, after notice and hearing, issue such rules and regulations as the Commissioner deems appropriate for the supervision of this chapter.

(b) Whenever the Commissioner finds that there has been a violation of this chapter or any rules or regulations issued pursuant thereto, and after written notice thereof and hearing given to the insurer or other person authorized or licensed by the Commissioner, the Commissioner may impose an administrative penalty in accordance with § 329 of this title. The Commissioner, in his or her discretion, may revoke or suspend the license or certificate of authority of the person, firm or corporation guilty of repeated wilful violations.

(c) Before the Commissioner may impose or order a penalty pursuant to this section, the violator shall be given notice of the violation and an opportunity to be heard at a public hearing. The procedures for such notice and hearing, and any appeal from the Commissioner's decision shall be the same as set forth in the Delaware Administrative Procedures Act, Chapter 101 of Title 29.

(d) The Commissioner may set forth by regulation prima facie reasonable premium rates, together with corresponding safe-harbor benefit provisions, which premium rates shall be conclusively presumed reasonable in relation to the benefits provided when used for policies containing such benefit provisions.

(70 Del. Laws, c. 576, § 1; 70 Del. Laws, c. 186, § 1.)

Part I
Insurance
Chapter 38
Dental Plan Organization Act

§ 3801. Short title.

This chapter shall be known and may be cited as the "Dental Plan Organization Act."

(63 Del. Laws, c. 49, § 1.)

§ 3802. Definitions.

Definitions as used in this chapter:

(1) "Child with a severe disability" means a person under the age of 21 who, due to a significant mental or physical condition, illness, or disease, is likely to require specialized treatment or supports to secure effective access to dental care.

(2) "Dental plan" means any contractual arrangement for dental services provided directly or arranged for or administered directly on a prepaid or postpaid individual or group capitation basis.

(3) "Dental plan organization" means any person who undertakes to provide directly or to arrange for or administer 1 or more dental plans providing dental services.

(4) "Dental services" means services included in the practice of dentistry as defined in § 1121 of Title 24.

(5) "Enrollee" means an individual and that individual's dependents who are enrolled in a dental plan organization.

(6) "Evidence of coverage" means any certificate, agreement or contract issued to an enrollee setting out the dental services to which the enrollee is entitled.

(63 Del. Laws, c. 49, § 1; 70 Del. Laws, c. 186, § 1; 77 Del. Laws, c. 54, § 3.)

§ 3803. Certificate of authority — Required; application procedure; filing fee.

(a) No person may establish, operate or administer a dental plan organization, or sell or offer to sell, or solicit offers to purchase, or receive advance or periodic consideration in conjunction with any dental plan organization, utilizing in the aggregate the services of more than 1 full-time equivalent dentist without obtaining and maintaining a certificate of authority pursuant to requirements of this chapter.

(b) Within 90 days after September 23, 1981, every dental plan organization utilizing in the aggregate the services of more than 1 full-time equivalent dentist shall submit an application for a certificate of authority to the Commissioner. A dental plan organization may continue to operate until the Commissioner acts upon the application. If the application is denied, the dental plan organization shall be treated as if its certificate of authority has been revoked.

(c) An application for a certificate of authority shall be in a form prescribed by the Commissioner, shall be verified by an officer or authorized representative of the dental plan organization and shall include the following:

(1) All basic organizational documents of the dental plan organization such as the articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement or other applicable documents and all amendments to those documents;

(2) The bylaws, rules and regulations or similar documents regulating the conduct or the internal affairs of the dental plan organization;

(3) The names, addresses and official positions of the persons who are responsible for the conduct of the affairs of the dental plan organization, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, the principal officers in the case of a corporation and the partners in the case of a partnership or association;

(4) All contracts made between any dentist and the dental plan organization;

(5) All contracts made between any dentist and any person listed in paragraph 3 of this subsection, any consultant or any business manager;

(6) A description of the dental plan organization, its dental plan or plans, facilities and personnel;

(7) The form of the evidence of coverage to be issued to the enrollees;

(8) The form of any group contract which is issued to employers, unions, trustees or others;

(9) Financial statements showing the dental plan organization's assets, liabilities and sources of financial support. If the dental plan organization's financial affairs are audited by independent certified public accountants, a copy of the most recent regular certified financial statement shall satisfy this requirement unless the Commissioner determines that additional or more recent financial information is required for the proper administration of this chapter;

(10) The proposed method of marketing the plan, a financial plan with a 3-year projection of the initial operating results and a statement of the sources of working capital and any other sources of funding;

(11) A power of attorney duly executed by the dental plan organization if not domiciled in this State, appointing the Commissioner, the Commissioner's successors in office and duly authorized deputies as the true and lawful attorney of the dental plan organization

in and for this State, upon whom lawful process and any legal action and proceeding against the dental plan organization on a cause of action arising in this State may be served;

(12) A description of the geographic area or areas to be served;

(13) A description of the procedures and programs to be implemented to achieve an effective dental plan; and

(14) Such other information as the Commissioner may require.

(d) The dental plan organization shall pay fees for filing an application for a certificate of authority and for filing an annual report as set forth in § 701 of this title.

(e) Within 10 days following any significant modification of information submitted with the application for a certificate of authority, a dental plan organization shall file notice of the modification with the Commissioner.

(63 Del. Laws, c. 49, § 1; 84 Del. Laws, c. 336, § 3.)

§ 3804. Certificate of authority — Conditions for issuance; disapproval; expiration; renewal.

(a) The Commissioner shall issue a certificate of authority if the Commissioner is satisfied that the following conditions are met:

(1) The persons responsible for conducting the affairs of the dental plan organization are competent and trustworthy and are professionally capable of providing, arranging for or administering the services offered by the plan;

(2) The dental plan organization constitutes an appropriate mechanism to achieve an effective dental plan, as determined by the Commissioner;

(3) The dental plan organization has demonstrated the potential to provide dental services in a manner that will assure both availability and accessibility of adequate personnel and facilities;

(4) The dental plan organization has arrangements for an ongoing quality of dental care assurance programs;

(5) The dental plan organization has a procedure to establish and maintain uniform systems of cost accounting and reports and audits that meet the requirements of the Commissioner;

(6) The dental plan organization is financially responsible and may reasonably be expected to meet its obligations to enrollees. In making this determination the Commissioner shall consider:

a. The financial soundness of the dental plan's arrangements for services and the schedule of charges used;

b. Any arrangement with an insurer or medical or dental service corporation for a continuation of coverage in the event of discontinuance of the plan on an indemnity basis through a group vehicle to the end of the period for which premiums were paid to the discontinued dental plan organization; and

c. The sufficiency of an agreement with dentists for the provision of dental services;

(7) A general surplus is maintained as required in § 3805 of this title;

(8) A contingent surplus is accumulated and maintained as required in § 3805 of this title;

(9) The condition or methods of operation of the dental plan organization are not such as would render its operation hazardous to its enrollees or the public;

(10) a. Each employer or other organization which employs or has 15 or more employees or members during the full preceding calendar year and which contributes to a dental plan organization contract which restricts the covered persons in selecting the providers of dental services to a single provider or limited number of providers shall also offer its employees and their eligible dependents and members and members' eligible dependents at the time a dental benefits plan is offered or renewed the option of selecting alternative coverage which permits covered persons to obtain dental services from any licensed dentist.

b. An employer or other organization shall be required to pay for or contribute towards the provision of alternative coverage an amount equal to the premium or cost which it pays or contributes to the dental plan organization contract which limits the number of providers of dental services.

c. By February 12, 1988, the Commissioner shall promulgate rules and regulations necessary to effectuate the purpose of this paragraph, including procedures for notice to covered persons, employers and other organizations of the provisions of this paragraph;

(11) The dental plan organization has demonstrated the potential to provide dental services and adequate reimbursement for such services for children with a severe disability.

(b) When the Commissioner disapproves an application for a certificate of authority he or she shall notify the dental plan organization in writing of the reasons for the disapproval.

(c) A certificate of authority shall expire 1 year following the date of issuance or previous renewal. If the dental plan organization remains in compliance with this chapter and has paid a renewal fee of $100 its certificate shall be renewed.

(63 Del. Laws, c. 49, § 1; 66 Del. Laws, c. 176, § 1; 70 Del. Laws, c. 186, § 1; 77 Del. Laws, c. 54, §§ 4, 5.)

§ 3805. General surplus; special contingent surplus.

(a) The Commissioner may determine, at his or her discretion, the amount of a general surplus, if any, that the dental plan organization shall be required to maintain.

(b) A dental plan organization utilizing in the aggregate the services of more than 10 full-time equivalent dentists shall accumulate and maintain a special contingent surplus in excess of its assets over liabilities the rate of 2 percent annually of its net contract and certificate income until the surplus totals $50,000.

(63 Del. Laws, c. 49, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3806. Bonding requirement.

Any director, officer, employee or partner of a dental plan organization who receives, collects, reimburses or invests moneys in connection with the activities of the organization shall be bonded for his or her fidelity in an amount which shall be determined by the Commission.

(63 Del. Laws, c. 49, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3807. Medical negligence insurance.

Each dentist employed by a dental plan organization shall be insured against professional liability or medical negligence by an insurer licensed to conduct business in this State for such minimum amounts as shall be determined by the Commissioner.

(63 Del. Laws, c. 49, § 1; 71 Del. Laws, c. 373, § 3.)

§ 3808. Evidence of coverage.

(a) An enrollee shall be entitled to receive evidence of coverage or a certificate indicating specifically the nature and extent of coverage, and evidence of the total amount or percentage of payment, if any, which the enrollee is obligated to pay for dental services. If an individual enrollee obtains coverage through an insurance policy or through a contract issued by a medical or dental service corporation, whether by option or otherwise, the insurer or medical or dental service corporation shall issue the evidence of coverage. Otherwise, the dental plan organization shall issue the evidence of coverage.

(b) No evidence of coverage or amendment thereto shall be issued or delivered to any person until a copy of the form of evidence of coverage or amendment thereto has been filed with the Commissioner.

(c) Evidence of coverage shall contain a clear and complete statement if a contract, or a reasonably complete summary if a certificate, of:

(1) The dental services and the insurance and other benefits, if any, to which enrollees are entitled;

(2) Any limitations on the services, kind of services, benefits, or kind of benefits to be provided including any charge, deductible or co-payment features;

(3) Where and in what manner information is available as to how services may be obtained; and

(4) A clear and understandable description of the dental plan organization's method for resolving enrollees' complaints.

(d) Any subsequent change in the evidence of coverage, or the amount or percentage of payment which the enrollee is obligated to pay, shall be evidenced in a separate document issued to the enrollee.

(63 Del. Laws, c. 49, § 1.)

§ 3809. Schedule of charges.

(a) No schedule of charges for enrollee coverage for dental services, or amendment thereto, may be used by a dental plan organization until a copy of such schedule, or amendment thereto, has been filed with the Commissioner. The Commissioner may disapprove the schedule of charges at any time if he or she finds that the charges are excessive, inadequate or unfairly discriminatory. If the Commissioner disapproves the schedule of charges he or she shall notify the dental plan organization within 5 days of the day of disapproval and specify in the notice the reason for his or her disapproval. A hearing shall be granted within 20 days after a request in writing by the filer. It shall be unlawful for any dental plan organization whose schedule of charges has been disapproved to effect any contract or issue any subscription certificate which uses the disapproved schedule of charges until a revised schedule of charges has been filed.

(b) Charges shall be established in accordance with actuarial principles, but charges applicable to an enrollee shall not be individually determined based on the status of his or her health.

(63 Del. Laws, c. 49, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3810. Examination of records.

(a) The Commissioner or his or her designee may, as often as he or she may reasonably determine, investigate the business and examine the books, accounts, records and files of every dental plan organization. For that purpose the Commissioner or his or her designee shall have reasonably free access to the offices and places of business, books, accounts, papers, records and files of all dental plan organizations. A dental plan organization shall keep and use in its business such books, accounts and records as will enable the Commissioner to determine whether the dental plan organization is complying with this chapter and with the rules and regulations promulgated pursuant to it. A dental plan organization shall preserve its books, accounts and records for at least 3 years; except that preservation by photographic reproduction or records in photographic form shall constitute compliance with this chapter.

(b) For the purpose of the examination, the Commissioner may, within the limits of funds appropriated for such purpose, contract with such persons as he or she may deem advisable to conduct the same or assist therein.

(c) The expenses incurred in making any examination pursuant to this section, up to $1,000 annually, shall be assessed against and paid by the dental plan organization so examined. Upon written notice by the Commissioner of the total amount of an assessment, a dental plan organization shall become liable for and shall pay the assessment to the Commissioner.

(63 Del. Laws, c. 49, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3811. Complaint system.

(a) A dental plan organization shall establish and maintain a complaint system to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning dental plan services. The dental plan organization shall maintain records of all written complaints initiated by enrollees.

(b) The Commissioner may examine the complaint system and if he or she determines that the system is not adequate he or she may require a revision of the complaint system.

(63 Del. Laws, c. 49, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3812. Annual report.

(a) Every dental plan organization annually on or before March 1 shall file with the Commissioner a report covering its activities for the preceding calendar year.

(b) The reports shall be on forms prescribed by the Commissioner and shall include:

(1) A financial statement of the dental plan organization, including its balance sheet, receipts and disbursements for the preceding year certified by a certified public accountant;

(2) Any significant modification of information submitted with the application for a certificate of authority;

(3) The number of persons who became enrollees during the year, the number of enrollees as of the end of the year and the number of enrollments terminated during the year;

(4) A description of the enrollee complaint system including the procedures of the complaint system, the total number of written complaints handled through the system, a summary of causes underlying the complaints filed, and the number, amount and disposition of medical negligence claims settled during the year by the dental plan organization and any of the dentists used by it; and

(5) Any other information relating to the performance of the dental plan organization as required by the Commissioner.

(63 Del. Laws, c. 49, § 1; 71 Del. Laws, c. 373, § 3.)

§ 3813. Maximum portion of income used for expenses.

A dental plan organization shall not use more than 30 percent of its gross contract and certificate income in the first year of operation, 25 percent in the second year of operation and 20 percent in any subsequent year for general expenses, acquisition expenses and miscellaneous taxes, licenses and fees.

(63 Del. Laws, c. 49, § 1.)

§ 3814. Advertising.

(a) No dental plan organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this subsection:

(1) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a dental plan;

(2) A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which the statement is made or the item of information is communicated, the statement or item of information may be reasonably understood by a person who does not possess special knowledge regarding dental plan coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation or disadvantage of possible significance to an enrollee of, or person considering enrollment in a dental plan, if the benefit or advantage or absence of exclusion, limitation or disadvantage does not in fact exist; and

(3) Evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography, format and language, may cause a person who does not possess special knowledge regarding dental plans and evidences of coverage therefor, to expect benefits, services, charges or other advantages which the evidence of coverage does not provide or which the dental plan organization issuing the evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

(b) No dental plan organization, unless licensed as an insurer, may use in its name, evidence of coverage or literature any of the words “insurance,” “assurance,” “casualty,” “surety,” “mutual” or any other words descriptive of the insurance, casualty or surety business or deceptively similar to the name or description of any insurer licensed to do business in this State.

(c) This section shall be enforced by the Division of Consumer Protection and, where applicable, the Commissioner. Nothing in this chapter shall limit the powers of the Attorney General and the procedures with respect to consumer fraud.

(63 Del. Laws, c. 49, § 1; 69 Del. Laws, c. 291, § 98(c).)

§ 3815. Suspension or revocation of certificate of authority.

(a) The Commissioner may suspend or revoke any certificate of authority issued to a dental plan organization pursuant to this chapter if he or she finds that any of the following conditions exists:

(1) The dental plan organization is operating in a manner significantly contrary to that described in § 3803 of this title;

(2) The dental plan organization issues an evidence of coverage which does not comply with the requirements of § 3808 of this title;

(3) The dental plan organization does not provide or arrange for an effective dental plan as determined by the Commissioner;

(4) The dental plan organization can no longer be expected to meet its obligations to enrollees;

(5) The dental plan organization, or any authorized person on its behalf, has advertised or merchandised its services in an untrue or misleading manner;

(6) The dental plan organization has failed to comply with this chapter or any rules and regulations promulgated thereunder.

(b) When the Commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, he or she shall notify the dental plan organization in writing, specifically stating the grounds for suspension or revocation. A hearing on the matter shall be granted by the Commissioner within 20 days after a request in writing by the dental plan organization. After the hearing, or upon failure of the dental plan organization to appear at the hearing, the Commissioner shall take action on his or her findings.

(c) If the Commissioner suspends the certificate of authority, the dental plan organization shall not accept any additional enrollees or engage in any advertising or solicitation during the period of the suspension.

(d) If the Commissioner revokes the certificate of authority, the dental plan organization shall proceed to dissolve its structure immediately following the effective date of the order of revocation, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the dental plan organization. The Commissioner by written order, however, may permit such further operation of the dental plan organization as he or she finds to be in the best interest of enrollees to the end that enrollees shall be afforded the greatest practical opportunity to obtain continuing dental plan coverage.

(e) Notwithstanding subsections (c) and (d) of this section, a dental plan organization which has had its certificate of authority suspended or revoked, or has suffered an adverse decision by the Commissioner, shall be entitled to appeal this decision. The appeal shall be granted as a matter of right and shall be taken to the Court of Chancery in any county in this State.

(63 Del. Laws, c. 49, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3816. Cease and desist order.

(a) The Commissioner may issue an order directing a dental plan organization or a representative of a dental plan organization to cease and desist from engaging in any act or practice in violation of this chapter.

(b) Within 20 days after service of the order of cease and desist, the respondent may request a hearing on a question of whether acts or practices in violation of this chapter have occurred.

(63 Del. Laws, c. 49, § 1.)

§ 3817. Civil penalty; exceptions.

Any dental plan organization which violates any provisions of this chapter, or neglects, fails or refuses to comply with any of the requirements of this chapter, except the failure to file an annual report and the failure to reply in writing to inquiries of the Commissioner, shall be liable for a civil penalty of no more than $1,000 for each violation.

(63 Del. Laws, c. 49, § 1.)

§ 3818. Injunctive power.

Whenever any dental plan organization shall become insolvent or shall suspend its ordinary business for want of funds to carry on the same, or whenever the Commissioner shall ascertain, as a result of examination as authorized by this chapter, or in any other manner, that the dental plan organization is exceeding its powers or violating the law or that its condition or methods of business may render the continuance of its operations hazardous to its enrollees or the public, or that its assets are less than its liabilities, the Commissioner may institute an action in the Court of Chancery to enjoin it from the transaction of any further business, or from the transfer or disposal of its property in any manner whatsoever. The Court may proceed in the action in a summary manner or otherwise. It may grant injunctive relief and appoint a receiver, with power to sue for, collect, receive and take into his or her possession all the goods and chattels, rights and credits, moneys and effects, lands and tenement, books, papers, choses in action, bills, notes and property of every description belonging to the dental plan organization and sell and convey and assign the same, and authorize the purchase of continuing coverage for enrollees utilizing the remaining assets, and hold and dispose of the proceeds thereof. The Court may cause the receiver to continue the existing operation of the organization, under Court supervision, until the next anniversary of the subscription certificates and contracts then in force. The dental plan organization may be deemed insolvent whenever it is presently or prospectively unable to fulfill its outstanding contracts and to maintain the surpluses required pursuant to this chapter.

(63 Del. Laws, c. 49, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3819. Confidentiality of documents.

Applications, filings and reports required under this chapter, except contracts referred to in § 3803(c)(4) and (5) of this title, shall be treated as public documents and shall not be considered confidential.

(63 Del. Laws, c. 49, § 1; 80 Del. Laws, c. 376, § 5.)

§ 3820. Confidentiality of data pertaining to diagnosis, treatment or health of enrollees.

Data or information pertaining to the diagnosis, treatment or health of any enrollee obtained by the dental plan organization from the enrollee or any dentist shall be confidential and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this chapter, or upon the express consent of the enrollee or pursuant to statute or court order for the production of evidence of the discovery thereof, or in the event of claim or litigation between the enrollee and the dental plan organization wherein the data or information is pertinent. A dental plan organization shall be entitled to claim any statutory privileges against such disclosure which the dentist who furnished the information to the dental plan organization is entitled to claim.

(63 Del. Laws, c. 49, § 1.)

§ 3821. Exemptions from application of chapter.

Except with respect to the dental plan organization activities of a duly organized and authorized insurer or medical or dental service corporation, which activities are authorized and regulated pursuant to this chapter, this chapter shall not apply to a person engaged as indemnitor or contractor in the business of life insurance, health insurance or of annuity, nor shall it apply to a medical service corporation or dental service corporation. This chapter shall not apply to the dental plan activities of a duly authorized health service corporation.

(63 Del. Laws, c. 49, § 1.)

§ 3822. Rules and regulations.

The Commissioner may promulgate such rules and regulations as he or she may deem necessary to effectuate the purposes of this chapter.

(63 Del. Laws, c. 49, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3823. Advisory Council.

Repealed by 77 Del. Laws, c. 106, § 2, effective July 6, 2009.

Part I
Insurance
Chapter 39
Casualty Insurance Contracts

§ 3901. Contracts subject to general provisions.

All contracts of casualty insurance covering subjects resident, located or to be performed in this State are subject to the applicable provisions of Chapter 27 (The Insurance Contract) of this title, and to other applicable provisions of this title.

(18 Del. C. 1953, § 3901; 56 Del. Laws, c. 380, § 1.)

§ 3902. Uninsured and underinsured vehicle coverage; insolvency of insurer.

(a) No policy insuring against liability arising out of the ownership, maintenance or use of any motor vehicle shall be delivered or issued for delivery in this State with respect to any such vehicle registered or principally garaged in this State unless coverage is provided therein or supplemental thereto for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured or hit-and-run vehicles for bodily injury, sickness, disease, including death, or personal property damage resulting from the ownership, maintenance or use of such uninsured or hit-and-run motor vehicle.

(1) No such coverage shall be required in or supplemental to a policy when rejected in writing, on a form furnished by the insurer or group of affiliated insurers describing the coverage being rejected, by an insured named therein, or upon any renewal of such policy or upon any reinstatement, substitution, amendment, alteration, modification, transfer or replacement thereof by the same insurer unless the coverage is then requested in writing by the named insured. The coverage herein required may be referred to as uninsured vehicle coverage.

(2) The amount of coverage to be so provided shall not be less than the minimum limits for bodily injury and property damage liability insurance provided for under the motorist financial responsibility laws of this State. The coverage for property damage shall be subject to a $250 deductible for property damage arising out of 1 accident, unless the insured and the insurer agree in writing to a different deductible. As used herein, the term “property damage” shall include the loss of use of a vehicle.

(3) For the purpose of this section, an uninsured vehicle shall be defined as:

a. One for which there is no auto liability bond, insurance or other security applicable at the time of the accident in at least the amounts required by the financial responsibility law where the auto is principally garaged or registered;

b. One for which the insuring company denies coverage or becomes insolvent; or

c. A hit-and-run motor vehicle that causes an accident resulting in bodily injury or property damage to property of the insured. Bodily injury or property damage must be caused by physical contact of the hit-and-run vehicle with the insured or with an insured motor vehicle, or by a noncontact vehicle where the identity of both the driver and the owner of such vehicle are unknown. The accident must be reported to the police or proper governmental authority. The insured must notify his or her insurer within 30 days, or as soon as practicable thereafter, that the insured or his or her legal representative has a legal action arising out of the accident.

(4) In the event of payment to any person under uninsured vehicle coverage and, subject to the terms of such coverage, to the extent of such payment, the insurer shall be entitled to the proceeds of any settlement recovery from any person legally responsible for the bodily injury or property damage as to which such payment was made and to amount recoverable from the assets of the insolvent insurer of the other vehicle; provided, that this right of subrogation is limited to the amount of coverage required by the financial responsibility law.

(b) Every insurer shall offer to the insured the option to purchase additional coverage for personal injury or death up to a limit of $100,000 per person and $300,000 per accident or $300,000 single limit, but not to exceed the limits for bodily injury liability set forth in the basic policy. Such additional insurance shall include underinsured bodily injury liability coverage.

(1) Acceptance of such additional coverage shall operate to amend the policy’s uninsured coverage to pay for bodily injury damage that the insured or his or her legal representative are legally entitled to recover from the driver of an underinsured motor vehicle.

(2) An underinsured motor vehicle is one for which there may be bodily injury liability coverage in effect, but the limits of bodily injury liability coverage under all bonds and insurance policies applicable at the time of the accident are less than the damages sustained by the insured. These limits shall be stated in the declaration sheet of the policy.

(3) The insurer shall not be obligated to make any payment under this coverage until after the limits of liability under all bodily injury bonds and insurance policies available to the insured at the time of the accident have been exhausted by payment of settlement or judgments.

(4) An insured who executes a release of a single tortfeasor owner or operator of an underinsured motor vehicle in exchange for payment of the entire limits of liability insurance afforded by the tortfeasor’s liability insurer shall continue to be legally entitled to recover against that tortfeasor for the purposes of recovery against the insured’s underinsurance carrier. An insured who executes a release of 1 of multiple tortfeasors shall have rights against that tortfeasor and the insured’s underinsurance carrier determined in accordance with the Uniform Contribution Among Joint Tortfeasors Act [Chapter 63 of Title 10] and paragraph (b)(3) of this section.

(c) The affording of insurance under this section to more than 1 person or to more than 1 vehicle shall not operate to increase the limits of the insurer's liability. When 2 or more vehicles owned or leased by persons residing in the same household are insured by the same insurer or affiliated insurers, the limits of liability shall apply separately to each vehicle as stated in the declaration sheet, but shall not exceed the highest limit of liability applicable to any 1 vehicle.

(18 Del. C. 1953, § 3902; 56 Del. Laws, c. 380, § 1; 58 Del. Laws, c. 98, §§ 2, 3; 61 Del. Laws, c. 265, § 1; 63 Del. Laws, c. 243, § 1; 64 Del. Laws, c. 426, § 1; 67 Del. Laws, c. 180, § 1; 69 Del. Laws, c. 253, § 1; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 91, § 1.)

§ 3902A. Notice of settlement offer to underinsured motor vehicle insurer.

(a) (1) If an attorney representing an injured individual, or an unrepresented injured individual, receives a written offer from a motor vehicle liability insurer, or that insurer's authorized agent, to settle a claim for bodily injury or death, and the amount of the settlement offer, in combination with any other settlements arising out of the same occurrence, would exhaust the bodily injury or death limits of all applicable liability insurance policies and bonds, the attorney or unrepresented individual may send to the injured individual's underinsured motor vehicle insurer notice of the settlement offer by certified mail or electronic mail.

(2) The notice must include a copy of the motor vehicle liability insurer's written settlement offer, the motor vehicle liability insurer's proposed release, and the motor vehicle liability insurer's declaration page for the applicable liability insurance policy.

(b) Within 60 days after receipt of the notice under subsection (a) of this section, the underinsured motor vehicle insurer shall send to the attorney representing an injured individual, or the unrepresented injured individual, 1 of the following by certified mail or electronic mail:

(1) Written consent to accept the settlement offer.

(2) Written refusal to consent to the acceptance of the settlement offer outlining the good faith reasons for the refusal.

(c) (1) The injured individual may accept the motor vehicle liability insurer's settlement offer and execute releases in favor of the motor vehicle liability insurer and the motor vehicle liability insurer's insured without prejudice to any claim the injured individual may have against the underinsured motor vehicle insurer if 1 of the following applies:

a. The injured individual receives written consent under paragraph (b)(1) of this section to accept the settlement offer.

b. The underinsured motorist insurer does not comply with subsection (b) of this section.

(2) If consent or no response is provided by the underinsured motor vehicle insurer within 60 days of receipt of the notice under subsection (a) of this section, the underinsured motor vehicle insurer cannot deny the validity of any underinsured motorist coverage on the basis that other liability insurance existed for a given claim.

(d) Written consent by any underinsured motor vehicle insurer to acceptance of a settlement offer under paragraph (b)(1) of this section may not be construed to limit the right of the underinsured motor vehicle insurer to raise any issue relating to liability as to the cause of the underlying accident or damages in an action against the underinsured motor vehicle insurer.

(e) Nothing in this section may be construed as requiring consent from an underinsured motor vehicle insurer for any person to establish the validity of an underinsured motor vehicle claim.

(84 Del. Laws, c. 67, § 1.)

§ 3903. Cancellation or nonrenewal of automobile policy; definitions; scope. [For application of this section, see 82 Del. Laws, c. 160, § 5]

(a) As used in §§ 3903-3907 of this title:

(1) "Certified mail" as used in this chapter shall refer to the following as used by the postal service:

a. Certified mail;

b. Certified mail, return receipt;

c. Certified mailing list.

(2) "Nonpayment of premium" means failure of the named insured to discharge when due any of his or her obligations in connection with the payment of premiums on a policy or any installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit.

(3) "Policy" means any 1 or more of the following portions of an automobile insurance policy:

a. Insuring against bodily injury and property damage liability;

b. Insuring against physical damage;

c. Insuring against risks commonly included under "comprehensive coverage";

d. Relating to medical payments;

e. Providing uninsured motorist coverage, where such policy is delivered or issued for delivery in this State, insuring an individual as named insured or 1 or more related individuals resident of the same household, and under which the insured vehicles therein designated are motor vehicles of the private passenger or station wagon type (not used for public or livery conveyance of passengers, or rented to others) or any other 4 wheel motor vehicles with a load capacity of 1500 pounds or less not used in the occupation, profession, or business of the insured, and other than a policy of automobile liability insurance that meets any of the following criteria:

1. Issued under an assigned risk plan.

2. Insuring more than 4 motor vehicles.

3. Covering garage, automobile sales agency, repair shop, service station, or public parking place operation hazards.

(4) "Renewal" or "to renew" means the issuance and delivery by an insurer of a policy superseding at the end of the policy period a policy previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term. Any policy with a policy period or term of less than 6 months or any policy with no fixed expiration date shall for the purpose of this section be considered as if written for successive policy periods or terms of 6 months.

(b) Sections 3903-3907 of this title shall not apply to any policy which has been in effect less than 60 days at the time notice of cancellation is mailed or delivered by the insurer, unless it is a renewal policy.

(c) (1) Notwithstanding § 3911 of this title, the transfer of a policyholder between authorized insurers within the same insurance group is not a cancellation or nonrenewal if the policyholder's premium does not increase and the policyholder does not experience a reduction in coverage. A policyholder so transferred must be provided with written notice of the transfer.

(2) A transfer under this subsection shall be treated as a renewal for purposes of the use of credit information pursuant to Chapter 83 of this title.

(3) The notice required under this subsection shall be made no less than 20 days before the effective date of the proposed transfer. The notice may be a part of a renewal form sent to the policyholder renewing the coverage by the new insurer.

(d) Where an insurer either fails to renew a policy or cancels a policy based solely upon the reason of nonpayment of premium, the insurer shall renew or reinstate the policy if the insured tenders to the insurer or its agent the full amount due within 30 days after the end of the policy period or cancellation date. The renewed or reinstated policy shall contain the same conditions at the same rates or premiums had he or she paid his or her premium on the due date. The effective date of such renewed or reinstated policy shall be the date of actual receipt by the insurer or its agent of the full premium payment due. The renewed or reinstated policy shall not cover and the insurer shall not be liable for any losses occurring or claims which were sustained during the period from the end of the policy period or cancellation date until the date the full premium payment was actually received by the insurer or its agent, regardless of whether or not such a loss or claim would otherwise fit within the coverage of such a policy.

(18 Del. C. 1953, § 3903; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 154, § 5; 63 Del. Laws, c. 243, § 2; 70 Del. Laws, c. 186, § 1; 77 Del. Laws, c. 217, § 1; 82 Del. Laws, c. 160, § 1; 83 Del. Laws, c. 221, § 1.)

§ 3904. Cancellation or nonrenewal of automobile policy — Reasons for cancellation or nonrenewal [For application of this section, see 84 Del. Laws, c. 209, § 3].

(a) No notice of cancellation of a policy shall be effective and the insurer shall not refuse renewal or threaten to refuse renewal of a policy unless based on 1 or more of the following reasons:

(1) Nonpayment of premium; or

(2) The policy was obtained through a material misrepresentation; or

(3) Any insured violated any of the terms and conditions of the policy; or

(4) The named insured knowingly failed to disclose fully the named insured motor vehicle accidents and moving traffic violations, or the named insured losses covered under any automobile physical damage or comprehensive coverage, for the preceding 36 months, if called for in the application; or

(5) As to renewal of the policy, if the insured at any time while the policy was in force failed to disclose fully to the insurer, upon request therefor, facts relative to accidents and losses incurred material to underwriting of the risk; or

(6) Any insured made a false or fraudulent claim or knowingly aided or abetted another in the presentation of such a claim; or

(7) The named insured or any other operator who either resides in the same household or customarily operates an automobile insured under such policy:

a. Has, within the 36 months prior to the notice of cancellation or nonrenewal, had a driver's license under suspension or revocation, except for any of the following:

1. A child whose license has been revoked or suspended pursuant to § 1009 of Title 10.

2. A child whose license had been revoked or suspended pursuant to § 904 of Title 4.

3. A person who had a driver's license under suspension or revocation for a nondriving-related offense, including a nondriving-related drug offense pursuant to § 2707(b)(10) of Title 21; or

b. Has a history of and is subject to epilepsy or heart attacks, and such individual cannot produce a certificate from a physician testifying to the named insured unqualified ability to operate a motor vehicle safely; or

c. Has an accident record, conviction record (criminal or traffic), physical, mental or other condition which is such that the named insured operation of an automobile might endanger the public safety; or

d. Has, while the policy is in force, engaged in a competitive speed contest while operating an automobile insured under the policy; or

e. Is addicted to or uses narcotics or other drugs; or

f. Uses alcoholic beverages to excess thereby impairing the named insured ability to operate a motor vehicle; or

g. Has been convicted, or forfeited bail, during the 36 months immediately preceding the notice of cancellation or nonrenewal, for:

1. Any felony related to fraud or to the type of risk being insured; or

2. Criminal negligence resulting in death, homicide or assault arising out of the operation of a motor vehicle; or

3. Operating a motor vehicle while in an intoxicated condition or while under the influence of drugs; or

4. Leaving the scene of an accident without stopping to report; or

5. Theft or unlawful taking of a motor vehicle; or

6. Making false statements in an application for a driver's license; or

h. Has been convicted of, or forfeited bail, for 3 or more violations, the point total for which exceeds 8 points, or 3 at fault accidents in which claims are paid in excess of $250 per accident within the 36 months immediately preceding the notice of cancellation or nonrenewal, of any law, ordinance or regulation limiting the speed of motor vehicles or any of the provisions of the motor vehicle laws of any state, violation of which constitutes a dangerous moving violation as set forth in Chapter 41 of Title 21, whether or not the violations were repetitions of the same offense or different offenses; or

(8) The insured automobile is:

a. So mechanically defective that its operation might endanger public safety; or

b. Used in carrying passengers for hire or compensation, except that the use of an automobile for a car pool shall not be considered use of an automobile for hire or compensation; or

c. Used in the business of transportation of flammables or explosives; or

d. An authorized emergency vehicle; or

e. Modified or changed in condition during the policy period so as to increase the risk substantially; or

f. Subject to an inspection law and has not been inspected or, if inspected fails to qualify.

(b) (1) Insureds protected by a policy covering 2 or more persons in a family or household shall not be subject to cancellation or nonrenewal because of the wrongdoing or fault of another insured under the policy;

(2) In the event 1 or more of the insureds under such policy is subject to cancellation or nonrenewal, such insured shall be excluded pursuant to the terms of § 3909 of this title;

(3) The excluded driver or drivers shall be required to furnish proof that the coverage required under Delaware law is carried with another company or through the Delaware Automobile Insurance Plan, or surrender the excluded driver's motor vehicle operator's license within 30 days.

(c) A policy may not be subject to cancellation or nonrenewal solely because the insured's driver license is denied or suspended in accordance with § 516(g) or § 2216 of Title 13.

(18 Del. C. 1953, § 3904; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 154, § 1; 59 Del. Laws, c. 307, § 4; 63 Del. Laws, c. 257, § 1; 69 Del. Laws, c. 125, § 5; 70 Del. Laws, c. 186, § 1; 70 Del. Laws, c. 452, § 10; 70 Del. Laws, c. 583, § 1; 71 Del. Laws, c. 216, § 88; 71 Del. Laws, c. 228, § 1; 72 Del. Laws, c. 448, § 1; 79 Del. Laws, c. 295, § 1; 84 Del. Laws, c. 42, § 1; 84 Del. Laws, c. 209, § 2.)

§ 3905. Cancellation or nonrenewal of automobile policy — Notice of cancellation or intention not to renew; notice of reasons [For application of this section, see 79 Del. Laws, c. 390, § 8].

(a) No cancellation of a policy to which § 3904(a) of this title applies shall be effective unless notice thereof is mailed or delivered by the insurer to the named insured at least 30 days prior to the effective date of cancellation and accompanied by the reason for cancellation, except that, where cancellation is for nonpayment of premium, at least 15 days' notice of cancellation accompanied by the reason therefor shall be given.

(b) No insurer shall fail to renew a policy except to which § 3903(b) of this title applies, unless it shall mail or deliver to the named insured, at his or her address last of record with the insurer, at least 30 days advance notice of its intention to nonrenew accompanied by the reason or reasons therefor. This subsection shall not apply in case of nonpayment of premium or if the insurer has manifested its willingness to renew. Notwithstanding the failure of an insurer to comply with this subsection, the policy shall terminate on the effective date of any other policy procured by the insured with respect to any automobile designated in both policies. Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation or nonrenewal which existed before the effective date of the renewal.

(c) The mailing of the notice of cancellation, or of intention not to renew, to the named insured at his or her last address of record with the insurer, shall be by certified mail or by USPS Intelligent Mail barcode (IMb). Proof of mailing of such notice shall be retained by the insurer for a period of not less than 1 year. This subsection shall not apply in case of nonpayment of premium.

(d) When a policy is cancelled or nonrenewed, other than for nonpayment of premium, the insurer shall notify the named insured of any possible eligibility for insurance through an automobile assigned risk plan. Such notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew, and shall state that such notice of availability of the automobile assigned risk plan is given pursuant to this section.

(e) Each notice of cancellation, except as provided in § 3903(b) of this title, or nonrenewal of a policy shall contain or be accompanied by a notice of the named insured's right to apply to the Commissioner for an appeal therefrom.

(18 Del. C. 1953, § 3905; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 154, § 2; 63 Del. Laws, c. 243, § 3; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 390, § 5; 82 Del. Laws, c. 160, § 2; 83 Del. Laws, c. 221, § 2.)

§ 3906. Cancellation or nonrenewal of automobile policy — Appeal to the Commissioner; order.

(a) A named insured who wishes to contest the reason or reasons for a cancellation or nonrenewal to which § 3904 of this title is applicable shall not less than 20 days prior to the effective date of cancellation or nonrenewal mail or deliver to the Commissioner a request for a review, which shall state clearly the basis for the appeal. The Commissioner's review of a named insured's appeal shall be on the papers. This subsection shall not apply to cancellation for nonpayment of premium. A cancellation or nonrenewal which is subject to the provisions of § 3904 of this title shall be deemed effective, unless the Commissioner determines otherwise in accordance with the provisions of such section.

(b) Within 2 working days after receipt of a timely request for an appeal, the Commissioner shall forward a copy of the insured's request to the insurer. Within 5 working days of its receipt of the appeal, the insurer shall submit to the Commissioner all documentation supporting the insurer's statutory authority to cancel or nonrenew the policy. The Commissioner may, where he or she finds that an unfairness will result to the insured because of delays or other circumstances beyond his or her control, extend the effective date of cancellation or nonrenewal for a period not to exceed 4 days from the date the notice of cancellation or nonrenewal was received by the insured. Each insurer authorized to transact automobile insurance in this State shall maintain a file with the Commissioner of the name and address of the person authorized to receive notices pursuant to this section on behalf of the insurer.

(c) The Commissioner, based on the documents submitted by the parties and at least 5 days prior to the effective date of the cancellation or nonrenewal, shall issue his or her written findings to the parties and, if he or she finds for the named insured, the Commissioner shall either order the insurer to rescind its notice of cancellation or nonrenewal or, if the date cancellation or nonrenewal is to be effective has lapsed, order the policy reinstated. Such order shall operate retroactively only to cover a period not to exceed 15 days from the date cancellation or nonrenewal otherwise would have been effective and prospectively from the date on which the order was issued, except that no policy shall be reinstated while the named insured is in arrears in payment of premium on the policy. If the Commissioner finds for the insurer, the Commissioner's written order shall so state. Reinstatement of a policy under this subsection shall not operate in any way to extend the expiration, termination or anniversary date provided in the policy.

(d) [Repealed.]

(18 Del. C. 1953, § 3906; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 154, § 3; 70 Del. Laws, c. 186, § 1; 78 Del. Laws, c. 350, § 1; 83 Del. Laws, c. 221, § 3.)

§ 3907. Cancellation or nonrenewal of automobile policy — Nonliability as to information; statements.

There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner or the insurer, its authorized representative, its agents, its employees or any firm, person or corporation furnishing to the insurer information as to reasons for cancellation or refusal to renew any policy under § § 3903-3906 of this title, for any statement made by any of them in any written notice or explanation of cancellation or refusal to renew, for the providing of information pertaining thereto, or for statements made or evidence submitted during an appeal conducted in connection therewith.

(18 Del. C. 1953, § 3907; 56 Del. Laws, c. 380, § 1; 83 Del. Laws, c. 221, § 4.)

§ 3908. Cancellation or nonrenewal of automobile policy — Exceptions related to insurer's condition.

Nothing contained in §§ 3903-3907 of this title shall be construed to prevent the cancellation or nonrenewal of any such insurance where:

(1) Cancellation or nonrenewal is ordered under or in connection with a statutory delinquency proceeding commenced against the insurer under Chapter 59 of this title (Rehabilitation and Liquidation); or

(2) Cancellation or nonrenewal has been consented to by the Commissioner on a showing that continuation of such insurance can reasonably be expected to create a condition in the insurer hazardous to its policyholders, or to its creditors, or to its members, subscribers or stockholders, or to the public.

(18 Del. C. 1953, § 3908; 56 Del. Laws, c. 380, § 1.)

§ 3909. Automobile insurance; exclusion, cancellation or nonrenewal.

(a) The insurer shall have the right to exclude, cancel or refuse to renew coverage under an automobile insurance policy as to designated individuals. Any such cancellation or refusal to renew shall be subject to the applicable provisions of § 3903 through and including § 3907 of this title, and the notice provisions of those said sections shall apply equally to the exclusion, cancellation or refusal to renew coverage as to a designated individual or individuals.

(b) In any case where an insurer is authorized under this chapter to cancel or nonrenew any automobile policy under which more than 1 person is insured because of the record of 1 or more, but less than all of the persons insured under the policy, the insurer shall, in lieu of cancellation or nonrenewal, offer to continue or renew the insurance, but to exclude from coverage, by name, the person or persons

whose record would have justified the cancellation or nonrenewal. The premiums charged on any such policy excluding a named driver or drivers shall not reflect the claims, experience or driving record of the excluded named driver or drivers.

(c) With respect to any person excluded from coverage under this section, the policy may provide that the insurer shall not be liable for damages, losses or claims arising out of this operation or use of the insured motor vehicle, whether or not such operation or use was with the express or implied permission of a person insured under the policy.

(d) Every insurer shall be required to offer to the driver or drivers excluded under this section coverage of the same type or types and in an amount or amounts at least as great as the types and amount of coverage carried on the vehicle or vehicles that the designated person is being excluded from, which coverage shall be offered at rates commensurate with the driving record of such excluded driver or drivers; provided, however, that such excluded driver or drivers shall not be required to carry coverage in any amount or amounts greater than those amounts required by the financial responsibility law of the State.

(e) The excluded driver or drivers shall be required to accept this offer of coverage, to furnish proof that such coverage is carried with another company, or surrender his or her motor vehicle operator's license to the Division of Motor Vehicles within 30 days after the offering of such coverage. Refusal to accept such coverage, the furnishing of adequate proof, or the failure to surrender his or her operator's license within the 30-day period will cause the cancellation of the policy or policies that they were excluded from. This provision shall apply as long as the designated individual could be considered a member of the household or possible occasional driver of the vehicle or vehicles he or she is being excluded from.

(18 Del. C. 1953, § 3909; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 201, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3910. Automobile insurance — Insurer's right to impose deductible on renewal.

Nothing in §§ 3903-3909 of this title shall prohibit or be construed to prohibit an insurer from requiring a provision for a reasonable deductible not exceeding $100 in amount as to physical damage and comprehensive coverages of the policy as a condition to renewal of an automobile insurance policy.

(18 Del. C. 1953, § 3910; 56 Del. Laws, c. 380, § 1.)

§ 3911. Legislation affecting renewal of policies — Notice of nonrenewal by insurer.

(a) Any legislation enacted subsequent to July 9, 1973, or subsequent legislation affecting Chapter 21 of Title 21, shall not effect the renewal of policies as described in § 3903(a)(4) of this title, unless the legislation itself so specifies.

(b) When an insurer intends not to renew a commercial liability insurance policy, other than an automobile insurance policy, notice of such nonrenewal shall be given to the named insured, in writing, not less than 60 days prior to the end of the policy period. For the purposes of this subsection, "renew" means the issuance and delivery by an insurer of a policy superseding at the end of the policy period a policy previously issued and delivered by the same insurer or the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term. Mailing of notice of intention not to renew to the named insured at his or her address last of record with the insurer shall be by certified mail.

(18 Del. C. 1953, § 3911; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 154, § 4; 66 Del. Laws, c. 309, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3912. Prohibition against premium increase or termination in certain circumstances.

(a) No premium may be increased on any contract of casualty insurance based on a named insured or any other operator who either resides in the same household or customarily operates an automobile insured under such policy being revoked or suspended pursuant to § 1009 of Title 10.

(b) No premium may be increased on any contract of casualty insurance based on a license revocation or suspension imposed on the named insured or any other operator who either resides in the same household or customarily operates an automobile insured under such policy for a nondriving-related drug offense pursuant to § 2707(b)(11) or § 4177H(a) of Title 21.

(c) No premium may be increased on any contract of casualty insurance based on a named insured or any other operator who either resides in the same household or customarily operates an automobile insured under such policy being revoked or suspended pursuant to § 904 of Title 4.

(d) No premium may be increased on any contract of casualty insurance based solely on a license denial or suspension imposed in accordance with § 516(g) or § 2216 of Title 13 on a named insured or any other operator who either resides in the same household or customarily operates an automobile insured under such policy.

(e) No insurer may terminate, or increase any premium on, a contract of casualty insurance solely based on a named insured or any other operator who either resides in the same household or customarily operates an automobile insured under such policy serving as a driver who is not monetarily compensated for a nonprofit transportation entity, such as Independent Transportation Network of America and its affiliates. For purposes of this subsection, "nonprofit" means any organization subject to § 501(c)(3) of the Internal Revenue Code of 1986 (26 U.S.C. § 501(c)(3)), as amended.

(59 Del. Laws, c. 307, § 5; 69 Del. Laws, c. 125, § 6; 70 Del. Laws, c. 452, § 9; 71 Del. Laws, c. 216, § 87; 71 Del. Laws, c. 228, §§ 2, 4; 80 Del. Laws, c. 366, § 2.)

§ 3913. Requests for driving records; limitation.

No insurer issuing a policy of insurance as described in this chapter shall, before such policy is issued, require that the proposed insured provide such insurer with his or her driving record for any period other than the 3 years immediately preceding the proposed effective date of such policy; provided, however, that if no violations or accidents are reflected on such record for 2 years immediately preceding the proposed effective date of such policy during which period the insured held a valid operator's license, then an insurer may not consider more than such 2-year period for the purpose of issuing a policy of insurance.

(62 Del. Laws, c. 391, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3914. Notice of statute of limitations required.

An insurer shall be required during the pendency of any claim received pursuant to a casualty insurance policy to give prompt and timely written notice to claimant informing claimant of the applicable state statute of limitations regarding action for his or her damages.

(63 Del. Laws, c. 236, § 1; 70 Del. Laws, c. 186, § 1.)

§ 3915. Cash refund on cancellation of policy.

(a) No insurer shall honor a request for a cash refund on cancellation of a policy by the insured until such time as the insured has provided sufficient evidence to the insurer that one of the following has occurred:

(1) The insured has other insurance in effect which provides at least such minimum insurance coverage as is set forth in § 2118 of Title 21.

(2) The insured vehicle is no longer owned by the insured.

(3) The vehicle is no longer operable or capable of being repaired so as to become operable.

(4) The insured becomes self-insured under the provisions of § 2904 of Title 21.

(b) The requirement of "sufficient evidence" under subsection (a) of this section is satisfied by the insured providing the insurer with an affidavit certifying that any 1 of the conditions set forth in subsection (a) of this section has occurred. The insurer shall notify any insured who requests a cash refund on cancellation of a policy of the requirements of this section, and shall provide an appropriate form of affidavit, approved by the Insurance Commissioner (who is expressly authorized to approve appropriate forms of such affidavit), for execution by the insured. Any form of affidavit presented to or executed by an insured under this section shall bear a notice to the effect that false statements therein are punishable pursuant to § 1233 of Title 11.

(67 Del. Laws, c. 142, § 1; 67 Del. Laws, c. 218, § 1.)

§ 3916. Unfair trade practices.

No insurance company, domestic or foreign, or any agent or employee shall require that automobile glass repair or replacement work be performed by a particular facility, individual or business establishment as a condition of payment of a claim.

(69 Del. Laws, c. 195, § 1.)

§ 3917. Military deployment as a factor in automobile insurance rates.

(a) An insurer shall not use a lapse in an insured's automobile insurance coverage as a factor in determining a new automobile insurance policy rate if the lapse was due to the cancellation or nonrenewal of the policy by the insurer, the cancellation of the policy by the insured, or by the insured's failure to pay the policy renewal premium, as a result of the insured's deployment, whether inside or outside the United States or its waters, as a member of the military, military reserve, or National Guard. An insurer may require the insured to provide reasonable documentation to verify the insured's deployment. As used in this section, the term "deployment" does not include a permanent change of station within the United States.

(b) The spouse of an insured protected by subsection (a) of this section shall be similarly protected if that spouse accompanies an insured on the deployment.

(76 Del. Laws, c. 263, § 1; 70 Del. Laws, c. 186, § 1; 83 Del. Laws, c. 221, § 5.)

§ 3918. Vehicle data-reporting device.

(a) An insurer seeking to install a data-reporting device in a private passenger vehicle, or seeking to use a previously installed device for the purpose of obtaining data, shall inform the policyholder of such installation or use, of the data that may be obtained by the insurer from such device, and how the installation or use and removal or discontinuation of such device can affect the cost of insurance coverage.

(b) An insurer may not install or use a data reporting device in a private passenger vehicle unless an insured listed as the policyholder consents to such installation or use.

(c) The disclosure of any nonpublic personal information and any nonpublic confidential information collected by a vehicle data reporting device shall be governed by § 535 of this title and 18 DE Admin. Code 904-1.0 to 18 DE Admin. Code 904-16.0.

(d) Any private passenger vehicle insurance rating plan that uses data obtained by a vehicle data-reporting device shall be subject to Chapter 25 of this title and 18 DE Admin. Code 1902-1.0 to 18 DE Admin. Code 1902-6.0.

(e) This section applies to private passenger vehicle insurance issued to individual policyholders primarily for personal, family or household purposes. This section does not apply to policies issued to commercial entities or individuals who obtain insurance products or services for business, commercial or agricultural purposes.

(f) For purposes of this section, a "data reporting device" is any device that is capable of maintaining, transmitting, or storing, a vehicle's telematics and driving data.

(79 Del. Laws, c. 219, § 1.)

§ 3919. Addition of minor children and foster children to existing motor vehicle policies.

(a) If requested by an insured, an insurer is required to add the following individuals to the insured's existing policy as an additional driver:

(1) Any licensed minor child of the insured who resides with the insured.

(2) Any licensed foster child placed into the temporary care of the insured by the Department of Services for Children, Youth and Their Families or pursuant to a court order.

(b) Policies under which coverage is extended to licensed foster children under this section must continue to be rated as personal, and not commercial, automobile policies.

(c) Insurers may not increase premium rates on policies under which coverage is extended under this section solely because of the addition of the licensed minor child or licensed foster child as a named driver, unless the increase is actuarially justified.

(d) (1) Unless actuarily justified, an insurer that issues an insurance policy on a private passenger motor vehicle to an insured who is a foster parent of a foster child may not charge an additional premium for coverage of the foster child while the child is operating the insured vehicle if the foster child has procured a separate policy through participation in the program established under § 9011A of Title 29.

(2) An insurer may exclude a foster child who has procured a separate policy through participation in the program established under § 9011A of Title 29 from the private passenger motor vehicle insurance policy of the foster child's foster parent.

(81 Del. Laws, c. 128, § 1; 83 Del. Laws, c. 453, §§ 2, 11; 84 Del. Laws, c. 345, § 1.)

§ 3920. Cancellation or nonrenewal of commercial automobile policy. [For application of this section, see 82 Del. Laws, c. 160, § 5]

(a) (1) An insurer licensed to do business in Delaware may not cancel mid-term any commercial automobile policy except for any of the following reasons:

a. Nonpayment of premium.

b. Material misrepresentation or nondisclosure to the insurer of a material fact at the time of acceptance of the risk.

c. Increased hazard or material change in the risk assumed, where the increased hazard or material change could not have been reasonably contemplated by the parties at the time of the assumption of the risk.

d. Substantial breaches of contractual duties, conditions, or warranties, which materially affect the nature or insurability of the risk.

e. Fraudulent acts against the insurer by the insured or its representatives, which materially affect the nature of the risk insured.

f. Lack of cooperation from the insured on loss control matters affecting insurability of the risk.

g. Bona fide loss of or substantial changes in applicable reinsurance if the insurer gives 60 days' written notice to both the insured and the Commissioner and submits a statement outlining the measures taken by the insurer to retain reinsurance and to obtain alternative sources of reinsurance in a form promulgated by the Commissioner.

h. Material increase in exposure arising out of changes in statutory or case law after the issuance of the insurance contract if the insurer gives 60 days' written notice to the insured and the Commissioner.

i. Bona fide loss of or reduction in available insurance capacity if the insurer gives 60 days' written notice to the insured and Commissioner.

(2) Except as otherwise provided in paragraph (a)(3) of this section, an insurer may not cancel a commercial automobile policy unless notice of the cancellation is mailed or delivered by the insurer to the named insured, at the insured's last address of record with the insurer, at least 60 days before the effective date of cancellation and accompanied by the reason for the cancellation. If the cancellation is for nonpayment of premium, the insurer shall give at least 10 days' notice of cancellation accompanied by the reason for the cancellation.

(3) Nothing in this section prohibits an insurer from issuing a notice of cancellation regarding a commercial automobile policy that has been in effect for less than 60 days at the time the notice is mailed or delivered.

(b) An insurer shall renew a commercial automobile policy unless the insurer mails or delivers to the named insured, at the insured's last address of record with the insurer, at least 60 days' advance notice of its intention to nonrenew accompanied by the reason or reasons for the nonrenewal. This subsection does not apply in case of nonpayment of premium or if the insurer has manifested its willingness to renew. Notwithstanding the failure of an insurer to comply with this subsection, the commercial automobile policy must terminate on the effective date of any other commercial automobile policy procured by the insured with respect to any automobile designated in both

policies. Renewal of a commercial automobile policy shall not constitute a waiver or estoppel with respect to grounds for cancellation or nonrenewal which existed before the effective date of the renewal.

(c) The mailing of the notice of cancellation or of intention to nonrenew to the named insured, at the last address of record with the insurer, must be by certified mail or by USPS Intelligent Mail barcode (IMb). Proof of mailing of such notice must be retained by the insurer for a period of not less than 1 year. This subsection does not apply in case of nonpayment of premium.

(d) When a policy is cancelled or nonrenewed, other than for nonpayment of premium, the insurer shall notify the named insured of any possible eligibility for insurance through an automobile assigned risk plan. The notice of availability of insurance through an automobile assigned risk plan must accompany or be included in the notice of cancellation or the notice of intent not to renew, and must state that the notice is given pursuant to this section.

(82 Del. Laws, c. 160, § 3.)

§ 3921. Youth in foster care status as a factor in automobile insurance rates.

(a) For purposes of this section, "youth in foster care" means any of the following:

(1) An individual in Department of Children, Youth, and Their Families ("Department") custody under Chapter 25 of Title 13.

(2) An individual who exited Department custody to adoption or guardianship at age 16 or later.

(3) An individual who exited Department custody at age 18.

(4) [Repealed.]

(5) An individual who receives independent living services from the Department.

(b) An insurer may not use any of the following as a factor in determining a youth in foster care's new automobile insurance policy rate:

(1) A lapse in the youth in foster care's automobile coverage if any of the following apply:

a. The lapse was due to the cancellation or nonrenewal of a policy because of the cancellation of the youth in foster care's participation in the program established under § 9011A of Title 29.

b. The youth in foster care has used all resources available under the program established under § 9011A of Title 29 or otherwise becomes ineligible for the program.

(2) That the youth in foster care did not receive a Class D operator's license through the youth in foster care's participation in the Level 1 Learner's Permit process under § 2710 of Title 21.

(c) An insurer may require a youth in foster care to provide reasonable documentation to verify the youth in foster care's change in eligibility for the program established under § 9011A of Title 29.

(83 Del. Laws, c. 453, §§ 3, 11; 84 Del. Laws, c. 345, § 2.)

Part I
Insurance

Chapter 40
Health Insurance for Children and Persons on Medicaid

§ 4001. Scope of chapter.

The provisions of this chapter shall apply to:

(1) Any insurer providing insurance of human beings against bodily injury, disablement or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance appertaining thereto;

(2) A health service corporation, notwithstanding any provision to the contrary in Chapter 63 of this title;

(3) A health maintenance organization, notwithstanding any provision to the contrary in Chapter 64 of this title;

(4) A group health plan, as defined in § 607(1) of the federal Employee Retirement Income Security Act of 1974 [29 U.S.C. § 1167(1)];

(5) An entity offering a service benefit plan or a pharmacy benefit manager;

(6) A self-funded entity or group providing health-care coverage;

(7) Any person or entity which provides coverage in this State for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital or optometric expenses, whether such coverage is by direct payment, reimbursement or otherwise; and

(8) Any other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health-care item or service.

(69 Del. Laws, c. 444, § 1; 76 Del. Laws, c. 190, §§ 2, 3.)

§ 4002. Health insurance for children.

(a) No health insurer shall deny enrollment of a child under the health coverage of the child's parent on the ground that:

(1) The child was born out of wedlock;

(2) The child is not claimed as a dependent on the parent's federal income tax return; or

(3) The child does not reside with the parent or in the insurer's service area.

(b) In any case in which a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage through a health insurer, such health insurer shall:

(1) Permit such parent to enroll under such family coverage any such child who is otherwise eligible for such coverage (without regard to any enrollment season restrictions);

(2) If such parent is enrolled but fails to make application to obtain coverage of such child, enroll such child under such family coverage upon application by the child's other parent, the Family Court or by a state agency administering a program under Part D, Title IV of the federal Social Security Act [42 U.S.C. § 651 et seq.], or Title XIX of the federal Social Security Act [42 U.S.C. § 1396 et seq.]; and

(3) Not disenroll (or eliminate coverage of) such a child unless the health insurer is provided satisfactory written evidence that:

a. Such court or administrative order is no longer in effect; or

b. The child is or will be enrolled in comparable health coverage through another health insurer which will take effect not later than the effective date of such disenrollment.

(c) In any case in which a child has health coverage through the health insurer of a noncustodial parent, the insurer shall:

(1) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through such coverage;

(2) Permit the custodial parent (or provider, with the custodial parent's approval) to submit claims for covered services without the approval of the noncustodial parent; and

(3) Make payment on claims submitted in accordance with paragraph (c)(2) of this section directly to such custodial parent, the provider, or the state agency administering a program under part D, Title IV of the federal Social Security Act [42 U.S.C. § 651 et seq.] or Title XIX of the federal Social Security Act [42 U.S.C. § 1396 et seq.].

(69 Del. Laws, c. 444, § 1; 71 Del. Laws, c. 216, § 12.)

§ 4003. Health insurance for persons on Medicaid.

(a) No health insurer, in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, shall take into account that the individual is eligible for or is provided medical assistance under a Medicaid Plan of this State or any other state.

(b) Where a state agency has been assigned the rights of an individual eligible for medical assistance under Title XIX of the federal Social Security Act [42 U.S.C. § 1396 et seq.] and such individual is covered for health benefits from a health insurer, no such health insurer shall impose requirements on the state agency that are different from requirements applicable to an agent or assignee of any other individual so covered.

(c) Where a state agency has been assigned the rights of an individual eligible for medical assistance under Title XIX of the federal Social Security Act (42 U.S.C. § 1396 et seq.) and such individual is covered for health benefits from a health insurer, such health insurer, or other liable third party, must accept authorization provided by the State that the item or service is covered under the state plan (or waiver of such plan) for such individual, as if such authorization was made by the third party prior to the item or service for such item or service.

(69 Del. Laws, c. 444, § 1; 84 Del. Laws, c. 257, § 1.)

§ 4004. Definitions.

As used in this chapter:

(1) “Department” means the Delaware Department of Health and Social Services.

(2) “Health insurer” includes all of the following:

a. An insurer providing insurance of human beings against bodily injury, disablement or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance appertaining thereto.

b. A health service corporation.

c. A health maintenance organization.

d. A group health plan, as defined in § 607(1) of the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1167(1)).

e. Any entity offering a service benefit plan.

f. A self-funded entity or group providing health-care coverage.

g. A pharmacy benefit manager.

h. Any other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health-care item or service.

i. Any person or other entity which provides coverage in this State for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether such coverage is by direct payment, reimbursement, or otherwise.

(69 Del. Laws, c. 444, § 1; 76 Del. Laws, c. 190, §§ 4, 5; 81 Del. Laws, c. 79, § 32.)

§ 4005. Administrative procedures.

The Commissioner may issue regulations in accordance with § 314 of this title and Chapter 101 of Title 29 for the implementation and administration of this chapter.

(69 Del. Laws, c. 444, § 1.)

§ 4006. Data sharing.

The Department is authorized to require any health insurer to provide, upon the request of the Department, eligibility and coverage information (including, but not limited to the name, address, date of birth, Social Security number, policy number, group identification number, types of covered services under the policy, effective dates of coverage, and termination date for each client) that will enable the Department to determine during what period Medicaid recipients may be or may have been covered by the health insurer and the nature of the coverage that is or was provided. This information shall be referred to as the “Plan Eligibility Data Elements.” The Department may enter into agreements with the health insurers for the purpose of carrying out the provisions of this section. The agreement shall provide for the electronic exchange of data between the parties at a mutually agreed upon frequency and in a format specified by the Department designed to verify that an individual has coverage, but no less frequently than once every 2 months. The agreement shall specify the data elements that shall be included on the electronic file from the health insurer. No health insurer that provides data required by the Department, whether confidential or not, shall be held liable for the provision of such data to the Department or for any use made thereof. The Department shall have procedures in place to ensure compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 [P.L. 104-191] relating to the privacy and security of individually identifiable health information, as applicable.

(76 Del. Laws, c. 190, § 6.)

Part I
Insurance

Chapter 41
Property Insurance Contracts

Subchapter I
Generally

§ 4101. Contracts subject to general provisions.

All contracts of property insurance covering subjects located in this State are subject to the applicable provisions of Chapter 27 (The Insurance Contract) of this title, and to other applicable provisions of this title.

(18 Del. C. 1953, § 4101; 56 Del. Laws, c. 468, § 1.)

§ 4102. Attorneys' fees.

The court upon rendering judgment against any insurer upon any policy of property insurance, as "property" insurance is defined in § 904 of this title, shall allow the plaintiff a reasonable sum as attorneys' fees to be taxed as part of the costs.

(18 Del. C. 1953, § 4102; 56 Del. Laws, c. 468, § 1.)

Subchapter II
Basic Property Protection Plan

§ 4103. Definitions.

As used in this subchapter, unless the context otherwise requires:

(1) "Basic property insurance" means insurance against direct loss to any property caused by perils as defined and limited in the standard fire policy and extended coverage endorsement as filed with the Commissioner.

(2) "Commissioner" means the Insurance Commissioner of the State of Delaware.

(3) "Inspection bureau" means any organization designated by the Commissioner to make inspections to determine the insurability and conditions of the properties where basic property insurance is sought.

(4) "Premiums written" means gross direct premiums charged on all policies of basic property insurance and the basic property insurance premium components of all multiperil policies, less return premiums, dividends paid or credited to policyholders and the unabsorbed portion of premium deposits.

(5) "Qualified property" means all real and tangible personal property at fixed locations, whether or not subject to exposure from an external hazard located on property not owned or controlled by the prospective insured, and whether or not subject to exposure from riot hazard which:

a. Complies with applicable state laws and regulations and local building codes and ordinances; and

b. Is not commonly owned or controlled, or combinable for rating purposes, with property insured for similar coverages elsewhere; and

c. Has characteristics of ownership, condition or occupancy which do not violate public policy.

d. For purposes of homeowners and insurance and fire protection insurance, no policy shall exclude a dwelling unit or personal property within the dwelling unit from coverage as being unoccupied if:

1. The unit is regularly maintained;

2. Utility services are available and in use; and

3. The unit remains furnished as a dwelling unit,

provided, however, that this protection shall not apply if the dwelling unit remains unoccupied beyond a period of 60 consecutive days.

e. The Commissioner shall require the insurer to notify the insured of the 60-day exception contained in paragraph (5)d. of this section.

(18 Del. C. 1953, § 4103; 56 Del. Laws, c. 468, § 2; 58 Del. Laws, c. 23, § 1; 64 Del. Laws, c. 371, § 1.)

§ 4104. Purpose.

The purposes of this subchapter are:

(1) To assure stability in the property insurance market of this State;

(2) To make basic property insurance available for qualified property established by this section;

(3) To encourage maximum use in obtaining basic property insurance of the available, normal insurance market provided by the private property insurance industry;

(4) To provide for equitable distribution among authorized insurers of the responsibility for insuring qualified property for which basic property insurance cannot be obtained through the normal insurance market.

(18 Del. C. 1953, § 4104; 56 Del. Laws, c. 468, § 2.)

§ 4105. Inspection.

(a) Any person having an insurable interest in real and tangible personal property at a fixed location who has made a diligent effort to obtain basic property insurance in the normal insurance market shall be entitled upon request to an inspection of the property by representatives of the inspection bureau. Such request shall be upon forms and in accordance with procedures reviewed by the Commissioner.

(b) The plan of operation of the inspection bureau, the manner and scope of the inspection and the form of the inspection report shall be submitted by the inspection bureau in written report for review by the Commissioner.

(c) A copy of the inspection report shall be made available to the applicant or the applicant's agent or the insurer upon request.

(18 Del. C. 1953, § 4105; 56 Del. Laws, c. 468, § 2; 70 Del. Laws, c. 186, § 1.)

§ 4106. Establishment of industry placement facility.

An industry placement facility shall be established by authorized insurers to formulate and administer a program for the equitable distribution and placement of applications for basic property insurance for qualified property which has been so inspected. Separate classifications may be established for the purpose of equitable distribution. Such programs should be intended to conform with the applicable provisions of the National Insurance Development Corporation Act of 1968 [former 12 U.S.C. § 1749bbb et seq., repealed], or other such title as such federal legislation may bear upon enactment.

(18 Del. C. 1953, § 4106; 56 Del. Laws, c. 468, § 2; 58 Del. Laws, c. 23, § 2.)

§ 4107. Review.

Any facility, plan, program or form required under this subchapter shall be subject to review by the Commissioner and deemed to meet the requirements of this subchapter unless disapproved.

(18 Del. C. 1953, § 4107; 56 Del. Laws, c. 468, § 2.)

§ 4108. Failure of industry placement facility program.

If the Commissioner finds, after a reasonable period of time, that the plan of operation set forth in § 4106 of this title is not creating a market which meets the purposes of that section, the Commissioner may order the implementation of §§ 4109 and 4110 of this title.

(18 Del. C. 1953, § 4108; 56 Del. Laws, c. 468, § 2; 70 Del. Laws, c. 186, § 1.)

§ 4109. Joint underwriting association.

(a) After hearing and upon promulgation of an order by the Commissioner pursuant to § 4108 of this title, a joint underwriting association shall be created consisting of all insurers authorized to write and engaged in writing within this State, on a direct basis, fire and extended coverage insurance, including insurers covering such perils in homeowners and commercial multiple peril package policies. Every such insurer shall be a member of the association and shall remain a member as a condition of its authority to continue to transact such kinds of insurance within this State.

(b) The association shall, pursuant to this chapter and the plan of operation and with respect to basic property insurance on qualified property, have the power to:

(1) Cause its members to issue policies of insurance to applicants;

(2) Assume reinsurance from members; and

(3) Cede reinsurance.

(c) Within 90 days following the effective date of the order of the Commissioner, the association shall submit to the Commissioner for review a proposed plan of operation, consistent with the provisions of this subchapter, which shall provide for economical, fair and nondiscriminatory administration and for the prompt and efficient provision of basic property insurance to promote orderly community development, including, but not limited to, preliminary assessment of all members for initial expenses necessary to commence operations, establishment of necessary facilities, management of the association, assessment of members to defray losses and expenses, commission arrangements, reasonable underwriting standards and limits of liability, acceptance and cession of reinsurance, and procedures for determining amounts of insurance to be provided.

(d) The plan of operation shall be subject to review by the Commissioner, after consultation with affected individuals and organizations, and shall take effect 10 days thereafter in the absence of any disapproval. If the Commissioner disapproves all or any part of the proposed plan of operation, the association shall, within 30 days, submit for review an appropriately revised plan of operation or part thereof, and,

if the association fails to do so, or if the revised plan so filed is unacceptable, the Commissioner shall promulgate such a plan of operation or part thereof as the Commissioner may deem necessary to carry out the purpose of this subchapter.

(e) The association may, on its own initiative, or at the request of the Commissioner, amend the plan of operation or part thereof subject to review by the Commissioner.

(18 Del. C. 1953, § 4109; 56 Del. Laws, c. 468, § 2; 70 Del. Laws, c. 186, § 1.)

§ 4110. Procedures.

(a) Any member of the association may cede to the association basic property insurance written on qualified property, to the extent, if any, and on the terms and conditions set forth in the plan of operation.

(b) All members of the association shall participate in its writings, expenses, profits and losses in the proportion that the premiums written by each such member (but excluding (1) premiums on farm or manufacturing property, and (2) that portion of premiums attributable to the operation of the association) during the preceding calendar year bear to the aggregate premiums written in this State by all members of the association. Such participation by each insurer in the association shall be determined annually on the basis of such premiums written during the preceding calendar year, as disclosed in the annual statements and other reports filed by the insurer with the Commissioner.

(c) The association shall be governed by a board of 11 directors, elected annually by cumulative voting by the members of the association, whose votes in such election shall be weighed in accordance with each member's premiums written during the preceding calendar year. The first board shall be elected at a meeting of the members or their authorized representatives, which shall be held within 30 days after approval of the plan of operation as provided in § 4109 of this title.

(18 Del. C. 1953, § 4110; 56 Del. Laws, c. 468, § 2.)

§ 4111. Examinations.

The operation of the inspection bureau, the industry placement facility and any joint underwriting association shall at all times be subject to the supervision and regulation of the Commissioner. The Commissioner, or any person designated by the Commissioner, shall have the power of visitation of and examination into such operations and free access to all books, records, files, papers and documents that relate to such operations, may summon and qualify witnesses under oath, and may examine directors, officers, agents or employees or any other person having knowledge of such operations.

(18 Del. C. 1953, § 4111; 56 Del. Laws, c. 468, § 2; 70 Del. Laws, c. 186, § 1.)

§ 4112. Appeals.

Any person aggrieved by any action or decision of the inspection bureau or industry placement facility may appeal to the Commissioner within 30 days from the action or the decision. The Commissioner shall after hearing held upon not less than 10 days written notice to the aggrieved person and the inspection bureau or the industry placement facility issue an order approving the action or decision, disapproving the action or decision or directing the inspection bureau or the industry placement facility to reassign and place the application pursuant to said plan.

(18 Del. C. 1953, § 4112; 56 Del. Laws, c. 468, § 2.)

§ 4113. Nonliability as to information, statements.

There shall be no liability on the part of, and no cause of action of any nature shall arise against, insurers, the inspection bureau, the industry placement facility, the joint underwriting association or their agents or employees, or the Commissioner or authorized representatives of the Commissioner, for any inspections undertaken or statements made by them in any reports and communications concerning the property to be insured or at the time of the hearings conducted in connection therewith, or in the findings required by this chapter.

(18 Del. C. 1953, § 4113; 56 Del. Laws, c. 468, § 2; 70 Del. Laws, c. 186, § 1.)

Subchapter III

Declinations, Renewals and Cancellations of Property Insurance Contracts

§ 4120. Scope of subchapter.

This subchapter shall apply to policies of property insurance, other than policies of inland marine insurance and policies of property insurance issued through a residual market mechanism, covering risks to property located in this State which take effect or are renewed after January 19, 1986, and which insure any of the following contingencies:

(1) Loss of or damage to real property which consists of not more than 4 residential units, 1 of which is the principal place of residence of the named insured; or

(2) Loss of or damage to personal property in which the named insured has an insurable interest where:

a. The personal property is used for personal, family or household purposes; and

b. The personal property is within a residential dwelling.

(65 Del. Laws, c. 199, § 1.)

§ 4121. Definitions.

(a) "Declination" is the refusal of an insurer, an agent or a broker to issue a property insurance policy on a written nonbinding application or written request for coverage. For the purpose of this subchapter, the offering of insurance coverage with a company within an insurance group which is different from the company requested on the nonbinding application or written request for coverage or the offering of insurance upon different terms than requested in the nonbinding application or written request for coverage shall be considered a declination.

(b) "Nonpayment of premium" means the failure of the named insured to discharge any obligation in connection with the payment of premiums on policies of property insurance subject to this subchapter, whether such payments are directly payable to the insurer or its agent or indirectly payable under a premium finance plan or extension of credit. "Nonpayment of premium" shall include the failure to pay dues or fees where payment of such dues or fees is a prerequisite to obtaining or continuing property insurance coverage.

(c) "Renewal" or "to renew" means the issuance and delivery by an insurer at the end of a policy period of a policy superseding a policy previously issued and delivered by the same insurer or the issuance and delivery of a certificate or notice extending the term of an existing policy beyond its policy period or term. For the purposes of this subchapter, any policy period or term of less than 6 months shall be considered a policy period or term of 6 months and any policy period or term of more than 1 year or any policy with no fixed expiration date shall be considered a policy period or term of 1 year.

(d) "Termination" means either cancellation or nonrenewal of property insurance coverage in whole or in part. A cancellation occurs during the policy term. A nonrenewal occurs at the end of the policy term as set forth in subsection (a) of this section. For purposes of this subchapter, the transfer of a policyholder between companies within the same insurance group shall be considered a termination, but requiring a reasonable deductible, reasonable changes in the amount of insurance or reasonable reductions in policy limits or coverage shall not be considered a termination if such requirements are directly related to the hazard involved and are made on the renewal date of the policy.

(65 Del. Laws, c. 199, § 1.)

§ 4122. Notification and reasons for declination or termination [For application of this section, see 79 Del. Laws, c. 390, § 8].

(a) Upon declining to insure any real or personal property subject to this subchapter, the insurer, agent, or broker making such declination shall either provide the insurance applicant with a written explanation of the specific reasons for the declination or an explanation will be provided within 21 days of the timely receipt of the applicant's written request for such an explanation. An applicant's written request shall be timely under this subsection if received within 90 days of the date of notice of the declination. In the event of a declination by an insurer of a risk submitted by an agent or broker on behalf of the applicant, the insurer shall provide that agent or broker with a written explanation of the reasons for the declination. In the event the agent or broker is unable to effect insurance for the applicant through an admitted insurer other than a residual market mechanism, the agent or broker shall submit an explanation in writing to the applicant of all insurer declinations. No agent, broker, or insurer not represented by an agent or broker shall decline to provide an insurance application form or other means of making a written request for insurance to a prospective applicant who requests insurance coverage from the agent, broker, or insurer.

(b) No cancellation of a property insurance policy shall be effective unless notice thereof is mailed or delivered by the insurer to the named insured at least 30 days prior to the effective date of cancellation, except that, where cancellation is for nonpayment of premium, at least 10 days' notice of cancellation shall be given. A notice of cancellation of property insurance coverage by an insurer shall be in writing, shall be delivered to the named insured or mailed to the named insured at the last known address of the named insured, shall state the effective date of the cancellation, and shall be accompanied by a written explanation of the specific reasons for the cancellation.

(c) At least 30 days before the end of a policy period, as described in § 4121(c) of this title, an insurer shall deliver or mail to the named insured, at the last known address of the named insured, either of the following:

(1) Written notice of the insurer's offer to renew the policy if the applicable premium for the policy is received within a specified billing period; or

(2) Written notice of the insurer's intention not to renew the policy upon expiration of the current policy period. The notice of intention not to renew shall include or be accompanied by a written explanation of the insurer's specific reason or reasons for the nonrenewal.

(d) Except for notices for nonpayment of premium, the notices required under subsection (b) and paragraph (c)(2) of this section shall be delivered to the named insured by certified mail or by USPS Intelligent Mail barcode. Proof of mailing of all notices under subsections (b) and (c) of this section shall be retained by the insurer for a period of not less than 1 year. If the insurer fails to comply with either paragraph (c)(1) or (2) of this section, coverage shall be deemed renewed under the same terms and conditions until the named insured has accepted replacement coverage with another insurer or until the named insured has agreed to the nonrenewal. For purposes of this section, "certified mail" includes certified mail, certified mail return receipt, and certified mailing list, as used by the postal service.

(65 Del. Laws, c. 199, § 1; 79 Del. Laws, c. 390, § 6; 83 Del. Laws, c. 92, § 1; 84 Del. Laws, c. 272, § 1.)

§ 4123. Permissible cancellations.

After coverage has been in effect for more than 60 days or after the effective date of a renewal policy a notice of cancellation shall not be issued unless it is based upon at least 1 of the following reasons:

(1) Nonpayment of premium;

(2) Discovery of fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy or in presenting a claim under the policy;

(3) Discovery of wilful or reckless acts or omissions on the part of the named insured which increase any hazard insured against;

(4) The occurrence of a change in the risk which substantially increases any hazard insured against after insurance coverage has been issued or renewed;

(5) A violation of any local fire, health, safety, building or construction regulation or ordinance with respect to any insured property or the occupancy thereof which substantially increases any hazard insured against;

(6) A determination of the Insurance Commissioner that the continuation of the policy would place the insurer in violation of the insurance laws of this State;

(7) Real property taxes owing on the insured property have been delinquent for 2 or more years and continue delinquent at the time notice of cancellation is issued.

(65 Del. Laws, c. 199, § 1.)

§ 4124. Discriminatory practices prohibited.

The declination or termination of a policy of property insurance subject to this subchapter by an insurer, agent or broker is prohibited if the declination or termination is:

(1) Based upon the race, religion, nationality, ethnic group, age, sex or marital status of the applicant or named insured;

(2) Based solely upon the lawful occupation or profession of the applicant or named insured, except that this provision shall not apply to an insurer, agent or broker which limits its market to 1 lawful occupation or profession or to several related lawful occupations or professions;

(3) Based upon the age or location of the residence of the applicant or named insured unless such decision is for a business purpose which is not a mere pretext for unfair discrimination;

(4) Based upon the fact that another insurer previously declined to insure the applicant or terminated an existing policy in which the applicant was named insured;

(5) Based upon the fact that the applicant or named insured previously obtained insurance coverage through a residual market insurance mechanism.

(65 Del. Laws, c. 199, § 1.)

§ 4125. Enforcement.

(a) Upon a complaint of person filed within 90 days of any violation of this subchapter, the Commissioner shall determine whether such complaint is reasonably founded. If the Commissioner determines that such complaint is reasonably founded, or if the Commissioner otherwise has reason to believe that an insurer, agent or broker has engaged in practices which violate this subchapter and that a proceeding in respect thereto would be in the public interest, the Commissioner shall set a date for a public hearing to determine whether a violation of this subchapter has in fact occurred. Such hearing shall be held upon no less than 10 days' notice to the person charged and the complainant, if any. Such notice shall set forth the specified grounds upon which the complaint is based. If a hearing is based upon a complaint, the hearing shall be set no later than 30 days from the date the complaint was filed. The hearing shall take place before a hearing examiner who shall make a record of the evidence and set forth findings and conclusions. Once a prima facie violation of this subchapter has been established, the person charged in the complaint shall have the burden of showing that such violation was based on a reason not prohibited by this subchapter. The findings of fact determined by the hearing examiner shall be reviewed by the Commissioner who shall issue a final order. A petition for hearing may be filed within 30 days of the final order of the Commissioner.

(b) If the Commissioner determines in a final order that:

(1) An insurer has violated §§ 4123 and 4124 of this title, the Commissioner may require the insurer to:

a. Accept the application or written request for insurance coverage at a rate and on the same terms and conditions as are available to other risks similarly situated; or

b. Reinstate insurance coverage to the end of the policy period; or

c. Continue insurance coverage at a rate and on the same terms and conditions as are available to other risks similarly situated.

(2) Any person has violated this subchapter, the Commissioner may:

a. Issue a cease and desist order to restrain such person from engaging in practices which violate this subchapter; or

b. Assess a penalty against such person of up to $500 for each violation of this subchapter.

(65 Del. Laws, c. 199, § 1.)

§ 4126. Civil liability and actions; limitation.

(a) If the Commissioner determined in a final order that an insurer has violated § 4123 or § 4124 of this title, the applicant or named insured aggrieved by the violation may bring an action in a court of competent jurisdiction in this State to recover from such insurer any loss, not otherwise recovered through insurance, which would have been paid under the insurance coverage that was declined or terminated in violation of this subchapter.

(b) Any amounts recovered under subsection (a) of this section shall not be duplicative of any recovery obtained through the exercise of any other statutory or common-law cause of action arising out of the same occurrence. No action under this section shall be brought 2 years after the date of a final order of the Commissioner finding a violation of § 4123 or § 4124 of this title.

(65 Del. Laws, c. 199, § 1.)

§ 4127. Judicial review.

Any person aggrieved by any determination or order of the Commissioner under this subchapter may seek judicial review in the Superior Court. Failure of the Commissioner to act upon a complaint under this subchapter within 30 days of the filing of such complaint shall constitute a determination that the complaint was not reasonably founded. Review in the Superior Court shall be de novo.

(65 Del. Laws, c. 199, § 1.)

§ 4128. Immunity.

(a) There shall be no liability on the part of and no cause of action shall arise against:

(1) The Insurance Commissioner;

(2) Any insurer or its authorized representatives, agents or employees;

(3) Any licensed insurance agent or broker; or

(4) Any person furnishing information to an insurer as to reasons for a termination or declination for any communication giving notice of or specifying the reasons for a declination.

(b) Subsection (a) of this section shall not apply to statements made in bad faith with malice in fact.

(65 Del. Laws, c. 199, § 1.)

§ 4129. Notice.

During the pendency of any claim received pursuant to a property insurance policy, the insurer shall be required to give prompt and timely written notice to a policyholder making a claim informing the policyholder of the applicable state statute of limitations or any contractual period of limitations regarding the filing of an action for the claimant's damages under the contract.

(76 Del. Laws, c. 223, § 1.)

§ 4130. Nonrenewal [For application of this section, see 79 Del. Laws, c. 390, § 8].

(a) (1) An insurer may not refuse to renew a policy of homeowners insurance solely on the basis of:

a. Claims caused by weather, unless 3 or more such claims have been made against the policy during the 36 months immediately preceding the expiration of the current policy period; or

b. Claims not caused by weather, unless 2 or more claims have been made against the policy during the 60 months immediately preceding the expiration of the current policy period; or

c. A combination of claims caused by weather and claims not caused by weather, unless such combination of 3 or more claims has been made against the policy during the 48 months immediately preceding the expiration of the current policy period; or

d. Claims closed without payment, notwithstanding any other provision of this section.

(2) However, an insurer may nonrenew a homeowner's policy if:

a. The claim or claims asserted against the policy demonstrate that there has been a reasonably substantial change or increase in the hazard or in the risk assumed by the carrier subsequent to the date the policy was issued, and such nonrenewal is applied to other homeowners policies similarly situated; or

b. The policyholder has refused or failed to make reasonably necessary changes or repairs after being notified by the insurer that failure to make such changes or repairs will constitute a breach of contractual duties, conditions or warranties that will change or increase the hazard or risk assumed by the insurer subsequent to the date the policy was issued.

(b) "Homeowners insurance" for purposes of this section and § 4131 of this title shall mean property insurance as defined at §§ 4103(5)d. and 4120 of this title insuring any real or personal property used by a person as a permanent or temporary place of residence.

(76 Del. Laws, c. 290, § 1; 79 Del. Laws, c. 390, § 7; 84 Del. Laws, c. 272, § 2.)

§ 4131. Inquiries.

An insurer shall not consider an inquiry regarding a homeowners policy or a loss under that policy to be a claim for purposes of making underwriting decisions, including but not limited to decisions to nonrenew a policy. An inquiry is any contact initiated by an insured that is not the filing of a claim to an insurer.

(76 Del. Laws, c. 290, § 1.)

Subchapter IV
Wind, Hail and Hurricanes

§ 4140. Notice regarding deductibles.

(a) All insurers licensed to and writing residential property insurance in Delaware shall provide clear and prominent notice to residential property insurance policyholders as to the existence of deductibles for losses caused by wind, hail or hurricanes, as follows:

(1) The notice shall be included:

a. With regard to any policy in effect before January 1, 2013, with the first renewal on or after that date.

b. On or after January 1, 2013, with a policy at first issuance and with the first renewal after any insurer-initiated change in the deductibles for losses caused by wind/hail or hurricanes.

(2) Such notice may be sent electronically to any policyholder who has consented to receive such notices electronically.

(3) The notice shall clearly disclose relevant details pertaining to the wind/hail and hurricane deductibles, including the trigger of the deductible, regardless of whether it is stated as a percentage or as a dollar amount.

(4) If there is a percentage deductible, the insurer must provide an example of how it applies to the loss. The example does not have to be tailored to the insured value of the specific property, but must show clearly how the deductible works (e.g., a 2% deductible on a house insured for $300,000 means the policy holder is responsible for $6,000 of the wind, hail or hurricane loss).

(5) If there is not a separate deductible for wind/hail or hurricane losses, the insurer is not required to provide a notice.

(b) This section sets forth the minimum information that must be included in the notice. Insurers may provide any other information to assist their insureds in understanding wind/hail and hurricane deductibles and their application to the insurance policy.

(c) For purposes of this section, "residential property insurance" means insurance that provides coverage for:

(1) A 1-, 2-, 3-, or 4-family dwelling primarily intended for occupancy as living quarters;

(2) A condominium unit primarily intended for occupancy as living quarters;

(3) Nonbusiness personal property of a tenant insured on an unscheduled basis and primarily located in the living quarters occupied by the tenant;

(4) A manufactured home situated in a fixed location and intended for occupancy as living quarters.

However, "residential property insurance" does not include insurance provided using commercial multiple-peril or commercial property policy forms.

(78 Del. Laws, c. 386, § 1.)

Subchapter V
Private Primary Residential Flood Insurance Model Act

(83 Del. Laws, c. 530, § 1.)

§ 4151. Short title.

This subchapter is known and may be cited as the "Private Primary Residential Flood Insurance Model Act."

(83 Del. Laws, c. 530, § 1.)

§ 4152. Purpose and intent.

To provide protection of lives and property from the peril of flood, this legislation is designed to encourage a robust private primary residential flood insurance market to provide consumer choices and alternatives to the existing National Flood Insurance Program.

(83 Del. Laws, c. 530, § 1.)

§ 4153. Definitions.

As used in this subchapter:

(1) "Authorized insurer" means an insurer that is authorized by the Department to write insurance under a certificate of authority issued by the Department to transact insurance in Delaware.

(2) "Commissioner" means the Insurance Commissioner of the State of Delaware.

(3) "Department" means the Delaware Department of Insurance.

(4) "National Flood Insurance Program" or "NFIP" means the program of flood insurance coverage and floodplain management administered under the National Flood Insurance Act of 1968 (42 U.S.C. § 4001 et seq.) and applicable federal regulations promulgated in Title 44 of the Code of Federal Regulations.

(5) "Primary residential flood insurance" means an insurance policy covering losses from flood to residential property, other than commercial property, written in Delaware by any insurer authorized to do business that is not written to apply coverage in excess of the coverage provided under another flood insurance policy, whether issued by a private insurer or the National Flood Insurance Program.

(83 Del. Laws, c. 530, § 1.)

§ 4154. Rates.

(a) Rates for flood insurance coverage established pursuant to this subchapter are subject to the requirements of Chapter 25 of this title.

(b) An insurer shall file with the Department all rates and any change to such rates in accordance with the requirements of Chapter 25 of this title. Any filing requesting a rate change must include the name of the insurer and the average statewide percentage change in rates.

(83 Del. Laws, c. 530, § 1.)

§ 4155. Forms.

(a) An insurer shall file with the Department all forms for flood insurance coverage in accordance with § 2712 of this title.

(b) The Department may require, through the promulgation of regulations, additional conditions related to the forms or rates for private residential flood insurance coverage, including any of the following:

(1) That an authorized insurer may issue an insurance policy, contract, or endorsement.

(2) For residential properties required to have flood insurance that are in a special flood hazard area designated by the Federal Emergency Management Agency, that the coverage at least meets the private flood insurance requirements as specified in 42 U.S.C. § 4012a(b) and applicable federal regulations in document 84 FR 4953, effective July 1, 2019.

(83 Del. Laws, c. 530, § 1.)

§ 4156. Duties of insurer to provide regulatory notice of intent to transact residential primary flood insurance.

Authorized insurers intending to sell primary residential flood insurance products in Delaware must do all of the following:

(1) Notify the Department of its plans at least 30 days before making a form or rate filing relating to such flood insurance in Delaware.

(2) File a plan of operation and financial projections or material revisions to such plan.

(83 Del. Laws, c. 530, § 1.)

§ 4157. Notice to consumers.

(a) If a consumer has no coverage under the NFIP, before placing the consumer applicant with private flood insurance, the consumer must be informed of the existence of the NFIP.

(b) All consumers covered by subsection (a) of this section as well as consumers who currently have coverage under the NFIP must be informed that the coverage under the NFIP may be provided at a subsidized rate and that the full-risk rate for flood insurance may apply to the property if the applicant later seeks to reinstate coverage under the program. The insurance producer, surplus lines broker, or the insurer upon its election or if there is no producer or broker must provide such notice.

(c) This section only applies if the applicant lives in a special flood hazard area. This section automatically sunsets if federal legislation is enacted allowing the insured to switch between private flood insurance and NFIP coverage without risk of penalty.

(83 Del. Laws, c. 530, § 1.)

§ 4158. Cancellation and nonrenewal notice.

(a) Notice of cancellation or nonrenewal, other than for nonpayment of premium, shall be made and provided in compliance with § 4122 of this title, provided that at least 45 days' notice must be provided before the cancellation or nonrenewal of private flood insurance coverage to the insured.

(b) Notwithstanding subsection (a) of this section, notice of cancellation for nonpayment of premium shall be made and provided in compliance with § 4122 of this title.

(83 Del. Laws, c. 530, § 1.)

§ 4160. Other provisions.

(a) *FAIR Plan participation. —*

Writing private flood insurance under this subchapter does not constitute participation in the property insurance market for purposes of determining participation in the Delaware Fair Access to Insurance Requirements (FAIR) Plan under Chapter 41, subchapter II of this title.

(b) *Filings open to inspection. —*

All rate filings and supporting information filed under this subchapter shall be open to public inspection by parties in interest after the filing becomes effective.

(c) With respect to the regulation of flood coverage written in this State by authorized insurers, this subchapter supersedes any other provision in this title in the event of a conflict.

(d) An insurer may certify that the insurance policy meets the definition of "private flood insurance," as specified in 42 U.S.C. § 4012a(b)(7) and applicable federal regulations.

(e) It is the intent of the General Assembly that nothing in this subchapter is intended to restrict the use of existing filings by an insurer or limit the ability of private insurers to provide flood insurance coverage of any type not addressed herein.

(83 Del. Laws, c. 530, § 1.)

§ 4161. Regulations.

The Commissioner may, in accordance with § 311 of this title, promulgate regulations necessary to carry out the provisions of this subchapter.

(83 Del. Laws, c. 530, § 1.)

Part I
Insurance
Chapter 42
Delaware Insurance Guaranty Association Act

§ 4201. Title.

This chapter shall be known and may be cited as the "Delaware Insurance Guaranty Association Act."

(18 Del. C. 1953, § 4201; 57 Del. Laws, c. 437.)

§ 4202. Purpose.

This chapter shall provide a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer, to assist in the detection and prevention of insurer insolvencies and to provide an association to assess the cost of such protection among insurers.

(18 Del. C. 1953, § 4202; 57 Del. Laws, c. 437.)

§ 4203. Scope.

This chapter shall apply to all kinds of direct insurance but does not apply to any of the following:

(1) Life, annuity, health and disability insurance;

(2) Mortgage guaranty, financial guaranty and other forms of financial guarantees;

(3) Fidelity and surety bonds, or other bonding obligations;

(4) Credit insurance, vendors single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;

(5) Insurance of warranties or service contracts, including insurance that provides for the repair, replacement, or service of goods or property, or indemnification for repair, replacement, or service, for the operational or structural failure of the goods or property due to a defect in materials, workmanship, or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;

(6) Title insurance;

(7) Ocean marine insurance;

(8) Any transaction or combinations of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insurer) which involves the transfer of an investment or credit risk unaccompanied by the transfer of insurance risk;

(9) Any insurance provided by or guaranteed by government.

(18 Del. C. 1953, § 4203; 57 Del. Laws, c. 437; 63 Del. Laws, c. 395, § 1; 68 Del. Laws, c. 112, § 1; 81 Del. Laws, c. 337, § 1.)

§ 4204. Construction.

This chapter shall be liberally construed to effect the purpose specified in § 4202 of this title, which shall constitute an aid and guide to interpretation.

(18 Del. C. 1953, § 4204; 57 Del. Laws, c. 437.)

§ 4205. Definitions.

As used in this chapter:

(1) "Affiliate" means a person who directly or indirectly, through 1 or more intermediaries, controls, is controlled by or is under common control with an insolvent insurer on December 31 of the year next preceding the date the insurer becomes an insolvent insurer.

(2) "Association" means the Delaware Insurance Guaranty Association created under § 4206 of this title.

(3) "Claimant" means any insured making a first-party claim or any person instituting a liability claim; provided that no person who is an affiliate of an insolvent insurer may be a claimant.

(4) "Commissioner" means the Commissioner of Insurance of this State.

(5) "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services or otherwise, unless the power is the result of an official position with or corporate office held by the person.Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds the power to vote or holds proxies representing 10 percent or more of the voting securities of any other person. This presumption may be rebutted by showing the control does not in fact exist.

(6) a. "Covered claim" means an unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage, and subject to the applicable limits, of an insurance policy to which this chapter applies, issued by an insurer, if such insurer becomes an insolvent insurer after July 5, 1991, and:

1. The claim is a first-party claim for damage to property with a permanent location; or

2. The claimant or insured is a resident of this State at the time of the insured event.For entities other than individuals, for purposes of this chapter, the state of residence of a claimant or insured shall be the state in which that entity has a principal place of business most closely related to the claim.

b. "Covered claim" shall in no event include:

1. Any amount awarded as punitive, bad faith or exemplary damages regardless of the language of the insurance policy invoked;

2. Any amount sought as a return of premium under any retrospective rating plan;

3. Any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation, or self-insurer as reinsurance recoveries, contribution, indemnification, subrogation moneys, or otherwise. No such claim for any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation, or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent such claim exceeds the association obligation limits set forth in § 4208 of this title;

4. Any first-party claim by an insured whose net worth exceeds $10,000,000 on December 31 of the year next preceding the date the insurer becomes an insolvent insurer; provided, that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its affiliates as calculated on a consolidated basis; or

5. Any first-party claim by an insured which is an affiliate of the insolvent insurer.

(7) "Insolvent insurer" means an insurer licensed to transact insurance in this State, either at the time the policy was issued or when the insured event occurred, and against whom an order of liquidation with a finding of insolvency has been entered after July 5, 1991, by a court of competent jurisdiction in the state of domicile or in this State under Chapter 59 of this title and which order of liquidation has not been stayed or been the subject of a writ of supersedeas or other comparable order.

(8) "Member insurer" means any person who:

a. Writes any kind of insurance to which this chapter applies under § 4203 of this title, including the exchange of reciprocal or inter-insurance contracts; and

b. Is licensed to transact insurance in this State.

(9) "Net direct written premiums" means direct gross premiums written in this State on insurance policies to which this chapter applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

(10) "Ocean marine insurance" includes any form of insurance, regardless of the name, label, or marketing designation of the insurance policy, which insures against maritime perils or risks and other related perils or risks, which are usually insured against by traditional marine insurance, such as hull and machinery, marine builders risk, and marine protection and indemnity. Such perils and risk insured against include without limitation loss, damage, expense, or legal liability of the insured for loss, damage, or expense arising out of or incident to ownership, operation, chartering, maintenance, use, repair, or construction of any vessel, craft, or instrumentality in use in ocean or inland waterways for commercial purposes, including liability of the insured for personal injury, illness, death, or for loss or damage to the property of the insured or another person.

(11) "Person" means any individual, corporation, partnership, association, governmental entity or voluntary organization.

(18 Del. C. 1953, § 4205; 57 Del. Laws, c. 437; 60 Del. Laws, c. 189, § 1; 64 Del. Laws, c. 346, § 1; 67 Del. Laws, c. 223, § 26; 68 Del. Laws, c. 112, § 2; 71 Del. Laws, c. 463, §§ 3-5; 81 Del. Laws, c. 337, § 2.)

§ 4206. Creation of the Association.

There is created a nonprofit unincorporated legal entity to be known as the Delaware Insurance Guaranty Association. All insurers, defined as member insurers in § 4205 of this title, shall be and remain members of the Association as a condition of their authority to transact insurance in this State. The Association shall perform its functions under a plan of operation established and approved under § 4209 of this title and shall exercise its powers through a board of directors established under § 4207 of this title.

(18 Del. C. 1953, § 4206; 57 Del. Laws, c. 437.)

§ 4207. Board of Directors.

(a) The Board of Directors of the Association shall consist of not less than 5 nor more than 9 persons serving terms as established in the plan of operation. The members of the Board shall be selected by member insurers subject to the approval of the Commissioner. Vacancies of the Board shall be filled for the remaining period of the term in the same manner as initial appointments. If no members are selected within 60 days after July 1, 1970, the Commissioner may appoint the initial members of the Board of Directors.

(b) In approving selections to the Board, the Commissioner shall consider among other things whether all member insurers are fairly represented.

(c) Members of the Board may be reimbursed from the assets of the Association for expenses incurred by them as members of the Board of Directors.

(18 Del. C. 1953, § 4207; 57 Del. Laws, c. 437.)

§ 4208. Powers and duties of the Association.

(a) The Association shall:

(1) Be obligated to pay valid covered claims existing prior to the order of liquidation of the insolvency and arising within 30 days after the order of liquidation or before the policy expiration date if less than 30 days after the order of liquidation, or before the insured replaces the policy or causes its cancellation, if it is done within 30 days of that order of liquidation. Such obligation shall be satisfied by paying to the claimant an amount as follows: (i) the full amount of a covered claim for benefits under a workers' compensation insurance policy; (ii) an amount not exceeding $10,000 per policy for a covered claim for the return of an unearned premium; (iii) an amount not exceeding $500,000 per claimant for all other covered claims provided that, for the purposes of this limitation, all claims of any kind arising from or relating to bodily injury or death to any person will constitute a single claim, regardless of the number of claims made, or the number of claimants. The Association is not obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. Notwithstanding any other provisions of this chapter, a covered claim does not include any claim filed with the Association after the earlier of: (i) 24 months after the date of the order of liquidation or (ii) final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer; provided, however, that a "covered claim" shall include any covered claim of which notice was given to the Association on or prior to June 30, 1991. Notwithstanding any other provisions of this chapter, except in the case of a claim for benefits under workers' compensation coverage, any obligation of the Association to any and all persons shall cease when $10,000,000 shall have been paid in the aggregate by the Association and any 1 or more associations similar to the Association of any other state or states or any property/casualty security fund which obtains contributions from insurers on a pre-insolvency basis, to or on behalf of any insured and its affiliates on covered claims or allowed claims arising under the policy or policies of any 1 insolvent insurer. For purposes of this section, the term "affiliate" shall mean a person who directly, or indirectly, through 1 or more intermediaries, controls, is controlled by or is under common control with another person. If the Association determines that there may be more than 1 claimant having a covered claim or allowed claim against the Association or any association similar to the Association or any property/casualty insurance security fund in other states, under the policy or policies of any 1 insolvent insurer, the Association may establish a plan to allocate amounts payable by the Association in such manner as the Association in its discretion deems equitable.

(2) Be deemed the insurer only to the extent of its obligation on the covered claims and, to such extent, subject to the limitations provided in this chapter, shall have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent.

(3) Be relieved of any obligation to defend an insured on a covered claim upon any of the following:

a. The Association's payment, by settlement releasing the insured or on a judgment, of an amount equal to the lesser of the Association's covered claim obligation limit or the applicable policy limit.

b. The Association's tender of an amount equal to the lesser of the Association's covered claim obligation limit or the applicable policy limit.

(4) For the purpose of providing the funds necessary to carry out the powers and duties of the Association, the Board of Directors shall assess the member insurers, separately for each class, at such times and in such amounts as the Board finds necessary. Assessments shall be due not less than 30 days after written notice to the member insurers.

a. There shall be 3 classes of assessments as follows:

1. Class A assessments shall be made for the purpose of meeting administrative costs and other expenses and examinations conducted under the authority of § 4213 of this title.

2. Class B assessments shall be made annually to partially subsidize the oversight activities of the Commissioner, thereby minimizing the need for class C assessments.

3. Class C assessments shall be made to the extent necessary to carry out the powers and duties of the Association under this chapter with regard to an insolvent member insurer.

b. The assessments shall be determined as follows:

1. The class A assessments will be equal in amount as to each member and may be assessed not more often than once each year. Such assessment shall not exceed $150 annually.

2. The class B assessments shall be made annually. The Commissioner shall determine the amount and shall so notify the Association on or before July 31 of each calendar year in which the assessment is to be made. Class B assessments will also be equal in amount as to each member. The said assessments shall be paid to the Insurance Commissioner's regulatory revolving fund. Not later than October 31 of each said calendar year, the Commissioner shall issue a report to the Association detailing the expenditure of those funds. Amounts not expended will remain in the revolving fund to be used in the succeeding year.

3. Class C assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year bears to the net direct written premiums of all member insurers for the preceding calendar year. If the maximum assessment, together with the other assets of the Association, does not provide in any 1 year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The Association may exempt or defer, in whole or in part, the assessment of any member insurer if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than

the minimum amounts required for a certificate of authority by any jurisdiction in which a member insurer is authorized to transact insurance.

c. The amounts assessed for class B assessments shall in no event exceed $^{1}/_{10}$ of 1 percent of the members' premiums for the year on which the assessment is based. The amounts assessed for class B and class C assessments combined shall not result in members being assessed a total B and C assessment amount which exceeds 2 percent of the members' premiums written in the applicable year.

(5) Investigate claims brought against the Association and adjust, compromise, settle and pay covered claims to the extent of the Association's obligation and deny all other claims and may review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which such settlements, releases and judgments may be properly contested.

(6) Notify such persons as the Commissioner directs under § 4210(b)(1) of this title.

(7) Handle claims through its employees or through 1 or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the Commissioner, but such designation may be declined by a member insurer.

(8) Reimburse each servicing facility for obligations of the Association paid by the facility and expenses incurred by the facility while handling claims on behalf of the Association and pay the other expenses of the Association authorized by this chapter.

(9) Issue to each insurer paying an assessment under this chapter a certificate of contribution, in a form prescribed by the Commissioner, for the amount so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the Commissioner may approve.

(10) Exercise all powers and do all things authorized by this chapter with respect to a division of a bank or trust company established pursuant to § 767(a) of Title 5 and determined to be insolvent pursuant to § 4205(7) of this title with the same effect as if such department or division was a stock insurer.

(b) The Association may:

(1) Employ or retain such persons as are necessary to handle claims and perform other duties of the Association.

(2) Borrow funds necessary to effect the purposes of this chapter in accord with the plan of operation.

(3) Sue or be sued and such power to sue includes the power and right to intervene as a party before any court in this State that has jurisdiction over an insolvent insurer as defined by this chapter. All actions against the Association must be brought in this State. This State shall have exclusive jurisdiction over all actions against the Association.

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this chapter.

(5) [Repealed.]

(6) Refund to the member insurers in proportion to the contribution of each member insurer to the Association that amount by which the assets of the Association exceed the liabilities if at the end of any calendar year the Board of Directors finds that the assets of the Association exceed the liabilities for the coming year of the Association as estimated by the Board of Directors.

(7) Establish procedures for requesting financial information from insureds on a confidential basis for the purpose of determining net worth, subject to such information being shared with any other association similar to the Association and the liquidator or receiver of an insolvent insurer on the same confidential basis. If the insured refuses to provide the requested financial information and an auditor's certification of the same where requested and available, the Association may deem the net worth of the insured to be in excess of the amounts specified in § 4205(6)b.4. of this title or § 4211(a)(2)a. of this title at the relevant time under the respective section under this title.

(8) Bring an action against any third-party administrator, agent, attorney, or other representative of the insolvent insurer to obtain custody and control of all files, records, and electronic data information related to an insolvent company that are appropriate or necessary for the Association, or a similar association in other states, to carry out its duties under this chapter. In such a suit, the Association shall have the absolute right through emergency equitable relief to obtain custody and control of all such information in the custody or control of such third-party administrator, agent, attorney, or other representative of the insolvent insurer, regardless of where such information may be physically located. In bringing such an action, the Association is not subject to any defense, lien (possessory or otherwise), or other legal or equitable ground whatsoever for refusal to surrender such information that might be asserted against the liquidator or receiver of the insolvent insurer. To the extent that litigation is required for the Association to obtain custody of the information requested and it results in the relinquishment of information to the Association after refusal to provide the same in response to a written demand, the court shall award the Association its costs, expenses, and reasonable attorney fees incurred in bringing the action. This section does not affect the rights and remedies that the custodian of such information may have against the insolvent insurers, so long as such rights and remedies do not conflict with the rights of the Association to custody and control of the files, records, and electronic data information under this title.

(9) Subject to approval by the Commissioner, provide claims-handling services to any "run-off insurer" only if the Association's expenses related to the provision of the claims-handling services are fully reimbursed. There shall be no liability on the part of, and no cause of action of any nature shall arise against any member insurer, the Association, or its agents or employees, the board of directors, or any person serving as a representative of any director for any action taken or any failure to act by them in the performance of the

services under this paragraph. For purposes of this paragraph, "run off insurer" means a property and casualty insurer that has any of the following:

a. Total adjusted capital under risk based capital requirements in an amount less than the Authorized Control Level RBC as defined in § 5801 of this title as of the date specified in § 5802 of this title for filing of the annual RBC report and has indicated that it will cease writing new insurance policies, either as part of its corrective action plan or pursuant to being placed under regulatory control.

b. Total adjusted capital under risk based capital requirements in an amount less than the Mandatory Control Level RBC as defined in § 5801 of this title as of the date specified in § 5802 of this title for the filing of the annual RBC report and that has not been placed into liquidation under § 5906 of this title.

(10) Perform such other acts as are necessary or proper to effectuate the purpose of this chapter.

(18 Del. C. 1953, § 4208; 57 Del. Laws, c. 437; 63 Del. Laws, c. 395, § 2; 65 Del. Laws, c. 5, § 1; 67 Del. Laws, c. 223, § 27; 68 Del. Laws, c. 112, §§ 3-5; 71 Del. Laws, c. 463, §§ 6-11; 81 Del. Laws, c. 337, § 3.)

§ 4209. Plan of operation.

(a) (1) The Association shall submit to the Commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the Association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the Commissioner.

(2) If the Association fails to submit a suitable plan of operation by September 29, 1970, or if at any time thereafter the Association fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this chapter. Such rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the Association and approved by the Commissioner.

(b) All member insurers shall comply with the plan of operation.

(c) The plan of operation shall:

(1) Establish the procedures whereby all the powers and duties of the Association under § 4208 of this title will be performed.

(2) Establish procedures for handling assets of the Association.

(3) Establish the amount and method of reimbursing members of the Board of Directors under § 4207 of this title.

(4) Establish procedures by which claims may be filed with the Association and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the Association or its agent and a list of such claims shall be periodically submitted to the Association or similar organization in another state by the receiver or liquidator.

(5) Establish regular places and times for meetings of the Board of Directors.

(6) Establish procedures for records to be kept of all financial transactions of the Association, its agents, and the Board of Directors.

(7) Provide that any member insurer aggrieved by any final action or decision of the Association may appeal to the Commissioner within 30 days after the action or decision.

(8) Establish the procedures whereby selections for the Board of Directors will be submitted to the Commissioner.

(9) Contain additional provisions necessary or proper for the execution of the powers and duties of the Association.

(d) The plan of operation may provide that any or all powers and duties of the Association, except those under § 4208(a)(3) and (b)(2) of this title, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this Association, or its equivalent, in 2 or more states. Such a corporation, association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the Association. A delegation under this subsection shall take effect only with the approval of both the Board of Directors and the Commissioner and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this chapter.

(18 Del. C. 1953, § 4209; 57 Del. Laws, c. 438.)

§ 4210. Duties and powers of the Commissioner.

(a) The Commissioner shall:

(1) Notify the Association of the existence of an insolvent insurer not later than 3 days after he or she receives notice of the determination of the insolvency;

(2) Upon request of the Board of Directors, provide the Association with a statement of the net direct written premiums of each member insurer.

(b) The Commissioner may:

(1) Require that the Association notify the insureds of the insolvent insurer and any other interested parties of the determination of insolvency and of their rights under this chapter. Such notification shall be by mail at their last known address, where available, but if sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation shall be sufficient.

(2) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the Commissioner may levy

a fine on any member insurer which fails to pay an assessment when due. Such fine shall not exceed 5% of the unpaid assessment per month, except that no fine shall be less than $100 per month.

(3) Revoke the designation of any servicing facility if he or she finds claims are being handled unsatisfactorily.

(c) Any final action or order of the Commissioner under this chapter shall be subject to judicial review in a court of competent jurisdiction.

(18 Del. C. 1953, § 4210; 57 Del. Laws, c. 437; 70 Del. Laws, c. 186, § 1.)

§ 4211. Effect of paid claims.

(a) (1) Any person recovering under this chapter shall be deemed to have assigned the rights under the policy to the Association to the extent of the person's recovery from the Association. Every insured or claimant seeking the protection of this chapter shall cooperate with the Association to the same extent as such person would have been required to cooperate with the insolvent insurer. The Association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out, except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer and except as provided in paragraph (a)(2) of this section. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the Association shall not operate to reduce the liability of the insureds to the receiver, liquidator or statutory successor for unpaid assessments.

(2) The Association shall have the right to recover from the following persons the amount of any covered claim paid on behalf of such person pursuant to this chapter:

a. Any insured whose net worth on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer exceeds $25,000,000 and whose liability obligations to other persons are satisfied in whole or in part by payments made under this chapter; and

b. Any person who is an affiliate of the insolvent insurer and whose liability obligations to any other person are satisfied in whole or in part by payment under this chapter. This paragraph (a)(2) shall not apply retroactively and/or retrospectively and shall apply only as to insurer insolvencies which occur on or after June 30, 1991.

(b) The receiver, liquidator or statutory successor of an insolvent insurer shall be bound by settlements of covered claims by the Association or a similar organization in another state. The court having jurisdiction shall grant such claims priority equal to that to which the claimant would have been entitled in the absence of this chapter against the assets of the insolvent insurer.

(c) The Association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the Association, and estimates of anticipated claims on the Association which shall preserve the rights of the Association against the assets of the insolvent insurer.

(18 Del. C. 1953, § 4211; 57 Del. Laws, c. 437; 68 Del. Laws, c. 112, § 6; 70 Del. Laws, c. 186, § 1; 71 Del. Laws, c. 463, §§ 12-14; 72 Del. Laws, c. 400, § 3.)

§ 4212. Exhaustion of other coverage.

(a) Any person having a claim under an insurance policy shall first exhaust all coverage provided by any such policy, whether or not it is a policy issued by a member insurer, if the claim under such policy arises from the same facts, injury, or loss that gave rise to the covered claim against the Association. Any amount payable on a covered claim under this title shall be reduced by the full applicable limits stated in such insurance policy and the Association shall receive a full credit for such stated limits, or, where there are no applicable stated limits, the claim shall be reduced by the total recovery. Notwithstanding the foregoing, no person shall be required to exhaust any right under the policy of an insolvent insurer.

(1) A claim under an insurance policy providing liability coverage to a person who may be jointly and severally liable or a joint tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury or loss that gave rise to the covered claim against the Association.

(2) For the purposes of this section, a claim against a health maintenance organization, a hospital plan corporation, or a professional health service corporation and any amount payable by or on behalf of a self-insurer will be considered under this section as a claim requiring exhaustion of other coverage if the claim arises from the same facts, injury, or loss that gave rise to the covered claim against the Association.

(3) To the extent that the Association's obligation is reduced by the application of this section, the liability of the person insured by the insolvent insurer's policy for the claim shall be reduced in the same amount.

(b) Any person having a claim which may be recovered under more than 1 insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that, if it is a first-party claim for damage to property with a permanent location, recovery must be sought first from the association of the location of the property; and if it is a workers' compensation claim, recovery must be sought first from the association of the residence of the claimant. Any recovery under this chapter shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.

(18 Del. C. 1953, § 4212; 57 Del. Laws, c. 437; 62 Del. Laws, c. 394, § 1; 68 Del. Laws, c. 112, §§ 7, 8; 70 Del. Laws, c. 186, § 1; 81 Del. Laws, c. 337, § 4.)

§ 4213. Prevention of insolvencies.

To aid in the detection and prevention of insurer insolvencies:

(1) The Board of Directors may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of insurer insolvencies.

a., b. [Repealed.]

(2) The Board of Directors may, at the conclusion of any domestic insurer insolvency in which the Association was obligated to pay covered claims, prepare a report on the history and causes of such insolvency, based upon the information available to the Association and submit such report to the Commissioner.

(3) It shall be the duty of the Commissioner to report to the board of directors when the Commissioner has reasonable cause to believe that any member insurer examined or being examined at the request of the board of directors may be insolvent or in a financial condition hazardous to the policyholders or the public.

(4) The board of directors may, upon majority vote, make reports and recommendations to the Commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer. Such reports and recommendations shall not be considered public documents.

(5) The board of directors may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of insurer insolvencies.

(6) The board of directors shall, at the conclusion of any insurer insolvency in which the Association was obligated to pay covered claims, prepare a report on the history and causes of such insolvency, based on the information available to the Association, and submit such report to the Commissioner.

(18 Del. C. 1953, § 4213; 57 Del. Laws, c. 437; 68 Del. Laws, c. 112, § 9; 70 Del. Laws, c. 186, § 1; 81 Del. Laws, c. 337, § 5.)

§ 4214. Examination of the Association.

The Association shall be subject to examination and regulation by the Commissioner. The Board of Directors shall submit, not later than June 30 of each year, a financial report for the preceding calendar year in a form approved by the Commissioner.

(18 Del. C. 1953, § 4214; 57 Del. Laws, c. 437; 68 Del. Laws, c. 112, § 10.)

§ 4215. Tax exemption.

The Association shall be exempt from payment of all fees and all taxes levied by this State or any of its subdivisions, except taxes levied on real or personal property.

(18 Del. C. 1953, § 4215; 57 Del. Laws, c. 437.)

§ 4216. Recognition of assessments in rates.

The rates and premiums charged for insurance policies to which this chapter applies shall include amounts sufficient to recoup a sum equal to the amounts paid to the Association by the member insurer less any amounts returned to the member insurer by the Association, and such rates shall not be deemed excessive because they contain an amount reasonably calculated to recoup assessments paid by the member insurer.

(18 Del. C. 1953, § 4216; 57 Del. Laws, c. 437.)

§ 4217. Immunity.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer, the Association or its agents or employees, the Board of Directors or the Commissioner or the Commissioner's representatives for any action or any failure to act taken by them in the performance of their powers and duties under this chapter. Neither shall the Association, its officers, agents and employees be subject to any claim for damages for bad faith.

(18 Del. C. 1953, § 4217; 57 Del. Laws, c. 437; 68 Del. Laws, c. 112, § 11; 70 Del. Laws, c. 186, § 1.)

§ 4218. Stay of proceedings; reopening of default judgments.

(a) All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this State shall be stayed for 120 days from the date the insolvency is determined, and for such time thereafter as may be determined by the court, to permit a proper defense by the Association of all pending causes of actions. As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend an insured, the Association, either on its own behalf or on behalf of such insured, may apply to have such judgment, order, decision, verdict or finding set aside by the same court or administrator that made such judgment, order, decision, verdict or finding and shall be permitted to defend against such claim on the merits.

(b) The liquidator, receiver, or statutory successor of an insolvent insurer covered by this title shall permit access by the board or its authorized representative to such of the insolvent insurer's records which are necessary for the board in carrying out its functions under this chapter with regard to covered claims. The liquidator, receiver, or statutory successor shall provide the board of directors or its representative with copies of such records upon request by the board and at the expense of the board.

(18 Del. C. 1953, § 4218; 57 Del. Laws, c. 437; 68 Del. Laws, c. 112, § 12; 81 Del. Laws, c. 337, § 6.)

§ 4219. Recoupment of assessment.

(a) Unless a longer period has been allowed by the Commissioner, a member insurer shall at its option have the right to show a certificate of contribution as an asset in the form approved by the Commissioner at percentages of the original face amount approved by the Commissioner, for calendar years as follows:

(1) One hundred percent for the calendar year of issuance;

(2) Eighty percent for the first calendar year after the year of issuance;

(3) Sixty percent for the second calendar year after the year of issuance;

(4) Forty percent for the third calendar year after the year of issuance;

(5) Twenty percent for the fourth calendar year after the year of issuance.

(b) The insurer may offset the amount written off by it in a calendar year under subsection (a) of this section above, against its premium tax liability to this State accrued with respect to business transacted in such year.

(c) Any sums acquired by refund from the Association which have theretofore been written off by contributing insurers and offset against premium taxes as provided above, and are not then needed for purposes of this chapter, shall be paid by the Association to the Commissioner and deposited by the Commissioner with the State Treasury for credit to the General Fund of this State.

(d) To the extent amounts have been written off under subsection (c) of this section above, § 4216 of this title shall not apply.

(63 Del. Laws, c. 395, § 3; 70 Del. Laws, c. 186, § 1.)

§ 4220. Preferred creditor status.

Repealed by 64 Del. Laws, c. 193, § 3, effective July 19, 1983.

§ 4221. Access to assets of insolvent insurer; application for court approval of plan to disburse assets.

Repealed by 68 Del. Laws, c. 112, § 13, effective July 5, 1991.

§ 4223. Applicability.

Unless otherwise provided by this chapter, 68 Del. Laws, c. 112 shall apply retroactively and/or retrospectively to all incomplete matters having arisen or arising under the Delaware Insurance Guaranty Association Act (this chapter).

(68 Del. Laws, c. 112, § 14.)

Part I
Insurance
Chapter 43
Surety Insurance Contracts
Subchapter I
General

§ 4301. Subject to general laws.

Contracts of surety insurance issued by surety insurers shall be subject to the applicable general provisions of Chapter 27 (The Insurance Contract) of this title and to applicable general laws of suretyship.

(18 Del. C. 1953, § 4301; 56 Del. Laws, c. 380, § 1; 76 Del. Laws, c. 394, § 1.)

Subchapter II
Bail Bond Agents

§ 4331. Purpose.

This subchapter governs the qualifications and procedures for the licensing of bail agents. This subchapter shall establish the qualifications for granting licenses to bail agents, establish the procedures to be followed in determining the initial and continuing qualifications for such persons, and provide standards for such persons' authorities, duties, responsibilities and prohibitions in a manner that will provide guidance to such personnel and control over such personnel by the Commissioner for the benefit and protection of the citizens of the State.

(76 Del. Laws, c. 394, § 2; 79 Del. Laws, c. 177, § 1.)

§ 4332. Definitions.

For purposes of this chapter, the following definitions shall apply:

(1) "Bail agent" or "bail producer" means a surety bail agent or a property bail agent. The term "bail agent" does not include the term "bail enforcement agent" as the same is used in Chapter 55 of Title 24. A surety bail agent may also act as a property bail agent, provided the surety bail agent complies with all provisions of this subchapter applicable to property bail agents.

(2) "Bail agent business entity" shall mean a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity that advertises or acts as a bail agent.

(3) "Bail funder" means, unless expressly exempted pursuant to this subchapter, any person who provides or loans the funds to property bail agents or bail agent business entities that are used or may be used for purposes of furnishing property bail in court proceedings, regardless of whether the provision of funds is classified as a personal or business loan (or whether such loan is secured or unsecured) or gift.

(4) "Collateral" means United States currency, United States postal money orders or cashier's checks or other property pledged as security or surety for a bail bond in connection with a judicial proceeding.

(5) "Commissioner" shall have the meaning ascribed to it in § 102 of this title.

(6) "Court" means any court of this State that has the power to set bail to enforce the appearance of a defendant in a criminal or civil proceeding.

(7) "Department" shall have the meaning ascribed to it in § 102 of this title.

(8) "Designated bail agent" or "designated responsible licensed producer" means the licensed bail agent who is the head or manager of a bail agent business entity that employs 1 or more licensed bail agents.

(9) "License" shall mean a document issued by the Commissioner authorizing a person to act as a bail agent. The license itself does not create any authority, actual, apparent or inherent, in the holder to represent or commit an insurance carrier.

(10) "Negotiate" shall mean the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a surety or property bail bond concerning any of the substantive benefits, terms or conditions of the surety or property bail bond.

(11) "Person" shall mean an individual or a business entity.

(12) "Premium" is the consideration for a surety or property bail bond by whatever name called.

(13) "Property bail" means United States currency, United States postal money orders or cashier's checks, real property or other property.

(14) "Property bail agent" means any person who pledges property bail as security or surety for a bail bond in connection with a judicial proceeding and receives or is promised therefor money or other things of value. All of the following are deemed property bail agents and are subject to the provisions of this subchapter:

a. Any person who charges or accepts a fee or anything of value for or makes a business of furnishing property bail in any court proceeding.

b. Any person who furnishes property bail in 4 or more court cases in any 1 year whether for compensation or otherwise.

c. Any person who is acting as a bail funder.

(15) "Revocation" shall mean recalling or taking back a license or licenses for a minimum period of 12 months. Any insurer appointments of such license shall likewise be revoked. No individual whose license is revoked shall be issued another license without first complying with all requirements for issuance of a new license under this subchapter.

(16) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company, a person or business entity.

(17) "Solicit" shall mean attempting to sell a surety or property bail bond or asking or urging a person to apply for a surety or bail bond bail bond.

(18) "Surety bail agent" means a person required to be licensed under the laws of this State to sell, solicit or negotiate contracts of surety bail bond insurance and appointed by a surety insurer that is authorized to transact business in this State to sell, solicit or negotiate contracts of surety bail bond insurance.

(19) "Surety insurer" shall mean an insurer having a certificate of authority from the Department to issue surety contracts or bonds to guarantee the performance of any person licensed under this subchapter.

(20) "Suspension" shall mean to bar temporarily the privileges of a bail agent. A suspension shall also include a suspension of the appointment of a surety bail agent by the surety insurer. Upon the expiration of the suspension period and upon satisfactory completion of such terms and conditions as the Commissioner has imposed pursuant to the suspension, all licenses and appointments shall be reinstated.

(21) "Termination" shall mean the cancellation of the relationship between a surety insurer and the surety bail agent or the termination of a surety bail agent's authority to transact surety insurance.

(22) "Uniform Application" shall mean the current version of the NAIC Uniform Application for resident producer licensing.

(23) "Uniform Business Entity Application" shall mean the current version of the NAIC Uniform Business Entity Application for resident business entities.

(76 Del. Laws, c. 394, § 2; 70 Del. Laws, c. 186, § 1; 77 Del. Laws, c. 2, §§ 1, 2; 79 Del. Laws, c. 177, § 1; 83 Del. Laws, c. 183, § 1.)

§ 4333. Application for license as a bail agent and licensure.

(a) A person applying for a bail agent license shall make application to the Commissioner on the Uniform Application or on forms prescribed by the Commissioner for license types and lines of authority not available on the Uniform Application and shall declare under penalty of denial, suspension or revocation of the license that the statements made in the application are true, correct and complete to the best of the individual's knowledge and belief.

(b) In addition to compliance with this section, every person seeking licensure as a surety bail agent shall comply with § 4333A of this title, and every person seeking licensure as a property bail agent shall comply with § 4333B of this title.

(c) Before approving the application, the Commissioner shall find that the individual:

(1) Is at least 18 years of age;

(2) Is a resident of the State of Delaware. For purposes of establishing Delaware residency, it shall be sufficient to show that the applicant maintains an office within the State that complies with all requirements of §§ 4341 and 4346 of this title.

(3) Has not committed any of the following acts:

a. Provided incorrect, misleading, incomplete or materially untrue information in the license application;

b. Violated any insurance laws, or violated any regulation, subpoena or order of the Insurance Commissioner or of another state's insurance commissioner;

c. Obtained or attempted to obtain a license through misrepresentation or fraud;

d. Improperly withheld, misappropriated or converted any moneys or properties received in the course of doing insurance business;

e. Intentionally misrepresented the terms of an actual or proposed insurance contract or application for insurance;

f. Pled guilty or nolo contendere to, or been found guilty of, a felony or a crime which includes an element of dishonesty or fraud or involves moral turpitude, or a crime punishable by imprisonment of 1 year or more under the law of any state, territory, or country;

g. Admitted or been found to have committed any insurance unfair trade practice or fraud;

h. Used fraudulent, coercive or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this State or elsewhere;

i. Had an insurance producer or bail agent license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory;

j. Forged another's name to an application for insurance or to any document related to an insurance transaction;

k. Improperly used notes or any other reference material to complete an examination for an insurance license;

l. Knowingly accepted bond business from an individual who is not licensed, whose license has been suspended or revoked, or who has been barred from acting as a bail agent by any court;

m. Failed to comply with an administrative or court order imposing a child support obligation; or

n. Failed to pay state income tax or comply with any administrative or court order directing payment of state income tax.

(4) Has paid the fees set forth in Chapter 7 of this title;

(5) Has successfully passed the examination for the lines of authority for which the person has applied, unless specifically exempted from such examination by this subchapter;

(6) Has not been suspended or prohibited from acting as a bail agent by any court, or had a license suspended or revoked by the District of Columbia or any state or territory of the United States. The Commissioner shall verify the applicant's licensing status through the producer database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries; and

(d) (1) A person applying for, or having been granted, a bail agent license, shall disclose to the Commissioner the identity of each person that will act as a bail funder for such applicant or licensee and each person having or seeking to acquire a 10% or greater financial interest in either of the following:

a. The bail agent's business.

b. Any 1 or more bail bonds pledged by or on behalf of the applicant or licensee.

(2) A person must be licensed as a bail agent under this section before any such person may act as a bail funder under this subchapter or before any person may acquire or maintain a 10% or greater financial interest in either of the following:

a. A bail agent's business.

b. Any 1 or more bail bonds.

(3) No licensee or applicant for a license shall accept funds from a bail funder unless such bail funder is licensed as a bail agent or bail agent business entity under this subchapter.

(4) No licensee or applicant for a license shall allow a person to acquire or maintain a 10% or greater financial interest in a bail agent's business or any 1 or more bail bonds, unless the person seeking to acquire such interest is licensed as a bail agent under this subchapter.

(5) For purposes of this section, "financial interest" means an interest that could result in directly or indirectly receiving a pecuniary gain or sustaining a pecuniary loss as a result of an ownership or interest in a business entity. For the avoidance of doubt, a person has a "financial interest" in a bail agent's business if either of the following apply:

a. Such person has a legal or equitable ownership interest in such bail agent's business of more than 10%.

b. Such person is a creditor of such bail agent's business in an amount equal to 10% or more of the debt of that business.

(6) The provisions in this subchapter requiring the licensure of bail funders as property bail agents shall not apply to banks and financial institutions supervised and regulated under Title 5 or by a banking regulatory agency of the United States.

(e) Except where prohibited by state or federal law, by submitting an application for license, the applicant shall be deemed to have appointed the Commissioner as the agent for service of process on the applicant in any action or proceeding arising in this State out of or in connection with the exercise of the license. Such appointment of the Commissioner as agent for service of process shall be irrevocable during the period within which a cause of action against the applicant may arise out of transactions with respect to subjects of insurance in this State. Process shall be served upon the Commissioner or such other person or persons as the Commissioner shall designate by rule or regulation.

(f) (1) Any person applying for a license under this chapter shall be required to submit fingerprints and other necessary information for the purpose of obtaining the following:

a. A report of the person's entire criminal history record from the State Bureau of Identification or a statement from the State Bureau of Identification that the State Bureau of Identification Central Repository contains no such information relating to that person.

b. A report of the person's entire federal criminal history record pursuant to the Federal Bureau of Investigation appropriation of Title II of Public Law 92-544 (28 U.S.C. § 534).

(2) The State Bureau of Identification shall be the intermediary for purposes of this subsection, and the Department shall be the screening point for the receipt of said federal criminal history records. All information obtained pursuant to this subsection section shall be forwarded by the State Bureau of Identification to the Department. All costs associated with obtaining the criminal history reports required by this subsection shall be borne by the applicant, and all criminal history reports shall be dated within 45 days of the application.

(g) All collateral, premiums, return premiums, or other funds received in any manner by a bail agent or bail agent business entity shall be held in a fiduciary capacity and shall be accounted for by such bail agent or bail agent business entity.

(h) A person who has received a nonresident bail agent license under prior law, shall not be permitted to renew the bail agent's license, unless such person shall comply with all provisions of this subchapter, including without limitation the residency requirement set forth in this section.

(i) The applicant for a bail agent license shall bear all costs associated with the application or any reapplication.

(j) Upon the Department's determination that the application is complete, the applicant has passed all required examinations and is otherwise qualified for the license applied for, the Department shall thereupon issue the license.

(k) All provisions in this subchapter applicable to bail agents shall apply equally to bail funders except as the Commissioner may provide by rule or regulation.

(76 Del. Laws, c. 394, § 2; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 102, § 4; 79 Del. Laws, c. 177, § 1; 83 Del. Laws, c. 183, § 2.)

§ 4333A. Additional application requirements for surety bail agents.

(a) In addition to the requirements of § 4333 of this title, every applicant for a surety bail agent license shall file with the Commissioner a notice of appointment executed by a surety insurer or its authorized representative authorizing such applicant to execute undertakings of bail and to solicit and negotiate such undertakings on its behalf.

(b) An appointment of a person as a surety bail agent by a surety insurer pursuant to this subsection shall constitute certification by such insurer that, to the best of the insurer's knowledge and belief, such person is competent, financially responsible and suitable to serve as a representative of the insurer. No person shall represent to the public that such person has the authority to represent an insurer as its surety bail agent until such person has been appointed by an insurer as such agent in accordance with this section. An insurer shall be bound by the acts of such person within the scope of such person's actual authority as such insurer's agent.

(c) Each appointment shall, by its terms, continue in force until:

(1) Termination of the surety bail bond agent's license; or

(2) The filing of a notice of termination with the Commissioner by the surety insurer or its representative or by such surety bail agent.

(d) Each insurer shall annually conduct an audit, for the period from January 1 through December 31 of each of its appointed surety bail agents to ensure such agents are charging the premium rate as required by § 4347 of this title. Not later than 45 days after the closing of the year (period of each audit), each insurer shall notify the Commissioner of the failure of any surety bail bond agent to charge the premium rate approved by the Commissioner pursuant to Chapter 25 of this title. Such notice shall include the name of the surety bail bond agent, the case docket number if assigned, the total amount of the bail bond, the date the bail bond was executed, the amount of the premium charged and reported to the surety insurer, the state, county and court in which the bond was executed, the 5-digit identification code assigned to the insurer by the National Association of Insurance Commissioners and the date the premium was due.

(79 Del. Laws, c. 177, § 1.)

§ 4333B. Additional application requirements for property bail agents.

(a) In addition to the requirements of § 4333 of this title, every applicant for a property bail agent license shall file with the Commissioner a statement under oath of the assets and liabilities of the applicant.

(b) A property bail agent and bail agent business entity shall have a continuing duty to all of the following:

(1) To advise the Commissioner in writing under oath of any material change in such property bail agent's or bail agent business entity's assets or liabilities affecting such property bail agent's or bail agent business entity's responsibility as a property bail agent or bail agent business entity.

(2) At any time, upon request of the Commissioner, to furnish the Commissioner with a statement under oath of such property bail agent's or bail agent business entity's assets and liabilities, including all bail bonds on which such property bail agent or bail agent business entity is obligated. The Commissioner may request, and the property bail agent or bail agent or business entity shall provide, financial statements and balance sheets, in the form requested by the Commissioner, bank statements and any other information requested by the Commissioner to allow the Commissioner to review the business operations of the bail agent or bail agent business entity.

(c) The applicant shall file with his or her application for licensure all rates and other charges proposed for use in writing bail bonds. Such rating plan must be approved by the Commissioner prior to issuance of the license. No rate or other charge may be imposed in connection with the property bail agent's business, unless it has been approved in advance by the Commissioner.

(79 Del. Laws, c. 177, § 1; 70 Del. Laws, c. 186, § 1; 83 Del. Laws, c. 183, § 3.)

§ 4334. Application for license as a bail agent business entity.

(a) A bail agent business entity is required to obtain a bail agent business entity insurance license. All surety bail bond contract transactions under the bail agent business entity license must be completed by a licensed bail agent of this State. Nonlicensed individuals may perform tasks that are strictly clerical in nature such as assisting customers to complete applications and taking payments and providing receipts or other documentation to principal, indemnitors, customers, or other persons, but only under the supervision of a licensed agent who shall be responsible for any noncompliance with this subchapter by the nonlicensed individual.

(b) Application for a bail agent business entity license shall be made using the Uniform Business Entity Application or on forms prescribed by the Commissioner for license types and lines of authority not available on the Uniform Business Entity Application.

(c) Before approving the application, the Commissioner shall make a finding as to both of the following:

(1) That the bail agent business entity has paid the fees set forth in Chapter 7 of this title.

(2) That the bail agent business entity has designated a licensed bail agent or producer licensed under this chapter responsible for the bail agent business entity's compliance with the insurance laws, rules and regulations of this State.

(d) If the license of a bail agent business entity's designated bail agent is no longer active, whether due to expiration, suspension, revocation, or otherwise, the license of such bail agent business entity shall be immediately suspended until such time as a licensed bail agent in good standing is designated as such bail agent business entity's designated agent. In addition, a bail agent business entity's designated bail agent shall be subject to the same penalties as the bail agent business entity for the bail agent business entity's failure to comply with the laws, rules, and regulations of this State.

(e) The Commissioner may require any documents reasonably necessary to verify the information contained in an application.

(76 Del. Laws, c. 394, § 2; 79 Del. Laws, c. 177, § 1; 83 Del. Laws, c. 183, § 4.)

§ 4335. License renewal.

(a) A person who is licensed as a bail agent shall renew the license in accordance with the same requirements established for insurance producers under Chapters 7 and 17 of this title. As a condition of renewal, the licensee also shall certify that he or she is in compliance with all requirements set forth in this subchapter for the issuance of an initial license.

(b) In addition, such person shall be required to show that since the last renewal or initial application in this State, neither the person nor any business in which the person is or was an owner, partner, officer or director, or member or manager of a limited liability company, has been suspended or prohibited in this State or any other jurisdiction from acting as a bail agent by any court, or otherwise been involved in an administrative proceeding regarding any professional or occupational license, or registration at the time of renewal.

(76 Del. Laws, c. 394, § 2; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 177, § 1; 83 Del. Laws, c. 183, § 5.)

§ 4336. Bonds.

(a) At the time of the application for license as a bail agent, the applicant shall file with the Department a bond executed and issued by a surety insurer authorized to transact business in the State in the minimum amount of $50,000, which bond shall secure the faithful performance of the applicant's duties as a bail agent. A bail agent license shall be automatically suspended if the bond is not in force or is otherwise impaired or unavailable to the Department. Current licensees who either do not currently have a bond filed with the Department or were required to provide a bond in an amount less than $50,000 at the time of their license applications under prior law shall file with the Department a new bond in the minimum amount of $50,000 within 1 year of the effective date of the increased bond requirement.

(b) The bond shall have the following characteristics:

(1) The bond must be conditioned upon a full accounting and payment to the person entitled thereto of money, property or other matters coming into the licensee's possession through bail bond transactions under the license.

(2) The bond shall be in favor of the State and shall specifically authorize recovery by the Commissioner of the damages sustained if the licensee violates any of the terms of the license or the applicable laws and regulations of this State.

(3) The aggregate liability of the surety for all damages shall not exceed the amount of the bond.

(4) The bond must remain in force until released by the Commissioner, or cancelled by the surety. The surety may cancel the bond upon 30-days' written notice to the licensee and the Commissioner provided that the surety shall remain liable for any obligation arising under the bond prior to the effective date of cancellation or termination.

(c) [Repealed.]

(76 Del. Laws, c. 394, § 2; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 177, § 1; 83 Del. Laws, c. 183, § 6.)

§ 4337. Examination for license as bail agent.

(a) Any natural person who intends to apply for a license as a bail agent, must personally take and pass a written examination of that person's competence to act as such. After passing the examination, the person may apply to the Commissioner for a bail agent license.

(b) The scope of the examination shall encompass all aspects of the bail bond business as shall be determined by the Department.

(c) The Department may make arrangements for administration and grading by an independent testing service.

(d) Any individual who fails to appear for the examination as scheduled or fails to pass the examination may reapply for a reexamination and remit all required fees and forms before being permitted to take the reexamination.

(e) All examination score reports are valid for a period of 12 months from the date of examination.

(f) A bail agent, whose license lapses and whose license is not suspended or revoked is exempt from retaking the examination required by this section if the bail agent applies for and is reinstated within 12 months after the date of lapse. All fees and fines associated with the lapsed and reinstated license must be paid in full prior to the Department's approval of the request for reinstatement.

(76 Del. Laws, c. 394, § 2; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 177, § 1.)

§ 4338. Issuance of license; notice of refusal to issue license; fees not refundable.

(a) Upon the Department's determination that the application is complete, the applicant has passed all required examinations and is otherwise qualified for the license applied for, the Department shall thereupon issue the license.

(b) A bail agent license shall remain in effect:

(1) Unless revoked or suspended;

(2) As long as the fee set forth in Chapter 7 of this title is paid and educational requirements as established by law or regulation for bail agents are met by the due date;

(3) Unless the bail agent fails to procure or maintain in full force and effect a bond required by § 4336 of this title herein; and

(4) As long as the license has been renewed in compliance with § 4335 of this title.

(c) If a bail agent fails to comply with subsection (b) of this section, the Department shall, without a hearing, deem the bail agent's license administratively lapsed until the requirements of subsection (b) of this section are met and the bail agent has satisfied all monetary and/or educational obligations and costs necessary under this subchapter to restore the license, provided that such action is taken within 1 year of the date the license is administratively suspended. However, a penalty of double the regular license fee shall be required for any renewal fee received after the due date and within the first 6 months from the due date of the renewal fee. A licensee who does not pay within 6 months of the due date but pays prior to the expiration of 12 months from the due date shall be subject to a fine of not less than $200 and not more than $1,000 prior to the reinstatement of the license. After 1 year, the bail agent's license shall be deemed revoked and the bail agent would be required to reapply for licensure under § 4333 of this title as a new applicant.

(d) If the applicant for a bail agent license fails to meet the requirements of this subchapter or any applicable regulation, the Department shall refuse to issue the license and shall notify the applicant of such refusal stating the grounds for the refusal. The applicant may make written demand upon the Commissioner within 10 days for a hearing before the Commissioner to determine the reasonableness of the Commissioner's action. The hearing shall be held pursuant to the Administrative Procedures Act, Chapter 101 of Title 29, and such additional promulgated regulations as may be published by the Commissioner.

(e) Any fees required to be paid pursuant to this subchapter are nonrefundable.

(f) The license shall contain the licensee's name, address, and personal identification number, and the date of issuance, the lines of authority, and any other information the Department deems necessary.

(g) Licensees shall inform the Department by any means approved by the Department of a change of address within 30 days of the change. Failure to timely inform the Department of a change in legal name or address shall result in a penalty pursuant to § 4354(d) of this title.

(h) [Repealed.]

(76 Del. Laws, c. 394, § 2; 79 Del. Laws, c. 177, § 1; 83 Del. Laws, c. 183, § 7.)

§ 4339. Waiver of license fee.

A licensed bail agent who is unable to comply with license renewal procedures due to military service or some other extenuating circumstance approved by the Commissioner may request a waiver of license fees and/or the extension of time to reinstate a license under such procedures as may be established by the Department. The bail agent may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with renewal procedures as a result of such military service or approved extenuating circumstance.

(76 Del. Laws, c. 394, § 2.)

§ 4340. Contractual services.

(a) In order to assist in the performance of the Department's duties, the Commissioner may contract with nongovernmental entities, including the National Association of Insurance Commissioners (NAIC) or any affiliates or subsidiaries that the NAIC oversees, to perform any ministerial functions, including the collection of fees, related to bail agent licensing that the Commissioner and the nongovernmental entity may deem appropriate.

(b) The Commissioner may participate, in whole or in part, with the NAIC, or any affiliates or subsidiaries the NAIC oversees, in a centralized producer license registry where bail agent licenses and appointments may be centrally or simultaneously affected for all states that require a bail agent license and participate in such centralized producer license registry. If the Commissioner finds that participation in such a centralized producer license registry is in the public interest, the Commissioner may adopt by rule any uniform standards and procedures as necessary to participate in the registry including the central collection of all fees for licenses or appointments that are processed through the registry.

(76 Del. Laws, c. 394, § 2; 79 Del. Laws, c. 177, § 1.)

§ 4341. Records.

(a) The bail agent shall maintain at that bail agent's principal place of business in this State, and transmit to the Commissioner upon request, the license issued by the Department, together with such records as may be reasonably required by the Department to:

(1) Evaluate the reasonableness of rates or ensure that such rates are not excessive, inadequate or unfairly discriminatory;

(2) Evaluate the financial condition or trade practices of property bail agents, surety bail agents and insurers executing bail bonds; and

(3) Evaluate the performance of the property bail agents, surety bail agents and insurers executing bail bonds in accordance with appropriate criminal justice system goals and standards.

Records shall be retained and available for inspection by the Commissioner for a period of at least 3 years after the bond has been exonerated by the courts. The records shall be open to examination by the Department at all times as provided for in Chapter 3 of this title.

(b) Each licensee, as a minimum requirement for office records shall maintain:

(1) A daily bond register which shall be the original and permanent record of all bonds or undertakings executed by the licensee, which shall state the number of the power of attorney form, date bond was executed, the state, county and court in which the bond was executed, the case docket number if assigned, name of principal, amount of bond, premium charged, premium reported to surety company, security or collateral received, indemnity agreements, a copy of the court receipt for the property bail, the name of the bail funder, if applicable, the amount of the funds provided, the bank account information from which the funds were obtained, or a notation that the funds were provided in cash, disposition of bond, date of disposition, and, if applicable, date that funds were repaid to the bail funder and the method of repayment of those funds, including relevant bank account information.

(2) An individual file for each principal for whom bond is made which shall contain the original application for bail bond or undertaking, copy of premium receipt, copy of collateral receipt, copy of a bond discharge if issued, security or collateral affidavit, where security or collateral is located, information as to any security or consideration received by the agency or licensee in connection with each particular bail bond or undertaking and purpose for which it was received, receipt or release executed by the person or persons posting security or collateral evidencing the return of such security or collateral, and indemnity agreement as executed by any co-indemnitors.

(3) For each bail bond, policy or contract placed or countersigned by or through the licensee, names of the insurers, principals, insureds, bond or policy number, expiration date thereof, premium payable under the terms of the bond, policy or contract.

(4) With respect to those licensees who are acting as bail funders, a daily register which must include all of the following:

a. Information relating to each bond for which funds were provided and the date the funds were provided to the bail agent or business entity;

b. The bail agent or business entity to whom the funds were provided;

c. The case docket number for the bond;

d. The amount of funds provided and the method by which they were provided;

e. The charge applied to such loan; and

f. The date the loan or funds were repaid and the method of repayment of those funds including relevant bank account information.

(76 Del. Laws, c. 394, § 2; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 177, § 1; 83 Del. Laws, c. 183, § 8.)

§ 4342. Transfer bonds.

A bail agent who is licensed by another state, but is not licensed as a bail agent in Delaware, may post a bail bond in Delaware only through a transfer bond posted by a bail agent licensed by the Department. Every Delaware bail agent who executes or countersigns a transfer bond shall indicate in writing on the bond the name and address of the referring bail bond agent, the transfer fee charged, the total premium charged, the total amount collected and the remaining balance owed. The Delaware licensed agent shall be responsible to assure compliance with all provisions of this subchapter with respect to the bond including but not limited to, the charging and collection of the appropriate premiums filed with and approved by the Department.

(79 Del. Laws, c. 177, § 1.)

§ 4343. Termination of appointment.

(a) A surety may terminate an appointment of a surety bail agent at any time. The surety shall promptly give written notice of termination and the effective date thereof to the Department, on forms approved by the Department and to the surety bail agent if reasonably possible. The Department may require the surety to provide reasonable proof that the surety has also given such a notice to the surety bail agent unless there are valid reasons why such notice can or should not be given by the surety.

(b) Accompanying each notice of termination given to the Department, the surety shall file a statement of the cause, if any, for the termination. Any information or documents so disclosed to the Department shall be deemed a confidential document, disclosure of which shall be governed by the provisions of § 1716(f) of this title.

(c) No agreement between a surety and a surety bail agent or between an employing bail agent and a licensed bail agent shall affect the Department's termination of the appointment or license if the termination is requested by the insurer or the employing bail agent.

(d) The Department shall notify the courts upon the termination, suspension or revocation of a bail license.

(e) A bail agent's license that is otherwise in good standing with the Department shall be immediately suspended and be subject to revocation by the Department upon notice from a court that the bail agent has been struck from the list of approved bail agents by the court or courts.

(76 Del. Laws, c. 394, § 2; 79 Del. Laws, c. 177, § 1.)

§ 4344. Bail agents and designated bail agents: special requirements.

(a) A bail agent may be concurrently employed or licensed by 1 surety bail bond agent, and either 1 property bail agent or 1 bail agent business entity. A bail agent shall not concurrently be employed or licensed by more than 1 surety bail agent, or more than 1 property bail agents or bail agent business entity.

(b) The designated bail agent is responsible for the acts or omissions of the bail agents employed or operating under the designated bail agent's authority only insofar as the bail agent is acting within the scope of that bail agent's employment or authority.

(c) The bail agent shall maintain that bail agent's office with that of the designated bail agent by whom he or she is employed.

(d) The bail agent's license must remain in the custody of the designated bail agent by whom he or she is employed. Upon termination of such employment as a bail agent, the designated bail agent shall give written notice of the reasons thereof to the Department.

(e), (f) [Repealed.]

(76 Del. Laws, c. 394, § 2; 70 Del. Laws, c. 186, § 1; 77 Del. Laws, c. 2, § 3; 79 Del. Laws, c. 177, § 1; 83 Del. Laws, c. 183, § 9.)

§ 4345. Registration with the courts.

No bail agent may operate under a license from the Department unless the bail agent has registered with and been approved by the courts of this State according to such rules and procedures as the courts shall have established. Nothing in this subchapter shall limit the authority of the various courts of the State to regulate the manner in which bail agents conduct business within the courts of the State, including, but not limited to, imposing sanctions for violations of any laws or administrative rules established by the courts notwithstanding the fact that such bail agent may be duly licensed by the Department of Insurance.

(76 Del. Laws, c. 394, § 2; 79 Del. Laws, c. 177, § 1.)

§ 4346. Bail agent: place of business; display of licenses and fees charged; retention of records at place of business.

(a) Every bail agent shall have and maintain in this State a principal place of business accessible to the public, and identified by a sign clearly visible to the public. The address of this principal place of business must appear upon the application for a license and upon the license, when issued, and the licensee shall notify the Department in writing of any change in that address within 30 days of such change. This subsection does not prohibit a licensee from conducting business from a residence in this State, provided that it meets all other requirements applicable to offices of bail agents.

(b) The licenses of the designated bail agent, and of those bail agents employed or authorized by the designated bail agent, and the fees charged for services rendered, must be conspicuously displayed in the principal place of business in a place or area customarily open to the public.

(c) The designated bail agent and those bail agents employed or authorized to operate under the designated bail agent's auspices shall maintain all of their business records at the principal place of business identified in the license issued by the Department.

(d) [Repealed.]

(76 Del. Laws, c. 394, § 2; 79 Del. Laws, c. 177, § 1.)

§ 4347. Collections and charges permitted.

(a) Surety bail bond rates are subject to the provisions of Chapter 25 of this title.

(b) It is unlawful for a bail agent to execute a bail bond without charging and collecting a premium or other charge therefor, and the premium rate or other charge may not exceed or be less than the premium rate as filed with and approved by the Department. With regard to any surety bail bond in excess of $1,000, the total filed premium for a surety bail bond shall be at least 5% and not more than 10%. It shall be unlawful for a bail agent to post a surety bail bond without first charging and receiving at least 5% of the surety bail bond amount, and entering into a written contract signed by the parties containing all terms and conditions of the bond.

(c) It is unlawful for any surety bail agent to charge any administrative fee, service charge, company or agent fee or the like not filed and approved pursuant to Chapter 25 of this title.

(d) The bond may contain provisions to reimburse the bail agent personally, or permit the bail agent to have a right of action against the defendant or any indemnitor, for actual expenses incurred in good faith, by reason of misrepresentation, fraud or breach by the defendant or any indemnitor of any of the terms of the written agreement under which and pursuant to which the undertaking of bail or bail bond was written. If there is no written agreement, or an incomplete writing, the bail agent may seek enforcement of such legal or equitable rights against the defendant and any of the defendant's indemnitors as may be permitted by law. Such reimbursement or right of action may not exceed the principal sum of the bond or undertaking, plus any reasonable expenses that may be verified by receipt in a total amount of not more than the principal sum of the bond or undertaking, incurred in good faith by the bail agent, its agents, licensees and employees by reason of the defendant's or indemnitor's breach.

(e) Property bail agents, in addition to the requirements set forth in this section, shall not be permitted to issue a bond without first obtaining the approval of their charge or commission schedule from the Department. Likewise, any change or modification to the approved charge or commission shall be submitted to the Department for approval prior to any use thereof. Property bail agents shall be required to maintain a written disclosure statement approved by the Department, of their approved charges or commissions and shall provide a copy of said written disclosure to every prospective client prior to accepting the payment for the bond from the prospective client. It shall be unlawful for any property bail agent to charge any administrative fee, service charge, company or agent fee or the like not filed and approved by the Commissioner.

(f) The total charges or commissions for a cash bail may not be less than 20% or more than 30% of the bail amount posted by the property bail agent. It shall be unlawful for a property bail agent to post a bail without first charging and receiving at least 20% of the cash bail amount, and entering into a written contract signed by the parties containing all terms and conditions of the bond.

(g) All written contracts and other documents related to a bail bond or cash bail shall be maintained by the bail agent in accordance with the record keeping requirements in § 4341 of this title.

(76 Del. Laws, c. 394, § 2; 79 Del. Laws, c. 177, § 1.)

§ 4348. Collateral; limitations on transfer of collateral; fiduciary capacity; requirements for receiving title to real property as collateral; written receipt for collateral.

(a) A bail agent may accept collateral or security in connection with a bail transaction if the collateral or security is reasonable in relation to the face amount of the bond. The bail agent shall not transfer the collateral or security to any person other than a bail agent licensed pursuant to this subchapter or to a surety insurer holding a valid certificate of authority issued by the Department. The collateral shall not be transported or otherwise removed from this State, except for a transfer directly into the custody of a surety insurer holding a valid certificate of authority issued by the Department.

(b) Any person who receives the collateral:

(1) Shall be deemed to hold the collateral in a fiduciary capacity to the same extent as a bail agent; and

(2) Shall retain, return and otherwise possess the collateral in accordance with the provisions of this subchapter.

(c) The collateral or security shall be received by the bail agent in a fiduciary capacity, and, until such time as there is a default of appearance by the defendant and demand for a forfeiture of the bail, the collateral or security shall be kept separate and apart from any other funds or assets of the licensee. Any collateral or security received by the bail agent shall be returned to the person, or that person's assignee or designated representative, who deposited it with the bail agent as soon as the obligation which was secured by the collateral or security, is discharged and all fees owed to the bail agent have been paid. The bail agent or any surety insurer having custody of the collateral or security shall, immediately after the bail agent or surety insurer receives a request for return of the collateral or security from the person who deposited the collateral or security, determine whether the bail agent or surety insurer has received notice that the obligation is discharged. If the collateral or security is deposited to secure the obligation of a bond, it must be returned immediately after receipt of the request for return of the collateral or security and notice of the entry of any order by an authorized official by virtue of which liability under the bond is terminated or upon payment of all fees owed to the bail agent, whichever is later. A certified copy of the order from the court wherein the bail or undertaking was ordered exonerated shall be deemed prima facie evidence of exoneration or termination of liability.

(d) When accepting real property as collateral for a bond, it shall be unlawful for a bail agent to require a transfer of title to the real property as a condition of issuing a bail bond. The bail agent may require the defendant, or anyone agreeing to post real property on the defendant's behalf, to provide such certifications as may be necessary to establish title and unencumbered value, at the defendant's expense, indemnitor, or other person agreeing to post real property on the defendant's behalf, together with the appropriate security documents that may be necessary to establish a lien interest in the real property by the bail agent. It shall be unlawful for the bail agent to provide, directly or indirectly, title or lien services to the defendant for a fee or to receive money or anything of value for a referral to an independent person or entity for such service.

(e) When accepting personal property as collateral for a bond, a bail agent may not require a transfer of title to the personal property as a condition of issuing a bail bond. The bail agent may require the defendant, or anyone agreeing to post personal property on the defendant's behalf, at their expense, to provide such financing statements, motor vehicle titles with a lien stamp or the like that may be necessary to establish a lien interest in the personal property by the bail agent. It shall be unlawful for the bail agent to provide, directly or indirectly, title or lien services to the defendant for a fee or to receive money or anything of value for a referral to an independent person or entity for such service.

(f) Upon release or exoneration of the bail obligation, the bail agent shall be required to provide such release documents as may be required to discharge any lien of record obtained under subsections (d) and (e) of this section above. The bail agent shall not charge any fee for such service but may require that the defendant, indemnitor, or other person agreeing to post real property on the defendant's behalf pay any direct costs of document preparation and filing fees.

(g) If the amount of any collateral received in a bail transaction exceeds the amount of any bail forfeited by the defendant for whom the collateral was accepted, the bail agent or any surety insurer having custody of the collateral shall, immediately after the bail is forfeited, return to the person who deposited the collateral the amount by which the collateral exceeds the amount of the bail forfeited. Any collateral returned to a person pursuant to this subsection is subject to a claim for fees, if any, owed to the bail agent returning the collateral.

(h) If a bail agent accepts collateral, that bail agent shall give a written numbered receipt for the collateral. The receipt must include in detail a full account of the collateral received and a copy thereof provided to the principal and any indemnitor, or person or persons pledging the collateral.

(i) When collateral security in excess of $5,000 cash or its equivalent is received by a surety bail bond agent, the entire amount shall be immediately forwarded to the insurer. Such collateral security may be placed in an interest-bearing account to accrue to the benefit of

the person giving the collateral security, and the bail bond agent or insurer may not make any pecuniary gain on the collateral security deposited. Any such account shall be in a depository office of a financial institution (located in this State). The insurer shall be liable for all collateral received. If the bail bond agent fails to return the collateral to the person or persons pledging the collateral within 20 days after final termination of liability on the bond, the surety shall be liable for the collateral and shall return the actual collateral to the person or persons pledging the collateral or, in the event that the surety cannot locate the collateral, the surety shall pay the person or persons pledging the collateral pursuant to the provisions of this section.

(j) When collateral security in cash or its equivalent in any amount is received by a property bail bond agent, the entire amount shall be placed in a fiduciary account with any interest to accrue to the benefit of the person giving the collateral security, and the bail bond agent may not make any pecuniary gain on the collateral security deposited. Any such account shall be in a depository office of a financial institution located in this State.

(76 Del. Laws, c. 394, § 2; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 177, § 1.)

§ 4349. Notice to law enforcement; bail enforcement agents.

(a) After a warrant or capias has been issued for a defendant's failure to appear, a bail agent having knowledge of the whereabouts of the defendant shall immediately notify the law-enforcement agency closest to the defendant's location of:

(1) The identity of the defendant;

(2) The identity of the bail agent;

(3) The location of the defendant where law-enforcement officers might be able to obtain custody of the defendant; and

(4) Whether the bail agent has retained a bail enforcement agent and/or notified a bail enforcement agent of the defendant's location.

(b) A bail agent may employ the services of a bail enforcement agent or similar person under such terms as may be permissible by law, regulation and/or court rule, the costs of which may be assessed to the indemnitor.

(76 Del. Laws, c. 394, § 2; 79 Del. Laws, c. 177, § 1.)

§ 4350. Prohibited acts; persons who may not be bail agents.

(a) A bail agent shall not:

(1) Suggest or advise the employment of or name for employment any particular attorney to represent the defendant.

(2) Solicit business in or about any place where prisoners are confined or in or about any court.

(3) Pay a fee or rebate or give or promise anything of value to any person in order to secure a settlement, compromise, remission or reduction of the amount of any undertaking or bail bond.

(4) Pay a fee or rebate or give anything of value to an attorney in bail bond matters, except for legal services actually rendered.

(5) Pay a fee or rebate or give or promise anything of value to the defendant or anyone in the defendant's behalf.

(6) Participate in the capacity of an attorney at a trial or hearing of a person on whose bond that bail agent is surety, except for the purposes of surrendering the defendant, making motions to set aside orders of bail forfeitures and motions to exonerate bails and protecting that bail agent's financial interest in such a bond.

(b) The following persons may not be bail agents, and shall not, directly or indirectly, receive any benefits from the execution of any bail bond:

(1) Jailers;

(2) Police officers;

(3) Any person acting in a judicial capacity, including but not limited to justices, judges, alderman, commissioners, clerks, etc.;

(4) Sheriffs, deputy sheriffs and constables;

(5) Attorneys or persons employed in an attorney's office;

(6) Any person having the power to arrest or having anything to do with the control of federal, state, county or municipal prisoners; and

(7) Prisoners incarcerated in any jail, prison or any other place used for the incarceration of persons.

(c) A bail agent shall not sign or countersign in blank any bond, or give the power of attorney to, or otherwise authorize, anyone to countersign that bail agent's name to bonds unless the person so authorized is a licensed bail agent directly employed by the agent giving the power of attorney.

(d) A bail agent, shall not advertise or hold himself or herself out to be a surety insurance company.

(e) No bail or bail agent business entity may conduct any business or advertise in this State under any firm or trade name that:

(1) Is false, misleading or deceptive;

(2) Implies any connection with any government agency; or

(3) Is not registered, licensed, and approved by the Department.

Any advertisement shall prominently display the registered name and license number of the bail agent, bail agent business entity. No advertisement may use terms such as "discounted" rates. No bail agent may use more than 2 trade names.

(f) No person shall advertise or represent that it does bail bond business in this State unless the person is licensed under § 4334 of this title.

(76 Del. Laws, c. 394, § 2; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 177, § 1; 83 Del. Laws, c. 183, § 10.)

§ 4351. Justification of suretyship.

A surety bail agent shall justify that bail agent's suretyship by attaching a copy of the power of attorney issued to that surety bail agent by the surety insurer to each bond.

(76 Del. Laws, c. 394, § 2; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 177, § 1.)

§ 4352. Reporting of actions; responding to Department inquiries.

(a) A bail agent, and the bail agent's managing general agent or surety insurer, shall report to the Department in writing:

(1) Any administrative action taken against the bail agent in another jurisdiction or by another governmental agency in this State within 30 days of the final disposition of the matter. This report shall include a copy of the order, consent to order, or other relevant legal documents.

(2) Any bankruptcy proceeding, action, or order in this State or another jurisdiction concerning such bail agent or bail agent business entity not later than 30 days after initiation of such proceeding, action, or order. The written notice required under this subsection shall be accompanied by all supporting documentation.

(b) A bail agent and the bail agent's managing general agent or surety insurer shall report to the Commissioner in writing not later than 30 days after receiving notice of or learning that a bail agent has been charged with, arrested for, pleaded guilty or nolo contendere to, or been found guilty of, a felony or a crime which includes an element of dishonesty or fraud or involves moral turpitude, or a crime punishable by imprisonment of 1 year or more under the law of any state. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

(c) All persons licensed under this subchapter shall provide preliminary substantive responses to inquiries from the Department regarding violations of this title or any lawful order, rule, or regulation of the Commissioner, within 21 days of such inquiry. All responses required under this subsection shall be in writing and shall be accompanied by all supporting documentation. Failure to timely respond to Department inquiries shall result in a penalty pursuant to § 4354(d) of this title.

(76 Del. Laws, c. 394, § 2; 79 Del. Laws, c. 177, § 1; 83 Del. Laws, c. 183, § 11.)

§ 4353. Regulations.

The Commissioner may promulgate such regulations as are necessary or proper to carry out the purposes of this subchapter.

(76 Del. Laws, c. 394, § 2.)

§ 4354. Enforcement.

(a) No person shall act in the capacity of a bail agent, advertise or solicit bail bond business, perform any of the functions or duties of a bail agent, collect premiums, charge fees or otherwise exercise or attempt to exercise powers prescribed for bail agents, unless such person is qualified, licensed and appointed as provided in this subchapter. Any person found guilty of violating this section is guilty of a class F felony.

(b) The Commissioner shall upon receipt of an information or indictment, immediately temporarily suspend any license or appointment issued under this subchapter when the licensee has been charged with a felony or a crime which includes an element of dishonesty or fraud or involves moral turpitude, or a crime punishable by imprisonment of 1 year or more under the law of any state, territory, or country. Such suspension shall continue if the licensee has been found guilty of, or has pleaded guilty or no contest to, the crime, whether or not a judgment or conviction has been entered, during a pending appeal. A person may not effect any additional bail bonds after suspension of his or her license or appointment. However, he or she may discharge any liability on bonds effected prior to such suspension.

(c) The Commissioner shall permanently revoke the license of any bail agent who has pleaded guilty or nolo contendere to, or been found guilty of, a felony or a crime which includes an element of dishonesty or fraud or involves moral turpitude, or a crime punishable by imprisonment of 1 year or more under the law of any state.

(d) The Commissioner may suspend, revoke, or refuse to renew any license or appointment issued under this subchapter, and it may suspend or revoke the eligibility of any person to hold a license or appointment under this subchapter, for any violation of the laws of this State relating to bail or any violation of the insurance code or if the person at any time fails to meet all the criteria for issuance or renewal of a license as enumerated in this subchapter. A person whose license has been revoked or suspended on 2 occasions shall not again be licensed under this title. In addition to or in lieu of any applicable denial, suspension, revocation, or refusal to renew any license, a person may, after hearing, be subject to a fine of not less than $200 and not more than $20,000 for each such violation. The Commissioner's order shall specify the date upon which such fine shall be paid and shall revoke the license of any licensee failing to comply with such order. The date on which payment is due may not be less than 30 days following the date of the Commissioner's order unless otherwise specified in the order. The Commissioner may institute a civil action to recover fines so levied and must pay over all fines paid and recovered to the State Treasurer.

(79 Del. Laws, c. 177, § 1; 70 Del. Laws, c. 186, § 1; 83 Del. Laws, c. 183, § 12.)

§ 4355. Enforcement after license lapses or is surrendered.

The Commissioner shall retain authority to enforce the provisions of, and impose any penalty or remedy authorized by, this subchapter and title against any person who is under investigation for, or charged with, a violation of this chapter and title even if, while the investigation or charges are pending, such person's license or registration is surrendered or lapses by operation of law.

(76 Del. Laws, c. 394, § 2; 79 Del. Laws, c. 177, § 1.)

§ 4356. Conservation of bail agent business.

(a) If the Commissioner finds that the business of any licensed bail agent in this State has become financially impaired or insolvent, or has been abandoned by the licensee, or has been conducted in such a manner as to require or justify revocation of the licenses of that licensee, and if the Commissioner further finds that the conservation and administration of the business of the licensee would be in the public interest, he or she shall file in the Court of Chancery in the county in which the bail agent business is located a petition for the appointment of the Commissioner as conservator or receiver of such bail agent's business except by leave of the Court.

(b) The petition shall be verified by the Commissioner and shall set forth the facts and circumstances from which the existence of 1 or more of the grounds required under subsection (a) of this section may be determined; such petition may request that the licensee be required to show cause why the petition should not be granted.

(c) A copy of the petition and of the order to show cause, if they are issued, shall be served upon the licensee in the same manner as provided by law of this State for service of other legal process.

(d) Upon the filing of a petition and pending a hearing upon the order to show cause, the Court may, upon good cause shown and without notice to the other party, appoint the Commissioner as temporary conservator or receiver of the bail agent's business.

(e) The Commissioner shall, as conservator or receiver, be authorized and empowered to conduct and administer the affairs of the bail agent business in order to expeditiously terminate such business and, to the extent reasonably possible, to provide services and an accounting for funds to all persons previously insured or doing business with the bail agent, and to insurers who have previously been doing business through such bail agent. Subject to the Court's order, the Commissioner shall have the power to collect funds owed to the bail agent on account of insurance or other bail business transacted by him or her, and to account for and make payment of those funds to such persons as are entitled to them.

(f) The Commissioner may delegate the actual conduct and administration of the business of the bail agent and no charges for services so rendered shall be made against the funds or assets of the bail agent except by leave of the Court.

(g) Except as expressly herein provided, receivership or conservatorship shall be subject to the applicable laws of this State and to the order of any court of competent jurisdiction.

(79 Del. Laws, c. 177, § 1; 70 Del. Laws, c. 186, § 1.)

Part I
Insurance
Chapter 44
Delaware Life and Health Insurance Guaranty Association Act

§ 4401. Short title.

This chapter shall be known and may be cited as the "Delaware Life and Health Insurance Guaranty Association Act."

(63 Del. Laws, c. 442, § 1.)

§ 4402. Purpose.

The purpose of this chapter is to protect, subject to certain limitations, the persons specified in § 4403(a) of this title against failure in the performance of contractual obligations, under life, health, and annuity policies, plans, or contracts specified in § 4403(b) of this title, because of the impairment or insolvency of the member insurer that issued the policies, plans, or contracts. To provide this protection, an association of member insurers is created to pay benefits and to continue coverage as limited in this chapter, and members of the Association are subject to assessment to provide funds to carry out the purpose of this chapter.

(63 Del. Laws, c. 442, § 1; 68 Del. Laws, c. 55, § 1; 82 Del. Laws, c. 113, § 1.)

§ 4403. Coverage and limitations.

(a) This chapter shall provide coverage for the policies and contracts specified in subsection (b) of this section:

(1) To persons who, regardless of where they reside (except for nonresident certificate holders under group policies or contracts), are the beneficiaries, assignees, or payees, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under paragraph (a)(2) of this section;

(2) To persons who are owners of or certificate holders or enrollees under such policies or contracts (other than unallocated annuity contracts, and structured settlement annuities) and in each case who:

a. Are residents; or

b. Are not residents, but only under all of the following conditions:

1. The member insurer which issued such policies or contracts is domiciled in this State;

2. The states in which the persons reside have associations similar to the Association created by this chapter;

3. The persons are not eligible for coverage by an association in any other state due to the fact that the insurer, managed care organization, or health maintenance organization was not licensed in the state at the time specified in the state's guaranty association law.

(3) For unallocated annuity contracts specified in subsection (b) of this section, paragraphs (a)(1) and (2) of this section shall not apply, and this chapter shall (except as provided in paragraphs (a)(5) and (6) of this section) provide coverage to:

a. Persons who are the owners of the unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this State; and

b. Persons who are owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents.

(4) For structured settlement annuities specified in subsection (b) of this section, paragraphs (a)(1) and (2) of this section shall not apply, and this chapter shall (except as provided in paragraphs (a)(5) and (6) of this section) provide coverage to a person who is a payee under a structured settlement annuity (or beneficiary of a payee if the payee is deceased), if the payee:

a. Is a resident, regardless of where the contract owner resides; or

b. Is not a resident, but only under both of the following conditions:

1. A. The contract owner of the structured settlement annuity is a resident; or

B. The contract owner of the structured settlement annuity is not a resident, but

I. The insurer that issued the structured settlement annuity is domiciled in this State; and

II. The state in which the contract owner resides has an association similar to the Association created by this chapter; and

2. Neither the payee (or beneficiary) nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(5) This chapter shall not provide coverage to:

a. A person who is a payee (or beneficiary) of a contract owner resident of this State if the payee (or beneficiary) is afforded any coverage by the association of another state;

b. A person covered under paragraph (a)(3) of this section if any coverage is provided by the association of another state to the person; or

c. A person who acquires rights to receive payments through a structured settlement factoring transaction, as defined in 26 U.S.C. § 5891(c)(3)(A), regardless of whether the transaction occurred before or after 26 U.S.C. § 5891(c)(3)(A) became effective.

(6) This chapter is intended to provide coverage to a person who is a resident of this State and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under this chapter. In determining the application of the provisions of this paragraph in situations where a person could be covered by the association of more than 1 state, whether as an owner, payee, enrollee, beneficiary, or assignee, this chapter shall be construed in conjunction with other state laws to result in coverage by only one association.

(b) (1) This chapter shall provide coverage to the persons specified in subsection (a) of this section for policies or contracts of direct, nongroup life insurance; health insurance, which for the purposes of this chapter includes managed care organization and health maintenance organization subscriber contracts and certificates; or annuities for certificates under direct group policies and contracts, and for supplemental contracts to any of these, and for unallocated annuity contracts, in each case issued by member insurers, except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include but are not limited to guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries, and any immediate or deferred annuity contracts.

(2) Except as otherwise provided in paragraph (b)(3) of this section, this chapter shall not provide coverage for the following:

a. Any portion of a policy or contract not guaranteed by the member insurer or under which the risk is borne by the policy or contract owner;

b. Any policy or contract of reinsurance unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

c. Any portion of a policy or contract to the extent that the rate of interest on which it is based or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

1. Averaged over the period of 4 years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting 2 percentage points from Moody's Corporate Bond Yield Average averaged for that same 4-year period or for such lesser period if the policy or contract was issued less than 4 years before the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier; and

2. On and after the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting 3 percentage points from Moody's Corporate Bond Yield Average as most recently available;

d. Any portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or others to the extent that such plan or program is self-funded or uninsured, including benefits payable by an employer, association, or other person under any of the following:

1. A multiple employer welfare arrangement, as defined in § 3(40) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002(40));

2. A minimum premium group insurance plan;

3. A stop-loss group insurance plan; or

4. An administrative services only contract;

e. Any portion of a policy or contract to the extent that it provides:

1. Dividends or experience rating credits;

2. Voting rights; or

3. Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of such policy or contract;

f. Any policy or contract issued in this State by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this State;

g. Any unallocated annuity contract issued to or in connection with a benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan;

h. Any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;

i. A portion of a policy or contract to the extent that the assessments required by § 4409 of this title with respect to the policy or contract are preempted by federal or state law;

j. An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner, or policy owner, including:

1. Claims based on marketing materials;

2. Claims based on side letters, riders or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

3. Misrepresentations of or regarding policy or contract benefits;

4. Extracontractual claims; or

5. A claim for penalties or consequential or incidental damages; and

k. A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer.

l. A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this paragraph (b)(2)*l.*, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture.

m. Any employer owned life insurance policy, as defined in § 2704(e) of this title.

n. A policy or contract providing any hospital, medical, prescription drug, or other health-care benefits under Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the U.S.C. (commonly known as Medicare Part C and D); Subchapter XIX, Chapter 7 of Title 42 of the U.S.C. (commonly known as Medicaid); or any regulations issued under either of these provisions.

o. Structured settlement annuity benefits to which a payee or beneficiary has transferred the payee's or beneficiary's rights in a structured settlement factoring transaction, as defined in 26 U.S.C. § 5891(c)(3)(A), regardless of whether the transaction occurred before or after 26 U.S.C. § 5891(c)(3)(A) became effective.

(3) The exclusion from coverage under paragraph (b)(2)c. of this section does not apply to any portion of a policy or contract, including rider, that provides long-term care or any other health insurance benefits.

(c) The benefits that the Association may become obligated to cover shall in no event exceed the lesser of the following:

(1) The contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(2) a. With respect to any one life, regardless of the number of policies or contracts:

1. $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

2. For health insurance benefits:

A. $100,000 for coverages not defined as disability income insurance, health benefit plans, or long-term care insurance including any net cash surrender and net cash withdrawal values;

B. $300,000 for disability income insurance and $300,000 for long-term care insurance. For purposes of this section, "disability income insurance" means the type of policy which pays a monthly or weekly amount if an individual is disabled and cannot work. "Long-term care insurance" means as defined in § 7103(5) of this title;

C. $500,000 for health benefit plans; or

3. $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal values.

b. With respect to each individual participating in a governmental retirement benefit plan established under § 401, § 403(b) or § 457 of the U.S. Internal Revenue Code (26 U.S.C. § 401, § 403(b) or § 457) covered by an unallocated annuity contract, or the beneficiaries of each such individual if deceased, $250,000 in the aggregate in present value annuity benefits, including net cash surrender and net cash withdrawal values;

c. With respect to each payee of a structured settlement annuity (or beneficiary or beneficiaries of the payee, if deceased), $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

d. However, in no event shall the Association be obligated to cover more than (i) an aggregate of $300,000 in benefits with respect to any 1 life under paragraphs (c)(2)a., (c)(2)b., and (c)(2)c. of this section except with respect to benefits for health benefit plans under paragraph (c)(2)a.2. of this section, in which case the aggregate liability of the Association shall not exceed $500,000 with respect to any 1 individual; or (ii) with respect to 1 owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, more than $1,000,000 in benefits, regardless of the number of policies and contracts held by the owner;

e. With respect to either (i) 1 contract owner provided coverage under paragraph (a)(3)b. of this section; or (ii) 1 plan sponsor whose plans own directly or in trust 1 or more unallocated annuity contracts not included in paragraph (c)(2)b. of this section,

$1,000,000 in benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. However, in the case where 1 or more unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit of 2 or more plan sponsors, coverage shall be afforded by the Association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this State and in no event shall the Association be obligated to cover more than $1,000,000 in benefits with respect to all these unallocated contracts.

f. The limitations set forth in this subsection are limitations on the benefits for which the Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the Association's obligations under this chapter may be met by the use of assets attributable to covered policies or reimbursed to the Association pursuant to its subrogation and assignment rights.

g. For purposes of this chapter, benefits provided by a long-term care rider to a life insurance policy or annuity contract are considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

(d) In performing its obligations to provide coverage under § 4408 of this title, the Association shall not be required to guarantee, assume, reinsure, reissue, or perform, or cause to be guaranteed, assumed, reinsured, reissued, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

(63 Del. Laws, c. 442, § 1; 67 Del. Laws, c. 161, § 4; 68 Del. Laws, c. 55, § 2; 69 Del. Laws, c. 462, § 5; 73 Del. Laws, c. 327, § 1; 77 Del. Laws, c. 215, §§ 1-5; 82 Del. Laws, c. 113, § 2.)

§ 4404. Construction.

This chapter shall be liberally construed to effect the purpose under § 4402 of this title which shall constitute and aid and guide to interpretation.

(63 Del. Laws, c. 442, § 1.)

§ 4405. Definitions.

As used in this chapter:

(1) "Account" means either of the 2 accounts created under § 4406 of this title.

(2) "Association" means the Delaware Life and Health Insurance Guaranty Association created under § 4406 of this title.

(3) "Authorized assessment" or "authorized," when used in the context of assessments, means a resolution by the board of directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(4) "Benefit plan" means a specific employee, union or association of natural persons benefit plan.

(5) "Called assessment" or "called," when used in the context of assessments, means that a notice has been issued by the Association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the Association to member insurers.

(6) "Commissioner" means the Commissioner of Insurance of this State.

(7) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof, for which coverage is provided under § 4403 of this title.

(8) "Covered contract" or "covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under § 4403 of this title.

(9) "Extracontractual claims" includes claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorneys' fees and costs.

(10) "Health benefit plan" means any hospital or medical expense policy or certificate, managed care organization or health maintenance organization subscriber contract, or any other similar health contract. "Health benefit plan" does not include any of the following:

a. Accident only insurance.

b. Credit insurance.

c. Dental insurance.

d. Vision only insurance.

e. Medicare Supplement insurance.

f. Benefits for long-term care, home health care, community-based care, or any combination thereof.

g. Disability income insurance.

h. Coverage for on-site medical clinics.

i. Specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

(11) “Impaired insurer” means a member insurer which, after the effective date of this chapter, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(12) “Insolvent insurer” means a member insurer which after the effective date of this chapter, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(13) “Member insurer” means an insurer, managed care organization, or health maintenance organization licensed or that holds a certificate of authority to transact in this State any kind of insurance, managed care organization, or health maintenance organization business for which coverage is provided under § 4403 of this title, and includes an insurer, managed care organization, or health maintenance organization whose license or certificate of authority in this State may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

a. A hospital or medical service organization, whether profit or nonprofit;

b. [Repealed.]

c. A fraternal benefit society;

d. A mandatory state pooling plan;

e. A mutual assessment company or other person that operates on an assessment basis;

f. An insurance exchange;

g. An organization which has a certificate or license limited to the issuance of charitable gift annuities; or

h. An entity similar to any of the above.

(14) “Moody’s Corporate Bond Yield Average” means the Monthly Average Corporates as published by Moody’s Investors Service, Inc., or any successor thereto.

(15) “Owner” of a policy or contract and “policyholder,” “policy owner,” and “contract owner” mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. The terms owner, contract owner, policyholder, and policy owner do not include persons with a mere beneficial interest in a policy or contract.

(16) “Person” means an individual, corporation, limited liability company, partnership, association, governmental body or entity or voluntary organization.

(17) “Plan sponsor” means:

a. The employer in the case of a benefit plan established or maintained by a single employer;

b. The employee organization in the case of a benefit plan established or maintained by an employee organization; or

c. In a case of a benefit plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

(18) “Premiums” means amounts or considerations (by whatever name called) received on covered policies or contracts less returned premiums, considerations and deposits and less dividends and experience credits. “Premiums” does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under § 4403(b) of this title except that assessable premium shall not be reduced on account of § 4403(b)(2)c. of this title relating to interest limitations and § 4403(c)(2) of this title relating to limitations with respect to 1 individual, 1 participant, and 1 policy or contract owner. “Premiums” does not include:

a. Premiums in excess of $1,000,000 on an unallocated annuity contract not issued under a governmental retirement benefit plan (or its trustee) established under § 401, § 403(b) or § 457 of the United States Internal Revenue Code [26 U.S.C. § 401, § 403(b) or § 457], or

b. With respect to multiple nongroup policies of life insurance owned by 1 owner, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of $1,000,000 with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(19) a. “Principal place of business” of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control and coordination of the operations of the entity as a whole primarily exercise that function, determined by the Association in its reasonable judgment by considering the following factors:

1. The state in which the primary executive and administrative headquarters of the entity is located;

2. The state in which the principal office of the chief executive officer of the entity is located;

3. The state in which the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

4. The state in which the executive or management committee of the board of directors (or similar governing person or persons) of the entity conducts the majority of its meeting;

5. The state from which the management of the overall operations of the entity is directed; and

6. In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors.

However, in the case of a plan sponsor, if more than 50 percent of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

b. The principal place of business of a plan sponsor of a benefit plan described in paragraph (17)c. of this section shall be deemed to be the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

(20) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation or liquidation of the member insurer.

(21) "Resident" means a person to whom a contractual obligation is owed and who resides in this State on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person may be a resident of only 1 state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either (i) residents of foreign countries, or (ii) residents of United States possessions, territories or protectorates that do not have an association similar to the Association created by this chapter shall be deemed residents of the state of domicile of the member insurer that issued the policies or contracts.

(22) "State" means a state, the District of Columbia, Puerto Rico, or a United States possession, territory or protectorate. "State," when capitalized, means the State of Delaware.

(23) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(24) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or contract.

(25) "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

(63 Del. Laws, c. 442, § 1; 67 Del. Laws, c. 223, § 28; 68 Del. Laws, c. 55, § 3; 70 Del. Laws, c. 547, § 1; 73 Del. Laws, c. 327, § 2; 82 Del. Laws, c. 113, § 3.)

§ 4406. Delaware Life and Health Insurance Guaranty Association — Created; accounts; supervision.

(a) There is created a nonprofit legal entity to be known as the Delaware Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the Association as a condition of their authority to transact insurance, managed care organization, or health maintenance organization business in this State. The Association shall perform its functions under the plan of operation established and approved under § 4410 of this title, and shall exercise its powers through a Board of Directors established under § 4407 of this title. For purposes of administration and assessment, the Association shall maintain 2 accounts:

(1) The life insurance and annuity account, which includes the following subaccounts:

a. Life insurance account;

b. Annuity account, which shall include annuity contracts owned by a governmental retirement plan (or its trustee) established under § 401, § 403(b) or § 457 of the United States Internal Revenue Code [26 U.S.C. § 401, § 403(b) or § 457], but shall otherwise exclude unallocated annuities; and

c. Unallocated annuity account, which shall exclude contracts owned by a governmental retirement benefit plan (or its trustee) established under § 401, § 403(b) or § 457 of the United States Internal Revenue Code [26 U.S.C. § 401, § 403(b) or § 457].

(2) The health account.

(b) The Association shall come under the immediate supervision of the Commissioner and shall be subject to the applicable provisions of the insurance laws of this State.

(63 Del. Laws, c. 442, § 1; 70 Del. Laws, c. 547, § 2; 73 Del. Laws, c. 327, § 3; 82 Del. Laws, c. 113, § 4.)

§ 4407. Delaware Life and Health Insurance Guaranty Association — Board of Directors.

(a) The Board of Directors of the Association shall consist of not less than 5 nor more than 9 member insurers serving terms as established in the plan of operation. The members of the Board shall be selected by member insurers subject to the approval of the Commissioner. Vacancies on the Board shall be filled for the remaining period of the term by a majority vote of the remaining Board members, subject to the approval of the Commissioner. To select the initial Board of Directors, and initially organize the Association, the Commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer shall be entitled to 1 vote in person or by proxy. If the Board of Directors is not selected within 60 days after notice of the organizational meeting, the Commissioner may appoint the initial members.

(b) In approving selections or in appointing members to the Board, the Commissioner shall consider, among other things, whether all member insurers are fairly represented.

(c) Members of the Board may be reimbursed from the assets of the Association for expenses incurred by them as members of the Board of Directors but members of the Board shall not otherwise be compensated by the Association for their services.

(63 Del. Laws, c. 442, § 1.)

§ 4408. Powers and duties of the Association.

(a) If a member insurer is an impaired insurer, the Association may, in its discretion, and subject to any conditions imposed by the Association that do not impair the contractual obligations of the impaired insurer and that are approved by the Commissioner:

(1) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, any or all of the policies or contracts of the impaired insurer; or

(2) Provide such moneys, pledges, loans, notes, guarantees or other means as are proper to effectuate paragraph (a)(1) of this section and assure payment of the contractual obligations of the impaired insurer pending action under paragraph (a)(1) of this section.

(b) If a member insurer is an insolvent insurer, the Association shall, in its discretion, either:

(1) a. 1. Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, the policies or contracts of the insolvent insurer; or

2. Assure payment of the contractual obligations of the insolvent insurer; and

b. Provide moneys, pledges, loans, notes, guarantees or other means reasonably necessary to discharge the Association's duties; or

(2) Provide benefits and coverages in accordance with the following provisions:

a. With respect to policies and contracts, assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

1. With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or 45 days, but in no event less than 30 days, after the date on which the Association becomes obligated with respect to the policies and contracts;

2. With respect to nongroup policies, contracts and annuities, not later than the earlier of the next renewal date (if any) under the policies or contracts or 1 year, but in no event less than 30 days from the date on which the Association becomes obligated with respect to the policies or contracts;

b. Make diligent efforts to provide all known insureds, enrollees, or annuitants (for nongroup policies and contracts), or group policy or contract owners with respect to group policies and contracts, 30 days' notice of the termination, under paragraph (b)(2)a. of this section, of the benefits provided;

c. With respect to nongroup policies and contracts covered by the Association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly an insured, enrollee, or annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of paragraph (b)(2)d. of this section, if the insureds, enrollees, or annuitants had a right under law or the terminated policy, contract, or annuity to convert coverage to individual coverage or to continue an individual policy, contract, or annuity in force until a specified age or for a specified time during which the insurer, managed care organization, or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class;

(3) a. In providing the substitute coverage required under paragraph (b)(2)c. of this section, the Association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates.

b. Alternative or reissued policies or contracts shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract.

c. The Association may reinsure any alternative or reissued policy or contract.

(4) a. Alternative policies or contracts adopted by the Association shall be subject to the approval of the Commissioner. The Association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency.

b. Alternative policies or contracts shall contain at least the minimum statutory provisions required in this State and provide benefits that shall not be unreasonable in relation to the premium charged. The Association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy or contract was last underwritten.

c. Any alternative policy or contract issued by the Association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the Association.

(5) If the Association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium shall be actuarially justified and set by the Association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to prior approval of the Commissioner.

(6) The Association's obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract shall cease on the date the coverage, policy, or contract is replaced by another similar policy or contract by the policy or contract owner, the insured, the enrollee, or the Association.

(7) When proceeding under paragraph (b)(2) of this section with respect to a policy or contract carrying guaranteed minimum interest rates, the Association shall assure the payment or crediting of a rate of interest consistent with § 4403(b)(2)c. of this title.

(c) Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall terminate the Association's obligations under the policy, contract, or coverage under this chapter with respect to the policy, contract, or coverage, except with respect to any claims incurred or any net cash surrender value which may be due under this chapter.

(d) (1) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the Association, and the Association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(2) If the liquidator of an insolvent insurer requests, the Association shall provide a report to the liquidator regarding such premiums collected by the Association.

(e) The protection provided by this chapter shall not apply where any guaranty protection is provided to residents of this State by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this State.

(f) In carrying out its duties under subsection (b) of this section, the Association may:

(1) Subject to approval by a court in this State, impose permanent policy or contract liens in connection with a guarantee, assumption or reinsurance agreement if the Association finds that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the Association's duties under this chapter or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens to be in the public interest;

(2) Subject to approval by a court in this State, impose temporary moratoriums or liens on payments of cash values and policy loans or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans or on any other right to withdraw funds held in conjunction with policies or contracts out of the assets of the impaired or insolvent insurer, the Association may defer the payment of cash values, policy loans or other rights by the Association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the Association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(g) A deposit in this State held pursuant to law or required by the Commissioner for the benefit of creditors, including policy or contract owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of a member insurer domiciled in this State or in a reciprocal state, shall be promptly paid to the Association. The Association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy or contract owners claims related to that insolvency for which the Association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in this State related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the Association less the amount retained pursuant to this subsection. Any amount so paid to the Association and retained by it shall be treated as a distribution of estate assets under § 5911 of this title or similar provision of the state of domicile of the impaired or insolvent insurer.

(h) If the Association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsection (b) of this section, the Commissioner shall have the powers and duties of the Association under this chapter with respect to the insolvent insurer.

(i) The Association may render assistance and advice to the Commissioner, upon the Commissioner's request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer.

(j) The Association shall have standing to appear or intervene before a court or agency in this State with jurisdiction over an impaired or insolvent insurer concerning which the Association is or may become obligated under this chapter or with jurisdiction over any person or property against which the Association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the Association, including proposals for reinsuring, reissuing, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The Association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the Association is or may become obligated or with jurisdiction over any person or property against whom the Association may have rights through subrogation or otherwise.

(k) (1) A person receiving benefits under this chapter shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to, the covered policy or contract to the Association to the extent of the benefits received because of this chapter, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative policies, contracts, or coverages. The Association may require an assignment to it of such rights and cause of action by any enrollee, payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this chapter upon the person.

(2) The subrogation rights of the Association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.

(3) In addition to paragraphs (k)(1) and (2) of this section, the Association shall have all common-law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee, or payee of a policy or contract with respect to the policy or contracts, including in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received under this chapter, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Internal Revenue Code § 130 [26 U.S.C. § 130].

(4) If paragraphs (k)(1) through (k)(3) of this section are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the Association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts, or portion thereof, covered by the Association.

(5) If the Association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the Association has rights as described in paragraphs (k)(1) through (k)(4) of this section, the person shall pay to the Association the portion of the recovery attributable to the policies or contracts, or portion thereof, covered by the Association.

(*l*) In addition to the rights and powers elsewhere in this chapter, the Association may:

(1) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter;

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under § 4409 of this title and to settle claims or potential claims against it;

(3) Borrow money to effect the purposes of this chapter; any notes or other evidence of indebtedness of the Association not in default shall be legal investments for domestic member insurers and may be carried as admitted assets;

(4) Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the Association, and to perform such other functions as become necessary or proper under this chapter;

(5) Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

(6) Exercise, for the purposes of this chapter and to the extent approved by the Commissioner, the powers of a domestic life insurer, health insurer, managed care organization, or health maintenance organization; but in no case may the Association issue policies or contracts other than those issued to perform its obligations under this chapter;

(7) Organize itself as a corporation or in other legal form permitted by the laws of this State;

(8) Request information from a person seeking coverage from the Association in order to aid the Association in determining its obligations under this chapter with respect to the person; and the person shall promptly comply with the request;

(9) Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under this chapter; and

(10) Take other necessary or appropriate action to discharge its duties and obligations under this chapter or to exercise its powers under this chapter.

(m) The Association may join an organization of 1 or more other state associations of similar purposes to further the purposes and administer the powers and duties of the Association.

(n) (1) At any time within 180 days of the date of the order of liquidation, the Association may elect to succeed to the rights and obligations of the ceding member insurer that relate to policies, contracts, or annuities covered, in whole or part, by the Association, in each case under any 1 or more reinsurance contract or contracts entered into by the insolvent insurer and its reinsurers and selected by the Association. Any such assumption shall be effective as of the date of the order of liquidation. The election shall be effected by the Association or the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) on its behalf sending written notice, return receipt requested, to the affected reinsurers.

(2) To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance and to protect the financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make available, upon request, to the Association or to NOLHGA on its behalf as soon as possible after commencement of formal delinquency proceedings:

a. Copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether such contracts should be assumed; and

b. Notices of any defaults under the reinsurance contracts or any known event or condition which, with the passage of time, could become a default under the reinsurance contracts.

(3) The following paragraphs (n)(3)a. through f. of this section shall apply to reinsurance contracts so assumed by the Association:

a. The Association shall be responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the date of the order of liquidation, and shall be responsible for the performance of all other obligations to be performed after the date of the order of liquidation, in each case which relate to policies, contracts, or annuities covered, in whole or part, by the Association. The Association may charge policies, contracts, or annuities covered in part by the Association, through reasonable

allocation methods, the costs for reinsurance in excess of the obligations of the Association and shall provide notice and an accounting of these charges to the liquidator.

b. The Association shall be entitled to any and all amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies, contracts, or annuities covered, in whole or part, by the Association, if, upon receipt of any such amounts the Association shall be obligated to pay to the beneficiary under the policy, contract, or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of:

1. The amount received by the Association; and

2. The excess of the amount received by the Association, over the amount equal to the benefits paid by the Association on account of the policy, contract, or annuity less the retention of the insurer applicable to the loss or event.

c. Within 30 days following the Association's election (the "election date"), the Association and each reinsurer under contracts assumed by the Association shall calculate the net balance due to or from the Association under each reinsurance contract as of the election date with respect to policies, contracts, or annuities covered, in whole or part, by the Association, which calculation shall give full credit to all items paid by either the member insurer or its receiver or the reinsurer before the election date. The reinsurer shall pay the receiver any amounts due for losses or events before the date of the order of liquidation, subject to any set-off for premiums unpaid for periods prior to the date, and the Association or reinsurer shall pay any remaining balance due the other, in each case within 5 days of the completion of the aforementioned calculation. Any disputes over the amounts due to either the Association or the reinsurer shall be resolved by arbitration under the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law. If the receiver has received any amounts due the Association under paragraph (n)(3)b. of this section, the receiver shall remit the same to the Association as promptly as practicable.

d. 1. If the Association or the receiver, on the Associations' behalf, within 60 days of the election date, pays the unpaid premiums due for periods both before and after the election date that relate to policies, contracts, or annuities covered, in whole or part, by the Association, the reinsurer shall not be entitled to terminate the reinsurance contracts for failure to pay a premium insofar as the reinsurance contracts relate to policies, contracts, or annuities covered, in whole or part, by the Association, and shall not be entitled to set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the Association, against amounts due the Association.

2. During the period from the date of the order of liquidation until the election date, or, if the election date does not occur, until 180 days after the date of the order of liquidation:

A. I. Neither the Association nor the reinsurer shall have any rights or obligations under reinsurance contracts that the Association has the right to assume under paragraph (n)(1) of this section, whether for periods before or after the date of the order of liquidation; and

II. The reinsurer, the receiver, and the Association shall, to the extent practicable, provide each other data and records reasonably requested;

B. Provided that once the Association has elected to assume a reinsurance contract, the parties' rights and obligations shall be governed by paragraph (n)(1) of this section.

3. If the Association does not elect to assume a reinsurance contract by the election date under paragraph (n)(1) of this section, the Association shall have no rights or obligations, in each case for periods both before and after the date of the order of liquidation, with respect to the reinsurance contract.

4. When policies, contracts, or annuities, or covered obligations with respect thereto, are transferred to an assuming insurer, reinsurance on the policies, contracts, or annuities may also be transferred by the Association, in the case of contracts assumed under paragraph (n)(1) of this section, subject to the following:

A. Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract that is transferred shall not cover any new policies of insurance, contracts, or annuities in addition to those transferred;

B. The obligations described in paragraph (n)(3)d.1. of this section shall no longer apply with respect to matters arising after the effective date of the transfer; and

C. Notice shall be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than 30 days before the effective date of the transfer.

e. The provisions of this subsection (n) shall supersede the provisions of any state law or of any affected reinsurance contract that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the date of the order of liquidation, to the receiver of the insolvent insurer or any other person. The receiver shall remain entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods before the date of the order of liquidation, subject to applicable setoff provisions.

f. Except as otherwise provided in this section, nothing in this subsection (n) shall:

1. Alter or modify the terms and conditions of any reinsurance contract;

2. Abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract;

3. Provide a policyholder, contract owner, enrollee, certificate holder, or beneficiary with an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract;

4. Limit or affect the Association's rights as a creditor of the estate against the assets of the estate;

5. Apply to reinsurance agreements covering property or casualty risks.

(o) The Board of Directors of the Association shall have discretion and may exercise reasonable business judgment to determine the means by which the Association is to provide the benefits of this chapter in an economical and efficient manner.

(p) Where the Association has arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the Association's obligations under this chapter, the person shall not be entitled to benefits from the Association in addition to or other than those provided under the plan or arrangement.

(q) Venue in a suit against the Association arising under the chapter shall be in New Castle County. The Association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter.

(r) In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under subsection (a) or (b) of this section, the Association may issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(1) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for:

a. A fixed interest rate; or

b. Payment of dividends with minimum guarantees; or

c. A different method for calculating interest or changes in value;

(2) There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

(3) The alternative policy or contract is substantially similar to the replaced policy or contract in all other materials terms.

(63 Del. Laws, c. 442, § 1; 65 Del. Laws, c. 162, § 1; 65 Del. Laws, c. 410, §§ 1, 2; 67 Del. Laws, c. 223, § 29; 68 Del. Laws, c. 55, § 4; 70 Del. Laws, c. 186, § 1; 73 Del. Laws, c. 327, § 4; 77 Del. Laws, c. 215, §§ 6-9; 82 Del. Laws, c. 113, § 5.)

§ 4409. Assessments.

(a) For the purpose of providing the funds necessary to carry out the powers and duties of the Association, the Board of Directors shall assess the member insurers, separately for each account, at such time and for such amounts as the Board finds necessary. Assessments shall be due not less than 30 days after prior written notice to the member insurers and shall accrue interest at 10% per annum on and after the due date.

(b) There shall be 3 classes of assessment as follows:

(1) Class A assessments, shall be authorized and called for the purpose of meeting administrative costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(2) Class B assessments shall be authorized and called annually to provide for the oversight activity of the Commissioner, thereby minimizing the need to make class C assessments.

(3) Class C assessments shall be authorized and called to the extent necessary to carry out the duties of the Association under this title with regards to an impaired or insolvent member insurer.

(c) (1) a. The amount of any class A assessment shall be determined by the Board and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the Board may provide that it be credited against future class C assessments.

b. The amount of class C assessment, except for assessments relating to long-term care insurance, shall be allocated for assessment purposes between the accounts and among the subaccounts of the life insurance and annuity account under an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the Board in its sole discretion as being fair and reasonable under the circumstances.

c. The amount of the class C assessment for long-term care insurance written by the impaired or insolvent insurer must be allocated according to a methodology included in the plan of operation and approved by the Commissioner. The methodology must provide for 50% of the assessment to be allocated to accident and health member insurers and 50% to be allocated to life and annuity member insurers.

(2) The amount of a class B assessment shall be determined by the Commissioner who shall so notify the Association not later than July 31 of the calendar year in which the assessment is to be made. A class B assessment may be made on a non-pro rata basis, but the amount shall not exceed $^{1}/_{10}$ of 1% of the members' premium written during the calendar year preceding the assessment. The amount assessed in conjunction with class C assessments shall not result in members being assessed more than 2% of the premiums written in the applicable year. The proceeds of this assessment shall be paid by the Association into the Commissioner's Regulatory Revolving Fund.

(3) Class C assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this State by each assessed member insurer on policies or contracts covered by each account for the 3 most

recent calendar years for which information is available preceding the year in which the member insurer became impaired or insolvent, as the case may be, bears to such premiums received in this State for such calendar years by all assessed member insurers.

(4) Assessments for funds to meet the requirements of the Association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under subsection (b) of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determination may not always be possible. The Association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within 180 days after the assessment is authorized.

(d) The Association may abate or defer, in whole or part, the assessment of the member insurer if, in the opinion of the Board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. If an assessment against a member insurer is abated or deferred in whole or part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments under this section. Once the conditions which caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the Association.

(e) (1) a. Subject to paragraph (e)(1)b. of this section, the total of all assessments authorized by the Association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health account shall not in 1 calendar year exceed 2% of that member insurer's average annual premiums received in this State on the policies and contracts covered by the subaccount or account during the 3 calendar years preceding the year in which the member insurer became an impaired or insolvent insurer.

b. If 2 or more assessments are authorized in 1 calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in paragraph (e)(1)a. of this section shall be equal and limited to the higher of the 3-year average annual premiums for the applicable subaccount or account as calculated under this section.

c. If the maximum assessment, together with the other assets of the Association in an account, does not provide in 1 year in either account an amount sufficient to carry out the responsibilities of the Association, the necessary additional funds shall be assessed as soon thereafter as permitted by this chapter.

(2) The Board may provide in the plan of operation a method of allocating funds among claims, whether relating to 1 or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(3) If the maximum assessment for any subaccount of the life and annuity account in any 1 year does not provide an amount sufficient to carry out the responsibilities of the Association, then under paragraph (c)(3) of this section, the Board shall assess all subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in paragraph (e)(1) of this section.

(f) The Board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to that account, the amount by which the assets of the account exceed the amount the Board finds is necessary to carry out during the coming year the obligations of the Association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the Association and for future claims.

(g) It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance, managed care organization, or health maintenance organization business within the scope of this chapter, consider the amount reasonably necessary to meet its assessment obligations under this chapter.

(h) The Association shall issue to each member insurer paying a class C assessment a certificate of contribution, in a form prescribed by the Commissioner, for the amount of the assessment so paid. All outstanding certificates shall be given equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the Commissioner may approve.

(i) (1) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the Association. The payment shall be available to meet Association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(2) Within 60 days following the payment of an assessment under protest by a member insurer, the Association shall notify the member insurer in writing of its determination with respect to the protest unless the Association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(3) Within 30 days after a final decision has been made, the Association shall notify the protesting member insurer in writing of that final decision. Within 60 days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the Commissioner.

(4) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the Association may refer protests to the Commissioner for a final decision, with or without a recommendation from the Association.

(5) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the Association.

(j) The Association may request information of member insurers in order to aid in the exercise of its power under this section and member insurers shall promptly comply with a request.

(63 Del. Laws, c. 442, § 1; 64 Del. Laws, c. 106, § 1; 65 Del. Laws, c. 6, §§ 1-5; 68 Del. Laws, c. 55, § 5; 70 Del. Laws, c. 547, §§ 3, 4; 73 Del. Laws, c. 327, § 5; 77 Del. Laws, c. 215, § 10; 82 Del. Laws, c. 113, § 6.)

§ 4410. Plan of operation.

(a) (1) The Association shall submit to the Commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the Association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the Commissioner.

(2) If the Association fails to submit a suitable plan of operation within 180 days following July 23, 1982, or if at any time thereafter the Association fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate this chapter. Such rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the Association and approved by the Commissioner.

(b) All member insurers shall comply with the plan of operation.

(c) The plan of operation shall, in addition to requirements enumerated elsewhere in this chapter:

(1) Establish procedures for handling the assets of the Association;

(2) Establish the amount and method of reimbursing members of the Board of Directors under § 4407 of this title;

(3) Establish regular places and times for meetings of the Board of Directors;

(4) Establish procedures for records to be kept of all financial transactions of the Association, its agents and the Board of Directors;

(5) Establish the procedures whereby selections for the Board of Directors will be made and submitted to the Commissioner;

(6) Establish any additional procedures for assessments under § 4409 of this title;

(7) Contain additional provisions necessary or proper for the execution of the powers and duties of the Association;

(8) Establish procedures whereby a Director may be removed for cause, including the case where a member insurer Director becomes an impaired or insolvent insurer; and

(9) Require the Board of Directors to establish policy and procedures for addressing conflicts of interest.

(d) The plan of operation may provide that any or all powers and duties of the Association, except those under §§ 4408(*l*)(3) and 4409 of this title, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this Association, or its equivalent, in 2 or more states. Such a corporation, association or organization shall be reimbursed for any payments made on behalf of the Association and shall be paid for its performance of any function of the Association. A delegation under this subsection shall take effect only with the approval of both the Board of Directors and the Commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this chapter.

(63 Del. Laws, c. 442, § 1; 77 Del. Laws, c. 215, § 11.)

§ 4411. Duties and powers of Commissioner.

In addition to the duties and powers enumerated elsewhere in this chapter:

(1) The Commissioner shall:

a. Upon request of the Board of Directors, provide the Association with a statement of the premiums in the appropriate states for each member insurer;

b. When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the impaired insurer to promptly comply with such demand shall not excuse the Association from the performance of its powers and duties under this chapter; and

c. In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator. If a foreign or alien member insurer is subject to a liquidation proceeding in its domiciliary jurisdiction or state of entry, the Commissioner shall be appointed conservator.

(2) The Commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact business in this State of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. Alternatively, the Commissioner may levy a forfeiture of any insurer which fails to pay an assessment when due. Such forfeiture shall not exceed 5% of the unpaid assessment per month, but no forfeiture shall be less than $100 per month.

(3) A final action of the Board of Directors or the Association may be appealed to the Commissioner by a member insurer if the appeal is taken within 60 days of its receipt of notice of the final action being appealed. A final action or order of the Commissioner shall be subject to judicial review in a court of competent jurisdiction in accordance with the laws of this State that apply to the actions or orders of the Commissioner.

(4) The liquidator, rehabilitator, or conservator of any impaired insurer may notify all interested persons of the effect of this chapter.

(63 Del. Laws, c. 442, § 1; 70 Del. Laws, c. 547, § 5; 73 Del. Laws, c. 327, § 6; 82 Del. Laws, c. 113, § 6.)

§ 4412. Detection and prevention of insolvencies.

To aid in the detection and prevention of member insurer insolvencies or impairments:

(1) It shall be the duty of the Commissioner:

a. 1. To notify the commissioners of all the other states when the Commissioner takes any of the following actions against a member insurer:

A. Revocation of license;

B. Suspension of license;

C. Makes any formal order that such member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from the State, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policyholders, policy owners, contract owners, certificate holders, or creditors.

2. Notice under paragraph (1)a.1. of this section must be mailed to all commissioners within 30 days following the action taken or the date on which such action occurs;

b. To report to the Board of Directors when the Commissioner has taken any of the actions set forth in paragraph (1)a.1. of this section or has received a report from any other commissioner indicating that any such action has been taken in another state. Such report to the Board of Directors shall contain all significant details of the action taken or the report received from another commissioner;

c. To report to the Board of Directors when the Commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member company that such company may be an impaired or insolvent insurer; and

d. To furnish to the Board of Directors the NAIC Early Warning Tests developed by the National Association of Insurance Commissioners, and the Board may use the information contained therein in carrying out its duties and responsibilities under this section. Such report and the information contained therein shall be kept confidential by the Board of Directors until such time as made public by the Commissioner or other lawful authority.

(2) The Commissioner may seek the advice and recommendations of the Board of Directors concerning any matter affecting the Commissioner's duties and responsibilities regarding the financial condition of member insurers and insurers, managed care organizations, or health maintenance organizations seeking admission to transact business in this State.

(3) The Board of Directors may, upon majority vote, make reports and recommendations to the Commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any insurer, managed care organization, or health maintenance organization seeking to do business in this State. Such reports and recommendations shall not be considered public documents.

(4) It shall be the duty of the Board of Directors, upon majority vote, to notify the Commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.

(5) The Board of Directors may, upon majority vote, request that the Commissioner order an examination of any member insurer which the Board in good faith believes may be an impaired or insolvent member insurer. Within 30 days of the receipt of such request, the Commissioner shall begin such examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by such persons as the Commissioner designates. The cost of such examination shall be paid by the Association and the examination report shall be treated as are other examination reports. In no event shall such examination report be released to the Board of Directors before its release to the public, but this shall not preclude the Commissioner from complying with paragraph (1) of this section. The Commissioner shall notify the Board of Directors when the examination is completed. The request for an examination shall be kept on file by the Commissioner but it shall not be open to public inspection before the release of the examination report to the public.

(6) The Board of Directors may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of member insurer insolvencies.

(7) The Board of Directors shall, at the conclusion of any member insurer insolvency in which the Association was obligated to pay covered claims, prepare a report to the Commissioner containing such information as it may have in its possession bearing on the history and causes of such insolvency. The Board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes for insolvency of a particular member insurer, and may adopt by reference any report prepared by such other associations.

(63 Del. Laws, c. 442, § 1; 70 Del. Laws, c. 186, § 1; 82 Del. Laws, c. 113, § 7.)

§ 4413. Credits for assessments paid.

(a) A member insurer may offset against its premium tax liability to this State an assessment described in § 4409(h) of this title to the extent of 20 percent of the amount of such assessment for each of the 5 calendar years following the year in which such assessment

was paid. If a member insurer should cease doing business, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

(b) Any sums acquired by refund, under § 4409(f) of this title, from the Association which have theretofore been written off by contributing insurers and offset against premium, franchise, or income taxes as provided in subsection (a) of this section and are not then needed for purposes of this chapter, shall be paid by the Association to the Commissioner and deposited by the Commissioner with the State Treasurer for credit to the General Fund of this State.

(63 Del. Laws, c. 442, § 1; 70 Del. Laws, c. 186, § 1; 82 Del. Laws, c. 113, § 8.)

§ 4414. Liability for unpaid assessments; Association records; Association as creditor; liquidation proceeding.

(a) Nothing in this chapter shall be construed to reduce the liability for unpaid assessments of the insureds on an impaired or insolvent insurer operating under a plan with assessment liability.

(b) Records shall be kept of all meetings of the Board of Directors to discuss the activities of the Association in carrying out its powers and duties under § 4408 of this title. The records of the Association with respect to an impaired or insolvent insurer shall not be disclosed prior to the liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer, except upon the termination of the impairment or insolvency of the insurer or upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the Association to render a report of its activities under § 4415 of this title.

(c) For the purpose of carrying out its obligations under this chapter, the Association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the Association is entitled as subrogee under § 4408(k) of this title. Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. Assets attributable to covered policies or contracts, as used in this subsection, is that proportion of the assets which the reserves that should have been established for such policies or contracts bear to the reserves that should have been established for all policies of insurance or health benefit plans written by the impaired or insolvent insurer.

(d) As a creditor of the impaired or insolvent insurer as established in subsection (c) of this section and consistent with § 5911 of this title, the Association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this chapter. If the liquidator has not, within 120 days of a final determination of insolvency of a member insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the Association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

(e) (1) Before the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the Association, the shareholders, contract owners, certificate holders, enrollees, and policy owners of the insolvent insurer, and any other party with a bond fide interest, in making an equitable distribution of the ownership rights of such insolvent insurer. In such a determination, consideration shall be given to the welfare of the policyholders, policy owners, contract owners, certificate holders, and enrollees of the continuing or successor member insurer.

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the Association for funds expended in carrying out its powers and duties under § 4408 of this title with respect to such member insurer have been fully recovered by the Association.

(f) (1) If an order for liquidation or rehabilitation of a member insurer domiciled in this State has been entered, the receiver appointed under such order shall have a right to recover on behalf of the member insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the member insurer on its capital stock made at any time during the 5 years preceding the petition for liquidation or rehabilitation subject to the limitations of paragraphs (f)(2) through (4) of this section.

(2) No such dividend shall be recoverable if the member insurer shows that, when paid, the distribution was lawful and reasonable and that the member insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the member insurer to fulfill its contractual obligations.

(3) Any person who was an affiliate that controlled the member insurer at the time the distributions were paid shall be liable up to the amount of distributions that person received. Any person who was an affiliate that controlled the member insurer at the time the distributions were declared shall be liable up to the amount of distributions that person would have received if they had been paid immediately. If 2 persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(4) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(5) If any person liable under paragraph (f)(3) of this section is insolvent, all its affiliates that controlled it at the time the dividend was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

(63 Del. Laws, c. 442, § 1; 70 Del. Laws, c. 186, § 1; 73 Del. Laws, c. 327, § 7; 77 Del. Laws, c. 215, § 12; 82 Del. Laws, c. 113, § 9.)

§ 4415. Annual reports by Board.

The Association shall be subject to examination and regulation by the Commissioner. The Board of Directors shall submit to the Commissioner, not later than May 1 of each year, a financial report for the preceding calendar year in a form approved by the Commissioner and a report of its activities during the preceding calendar year.

(63 Del. Laws, c. 442, § 1.)

§ 4416. Tax status of Association.

The Association shall be exempt from payment of all fees and all taxes levied by this State or any of its subdivisions, except taxes levied on real property.

(63 Del. Laws, c. 442, § 1.)

§ 4417. Immunity.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the Association or its agents or employees, members of the Board of Directors or the Commissioner or the Commissioner's representatives, for any action taken by them in the performance of their powers and duties under this chapter. Such immunity shall extend to the participation in any organization of 1 or more other state associations of similar purposes and to any such organization and its agents or employees.

(63 Del. Laws, c. 442, § 1; 68 Del. Laws, c. 55, § 6; 70 Del. Laws, c. 186, § 1.)

§ 4418. Stay of proceedings; reopening default judgments.

All proceedings in which the insolvent insurer is a party in any court in this State shall be stayed 180 days from the date an order of liquidation, rehabilitation or conservation is final to permit proper legal action by the Association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict or finding based on default the Association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits.

(63 Del. Laws, c. 442, § 1; 77 Del. Laws, c. 215, § 13.)

§ 4419. Advertising.

No person, including a member insurer, agent or affiliate of a member insurer shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement which uses the existence of the Insurance Guaranty Association of this State for the purpose of sales, solicitation, or inducement to purchase any form of insurance or other coverage covered by this chapter. Provided, however, that this section shall not apply to the Delaware Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance or coverage by a managed care organization or health maintenance organization.

(63 Del. Laws, c. 442, § 1; 82 Del. Laws, c. 113, § 10.)

§ 4420. Access to assets of insurer in liquidation; application for court approval of plan to disburse assets.

Repealed by 68 Del. Laws, c. 55, § 7, effective June 25, 1991.

Part I
Insurance
Chapter 45
Certificates of Insurance Act

§ 4501. Title.

This chapter may be cited as the “Certificates of Insurance Act.”

(79 Del. Laws, c. 217, § 1.)

§ 4502. Definitions.

For the purpose of this chapter, the following definitions apply:

(1) “Certificate of insurance” means a document or instrument, regardless of how titled or described, that is prepared or issued by an insurer or insurance producer as evidence of property or casualty insurance coverage. The term does not include a policy of insurance, insurance binder, policy endorsement, or automobile insurance identification or information card.

(2) “Commissioner” means the Insurance Commissioner of this State.

(3) “Insurance producer” means a person required to be licensed under the laws of this State to sell, solicit, or negotiate property or casualty insurance.

(4) “Insurer” means any organization that issues property or casualty insurance.

(5) “Person” means any individual, partnership, corporation, association, or other legal entity, including any government or governmental subdivision or agency.

(79 Del. Laws, c. 217, § 1.)

§ 4503. Certificate forms.

(a) The Commissioner shall prohibit the use of a certificate of insurance form if the form:

(1) Is unfair, misleading, or deceptive, or violates public policy; or

(2) Violates any law, including any regulation promulgated by the Commissioner of Insurance.

(b) A certificate of insurance is not a policy of insurance and does not affirmatively or negatively amend, extend, or alter the coverage afforded by the policy to which the certificate of insurance makes reference. A certificate of insurance shall not confer to any person new or additional rights beyond what the referenced policy of insurance expressly provides.

(79 Del. Laws, c. 217, § 1.)

§ 4504. Limitations on use.

(a) A person shall not:

(1) Prepare, issue, or request or require the issuance of a certificate of insurance that contains any false or misleading information concerning the policy of insurance to which the certificate of insurance makes reference; or

(2) Prepare, issue, request, or require the issuance of a certificate of insurance that purports to affirmatively or negatively alter, amend, or extend the coverage provided by the policy of insurance to which the certificate of insurance makes reference.

(b) A certificate of insurance shall not warrant that the policy of insurance referenced in the certificate comply with the insurance or indemnification requirements of a contract, and the inclusion of a contract number or description within a certificate of insurance shall not be interpreted as doing such.

(79 Del. Laws, c. 217, § 1.)

§ 4505. Notice requirements.

A person is entitled to notice of cancellation, nonrenewal, or any material change, and to any similar notice concerning a policy of insurance only if the person has such notice rights under the terms of the policy of insurance or any endorsement to the policy. The terms and conditions of the notice are governed by the policy of insurance or endorsement and may not be altered by a certificate of insurance.

(79 Del. Laws, c. 217, § 1.)

§ 4506. Applicability.

(a) The provisions of this chapter shall apply to all certificates of insurance issued in connection with property, operations, or risks located in this State, regardless of where the policyholder, insurer, insurance producer, or person requesting or requiring the issuance of a certificate of insurance is located.

(b) A certificate of insurance or any other document or correspondence prepared, issued, requested, or required in violation of this chapter shall be null and void.

(79 Del. Laws, c. 217, § 1.)

§ 4507. Enforcement and penalties.

(a) The Commissioner shall have the power to examine and investigate the activities of any person that the Commissioner reasonably believes has been or is engaged in an act or practice prohibited by this chapter.

(b) The Commissioner shall have the power to enforce the provisions of this chapter, including the authority to issue orders to cease and desist and to impose a fine of up to $1,000 per violation against any person who violates this chapter. This subsection shall not be construed to limit the Commissioner's authority to investigate, enforce and issue penalties pursuant to any other applicable provision in this title including, without limitation, Chapters 17, 23 and 24 of this title.

(c) The Commissioner may adopt reasonable rules and regulations as are necessary or proper to carry out the provisions of this chapter.

(79 Del. Laws, c. 217, § 1.)

Part I
Insurance
Chapter 46
Life-Care Registration Act

§ 4601. Definitions.

The following words and phrases when used in this chapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

(1) *"Continuing care."* —

The furnishing to an individual, other than an individual related by consanguinity or affinity to the person furnishing such care, of housekeeping services, board and lodging or lodging services, together with furnishing or promising to furnish nursing services, medical services or other health-related services, regardless of whether or not the lodging and services are provided at the same location and pursuant to an agreement effective for the life of the individual or for a period in excess of 1 year, including mutually terminable contracts and in consideration of the payment of an entrance fee with or without other periodic charges. The payment of, or agreement to pay, condominium or cooperative assessments for common expenses of the condominium or cooperative with respect to a condominium or cooperative housing unit which is part of or associated with a continuing care facility shall be considered as the furnishing of lodging services.

(2) *"Deposit."* —

A portion of the entrance fee or any other charges of the provider, except the application fee, received by the provider to reserve a living unit, or reserve a priority position on the facility's waiting list.

(3) *"Entrance fee."* —

An initial or deferred transfer to a provider of a sum of money or other property made or promised to be made as full or partial consideration for acceptance of a specified individual as a resident in a facility. A fee which is less than the sum of the regular periodic charges for 1 year of residency will not be considered to be an entrance fee for the purposes of this chapter. If a resident is required to own a condominium or cooperative unit in order to obtain continuing care at a continuing care facility, the price paid for such unit shall be considered as an entry fee and the purchased unit shall be considered as a living unit for the purposes of this chapter.

(4) *"Facility."* —

The place or places in which a person undertakes to provide continuing care to an individual.

(5) *"Living unit."* —

A room, apartment, cottage, house, condominium, cooperative or other area within a facility set aside for the exclusive use or control of 1 or more identified individuals.

(6) *"Manager."* —

An entity operating a facility on behalf of the provider. This does not include personal financial statements of any employee of the manager.

(7) *"Omission of a material fact."* —

The failure to state a material fact required to be stated in any disclosure statement or registration in order to make the statements made therein not misleading in light of the circumstances under which they were made.

(8) *"Provider."* —

A person undertaking to provide continuing care in a facility.

(9) *"Resident."* —

An individual entitled to receive continuing care in a facility.

(10) *"Secretary."* —

The Secretary of State of Delaware.

(11) *"Solicit."* —

All actions of a provider or manager in seeking to have individuals residing in this State pay an application fee and enter into a continuing care agreement by any means such as, but not limited to, personal, telephone or mail communication or any other communication directed to and received by any individual in this State and any advertisements in any media distributed or communicated by any means to individuals in this State.

(67 Del. Laws, c. 357, § 1.)

§ 4602. Registration.

No provider shall engage in the business of providing continuing care in this State until it shall have:

(1) Filed a registration statement on a form to be prescribed by the Secretary;

(2) Filed with the Secretary the disclosure statement provided for in § 4603 of this title; and

(3) Paid a registration fee of $50 to the Secretary;

provided, however, a nonprofit continuing care facility as defined in this chapter whose facilities will not accommodate more than 100 residents shall be exempt from the provisions of this chapter, providing the facility annually submits to the Secretary of State a certified audit evidencing qualifications for this exemption.

(67 Del. Laws, c. 357, § 1.)

§ 4603. Disclosure statement.

(a) Prior to the execution of a contract to provide continuing care or prior to the transfer of any money or other property (other than an application fee not to exceed $1,500) to a provider by or on behalf of a prospective resident, whichever shall first occur, the provider shall advise in writing the person with whom the contract is to be entered into that a copy of the current disclosure statement verified by the provider's chief financial officer is available for examination by the said person and that the person may also have a copy of the current disclosure statement if requested. If said person requests a copy, it shall be provided to the person at least 2 days prior to the execution of the contract or the transfer of money to a provider whichever shall first occur. In the disclosure statement for each facility, a multiple facility provider does not have to disclose information about its other facilities unless the operation of the facilities is financially connected. The disclosure statement shall contain all of the following information unless such information is in the contract, a copy of which must be attached to the statement:

(1) The name and business address of the provider and a statement of whether the provider is a partnership, corporation or other type of legal entity.

(2) The names and business addresses of the officers, directors, trustees, managing or general partners, and any person having a 10% or greater equity or beneficial interest in or of the provider and a description of such person's interest in or occupation with the provider.

(3) With respect to:

a. The provider;

b. Any person named in response to paragraph (a)(2) of this section; and

c. The proposed manager, if the facility will be managed on a day-to-day basis by a person other than an individual directly employed by the provider:

1. A description of the business experience of such person, if any, in the operation or management of similar facilities.

2. The name and address of any professional service, firm, association, trust, partnership or corporation in which such person has, or which has in such person, a 10% or greater interest and which it is presently intended will or may provide goods, leases or services to the facility of a value of $500 or more, within any year, including:

(A) A description of the goods, leases or services and the probable or anticipated cost thereof to the facility or provider;

(B) The process by which the contract was awarded; and

(C) Any additional offers that were received.

3. A description of any matter in which such a person:

(A) Has been convicted of a felony or pleaded nolo contendere to a felony charge or been held liable or enjoined in a civil action by final judgment if the felony or civil action involved fraud, embezzlement, fraudulent conversion or misappropriation of property; or

(B) Is subject to a currently effective injunctive or restrictive order of a court of record, or within the past 5 years had any state or federal license or permit suspended or revoked as a result of an action brought by a governmental agency or department, arising out of or relating to business activity or health care, including, without limitation, actions affecting a license to operate a foster care facility, nursing home, retirement home, home for the aged or facility registered under this chapter or a similar act in another state.

(4) A statement as to:

a. Whether the provider or manager is or ever has been affiliated with a religious, charitable or other nonprofit organization;

b. The nature of the affiliation, if any;

c. The extent to which the affiliate will be responsible for the financial and contractual obligations of the provider; and

d. The provision of the federal Internal Revenue Code, if any, under which the provider or affiliate is exempt from the payment of income tax.

(5) The location and description of the physical property or properties of the facility, existing or proposed, and, to the extent proposed, the estimated completion date or dates, whether or not construction has begun and the contingencies subject to which construction may be deferred.

(6) Each of the services provided or proposed to be provided under contracts for continuing care at the facility, including the extent to which medical and/or nursing care is furnished. The disclosure statement shall clearly state which services are included in the basic contracts for continuing care and which services are made available at or by the facility at extra charge.

(7) A description of all fees required of residents, including the entrance fee and periodic charges, if any. The description shall include the manner by which the provider may adjust periodic charges or other recurring fees and the limitations on such adjustments, if any. If the facility is already in operation or if the provider or manager operates 1 or more facilities within this State, there shall be included tables showing the frequency and average dollar amount of each increase in periodic rates at each such facility for the previous 5 years or such shorter period as the facility may have been operated by the provider or manager.

(8) The provisions that have been made or will be made, if any, to provide reserve funding or security to enable the provider to fully perform its obligations under contracts to provide continuing care at the facility, including the establishment of escrow accounts, trusts or reserve funds, together with the manner in which such funds will be invested and the names and experience of persons who will make the investment decisions.

(9) Financial statements of the provider and manager for each facility in Delaware certified as complete and accurate by the Treasurer or other officer of the provider and manager, and prepared in accordance with generally accepted accounting principles, including:

a. A balance sheet as of the end of the 2 most recent fiscal years. The balance sheet shall include the amount and purpose of all reserve accounts, how the reserves are invested and the interest or other income earned thereon.

b. Income and expense statements for each facility in Delaware for the 2 most recent fiscal years or such shorter period of time the facility shall have been in existence. The income and expense statement shall show the total receipts from and expenditures for each service (residential, dining, health care, etc.) provided to residents.

c. The plans of the provider of an existing facility for the year following the date of the disclosure statement projecting the items in paragraphs (a)(6) through (9) of this section inclusive, or any other anticipated financial items.

d. Annual reports or financial statements as set forth in paragraph (a)(9)a. or b. of this section of all persons or entities having more than a 10 percent interest in the provider or manager. This paragraph shall apply only to initial application for new or existing facilities.

(10) If operation of the facility has not yet commenced, a statement of the anticipated source and application of the funds used or to be used in the purchase or construction of the facility for the 3 years after the date of opening, including:

a. An estimate of the cost of purchasing or constructing and equipping the facility including such related costs as financing expense, legal expense, land costs, occupancy development costs and all other similar costs which the provider expects to incur or become obligated for prior to the commencement of operations.

b. A description of any mortgage loan or other long-term financing intended to be used for the financing of the facility, including the anticipated terms and costs of such financing.

c. An estimate of the total entrance fees to be received from or on behalf of residents at or prior to commencement of operation of the facility.

d. An estimate of the funds, if any, which are anticipated to be necessary to fund start-up losses and provide reserve funds to assure full performance of the obligations of the provider under contracts for the provision of continuing care.

e. A projection of estimated income from fees and charges other than entrance fees, showing individual rates presently anticipated to be charged and including a description of the assumptions used for calculating the estimated occupancy rate of the facility and the effect on the income of the facility of government subsidies for health-care services, if any, to be provided pursuant to the contracts for continuing care.

f. A projection of estimated operating expenses of the facility, including a description of the assumptions used in calculating the expenses and separate allowances, if any, for the replacement of equipment and furnishings and anticipated major structural repairs or additions.

g. Identification of any assets pledged as collateral for any purpose.

h. An estimate of annual payments of principal and interest required by any mortgage loan or other long-term financing.

(11) The cover page of the disclosure statement shall state, in a prominent location and type face, the date of the disclosure statement and that registration with the Secretary does not constitute approval, recommendation or endorsement of the facility by the Secretary, nor is it evidence of, nor does it attest to, the accuracy or completeness of the information set out in the disclosure statement.

(12) A copy of the standard form or forms of contract for continuing care used by the provider shall be attached as an exhibit to each disclosure statement. If not part of the contract, any contract changes since the last filing of a disclosure statement, any rules and regulations regarding the administration of the facility, conduct of the residents, or rights of the residents shall also be filed.

(13) Any initial or annual disclosure statement shall be made available to any member of the public upon request upon payment of reasonable copying charges.

(b) The provider shall file with the Secretary, annually within 4 months following the end of the provider's fiscal year, an annual verified disclosure statement which shall contain the information required by this chapter for the initial disclosure statement. The annual disclosure statement shall also be accompanied by a narrative describing any material differences between:

(1) The pro forma income statements filed pursuant to this chapter either as part of the application for registration or as part of the most recent annual disclosure statement; and

(2) The actual results of operations during the fiscal year.

(c) Each provider shall have 5 copies of the current disclosure statement readily available during normal business hours for examination by all residents at a convenient location in each continuing care facility operated by or for the provider in Delaware. The residents shall be given a reasonable opportunity to examine the disclosure statement and copies of all or any part thereof shall be made by the facility for the resident when requested. Except for the copy of the disclosure statements referred to in subsection (a) of this section, the reasonable copying cost may be charged for such copies.

(d) In addition to filing the annual disclosure statement, the provider may amend its currently filed disclosure statement at any other time if, in the opinion of the provider, an amendment is necessary to prevent the disclosure statement and annual disclosure statement from containing any material misstatement of fact or omission to state a material fact required to be stated therein. Any such amendment or amended disclosure statement must be filed with the Secretary before it is delivered to any resident or prospective resident and is subject to all the requirements, including those as to content and delivery, of this chapter.

(67 Del. Laws, c. 357, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4604. False information.

(a) No provider shall make, publish, disseminate, circulate or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television statement, or in any other way, an advertisement, announcement or statement of any sort containing any assertion, representation or statement which is untrue, deceptive or misleading.

(b) No provider shall file with the Secretary or make, publish, disseminate, circulate or deliver to any person or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or delivered to any person or placed before the public, any financial statement which does not accurately state its true financial condition.

(67 Del. Laws, c. 357, § 1.)

§ 4605. Civil liability.

(a) Any person who, as a provider or manager, or on behalf of the provider or manager has not filed the registration statement and disclosure statement with the Secretary and paid the fee required by § 4602 of this title:

(1) Enters into a contract for continuing care at a facility;

(2) Enters into a contract for continuing care at a facility without having first delivered a disclosure statement meeting the requirements of this chapter to the person contracting for such continuing care; or

(3) Enters into a contract for continuing care at a facility with a person who has relied on a disclosure statement which omits a material fact required to be stated therein or necessary in order to make the statements made therein, in light of the circumstances under which they are made, not misleading;

shall be liable to the person contracting for such continuing care for damages and repayment of all fees including entrance fees paid to the provider, facility or person violating this chapter, together with interest thereon at the legal rate for judgments, court costs and reasonable attorney fees less the reasonable value of care and lodging provided to the resident not previously paid for by the resident by or on whose behalf the contract for continuing care was entered into prior to discovery of the violation, misstatement or omission or the time the violation, misstatement or omission should reasonably have been discovered.

(b) Any provider who fails after a written request therefor to deliver a copy of the disclosure statement to any person who is party to a resident agreement with the provider, shall be liable to such resident for all costs, including counsel fees, incurred by such resident in requiring the provider to provide the resident with a copy of its disclosure statement.

(c) Liability under this section shall exist regardless of whether or not the provider or person liable had actual knowledge of the misstatement or omission.

(d) A person may not file or maintain an action under this section unless and until the person makes written demand on the provider for the refund provided under this subsection, the demand describes the act or omission complained of, and the demand is refused by the provider or not answered by the provider in writing within 10 days of the date the provider received the demand.

(e) An action shall not be maintained to enforce a liability created under this chapter unless brought before the expiration of 6 years after the execution of the contract for continuing care which gave rise to the violation.

(f) A nonprofit continuing care facility within the definition of continuing care in this chapter, which maintains a resident population of which $^{1}/_{3}$ or more residents are unable to pay the full costs of care each month; and which guarantees lifetime care regardless of ability to pay in its resident's agreement prior to accepting a resident, and whose resident's agreement specifically states the reason a person may be transferred or removed to another facility or expelled for cause, and which facility is subject to other state and federal regulations affecting the nature and character of services provided, shall be exempted from the provisions of this chapter, providing the facility annually submits to the Secretary of State a certified audit evidencing qualifications for this exemption.

(67 Del. Laws, c. 357, § 1; 70 Del. Laws, c. 186, § 1.)

Part I
Insurance
Chapter 47
Financing of Insurers

§ 4701. Scope of chapter.

This chapter applies as to domestic and foreign insurers of all types, and as to persons providing finances to such insurers.

(18 Del. C. 1953, § 4701; 56 Del. Laws, c. 380, § 1.)

§ 4702. Solicitation permit required; penalty.

(a) No person forming or proposing to form an insurer, or insurance holding corporation or corporation to be attorney-in-fact for a reciprocal insurer or proposing to secure funds for the formation or financing of an insurer, or production of insurance business therefor, or an insurance holding corporation or attorney-in-fact corporation of a reciprocal insurer or for the formation of a syndicate, association, firm, partnership or organization for any such purposes, whether domestic or foreign, shall in this State advertise or offer for sale any securities or solicit or receive any funds, subscriptions, applications or membership except as authorized by a currently effective permit (hereinafter sometimes referred to as a "solicitation permit") issued by the Commissioner.

(b) Any person violating this section shall upon conviction thereof be subject to a fine of not more than $10,000 or imprisonment for not more than 10 years, or both.

(18 Del. C. 1953, § 4702; 56 Del. Laws, c. 380, § 1.)

§ 4703. Insurance holding corporation defined.

Within the intent of this chapter an insurance holding corporation is one owning or proposing to own a controlling stock interest in a stock insurer. Shares owned directly or indirectly by the corporation or by its subsidiary or affiliate corporation, firm or organization or by its officers, directors or principal stockholders shall be deemed to be owned by the corporation for the purposes of this provision.

(18 Del. C. 1953, § 4703; 56 Del. Laws, c. 380, § 1.)

§ 4704. Exemptions.

Section 4702 of this title shall not apply to:

(1) Sales of securities not involving a public offering, that is, sales on which no commission is payable resulting from offers privately made to not over 20 persons (other than banks, savings associations, investment companies registered as such under the Investment Companies Act of 1940 [15 U.S.C. § 80a-1 et seq.], registered securities dealers, investment houses and other financial institutions) within a 12-month period and where all persons (including such banks, associations, companies, dealers, houses and institutions) so acquiring such securities do so for investment purposes only and not with a view to further distribution.

(2) Sales of securities by an insurance holding corporation for purposes which do not include that of financing, directly or indirectly, an insurer.

(3) Stock of the insurer or insurance holding corporation to be offered and sold without payment of commission thereon exclusively to directors, employees and agents of the insurer or corporation or any of them under stock options granted pursuant to a written lawful plan therefor adopted by the board of directors and approved by a majority of the stock of the issuer corporation having voting rights, and which plan has been filed with the Commissioner.

(4) Securities issued or proposed to be issued pursuant to any merger, consolidation, bulk reinsurance, conversion, mutualization or corporate affiliation approved by the Commissioner pursuant to Chapter 49 of this title.

(5) Securities issued in exchange for outstanding securities of the issuer or partly in exchange for such outstanding securities and partly for cash in connection with a recapitalization of the issuer or the exercise of conversion or exchange rights under such outstanding securities.

(6) Fractional share interests in stock of the issuer offered and sold for the purpose of rounding out to whole shares in connection with any stock dividend or other distribution of shares to existing security holders of the issuer.

(7) Sales of securities of a corporation established under Chapter 7 or regulated under Chapter 9 of Title 5 which maintains an insurance department or division.

(18 Del. C. 1953, § 4704; 56 Del. Laws, c. 380, § 1; 67 Del. Laws, c. 223, § 30; 70 Del. Laws, c. 186, § 1.)

§ 4705. Application for permit.

(a) Written application for any permit required under § 4702 of this title shall be filed with the Commissioner. The application shall show or be accompanied by:

(1) The name, type and purpose of the insurer, corporation, syndicate, association, firm or organization formed or proposed to be formed or financed;

(2) The name, residential address, business background and qualifications of each person associated or to be associated in the enterprise or in the formation of the proposed insurer, corporation, syndicate, association, firm or organization or in the proposed financing;

(3) Full disclosure of the terms of all pertinent understandings and agreements existing or proposed among persons so associated or to be associated, and a copy of each such agreement relating to the proposed financing or insurer, corporation, syndicate, association, firm or organization or the formation thereof;

(4) The plan according to which solicitations are to be made;

(5) A copy of any security, receipt or certificate proposed to be issued and a copy of any proposed application or subscription agreement;

(6) A copy of any prospectus, offering circular, advertising or sales literature or material proposed to be used;

(7) A copy of the proposed form of any escrow agreement required;

(8) Irrevocable appointment of the Commissioner as process agent to receive service of process issued in this State and arising out of any transaction under the permit, if issued. The Commissioner shall prescribe and furnish the form of such appointment;

(9) A copy of the certificate of incorporation or charter of the insurer or proposed insurer or of any other corporation proposing to offer its securities, certified by the public official having custody of the original thereof, and a copy of any syndicate, association, firm, organization or other similar agreement by whatever name called if funds for any of the purposes referred to in § 4702 of this title are to be secured through the sale of any security, interest or right in or relative to such syndicate, association, firm or organization, and, if the insurer is or is to be a reciprocal insurer, a copy of the power of attorney and of other agreements existing or proposed affecting subscribers, investors, the attorney-in-fact or the insurer; and

(10) Such additional pertinent information as the Commissioner may reasonably require.

(b) The application shall be accompanied by deposit of the fees required under § 701 (fee schedule) of this title for the filing of the application and for issuance of the permit, if granted.

(c) In lieu of a special filing thereof of information called for in subsection (a) of this section, the Commissioner may, in his or her discretion, accept a copy of any pertinent filing made with the Securities and Exchange Commission relative to the same offering.

(18 Del. C. 1953, § 4705; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4706. Application for permit required by § 4702 of this title.

Written application for any permit required under § 4702 of this title, in connection with the formation of a domestic mutual insurer by the securing of qualifying applications for insurance as provided in § 4905 of this title, shall be filed with the Commissioner. The application shall contain such information and be accompanied by such of the documents and the fees as required under § 4705 of this title as may be applicable and shall be accompanied by:

(1) A copy of the policy for which applications are proposed to be solicited;

(2) A copy of the proposed insurance application form, consistent with the requirements of § 4907 (qualifying application for insurance) of this title;

(3) A schedule of the premiums or premium rates proposed to be charged in connection with such insurance applications; and

(4) A copy of the bylaws of the proposed insurer.

(18 Del. C. 1953, § 4706; 56 Del. Laws, c. 380, § 1.)

§ 4707. Investigation.

(a) Upon completion of the application for a permit under §§ 4705 and 4706 of this title, the Commissioner shall promptly cause an investigation to be made of:

(1) The identity, character, reputation, financial standing and motives of the persons proposing to organize or promote and manage the proposed insurer or organization;

(2) The character, financial responsibility, insurance management experience and business qualifications of the officers, directors and managers of the insurer or proposed insurer or organization; and

(3) Such other aspects of the proposed insurer or financing as the Commissioner deems advisable.

(b) The Commissioner may waive such an investigation of an insurer already duly authorized to transact insurance in this State.

(18 Del. C. 1953, § 4707; 56 Del. Laws, c. 380, § 1.)

§ 4708. Grant, denial of permit.

(a) The Commissioner shall expeditiously examine an application for a solicitation permit as soon as it is completed and complete the investigation as called for. Subject to subsection (b) of this section below, if the Commissioner finds on such examination and investigation that:

(1) The application is complete; and

(2) The documents therewith filed are proper in form; and

(3) That the proposed finances are reasonable and adequate in amount for the purposes intended, the Commissioner shall give notice to the applicant that he or she will issue the permit upon the filing of any bond required by § 4713 of this title or deposit required by § 4906 of this title and the filing of an executed copy of any escrow agreement required in connection therewith.

(b) If the Commissioner does not so find or finds that:

(1) The proposed sale of securities would be or tend to be unfair or inequitable as to present or proposed security holders or investors; or

(2) Any of the individuals associated or to be associated in the insurer, corporation, syndicate, association, firm, organization or financing are not of good reputation as to business affairs; or

(3) The insurer or proposed insurer would not be able to qualify for a certificate of authority in this State by virtue of the provisions of § 508(b) of this title,

the Commissioner shall give notice to the applicant that a permit will not be granted, stating the particulars of the grounds therefor, and refund to the applicant all sums deposited in connection with the application except the fee for filing the application for a permit.

(18 Del. C. 1953, § 4708; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4709. Terms of permit; compliance.

(a) Upon filing any bond required by § 4713 or deposit required by § 4906 of this title or upon decision to grant the permit if such a bond is not so required and upon filing an executed copy of any required escrow agreement, the Commissioner shall issue a permit to the applicant.

(b) Every such permit shall contain provisions, as applicable, as follows:

(1) It shall state the securities which are to be offered, the number, par value, if any, and selling price, or identify the insurance contract or contracts for which applications and advance premiums are to be solicited in the case of formation of a new domestic mutual insurer;

(2) It shall require that all purchases and premiums shall be payable only in lawful money of the United States of America, except where stock or other securities are to be issued in exchange for securities or rights thereto under a plan of recapitalization or refinancing of an insurer or other corporation approved by the Commissioner;

(3) It shall require that any securities proposed to be offered or sold under the permit shall be so offered and sold at the same price to all parties, subject, at the option of the issuer in the case of subscriptions to be paid in installments, to a reasonable additional charge to cover expenses and loss of interest earnings attributable to such installment subscriptions;

(4) It shall limit the portion of funds received on account of sale of securities under the permit which may be used for organization, securities sales and promotion expenses to such amount as the Commissioner deems reasonably adequate under the proposed plan of solicitation but in no event to exceed 15% of such funds as and when the funds are actually received;

(5) If the Commissioner believes the same to be desirable for the protection of the public or for any other reasonable purpose the permit may:

a. Require the founders, promoters, incorporators or other persons directly involved in the proposed offering to subscribe and pay for, immediately and in cash, a reasonable proportion of the same securities as proposed to be offered in this State, at a price not less than that at which any such securities are to be offered to other subscribers or purchasers;

b. Prohibit, limit or control the granting of options to such founders, promoters, incorporators or other persons to buy the securities;

c. Prohibit, by any founder, promoter, incorporator or other person associated or to be associated in solicitations under the permit, the resale or transfer for a period terminating 1 year after expiration, or other termination of the permit, of such person's interest in any security, right or interest of the kind proposed to be offered under the permit or any other security, interest or right which such person may have in or as to the same issuing entity or the granting of any option or lien as to any such security, right or interest. The Commissioner may, require that any security, right or interest of which the resale or transfer is herein prohibited, shall be deposited and held in escrow for the prescribed period. This provision shall not prohibit the sale or transfer of any such security, right or interest by the estate or personal representative of a deceased founder, promoter or incorporator or deceased person associated in solicitations under the permit;

d. Contain other reasonable provisions for the protection of existing or proposed investors in this State;

(6) If the permit is issued in connection with the solicitation of qualifying applications for a proposed domestic mutual insurer, it shall limit the portion of funds received therefor which may be used for organization and sales expense to a reasonable commission related to the kind of insurance policy involved and costs incurred by mutual insurers in Delaware in the production of similar business and provide that no such commissions shall be paid or be deemed earned until the insurer has received its certificate of authority and the policies so applied for have been actually issued, delivered to and accepted by the respective insureds;

(7) The permit shall expire after a period stated therein, which period shall be not more than 2 years after its date of issue, unless earlier terminated by the Commissioner, but subject to an extension of time for such additional reasonable period, not to exceed 1 year, as the Commissioner may grant for good cause shown;

(8) The permit shall contain such other reasonable conditions relative to accounting, reports, deposits or other matters consistent with this chapter as the Commissioner deems advisable for the reasonable protection of existing or prospective investors.

(c) The holder of the permit and its directors, officers, employees, agents, founders, promoters, incorporators and representatives shall comply with the terms of the permit.

(18 Del. C. 1953, § 4709; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4710. Permit as inducement.

The granting of a solicitation permit is permissive only and shall not constitute an endorsement by the Commissioner of any person or thing related to any such insurer, corporation, syndicate, association, firm, organization or financing nor constitute evidence of the completeness or accuracy of information presented in any prospectus or other sales literature, and the existence of the permit shall not be advertised or used as an inducement in any solicitation. The Commissioner shall place the substance of this section in conspicuous type at the top of each such permit issued.

(18 Del. C. 1953, § 4710; 56 Del. Laws, c. 380, § 1.)

§ 4711. Prospectus required; other literature.

(a) An offering of securities under a solicitation permit shall be made only by a written prospectus delivered to the prospective investor.

(b) The prospectus shall make a disclosure of all facts relative to the issuer and the offered security which are reasonably material to the offered investment and shall not omit a material fact necessary to make the statements clear, in the light of the circumstances under which they are made. The Commissioner may make reasonable rules and regulations concerning the form and contents of prospectuses not inconsistent with the provisions of this chapter.

(c) The Commissioner may accept, as a compliance with this section, a prospectus or offering circular covering securities to be offered in this State under an existing registration thereof with the Securities and Exchange Commission or under an existing exemption from such registration pursuant to "Regulation A" of the general rules and regulations of the Securities and Exchange Commission under the Securities Act of 1933, as amended [15 U.S.C. § 77a et seq.].

(d) As to securities covered by a solicitation permit, no sales literature or other visual sales material, other than the prospectus or offering circular, shall be used in solicitations unless a copy of the same has been filed with the Commissioner in advance of such use and not disapproved by the Commissioner in writing, mailed or delivered to the filing party within 10 days after the date of such filing. The Commissioner shall disapprove any such literature or material found to be untrue or misleading. This provision shall not be deemed to modify or affect any applicable requirement or prohibition under or pursuant to the Securities Act of 1933 [15 U.S.C. § 77a et seq.], as amended.

(18 Del. C. 1953, § 4711; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4712. Modification or revocation of permit.

The Commissioner may, for cause, modify a solicitation permit theretofore issued, or may, after a hearing thereon, revoke the permit for violation of law or of the terms of the permit or any proper order of the Commissioner or for material misrepresentation in the offering or sale of securities or policies under the permit.

(18 Del. C. 1953, § 4712; 56 Del. Laws, c. 380, § 1.)

§ 4713. Bond for permit.

(a) The Commissioner shall not issue a solicitation permit until the applicant therefor has filed with the Commissioner a corporate surety bond in the penalty of $10,000, aggregate amount, in favor of the State and for the use and benefit of the State and of proposed Delaware investors in and creditors of the permittee.

(b) The bond shall be conditioned upon the payment of costs incurred by the State in event of any proceeding for liquidation or dissolution of the proposed organization before completion of organization or if a certificate of authority to be an insurer is not granted; and upon a full accounting for funds received until the proposed insurer has been granted its certificate of authority or until the corporation, syndicate, association, firm or organization or financing has been completed within the terms of the permit.

(c) In lieu of filing such bond the applicant may deposit with the State Treasurer, through the Commissioner, $10,000 in cash or a certificate of deposit issued by a bank located in Delaware or an equivalent amount in United States government bonds at market value to be held in trust under the same conditions as required of the bond. The amount so deposited may be credited toward payment of subscription to securities by founders, promoters and incorporators if required under § 4709(b)(5)a. of this title.

(d) The Commissioner may waive the requirement for a bond or deposit in lieu thereof if the securities are to be issued in connection with subsequent financing as provided in § 4717 of this title.

(e) The Commissioner shall release and discharge any such bond or deposit or remaining portion thereof held under this section upon written request of the person entitled thereto and upon proof to the Commissioner's satisfaction that all liabilities and obligations with respect to which the bond or deposit was filed or made have been fully settled or terminated or otherwise adequately provided for.

(f) This section does not apply as to solicitation of initial qualifying applications for insurance in a domestic mutual insurer pursuant to § 4906 of this title, except as provided in such § 4906.

(18 Del. C. 1953, § 4713; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4714. Escrow of funds.

(a) The holder of the solicitation permit shall promptly deposit all funds received from an offering of securities in this State pursuant to the permit, other than advance premiums for insurance which are subject to § 4907 of this title, in escrow in a bank or trust company located in this State and under an agreement consistent with this chapter approved by the Commissioner.

(b) No part of such funds shall be withdrawn from such deposit except:

(1) For payment of organization, sales and promotion expenses as earned and as authorized by the permit, and funds for such purposes may be withheld from the deposit; or

(2) For the purpose of making any deposit with the Commissioner required for issuance of a certificate of authority to an insurer or, if the organization is not or is not to be, an insurer, upon completion of payments on securities subscriptions made under the permit and deposit or appropriation of such funds to the purposes specified in the permit; or

(3) For the making of refunds as provided in § 4716 of this title.

(c) Funds while so held in escrow may be invested in certificates of deposit or savings accounts. Interest accruing thereon shall become part of the funds released as provided in paragraph (b)(2) of this section above, or shall be applied toward the costs of making refunds under paragraph (b)(3) of this section above, or to supplement the bond or deposit in lieu thereof in the event the same is called on pursuant to § 4713 of this title.

(d) When the Commissioner has issued a certificate of authority to a proposed insurer, any such funds remaining in escrow for its account shall be released to the insurer.

(e) The Commissioner may waive compliance with this section as to funds to be received under a subsequent financing permit under § 4717 of this title or in other circumstances where the Commissioner deems such an escrow to be reasonably unnecessary for the protection of investors or of the public.

(18 Del. C. 1953, § 4714; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4715. Subscriptions.

All subscriptions to securities under a solicitation permit shall be binding upon and enforceable against the parties thereto in accordance with the terms of the subscription contract and subject to the provisions of this chapter. No such contract shall be made conditional except upon such reasonable conditions consistent with applicable statutes as may uniformly be set forth in all such contracts with the Commissioner's approval as not being inappropriate or inequitable.

(18 Del. C. 1953, § 4715; 56 Del. Laws, c. 380, § 1.)

§ 4716. Failure to complete or qualify.

(a) The Commissioner shall withdraw all funds held in escrow under § 4714 of this title and refund to securities subscribers or purchasers all sums paid therein under the solicitation permit, less that part allowed and used for organization, sales and promotion expenses, if:

(1) The permit holder has failed to complete its organization or financing within the terms of the permit or if it has failed to secure its certificate of authority to be an insurer, all before expiration of the permit; or

(2) The permit is revoked.

(b) As to funds paid in on subscriptions by founders, promoters and incorporators and held on deposit in lieu of bond under § 4713(c) of this title, only such portion of such funds shall be refundable under this section as may remain after discharge of all liabilities against the deposit under § 4713 of this title and after the charging of such funds with a proportionate share of organization, sales and promotion expenses.

(18 Del. C. 1953, § 4716; 56 Del. Laws, c. 380, § 1.)

§ 4717. Subsequent financing; penalty.

(a) No person referred to in § 4702 (solicitation permit required; penalty) of this title, after receiving a certificate of authority, if an insurer in this or any other State or after completing its original organization and financing, if other than an insurer, shall in this State solicit or receive funds in exchange for its securities until it has applied to the Commissioner for and has been granted a solicitation permit. This provision is subject to the same exemptions as are provided by § 4704 of this title.

(b) The Commissioner shall expeditiously issue such a permit unless the Commissioner finds:

(1) That the funds proposed to be secured are inadequate or excessive in amount for the purposes intended; or

(2) That the proposed securities or the manner of their distribution would be unfair or inequitable to existing or proposed security holders or policyholders of the issuer.

(c) Any such permit granted by the Commissioner shall be for such duration and shall contain such terms and be issued upon such conditions as the Commissioner may reasonably specify or require for the protection of existing or proposed investors. In the Commissioner's discretion, such terms and conditions may be substantially the same as or materially different from requirements made under this chapter as to solicitation permits for initial financing.

(d) Violation of subsection (a) of this section shall be subject to the same penalties as prescribed by § 4702(b) (solicitation permit required; penalty) of this title.

(18 Del. C. 1953, § 4717; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

Part I
Insurance
Chapter 48
Insurance Premium Financing

§ 4801. Definitions.

As used in this chapter, unless the context otherwise requires:

(1) "Commissioner" means the Insurance Commissioner.

(2) "Insurance premium finance company" means a person engaged in the business of entering into premium finance agreements or otherwise financing the payment of insurance premiums.

(3) "Licensee" means a premium finance company holding a license issued by the Commissioner under this chapter.

(4) "Premium finance agreement" means an agreement by which an insured or prospective insured promises to pay to an insurance premium financing company the amount advanced or to be advanced under the agreement to an insurer or to an insurance agent or broker in payment of premiums on an insurance contract together with a service charge as authorized and limited by this chapter.

(60 Del. Laws, c. 406, § 1.)

§ 4802. License required of insurance premium finance companies.

(a) No person shall engage in the business of financing insurance premiums in this State without first having obtained a license as a premium finance company from the Commissioner, unless such person is exempted from obtaining such a license pursuant to § 4810 of this title. The fee for such a license shall be the sum of $ 500 per year which license shall be valid until the 1st day of January at which time it may be renewed for a full year and every year thereafter provided that the licensee shall have paid the said annual license fee of $ 500 and shall otherwise qualify for a license hereunder. All fees for licenses hereunder shall be paid to the Commissioner. The increase in fees collected in Fiscal Year 2018 pursuant to this section shall be used solely to make appropriations for certain grants-in-aid for the fiscal year ending June 30, 2018.

(b) All licensees or persons applying for licenses shall file sworn answers to such questions as the Commissioner may deem appropriate. The Commissioner shall have authority at any time to require the applicant to fully disclose the identity of all stockholders, partners, officers and employees and the Commissioner may refuse to issue or renew a license in the name of any firm, partnership or corporation so long as the Commissioner remains satisfied that any officer, employee, stockholder or partner thereof who may materially influence the applicant's conduct fails to meet the standards of this chapter.

(60 Del. Laws, c. 406, § 1; 70 Del. Laws, c. 186, § 1; 81 Del. Laws, c. 57, § 3.)

§ 4803. Action by Commissioner on application.

(a) Upon the filing of an application and the payment of the license fee the Commissioner shall make an investigation of each applicant and shall issue a license if the applicant is qualified in accordance with this chapter. If the Commissioner does not so find, he or she shall, within 30 days after receipt of such application, if so requested by the applicant, give the applicant a full hearing on its application.

(b) The Commissioner shall issue or renew a license as may be applied for when the Commissioner is satisfied that the person to be licensed:

(1) Is competent and trustworthy and intends to act in good faith in the capacity required by the license applied for;

(2) Has a good business reputation and has sufficient experience, training or education to be qualified in the business represented by the license applied for;

(3) If a corporation, is a corporation incorporated under the laws of this State or is a foreign corporation authorized to transact business in this State; and

(4) Has the necessary financial resources available to enter in the business for which such person is asking to be licensed or as to which such person is requesting renewal of his or her license.

(60 Del. Laws, c. 406, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4804. Revocation and suspension of licenses.

(a) The Commissioner may revoke or suspend the license of any premium finance company when and if, after investigation, it appears to the Commissioner that:

(1) Any license issued to such company was obtained by fraud;

(2) There was any material misrepresentation in the application for the license;

(3) The holder of such license has otherwise shown himself or herself untrustworthy or incompetent to act as a premium finance company; or

(4) Such company has violated this chapter.

(b) Before the Commissioner shall revoke, suspend or refuse to renew the license of any premium finance company, the Commissioner shall give to such person an opportunity to be fully heard and to introduce evidence in his or her behalf and, in lieu of revoking or suspending his or her license for any of the causes enumerated in this section, after hearing as herein provided, the Commissioner may, for each of the first and second such offenses, subject such company to an administrative penalty of not less than $25 nor more than $500 for each such offense when in the Commissioner's judgment the public interest would not be harmed by the continued operation of such company. The amount of any such administrative penalty shall be paid by such company to the Commissioner within 30 days of the date such a penalty is levied.

(c) If the Commissioner refuses to issue or renew any license or if the applicant or licensee is aggrieved by any action of the Commissioner, such applicant or licensee shall have the same right to a hearing and appeal as provided for other aggrieved parties in this title.

(d) At any hearing provided for by this chapter the Commissioner shall have all such authority as the Commissioner otherwise has under this title to conduct hearings.

(60 Del. Laws, c. 406, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4805. Books and records.

(a) Every licensee shall maintain records of its premium finance transactions and the said records shall be open to examination and investigation by the Commissioner. The Commissioner may at any time require any licensee to bring such records as directed to the Commissioner's office for examination provided that this can be done without causing that licensee undue hardship and further provided that the Commissioner shall give reasonable notice for the bringing of such records to the Commissioner's office for examination.

(b) Every licensee shall preserve its records of such premium finance transactions, including cards used in any card system, for at least 3 years after making the final entry in respect to any premium finance agreement. The preservation of records in photographic form shall constitute compliance with this requirement.

(60 Del. Laws, c. 406, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4806. Form of premium finance agreement.

(a) A premium finance agreement shall:

(1) Be dated, signed by or on behalf of the insured and the printed portion thereof shall be in at least 8-point type;

(2) Contain the name and place of business of the insurance agent negotiating the related insurance contract, the name and residence or the place of business of the insured as specified by the insured, the name and place of business of the premium finance company to which payments are to be made, a description of the insurance contracts involved and the amount of the premium therefor; and

(3) Set forth the following items where applicable:

a. The total amount of the premiums;

b. The amount of the down payment;

c. The principal balance (the difference between paragraphs (a)(3)a. and b.);

d. The amount of the service charge;

e. The balance payable by the insured (sum of paragraphs (a)(3)c. and d.); and

f. The number of installments required, the amount of each installment, expressed in dollars, and the due date or period thereof.

(b) The items set out in paragraph (a)(3) of this section need not be stated in the sequence or order in which they appear in such paragraph, and additional items may be included to explain the computations made in determining the amount to be paid by the insured.

(60 Del. Laws, c. 406, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4807. Maximum service charge.

(a) A premium finance company shall not charge, contract for, receive or collect a service charge other than as permitted by this chapter.

(b) The service charge is to be computed on the balance of the premiums due, after subtracting the down payment made by the insured in accordance with the premium finance agreement, from the effective date of the insurance coverage for which the premiums are being advanced to and including the date when the final installment is payable under the premium finance agreement.

(c) The maximum service charge permissible shall be $9.00 per $100 per year plus an additional nonrefundable initial charge of $10 per premium finance contract and the said maximum service charge shall include any interest charged on such loans within the limitations thereon stated above. Any service charge, including interest, which exceeds the said permissible maximum rate limitation, shall be considered usurious and any person paying such usurious rate shall be entitled to all the remedies permitted under § 2304 of Title 6 for recovery of funds in an usurious loan.

(d) Notwithstanding any provisions to the contrary within any premium finance agreements, any insured may prepay obligations under any such agreement in full at any time. In such event the insured shall receive a refund credit. The amount of such refund credit shall represent at least as great a proportion of the service charge as the sum of the periodic balances after the month in which prepayment is

made bears to the sum of all periodic balances under the schedule of installments in the agreement. Where the amount of the refund credit is less than $1.00, no refund need be made. If in addition to the service charge, an additional, nonrefundable initial charge as permitted in subsection (c) of this section was imposed, such additional charge need not be refunded nor taken into consideration in computing the refund credit.

(e) No premium finance company shall induce an insured to become obligated under more than 1 premium finance agreement for the purpose of obtaining more than 1 additional nonrefundable initial charge.

(60 Del. Laws, c. 406, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4808. Delinquencies and cancellation charges.

A premium finance agreement may provide for the payment by the insured of a delinquency charge per installment of at least $1.00 but which may not exceed a maximum charge of 5% of the delinquent installment or $5.00, whichever is less, for each installment which is in default for a period of 10 days or more. Further, if the default results in the cancellation of any insurance contract listed in the agreement, the agreement may provide for the payment by the insured of a cancellation charge equal to the difference between any delinquency charge imposed in respect to the installment in default as permitted hereinabove and the sum of $5.00.

(60 Del. Laws, c. 406, § 1.)

§ 4809. Cancellation of insurance contract upon default.

(a) When in connection with a premium finance agreement, a power of attorney or other authority to cancel any insurance contract or contracts on behalf of the insured is given to a premium finance company, such insurance contract or contracts may not be cancelled by the premium finance company unless such cancellation is effectuated in accordance with this section; provided, however, that cancellation of automobile casualty insurance contracts pursuant to this section may be made only in a manner which is consistent with Chapter 39 of this title and the method of such cancellation shall be consistent with the time periods and be subject to the rights of reinstatement provided in that chapter for cancellation on the basis of nonpayment of premium.

(b) Not less than 10 days' written notice shall be mailed to the insured at the insured's last known address of the intent of the premium finance company to cancel the insurance contract unless a default is cured within such 10-day period.

(c) After the expiration of such 10-day period, the premium finance company may thereafter cancel in the name of the insured such insurance contract or contracts by mailing to the insurer a notice of cancellation, and the insurance contract shall be cancelled as if notice of cancellation had been submitted by the insured but without requiring the return of the insurance contract or contracts. The premium finance company shall also mail notice of cancellation to the insured at the insured's last known address.

(d) No policy may be cancelled by a premium finance company solely because of nonpayment of a delinquency or collection charge provided for in this chapter.

(e) All statutory, regulatory and contractual restrictions providing that the insurance contract may not be cancelled unless notice is given to a government agency, mortgagee or other third party shall apply where cancellation is effected under this section. The insurer, in accordance with the said prescribed notice, any time it is required to give such notice on behalf of itself or the insured, shall give notice to such governmental agency, mortgagee or other person before the end of the second business day after the day it receives the notice of cancellation from the premium finance company and shall determine the effective date of cancellation, taking into consideration the number of days' notice required to complete the cancellation.

(f) Whenever an insurance contract is cancelled in accordance with this section, the insurer shall return whatever gross unearned premiums are due under the contract to the premium finance company effecting the cancellation for the account of the insured or insureds as soon as reasonably possible, but in no event shall the period for such payment exceed 90 days after the effective date of the cancellation.

(60 Del. Laws, c. 406, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4810. Applicability.

(a) The provisions of this chapter relating to licensing, the filing of reports and the keeping of books and records shall not apply with respect to:

(1) Insurers, agents or brokers otherwise licensed by the Commissioner and who engage in the business of financing insurance premiums or any subsidiaries owned or controlled, directly or indirectly, by such insurer; and

(2) Any bank, savings bank, trust company, savings and loan association, credit union, industrial finance company or other such entity regulated pursuant to the laws of the State or of the United States; provided, however, that all other provisions of this chapter shall apply to all such institutions or persons who engage in the business of financing insurance premiums in the State.

(b) Notwithstanding subsection (a) of this section, the provisions of this chapter shall not apply with respect to the inclusion or deduction of a charge for insurance made pursuant to any other law of this State expressly or impliedly authorizing the financing of insurance premiums in connection with loan transactions or the financing of goods or services or both goods and services, including, but not limited to, charges for premiums for either or both credit life insurance and credit accident or health insurance.

(60 Del. Laws, c. 406, § 1.)

§ 4811. Exemptions.

(a) No filing of the premium finance agreement shall be necessary to perfect the security interest of the premium finance company as against creditors, subsequent purchasers, pledgees and other such parties, their successors or assigns.

(b) Notwithstanding Title 30, all institutions licensed in accordance with this chapter shall be exempt from all other occupational and use taxes levied by the State.

(60 Del. Laws, c. 406, § 1.)

§ 4812. Rules.

The Commissioner may make and enforce reasonable rules and regulations to make this chapter effective but such rules and regulations shall not be contrary to, nor inconsistent with, this chapter.

(60 Del. Laws, c. 406, § 1.)

Part I
Insurance
Chapter 49
Organization and Corporate Powers; Procedures of Domestic Stock and Mutual Insurers

§ 4901. Scope of chapter.

This chapter shall apply only to domestic stock insurers and domestic mutual insurers. This chapter shall apply to domestic mutual assessment property insurers only as stated in § 5306 of this title.

(18 Del. C. 1953, § 4901; 56 Del. Laws, c. 380, § 1.)

§ 4902. "Stock," "mutual" insurer, definitions.

"Stock" insurer and "mutual" insurer are as defined in §§ 501 and 502, respectively, of this title.

(18 Del. C. 1953, § 4902; 56 Del. Laws, c. 380, § 1.)

§ 4903. General corporation statutes; applicability.

Domestic stock and mutual insurers shall be governed by the applicable provisions of the general statutes of this State relating to private corporations except where such general statutes are in conflict with the express provisions of this title and the reasonable implications of such provisions, in which case the provisions of this title shall govern.

(18 Del. C. 1953, § 4903; 56 Del. Laws, c. 380, § 1.)

§ 4904. Insurance business exclusive.

No domestic insurer heretofore or hereafter formed shall engage directly or indirectly in any business other than the insurance business and in business activities reasonably and necessarily incidental to such insurance business, except that:

(1) A title insurer may also engage in business as an escrow agent; and

(2) Any insurer may also engage in business activities reasonably relating to the management, supervision, servicing of and protection of its interests as to its lawful investments and to the full utilization of its facilities; and

(3) It may invest in corporations engaged or organized to engage in the marketing of financial, insurance or service products, in accordance with § 1313 of this title; and

(4) A corporation established under Chapter 7 or regulated under Chapter 9 of Title 5 may also engage in the other activities authorized by such chapter; and

(5) This section shall not preclude a corporation heretofore or hereafter formed under the laws of this State from possessing corporate powers to engage in business additional to the insurance business or preclude such a corporation, prior to issuance of a certificate of authority thereto as an insurer, from engaging in any such additional business or businesses.

(18 Del. C. 1953, § 4904; 56 Del. Laws, c. 380, § 1; 66 Del. Laws, c. 179, § 2; 67 Del. Laws, c. 223, § 31.)

§ 4905. Mutual insurers — Initial qualifications.

(a) When newly organized, a domestic mutual insurer may be authorized to transact any one of the kinds of insurance listed in the schedule contained in subsection (b) below.

(b) When applying for an original certificate of authority, the insurer must be otherwise qualified therefor under this title and must have received and accepted bona fide applications as to substantial insurable subjects for insurance coverage of a substantial character of the kind of insurance proposed to be transacted, must have collected in cash the full premium therefor at a rate not less than that usually charged by other insurers for comparable coverages, must have surplus funds on hand and deposited as of the date such insurance coverages are to become effective or, in lieu of such applications, premiums and surplus, may deposit and thereafter maintain surplus, all in accordance with that part of the following schedule which applies to the 1 kind of insurance the insurer proposed to transact:

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Kind of Ins.	Min. No. of Apps Accepted	Min. No. Subjects Covered	Minimum Premium Collected	Minimum Amt. Ins. Ea. Subj.	Max. Amt. Ins. Ea. Subject (v)	Deposit Min. Surplus Fund (vi)	Deposit Surplus in lieu (vi)
Life(i)	500	500	Annual	$ 2,000	$ 5,000	$100,000	$200,000
Health(ii)	500	500	Quarterly	$ 25 (weekly indem.)	$ 50 (weekly indem.)	$100,000 Subjects	$200,000 Covered
Property(iii)	100	250	Annual	$ 3,000	$ 7,000	$100,000	$200,000
Casualty(iv)	250	250	Annual	$ 5,000	$25,000	$200,000	$300,000

Expendable surplus: In addition to surplus deposited and thereafter to be maintained as shown in columns (G) or (H) above, the insurer when first authorized must have on hand surplus funds, which it can thereafter expend in the conduct of its business, in amount not less than 50% of the applicable deposited and maintained surplus required of it under the above schedule. The following provisos are respectively applicable to the foregoing schedule and provisions as indicated by like Roman numerals appearing in such schedule:

(i) No group insurance or term policies for terms of less than 10 years shall be included.

(ii) No group, blanket or family plans of insurance shall be included. In lieu of weekly indemnity a like premium value in medical, surgical and hospital benefits may be provided. Any accidental death or dismemberment benefit provided shall not exceed $5,000.

(iii) Only insurance of the owner's interest in real property may be included.

(iv) Insurance of legal liability for bodily injury and property damage, to which the maximum and minimum insured amounts apply, must be included.

(v) The maximums provided for in column (F) are the net of applicable reinsurance.

(vi) The deposit of surplus in the amount specified in columns (G) and (H) must thereafter be maintained unimpaired. The deposit is subject to the provisions of Chapter 15 (Administration of Deposits) of this title.

(18 Del. C. 1953, § 4905; 56 Del. Laws, c. 380, § 1.)

§ 4906. Mutual insurers — Permit; deposit.

(a) Before soliciting any applications for insurance as required under § 4905 of this title, the incorporators of the proposed insurer shall procure a solicitation permit as required by § 4702 of this title and shall deposit with the Commissioner $10,000 in cash or in certificate of deposit issued by a bank located in this State or in United States Government bonds at market value to be held in trust for the use and benefit of the State and of applicant members and creditors of the corporation. The deposit shall be conditioned as follows:

(1) Upon due accounting for and deposit, as required under § 4908 of this title, of funds received as premium upon preliminary applications for insurance; and

(2) In event the corporation fails to complete its organization and secure a certificate of authority issued by the Commissioner within 1 year after the date of its solicitation permit, all premiums collected in advance from applicant members will be promptly returned to them, all other indebtedness of the corporation other than any compensation to directors, officers or solicitors of insurance applications will be paid and for payment of costs incurred by the State in the event of any legal proceedings for liquidation or dissolution of the corporation.

(b) If the corporation or an affiliate corporation proposes also to issue securities for initial financing of the proposed insurer in addition to the securing of qualifying applications for insurance, the deposit required by this section may be combined with that required under § 4713 of this title, with appropriate extension of the conditions of such deposit to comply with the requirements of both sections, in order that only 1 such deposit of $10,000 shall be necessary for all such purposes.

(c) The Commissioner shall release such deposit or remaining portion thereof held under this section upon written request of the person entitled thereto and upon proof to the Commissioner's satisfaction that all liabilities and obligations, with respect to which the deposit was made and held, have been fully settled or terminated or otherwise adequately provided for.

(d) Any such bond filed or deposit or remaining portion thereof held under this section may be released and discharged upon settlement and termination of all liabilities against it hereunder.

(18 Del. C. 1953, § 4906; 56 Del. Laws, c. 380, § 1.)

§ 4907. Mutual insurers — Qualifying applications for insurance.

(a) Upon receipt of the Commissioner's approval of the deposit as provided in § 4906 of this title, the directors and officers of the proposed domestic mutual insurer may commence solicitation of such requisite applications for insurance policies as they may accept and may receive deposits of premiums thereon.

(b) All such applications shall be in writing signed by the applicant, covering subjects of insurance resident, located or to be performed in this State.

(c) All such applications shall provide that:

(1) Issuance of the policy is contingent upon the insurer's qualifying for and receiving a certificate of authority;

(2) No insurance is in effect unless and until the certificate of authority has been issued; and

(3) The prepaid premium or deposit and membership or policy fee, if any, shall be refunded in full to the applicant if organization is not completed and the certificate of authority is not issued and received by the insurer before a specified reasonable date, which date shall be not later than 1 year after the date of the solicitation permit.

(d) All qualifying premiums collected shall be in cash.

(e) Solicitation for such qualifying applications for insurance shall be by licensed agents of the corporation, and the Commissioner shall, upon the corporation's application therefor, issue temporary agent's licenses, expiring on the date specified pursuant to paragraph (c)(3) of this section above, to individuals qualified for an agent's license. The Commissioner may suspend or revoke any such license

for any of the causes and pursuant to the same procedures as are applicable to suspension or revocation of licenses of agents in general under Chapter 17 of this title.

(18 Del. C. 1953, § 4907; 56 Del. Laws, c. 380, § 1.)

§ 4908. Mutual insurers — Trust deposit of qualifying premiums; issuance of policies.

(a) All sums collected by a domestic mutual corporation as premiums or fees on qualifying applications for insurance therein shall be deposited in trust in a bank or trust company in this State under a written trust agreement approved by the Commissioner and consistent with this section and with § 4907 of this title. The corporation shall file an executed copy of such trust agreement with the Commissioner.

(b) Upon issuance to the corporation of a certificate of authority as an insurer for the kind of insurance for which such applications were solicited, all funds so held in trust shall become the funds of the insurer, and the insurer shall thereafter in due course issue and deliver its policies for which premiums had been paid and accepted. The insurance provided by such policies shall be effective as of the date of the certificate of authority or thereafter as provided by the respective policies.

(18 Del. C. 1953, § 4908; 56 Del. Laws, c. 380, § 1.)

§ 4909. Mutual insurers — Failure to qualify.

If the proposed domestic mutual insurer fails to complete its organization and to secure its original certificate of authority within 1 year from and after date of its solicitation permit, the corporation shall transact no further business, and the Commissioner shall return or cause to be returned to the persons entitled thereto all advance deposits or payments of premiums held in trust under § 4907 of this title.

(18 Del. C. 1953, § 4909; 56 Del. Laws, c. 380, § 1.)

§ 4910. Mutual insurers — Additional kinds of insurance.

A domestic mutual insurer, after being authorized to transact 1 kind of insurance, may be authorized to transact such additional kinds of insurance as are permitted under § 510 of this title, while otherwise in compliance with this title and while maintaining unimpaired surplus funds in an amount not less than the amount of paid-in capital stock required of a domestic stock insurer transacting like kinds of insurance, subject further, when first so authorized to transact an additional kind of insurance, in the case of insurers other than those to which § 511(a)(1) of this title is applicable, to the additional expendable surplus requirements of such § 511 applicable to such a stock insurer.

(18 Del. C. 1953, § 4910; 56 Del. Laws, c. 380, § 1.)

§ 4911. Membership in mutual.

(a) Each policyholder of a domestic mutual insurer, other than of a reinsurance contract, is a member of the insurer during the period of the insurance with all rights and obligations of such membership, and the policy shall so specify.

(b) Any person, government or governmental agency, state or political subdivision thereof, public or private corporation, board, association, estate, trustee or fiduciary may be a member of a domestic mutual insurer. The right of certain governmental bodies or agencies of this State to become and be members of mutual insurers shall be subject further to the laws of this State governing such bodies or agencies.

(18 Del. C. 1953, § 4911; 56 Del. Laws, c. 380, § 1.)

§ 4912. Bylaws of mutual insurer.

Every domestic mutual insurer shall promptly file with the Commissioner a copy, certified by the insurer's secretary, of its bylaws and of every modification thereof or addition thereto. The bylaws and modifications thereof shall be subject to the Commissioner's approval. The Commissioner shall not disapprove any such bylaw or modification unless found by the Commissioner, after a hearing held thereon, to be unlawful, unreasonable, inadequate, unfair or injurious to the proper interests or protection of the insurer's members or any class thereof. The insurer shall not, after receiving written notice of such disapproval and during the existence thereof, effectuate any bylaw provision so disapproved.

(18 Del. C. 1953, § 4912; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4913. Minutes of corporate meetings of mutual insurers.

A domestic mutual insurer upon the Commissioner's written request therefor shall promptly file with the Commissioner a copy, certified by the insurer's secretary, of the notice, minutes and other record of every meeting of the insurer's board of directors or other similar governing body and of every meeting of the insurer's members. All such copies so filed shall constitute confidential records for the information of the Commissioner only, and shall not constitute or be treated as public records or be open to public inspection.

(18 Del. C. 1953, § 4913; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4914. Contingent liability of mutual members.

(a) Except as provided otherwise in § 4916 of this title with respect to nonassessable policies, each member of a domestic mutual insurer shall have a contingent liability, pro rata and not one for another, for the discharge of its obligations, which contingent liability shall be in such maximum amount — not less than 1 nor more than 6 times the premium for the member's policy at the annual premium rate — as shall be specified in the insurer's certificate of incorporation or bylaws.

(b) Every policy issued by the insurer shall contain a statement of the contingent liability.

(c) Termination of the policy of any such member shall not relieve the member of contingent liability for such member's proportion of the obligations of the insurer which accrued while the policy was in force.

(d) Unrealized contingent liability of members does not constitute an asset of the insurer in any determination of its financial condition.

(18 Del. C. 1953, § 4914; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4915. Levy of contingent liability.

(a) If at any time the assets of a domestic mutual insurer are less than its liabilities and the minimum amount of surplus required to be maintained by it under this title for authority to transact the kinds of insurance being transacted and the deficiency is not cured from other sources, its directors may, if the same is approved by the Commissioner as being reasonable and in the best interests of the insurer and its members, levy an assessment only on its members who held the policies providing for contingent liability at any time within the 12 months next preceding the date the levy was authorized by the board of directors, and such members shall be liable to the insurer for the amount so assessed.

(b) The levy of assessment shall be for such an amount as is required to cure such deficiency and to provide a reasonable amount of working funds above such minimum amount of surplus, but such working funds so provided shall not exceed 5% of the sum of the insurer's liabilities and such minimum required surplus as of the date of the levy.

(c) As to the respective policies subject to the levy, the assessment shall be computed upon the basis of premium earned during the period covered by the levy.

(d) No member shall have an offset against any assessment for which such member is liable, on account of any claim for unearned premium or loss payable.

(e) As to life insurance, any part of such an assessment upon a member which remains unpaid following notice of assessment, demand for payment, and lapse of a reasonable waiting period as specified in such notice, may, if approved by the Commissioner as being in the best interests of the insurer and its members, be secured by placing a lien upon the cash surrender values and accumulated dividends held or to be held by the insurer to the credit of the member's policy.

(18 Del. C. 1953, § 4915; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4916. Enforcement of contingent liability.

(a) The insurer shall notify each member of the amount of the assessment to be paid by written notice mailed to the address of the member last of record with the insurer. Failure of the member to receive the notice so mailed, within the time specified therein for the payment of the assessment or at all, shall be no defense in any action to collect assessment.

(b) If a member fails to pay the assessment within the period specified in the notice, which period shall not be less than 20 days after mailing, the insurer may institute suit to collect the same.

(18 Del. C. 1953, § 4916; 56 Del. Laws, c. 380, § 1.)

§ 4917. Nonassessable policies, mutual insurers; revocation of authority.

(a) A domestic mutual insurer, by depositing through the Commissioner and thereafter maintaining unimpaired surplus funds not less in amount than the minimum paid-in capital stock required of a domestic stock insurer for authority to transact the same kind or kinds of insurance, may, upon receipt of the Commissioner's order so authorizing, extinguish the contingent liability to assessment of its members as to all its policies in force and, so long as such surplus and deposit are maintained, may omit provisions imposing contingent liability in all policies currently issued. Any deposit of the insurer made through the Commissioner as prerequisite to its certificate of authority may be included as part of the deposit required under this section.

(b) The Commissioner shall not authorize a domestic insurer to extinguish the contingent liability of any of its members or in any of its policies to be issued, unless it qualifies to and does extinguish such liability of all its members and in all such policies for all kinds of insurance transacted by it.

(c) The Commissioner shall revoke the authority of a domestic mutual insurer to issue policies without contingent liability if:

(1) At any time the insurer's assets are less than the sum of its liabilities and the surplus required for such authority, or

(2) The insurer, by resolution of its board of directors approved by a majority of its members, requests that the authority be revoked.

(d) During the absence of such authority, the insurer shall not issue any policy without providing therein for the contingent liability of the policyholder, nor renew any policy which is then in force without endorsing the same to provide for such contingent liability.

(18 Del. C. 1953, § 4917; 56 Del. Laws, c. 380, § 1.)

§ 4918. Information to stockholders and proxy regulations.

(a) This section shall apply to all domestic stock insurers except:

(1) A domestic stock insurer having less than 100 stockholders, except, that if 95% or more of the insurer's stock is owned or controlled by a parent or affiliated insurer, this section shall not apply to such insurer unless its remaining shares are held by 500 or more stockholders;

(2) Domestic stock insurers which file with the Securities and Exchange Commission forms of proxies, consents and authorizations pursuant to the Securities Exchange Act of 1934, as amended [15 U.S.C. § 78a et seq.]; and

(3) Insurance departments or divisions of corporations established under Chapter 7 of Title 5.

(b) Every insurer to which this section is applicable shall seasonably furnish its stockholders, in advance of stockholder meetings, information in writing reasonably adequate to inform them relative to all matters to be presented by the insurer's management for consideration of stockholders at such meeting.

(c) No person shall solicit a proxy, consent or authorization in respect of any stock or other voting security of such an insurer unless that person furnishes the person so solicited with written information reasonably adequate as to:

(1) The material matters in regard to which the powers so solicited are proposed to be used; and

(2) The person or persons on whose behalf the solicitation is made and the interest of such person or persons in relation to such matters.

(d) No person shall so furnish to another information which the informer knows or has reason to believe is false or misleading as to any material fact or which fails to state any material fact reasonably necessary to prevent any other statement made from being misleading.

(e) The form of all such proxies shall:

(1) Conspicuously state on whose behalf the proxy is solicited;

(2) Provide for dating the proxy;

(3) Impartially identify each matter or group of related matters intended to be acted upon;

(4) Provide means for the principal to instruct the vote of the principal's shares as to approval or disapproval of each matter or group, other than election to office; and

(5) Be legibly printed, with context suitably organized.

Except, that a proxy may confer discretionary authority as to matters as to which choice is not specified pursuant to paragraph (e)(4) of this section, above, if the form conspicuously states how it is intended to vote the proxy or authorization in each such case, and may confer discretionary authority as to other matters which may come before the meeting but unknown for a reasonable time prior to the solicitation by the persons on whose behalf the solicitation is made.

(f) No proxy shall confer authority:

(1) To vote for election of any person to any office for which a bona fide nominee is not named in the proxy statement; or

(2) To vote in any annual meeting (or adjournment thereof) other than the annual meeting next following the date on which the proxy statement and form were furnished stockholders.

(g) The Commissioner shall have authority to make and promulgate reasonable rules and regulations for the effectuation of this section, and in so doing shall give due consideration to rules and regulations promulgated for similar purposes by the insurance supervisory officials of other states.

(h) Any proxy, consent or authorization obtained in violation of this section or of the lawful rules and regulations of the Commissioner hereunder shall be void.

(18 Del. C. 1953, § 4918; 56 Del. Laws, c. 380, § 1; 67 Del. Laws, c. 223, § 32; 70 Del. Laws, c. 186, § 1.)

§ 4919. Change of directors, officers; notice.

Every domestic stock or mutual insurer shall promptly notify the Commissioner in writing of any change of personnel among its directors or principal officers.

(18 Del. C. 1953, § 4919; 56 Del. Laws, c. 380, § 1.)

§ 4920. Prohibited pecuniary interest of officials.

(a) Any officer or director, or any member of any committee or an employee of a domestic insurer, having the duty or power of investing or handling the insurer's funds, shall not deposit or invest such funds except in the insurer's name, shall not borrow the funds of the insurer or be pecuniarily interested in any loan, pledge, deposit, security, investment, sale, purchase, exchange, reinsurance or other similar transaction or property of the insurer, except as a stockholder, member, employee or director, unless the transaction is authorized or approved by the insurer's board of directors, with knowledge and recording of such pecuniary interest, by affirmative vote of not less than $^{2}/_{3}$ of the directors, and shall not take or receive to his or her own use any fee, brokerage, commission, gift or other similar consideration for or on account of any such transaction made by or on behalf of the insurer.

(b) No insurer shall guarantee the financial obligation of any of its officers or directors.

(c) This section shall not prohibit such a director, officer, member of a committee, or employee from becoming a policyholder of the insurer and enjoying the usual rights of a policyholder, or from participating as beneficiary in any pension trust, deferred compensation plan, profit sharing plan, stock option plan or similar plan authorized by the insurer and to which such person may be eligible, or prohibit any director or member of a committee from receiving a reasonable fee for lawful services actually rendered to the insurer.

(d) The Commissioner may, by regulation from time to time, define and permit additional exceptions to the prohibition contained in subsection (a) of this section solely to enable payment of a reasonable compensation to a director who is not otherwise an officer or

employee of the insurer, or to a corporation or firm in which a director is interested, for necessary services performed or sales or purchases made to or for the insurer in the ordinary course of the insurer's business and in the usual private professional or business capacity of such director, corporation or firm.

(18 Del. C. 1953, § 4920; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4921. Management and exclusive agency contracts.

(a) No domestic insurer shall hereafter make any contract whereby any person is granted or is to enjoy in fact the management of the insurer to the material exclusion of its board of directors or to have the controlling or preemptive right to produce substantially all insurance business for the insurer, or, if an officer, director or otherwise part of the insurer's management, is to receive any commission, bonus or compensation based upon the volume of the insurer's business or transactions, unless the contract is filed with and not disapproved by the Commissioner. The contract shall become effective in accordance with its terms unless disapproved by the Commissioner within 20 days after date of filing, subject to such reasonable extension of time as the Commissioner may require by notice given within such 20 days. Any disapproval shall be delivered to the insurer in writing stating the grounds therefor.

(b) Any such contract shall provide that any such manager, producer of its business, or contract holder shall within 90 days after expiration of each calendar year furnish the insurer's board of directors a written statement of amounts received under or on account of the contract and amounts expended thereunder during such calendar year, with specification of the emoluments received therefrom by the respective directors, officers and other principal management personnel of the manager or producer, and with such classification of items and further detail as the insurer's board of directors may reasonably require.

(c) The Commissioner shall disapprove any such contract if the Commissioner finds that it:

(1) Subjects the insurer to excessive charges; or

(2) Is to extend for an unreasonable length of time; or

(3) Does not contain fair and adequate standards of performance; or

(4) Contains other inequitable provision or provisions which impair the proper interests of stockholders or members of the insurer.

(d) The Commissioner may, after a hearing held thereon, disapprove any such contract theretofore permitted to become effective if the Commissioner finds that the contract should be disapproved on any of the grounds referred to in subsection (c) of this section above.

(e) This section does not apply as to contracts entered into prior to November 1, 1968, or to extensions or amendments of such contracts.

(18 Del. C. 1953, § 4921; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4922. Dividends to stockholders.

(a) A domestic stock insurer shall not pay any cash dividend to stockholders except out of that part of its available and accumulated surplus funds which is derived from realized net operating profits on its business and realized capital gains.

(b) A cash dividend otherwise lawful may be payable out of the insurer's earned surplus even though its total surplus is then less than the aggregate of its past contributed or paid-in surplus.

(c) A stock dividend may be paid out of any available surplus funds.

(d) The insurance department or division of a corporation established under Chapter 7 of Title 5 shall only make distributions (other than for payment of expenses) to such corporation out of that part of its available and accumulated surplus funds which is derived from realized net operating profits on its business and realized capital gains.

(18 Del. C. 1953, § 4922; 56 Del. Laws, c. 380, § 1; 67 Del. Laws, c. 223, § 33.)

§ 4923. Participating policies.

(a) If provided for in its certificate of incorporation or charter, a stock insurer or mutual insurer may issue any or all of its policies or contracts with or without participation in profits, savings, unabsorbed portions of premiums, or surplus, may classify policies issued and perils insured on a participating and nonparticipating basis, and may determine the right to participate and the extent of participation of any class or classes of policies. Any such classification or determination shall be reasonable and shall not unfairly discriminate as between policies so classified.

(b) A life insurer may issue both participating and nonparticipating policies or contracts if the right or absence of right to participate is reasonably related to the premium charged.

(c) After the first policy year, no dividend, otherwise earned, shall be made contingent upon the payment of renewal premium on any policy or contract, except, that a participating life or health insurance policy providing for participation at the end of the first and/or second policy year may provide that the dividend or dividends will be paid subject to payment of premium for the next ensuing year.

(18 Del. C. 1953, § 4923; 56 Del. Laws, c. 380, § 1.)

§ 4924. Dividends to policyholders.

(a) The directors of a domestic mutual insurer may from time to time apportion and pay or credit to its members dividends only out of that part of its surplus funds which represents net realized savings, net realized earnings, and net realized capital gains, all in excess of the surplus required by law to be maintained by the insurer.

(b) A dividend otherwise proper may be payable out of such savings, earnings and gains even though the insurer's total surplus is then less than the aggregate of contributed surplus remaining unpaid by the insurer.

(c) A domestic stock insurer may pay dividends to holders of its participating policies out of any available surplus funds.

(d) No dividend shall be paid which is inequitable or which unfairly discriminates as between classifications of policies or policies within the same classifications.

(18 Del. C. 1953, § 4924; 56 Del. Laws, c. 380, § 1.)

§ 4925. Solicitation of business; issuance of policies in other jurisdictions.

(a) No domestic insurer shall knowingly solicit insurance business in any reciprocating state in which not then licensed as an authorized insurer. This subsection shall not prohibit advertising through publications and radio, television and other media originating outside such reciprocating state, if the insurer is licensed in the state in which the advertising originates and the advertising is not specifically directed to residents of such reciprocating state. This subsection shall not apply as to surplus line insurance, or prohibit insurance covering persons or risks located in a reciprocating state, under contracts solicited and issued in states in which the insurer is then licensed, or insurance otherwise effectuated in accordance with the laws of the reciprocating state. A "reciprocating" state, as used herein, is one under the laws of which a similar prohibition is imposed upon and enforced against insurers domiciled in that state.

(b) A domestic insurer duly authorized to transact insurance in another jurisdiction may frame and issue policies for delivery in such jurisdiction pursuant to applications for insurance solicited and obtained therein, in accordance with the laws thereof, subject only to such restrictions, if any, as may be contained in the insurer's certificate of incorporation or bylaws, and subject, in the case of health insurers, to the provisions of § 3330 of this title (policies issued for delivery in another state).

(18 Del. C. 1953, § 4925; 56 Del. Laws, c. 380, § 1.)

§ 4926. Payment of taxes; exoneration.

(a) Every domestic insurer may comply with any law of any state or political subdivision imposing any license, excise, privilege, premium, occupation or other fee or tax, and pay such fee or tax, unless prior to such payment the law shall have been expressly held invalid by the state court having final appellate jurisdiction in the premises or by the Supreme Court of the United States.

(b) No officer, director or trustee of any insurer shall be subject to personal liability by reason of any payment, or determination not to contest payment, deemed by the board of directors or trustee to be in the corporate interests of the insurer, of any license, excise, privilege, premium, occupation or other fee or tax to any such state or political subdivision, unless prior to such payment the law imposing such fee or tax shall have been expressly held invalid by the state court having final appellate jurisdiction in the premises or by the Supreme Court of the United States.

(18 Del. C. 1953, § 4926; 56 Del. Laws, c. 380, § 1.)

§ 4927. Impairment of capital or assets.

(a) If a domestic stock insurer's paid-in capital stock (as represented by the aggregate par value of its outstanding capital stock) or capital account (of an insurance department or division of a corporation established under Chapter 7 of Title 5) becomes impaired, or the assets of a domestic mutual insurer are less than its liabilities and the minimum amount of surplus required to be maintained by it under this title for authority to transact the kinds of insurance being transacted, the Commissioner shall at once determine the amount of deficiency and serve notice upon the insurer to cure the deficiency and file proof thereof with the Commissioner within the period specified in the notice, which period shall be not less than 30 nor more than 90 days from the date of the notice. Such notice may be so served by delivery to the insurer or by mailing to the insurer addressed to its registered office in this State.

(b) The deficiency may be made good in cash or in assets eligible under Chapter 13 (Investments) of this title for the investment of the insurer's funds or by amendment of the insurer's certificate of authority to cover only such kind or kinds of insurance thereafter for which the insurer has sufficient paid-in capital stock (if a stock insurer) or surplus (if a mutual insurer) under this title, or, if a stock insurer, by reduction of the number of shares of the insurer's authorized capital stock or the par value thereof through amendment of its articles of incorporation, to an amount of authorized and unimpaired paid-in capital stock not below the minimum required for the kinds of insurance thereafter to be transacted.

(c) If the deficiency is not made good and proof thereof filed with the Commissioner within the period required by the notice, as specified in subsection (a) of this section above, the insurer shall be deemed insolvent and the Commissioner shall institute delinquency proceedings against it under Chapter 59 of this title.

(18 Del. C. 1953, § 4927; 56 Del. Laws, c. 380, § 1; 67 Del. Laws, c. 223, § 34; 70 Del. Laws, c. 186, § 1.)

§ 4928. Mutualization of stock insurer.

(a) A stock insurer other than a title insurer may become a mutual insurer under such plan and procedure as may be approved by the Commissioner after a hearing thereon.

(b) The Commissioner shall not approve any such plan, procedure or mutualization unless:

(1) It is equitable to stockholders and policyholders;

(2) It is subject to approval by the holders of not less than $^2/_3$ of the insurer's outstanding capital stock having voting rights, and, provided there are any qualified policyholders, by not less than $^2/_3$ of the insurer's policyholders who vote on such plan in person, by proxy or by mail, pursuant to such notice and procedure as may be approved by the Commissioner;

(3) If a life insurer, the right to vote thereon is limited to holders of policies other than term or group policies, and whose policies have been in force for more than 1 year;

(4) Mutualization will result in retirement of shares of the insurer's capital stock at a price not in excess of the fair market value thereof as determined by competent disinterested appraisers;

(5) The plan provides for the purchase of the shares of any nonconsenting stockholder in the same manner and subject to the same applicable conditions as provided by the general corporation law of the State as to rights of nonconsenting stockholders, with respect to consolidation or merger of private corporations;

(6) The plan provides for definite conditions to be fulfilled by a designated early date upon which such mutualization will be deemed effective; and

(7) The mutualization leaves the insurer with surplus funds reasonably adequate for the security of its policyholders and to enable it to continue successfully in business in the states in which it is then authorized to transact insurance, and for the kinds of insurance included in its certificates of authority in such states.

(c) No director, officer, agent or employee of the insurer, or any other person, shall receive any fee, commission or other valuable consideration whatsoever, other than their customary salaries or other regular compensation, for in any manner aiding, promoting or assisting in the mutualization, except as set forth in the plan of mutualization as approved by the Commissioner.

(d) This section shall not apply to mutualization under order of court pursuant to rehabilitation or reorganization of an insurer under Chapter 59 of this title.

(18 Del. C. 1953, § 4928; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, § 36.)

§ 4929. Conversion to ordinary business corporation.

(a) A domestic stock insurer may convert to a Delaware ordinary business corporation through the following procedures:

(1) The insurer must give the Commissioner written notice of its intent to convert to an ordinary business corporation;

(2) The insurer must bulk reinsure all of its insurance in force, if any, with another authorized insurer under a bulk reinsurance agreement approved by the Commissioner as provided in § 4944 of this title. The agreement of bulk reinsurance may be made contingent upon approval of stockholders as provided in paragraph (a)(4) of this section below;

(3) The insurer must set aside in a special reserve fund, in such amount and subject to such administration as may be found by the Commissioner to be adequate and reasonable for the purpose, for payment of all obligations, if any, of the insurer incurred by it under its insurance contracts prior to the effective date of such bulk reinsurance and remaining unpaid or make other reasonable disposition satisfactory to the Commissioner for such payment;

(4) The proposed conversion must be approved by affirmative vote of not less than $^2/_3$ of the holders of each class of the outstanding securities of the insurer having voting rights at a special meeting of holders of such securities called for the purpose. At such meeting and by a like vote the certificate of incorporation of the corporation must be amended to remove therefrom the power to transact an insurance business as an insurer and to provide for such new powers and purposes as may be consistent with the purposes for which the corporation is thereafter to exist;

(5) Security holders of the corporation who dissent from such proposed conversion shall have the same applicable rights as exist under the general corporation laws of this State with respect to dissent from a proposed merger of the corporation;

(6) Upon compliance with paragraphs (a)(1) through (4) of this section above, and upon filing of the amendment of the certificate of incorporation as required by law, the conversion shall thereupon become effective.

(b) An insurer which has once converted to an ordinary business corporation shall not have the power thereafter to reconvert to an insurer.

(18 Del. C. 1953, § 4929; 56 Del. Laws, c. 380, § 1.)

§ 4930. Merger, consolidation of stock insurers.

(a) A domestic stock insurer may merge or consolidate with 1 or more domestic or foreign stock insurers by complying with the applicable provisions of the statutes of this State governing the merger or consolidation of stock corporations formed for profit but subject to subsections (b) and (c) of this section below. A domestic stock insurer may not merge or consolidate with any corporation not formed for the purpose of transacting insurance as an insurer.

(b) No such merger or consolidation may be effectuated unless in advance thereof the plan and agreement therefor have been filed with the Commissioner and approved in writing by the Commissioner after a hearing thereon after notice to the stockholders of each insurer involved. The Commissioner shall give such approval within a reasonable time after such filing unless the Commissioner finds such plan or agreement is 1 or more of the following:

(1) Is contrary to law.

(2) Unfair or inequitable to the stockholders of any insurer involved.

(3) Would substantially reduce the security of and service to be rendered to policyholders of the domestic insurer in this State or elsewhere.

(4) Would materially tend to lessen competition in the insurance business in this State or elsewhere as to the kinds of insurance involved or would materially tend to create a monopoly as to such business.

(5) Is subject to other material and reasonable objections.

(c) No director, officer, agent or employee of any insurer party to such merger or consolidation may receive any fee, commission, compensation or other valuable consideration, whatsoever for, in any manner aiding, promoting or assisting therein except as set forth in such plan or agreement.

(d) If the Commissioner does not approve any such plan or agreement the Commissioner shall so notify the insurer in writing specifying reasons therefor.

(e) The Commissioner may retain at the applicant's expense any attorneys, actuaries, accountants, and other experts not otherwise a part of the Commissioner's staff as may be reasonably necessary to assist the Commissioner in reviewing the proposed merger or consolidation.

(18 Del. C. 1953, § 4930; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; 83 Del. Laws, c. 320, § 1.)

§ 4931. Affiliation of stock insurers.

(a) A domestic stock insurer shall not acquire a controlling interest in the shares of another stock insurer by an exchange of securities or partly in exchange for securities and partly for cash or property, unless the insurer has first submitted the plan for such acquisition and exchange to the Commissioner and the Commissioner has approved the same.

(b) The Commissioner shall not so approve unless the Commissioner finds the plan for such acquisition and the terms and conditions thereof to be fair and equitable to all parties concerned therein after a hearing to which all persons to whom it is proposed to issue securities in such exchange shall have the right to appear.

(c) Notice and conduct of such hearing shall be as provided in Chapter 3 of this title.

(18 Del. C. 1953, § 4931; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4932. Acquisition of controlling stock.

Repealed by 68 Del. Laws, c. 325, § 3, effective Aug. 7, 1992.

§ 4933. Converting mutual insurer.

Repealed by 77 Del. Laws, c. 466, § 1, effective Oct. 17, 2010.

§ 4934. Merger, consolidation — Allowable circumstances; "surviving insurer" defined.

(a) A domestic mutual insurer shall not merge or consolidate with a stock insurer.

(b) A domestic mutual insurer may merge or consolidate with another domestic or foreign mutual insurer under the procedures provided for in this and §§ 4935-4942 of this title.

(c) If for a consolidation and the new corporation is to be domiciled in this State, the new corporation shall be formed under the applicable provisions of the general corporation laws of this State.

(d) For the purposes of this chapter the "surviving insurer" is that which survives and continues as a result of a merger of 2 or more corporations into 1 corporation.

(18 Del. C. 1953, § 4934; 56 Del. Laws, c. 380, § 1.)

§ 4935. Merger, consolidation of mutual insurers — Approval of merger; consolidation agreement by boards of directors.

(a) The board of directors of each of the mutual insurers proposing to merge or consolidate shall, by resolution adopted by at least a majority of all the members of each board, approve a joint agreement of merger or consolidation, as the case may be, between the insurer parties, setting forth the terms and conditions of the merger or consolidation, the mode of carrying the same into effect and such other provisions as are deemed advisable.

(b) Upon approving such agreement, each such board shall by resolution direct that the same be submitted to the Commissioner and be subject to the Commissioner's disapproval as provided in § 4936 of this title and to approval of the members of the respective insurers as provided in § 4937 of this title.

(18 Del. C. 1953, § 4935; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4936. Merger, consolidation of mutual insurers — Effectuation; disapproval by Commissioner.

(a) No such merger or consolidation of a domestic mutual insurer shall be effectuated unless in advance thereof the agreement therefor has been filed with the Commissioner and has not been disapproved by the Commissioner in writing. If the insurer is not then impaired, the Commissioner shall not act with respect to such agreement until after a hearing thereon. The agreement shall be effectuated in accordance

with its terms unless the Commissioner disapproves the same within 10 days after the date of such filing or the conclusion of such hearing, if any, whichever is the later date, subject to the Commissioner's right to have a reasonable extension of time not to exceed 10 days upon written notice to the insurers involved. The Commissioner may disapprove the agreement upon one or more of the following grounds —that the agreement:

(1) Is inequitable to the policyholders of any domestic insurers involved; or

(2) Would materially reduce the security of and service to be rendered to policyholders of the domestic insurer in this State and elsewhere; or

(3) Would materially tend to lessen competition in this State or elsewhere as to the kinds of insurance involved or would materially tend to create a monopoly therein; or

(4) Is subject to other reasonable objections.

(b) If the Commissioner disapproves the agreement the Commissioner shall so notify the insurers in writing specifying the reasons therefor.

(c) No director, officer, agent or employee of any insurer involved or any other person shall receive any fee, commission or other valuable consideration whatsoever, other than their usual regular salaries and compensation, for in any manner aiding, promoting or assisting in such merger or consolidation except as set forth in the agreement approved by the Commissioner. This provision shall not be deemed to prohibit payment of reasonable fees and compensation to attorneys-at-law, accountants and actuaries for services performed in the independent practice of their professions even though also directors of the insurer.

(18 Del. C. 1953, § 4936; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4937. Merger, consolidation of mutual insurers — Approval by members.

(a) After the Commissioner has approved the proposed agreement of merger or consolidation and if the insurer is then unimpaired, the agreement shall be submitted to the domestic insurer's members for approval at a regular or special meeting of members. If a life insurer, right to vote shall be limited to members whose policies are other than term policies for terms of less than 20 years and other than group policies and have been in force for at least 1 year.

(b) Not less than 15 days before such meeting written notice of the meeting and of the proposed merger or consolidation shall be given to each member of the insurer. The notice shall state the day, hour, place and purposes of the meeting and be accompanied by a copy or summary of agreement of merger or consolidation as the case may be. Notice and accompanying copy or summary shall be deemed given when enclosed in an envelope addressed to the member at the member's address last of record with the insurer and deposited postage paid in a depository of the United States post office. In the case of mutual insurers with more than 10,000 members, in lieu of such notice by mail, such notice may be given by publication in a newspaper of general circulation in either of the 2 largest cities in each state in which the insurer shall be authorized to transact an insurance business.

(c) Upon receiving the affirmative vote of $^{2}/_{3}$ of all votes cast by members present or represented at the meeting, the agreement shall be deemed to have been approved. Each member of the insurer shall be bound by such vote without right of dissent other than the right to vote against the proposal at the meeting. Such a dissenting member shall have no right or equity as to the assets of the insurer except as expressly provided in the member's policy or policies.

(d) In the event that a mutual insurer shall have no members entitled to vote, the merger agreement need not be submitted to its members, and notice need not be given to its members, and the Commissioner may approve the agreement of merger or consolidation without a hearing thereon, and the same may be effectuated without approval of the insurer's members.

(18 Del. C. 1953, § 4937; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 79, §§ 37, 38; 70 Del. Laws, c. 186, § 1.)

§ 4938. Merger, consolidation of mutual insurers — Impaired mutuals.

If a domestic mutual insurer is then impaired, that is, if the insurer's surplus is less than the amount thereof required under this title for authority to transact the kinds of insurance being transacted by the insurer, the Commissioner may approve the agreement of merger or consolidation without a hearing thereon, and the same may be effectuated without approval of the insurer's members.

(18 Del. C. 1953, § 4938; 56 Del. Laws, c. 380, § 1.)

§ 4939. Merger, consolidation of mutual insurers — Articles of merger, consolidation, mutual insurers.

Upon the approval by the Commissioner and members, if required, and upon agreement of merger or consolidation, articles of merger or consolidation, as the case may be, shall be executed under the seal of each insurer and verified by a duly authorized officer of each insurer and shall set forth as applicable:

(1) The name of the surviving or new corporation.

(2) The time and place of the meeting of the directors at which the agreement of merger or consolidation was approved and, except where pursuant to § 4938 of this title, the agreement is not submitted to a vote of the members of the insurer, the time and place of the meeting of the members of each insurer at which the agreement of merger or consolidation, as the case may be, was approved, the kind and period of notice given to the members and the total vote by which the agreement was approved.

(3) In the case of a merger into a surviving insurer, any changes desired to be made in the articles of the surviving insurer or in the case of a consolidation into a new domestic insurer, all of the statements required by law to be set forth in the original articles in the case of the formation of a domestic insurer.

(4) The number, names and addresses of the persons to be the first directors of the surviving or new insurer.

(5) The agreement of merger or consolidation.

(18 Del. C. 1953, § 4939; 56 Del. Laws, c. 380, § 1.)

§ 4940. Merger, consolidation of mutual insurers — Filing of articles of merger or consolidation; payment of fees; approval by Secretary of State.

(a) The articles of merger or consolidation, as the case may be, referred to in § 4939 of this title, together with a certificate or certificates from the proper department or departments evidencing payment of all applicable taxes and charges required by law, shall be delivered to the Secretary of State.

(b) The Secretary of State shall examine the articles and the certificate or certificates to determine whether they contain all necessary information and satisfy all requirements as to form. If the Secretary of State finds that the articles and certificates contain all necessary information and satisfy all requirements as to form, the Secretary of State shall endorse his or her approval upon the articles. If the Secretary of State does not so find, he or she shall forthwith give notice thereof to the parties stating in detail the Secretary of State's reasons for so doing and stating how the nonconformance can be remedied. Upon remedying the defects, the party may in the same manner file the same or amended articles, whichever the particular case may require, and the Secretary of State shall endorse his or her approval thereon.

(18 Del. C. 1953, § 4940; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4941. Merger, consolidation of mutual insurers — Issuance of certificate of merger or consolidation; effective date.

(a) Immediately upon the Secretary of State's approval of the articles of merger or consolidation as provided in § 4940 of this title, the Secretary of State shall file the articles and issue to the surviving or new corporation or its representative a certificate of merger or consolidation, and shall deliver a copy of the articles so approved to the Commissioner.

(b) The merger or consolidation shall be effective upon the issuance of the certificate by the Secretary of State as above provided.

(c) The certificate shall be conclusive evidence of the performance of all conditions precedent to such consolidation or merger and of the continuation or creation of the surviving or new corporation to the extent that the same is governed by the laws of this State.

(18 Del. C. 1953, § 4941; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4942. Merger, consolidation of mutual insurers — Effect of merger or consolidation.

(a) Upon the merger or consolidation becoming effective, the several corporations, parties to the agreement of merger or consolidation, shall be a single corporation, which in the case of a merger shall be that corporation designated in the agreement as the surviving corporation and, in the case of a consolidation, shall be the new corporation provided for in the agreement of consolidation. The separate existence of all the constituent corporations parties to said agreement except the surviving corporations, in the case of a merger, or the new corporation, in the case of a consolidation, shall thereupon cease.

(b) All the property, real, personal and mixed of each of the corporations, parties to the agreement of merger or consolidation, and all debts or obligations due to any of them shall be taken and be deemed to be transferred to and vested in the surviving or new corporation, as the case may be, without further act or deed.

(c) The surviving or new corporation shall, upon effectuation of the merger or consolidation, thenceforth be responsible for all the liabilities and obligations of each of the corporations so merged or consolidated; but the liabilities of the merging or consolidating corporations or of their directors or officers shall not be affected, and the rights of creditors thereof or of any person dealing with such corporations or any liens upon the property of such corporations shall not be impaired by the merger or consolidation, and any claim existing or action or proceeding pending by or against any of such corporations may be prosecuted to judgment as if the merger or consolidation had not taken place, or the surviving or new corporation may be proceeded against or substituted in its place.

(d) In the case of a merger, the certificate of incorporation of the surviving corporation, if such corporation is a domestic insurer, shall be deemed to be amended to the extent, if any, that changes in its certificate are stated in the articles of merger; and in the case of a consolidation, the statements set forth in the articles of consolidation, in case the new corporation is one formed under the laws of this State, which are required or permitted to be set forth in the certificate of incorporation of such insurer formed under the general corporation laws of this State, shall be deemed to be the certificate of incorporation of the new corporation.

(18 Del. C. 1953, § 4942; 56 Del. Laws, c. 380, § 1.)

§ 4943. Preservation of old charter in merger or consolidation.

(a) In any merger or consolidation of a foreign stock or mutual insurer into or with a domestic insurer under § 4930 of this title, in accordance with this section, the continuing Delaware corporation shall for all purposes be deemed to be a continuation of the corporate

existence of the foreign corporation with Delaware as the adoptive state of domicile and with date of corporate origin the same as the original date of incorporation of the foreign insurer in its original domiciliary state or country, subject to the following conditions:

(1) The plan and agreement for merger or consolidation shall provide for such continuation or corporate existence through designation of Delaware as the state of domicile of the foreign corporation by adoption, and shall specify the original date of incorporation of the foreign corporation in its original domiciliary state or country as being the date of incorporation of the Delaware corporation pursuant to this section.

(2) The certificate of incorporation of the Delaware corporation shall provide, or be amended to provide, that the corporation is a continuance of the corporate existence, through adoption of the State as the corporate domicile, of the foreign corporation, and shall specify the original date of incorporation of the foreign corporation in its original domiciliary state or country as being the date of incorporation of the Delaware corporation pursuant to this section.

(b) The continuing Delaware corporation shall have all the rights and obligations of, and be given recognition in all respects as a corporation formed under the laws of this State as of the date of incorporation of the foreign corporation in its original domiciliary state or country. This provision shall not be deemed to impose upon the continuing Delaware corporation any liability or obligation with respect to filings, fees, taxes or otherwise which might have accrued prior to the effective date of the merger or consolidation.

(c) This section shall not be deemed in any manner to preserve, after the effective date of such merger or consolidation, the corporate existence of such foreign corporation as a corporation of its original domiciliary state or country.

(60 Del. Laws, c. 176, § 1.)

§ 4944. Bulk reinsurance.

(a) A domestic insurer may reinsure all or substantially all of its business in force, or all or substantially all of a major class thereof, with another insurer, stock or mutual, by an agreement of bulk reinsurance after compliance with this section. No such agreement shall become effective unless filed with or disapproved by the Commissioner.

(b) The Commissioner shall disapprove such agreement within a reasonable time after filing if the Commissioner finds:

(1) That the plan and agreement are unfair and inequitable to any insurer or to policyholders involved;

(2) That the reinsurance, if effectuated, would substantially reduce the protection or service to the policyholders of any domestic insurer involved;

(3) That the agreement does not embody adequate provisions by which the reinsuring insurer becomes liable to the original insureds for any loss or damage occurring under the policies reinsured in accordance with the original terms of such policies or does not require the reinsuring insurer to furnish each such insured with a certificate evidencing such assumption of liability;

(4) That the assuming reinsurer is not authorized to transact such insurance in this State or is not qualified as for such authorization or will not appoint the Commissioner and the Commissioner's successors as its irrevocable attorney for service of process, so long as any policy so reinsured or claim thereunder remains in force or outstanding;

(5) That such reinsurance would materially tend to lessen competition in the insurance business in this State or elsewhere as to the kinds of insurance involved or would materially tend to create a monopoly as to such business;

(6) That the proposed bulk reinsurance is not free of other reasonable objections.

(c) If the Commissioner disapproves the agreement the Commissioner shall forthwith notify in writing each insurer involved specifying reasons therefor.

(d) If for reinsurance of all or substantially all of the business in force of an insurer at a time when the insurer's capital (if a stock insurer) or surplus (if a mutual insurer) is not impaired, the plan and agreement of such reinsurance must be approved by a vote of not less than $^{2}/_{3}$ of the insurer's outstanding stock having voting rights (if a stock insurer) or of members (if a mutual insurer) voting thereon at a meeting of stockholders or members called for the purpose, pursuant to such reasonable notice and procedure as is provided for in the agreement. If a mutual life insurer, right to vote may be limited to members whose policies are other than term policies for terms of less than 20 years or group policies and have been in effect for more than 1 year.

(e) No director, officer, agent or employee of any insurer party to such reinsurance nor any other person shall receive any special compensation for arranging or with respect to any such reinsurance except as is set forth in the reinsurance agreement filed with the Commissioner.

(18 Del. C. 1953, § 4943; 56 Del. Laws, c. 380, § 1; 60 Del. Laws, c. 176, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4945. Mutual member's share of assets on liquidation.

(a) Upon any liquidation of a domestic mutual insurer, its assets remaining after discharge of its indebtedness, policy obligations, repayment of contributed or borrowed surplus, if any, and expenses of administration shall be distributed to currently existing persons who had been members of the insurer for at least 1 year and who were its members at any time within 36 months next preceding the date such liquidation was authorized or ordered or the date of last termination of the insurer's certificate of authority, whichever date is the earlier, except that if the Commissioner has reason to believe that those in charge of the management of the insurer have caused or

encouraged the reduction of the number of members of the insurer in anticipation of liquidation and for the purpose of reducing thereby the number of persons who may be entitled to share in distribution of the insurer's assets, the Commissioner may enlarge the 36-month qualification period as the Commissioner may deem to be reasonable.

(b) The insurer shall make a reasonable classification of its policies so held by such members, and a formula based upon such classification for determining the equitable distributive share of each such member. Such classification and formula shall be subject to the approval of the Commissioner.

(18 Del. C. 1953, § 4944; 56 Del. Laws, c. 380, § 1; 60 Del. Laws, c. 176, § 1; 70 Del. Laws, c. 186, § 1.)

§ 4946. Redomestication; approval as domestic insurer; conversion to foreign insurer; rules and regulations.

(a) Any insurer which is organized under the laws of any other state and is admitted to do business in this State for the purpose of writing insurance may become a domestic insurer by complying with all of the requirements of law relative to the organization and licensing of a domestic insurer of the same type and by designating its principal place of business at a place in this State. Said domestic insurer will be entitled to like certificates and licenses to transact business in this State and shall be subject to the authority and jurisdiction of this State.

(b) Any domestic insurer may upon approval of the Commissioner transfer its domicile to any other state in which it is admitted to transact the business of insurance and upon such transfer shall cease to be a domestic insurer and shall be admitted to this State if qualified as a foreign insurer. The Commissioner shall approve any such proposed transfer unless the Commissioner shall determine such transfer is not in the interest of the policyholders of this State.

(c) The certificate of authority, agent's appointments and licenses, rates and other items which the Commissioner of Insurance allows, in his or her discretion, which are in existence at the time any insurer licensed to transact the business of insurance in this State transfers its corporate domicile to this or any other state by merger, consolidation or any other lawful method shall continue in full force and effect upon such transfer while the insurer remains duly qualified to transact the business of insurance in this State. All outstanding policies of any transferring insurer shall remain in full force and effect and need not be endorsed as to the new name of the company or its new location unless so ordered by the Commissioner of Insurance. Every transferring insurer shall file new policy forms with the Commissioner of Insurance on or before the effective date of the transfer but may use existing policy forms with appropriate endorsements if allowed by, and under such conditions as approved by, the Commissioner of Insurance. However, every such transferring insurer shall notify the Commissioner of the details of the proposed transfer and shall file promptly any resulting amendments to corporate documents filed or required to be filed with Commissioner.

(d) The Commissioner of this State may promulgate rules and regulations to carry out the purposes of the section.

(66 Del. Laws, c. 77, § 1; 70 Del. Laws, c. 186, § 1.)

Part I
Insurance

Chapter 49A
Delaware Insurance Company Mutual-to-Stock Conversion Act

§ 4970. Finding; purpose.

(a) It is determined and declared as a matter of legislative finding that policyholders of a mutual insurer have contractual rights to insurance coverage and certain membership rights consisting principally of the right to elect directors of a mutual insurer, the right to vote on certain fundamental transactions undertaken by a mutual insurer, and the right to share in surplus in the event of a solvent liquidation of a mutual insurer. It is determined and declared that the membership rights of policyholders in a domestic mutual company existing as of October 17, 2010, who vote to make such mutual company subject to this chapter, or policyholders of a foreign mutual insurer who vote to redomesticate to Delaware pursuant to § 4974 of this title, are not equivalent to an ownership interest in such mutual insurer and that, in connection with the mutual to stock conversion of a mutual insurer, the grant to policyholders of a first priority right to purchase stock in the converting company or a holding company for such converting company is adequate compensation for the relinquishment of the membership rights of a policyholder. The General Assembly determines that it is desirable to provide for the conversion of a mutual insurer from the mutual form to the stock form in a manner similar to the manner in which mutual savings institutions convert from mutual to stock form under federal law and regulation.

(b) It is further determined and declared that the purpose and policy of this chapter shall be:

(1) To provide for the mutual to stock conversion of a mutual insurer in a manner consistent with the manner in which a mutual savings institution converts from mutual to stock form under federal law and regulation; and

(2) To facilitate the recapitalization of the insurance industry nationally by establishing a proven method of capital formation for insurers that elect to domicile in Delaware.

(77 Del. Laws, c. 466, § 2.)

§ 4971. Short title of chapter.

This chapter shall be known and may be cited as the "Delaware Insurance Company Mutual-to-Stock Conversion Act."

(77 Del. Laws, c. 466, § 2.)

§ 4972. Definitions.

As used in this chapter, the following words and phrases shall have the meanings as ascribed in this section:

(1) "Capital stock" means common or preferred stock or any hybrid security or other equity security issued by a converted stock insurer or other company or entity pursuant to the exercise of subscription rights granted pursuant to the provisions of § 4975(a)(3) of this title.

(2) "Commissioner" means the Insurance Commissioner of this State.

(3) "Converted stock company" means a stock insurer that converted from a mutual insurer under this chapter, or under the laws of any other jurisdiction, or any successor thereto provided that not less than a majority of the shares of voting stock of such successor are owned by a mutual holding company.

(4) "Department" means the Department of Insurance of this State.

(5) "Domestic mutual company" means a mutual insurer domiciled in this State.

(6) "Eligible member" means a member of a mutual company whose policy is in force on the date the mutual company's governing body adopts a plan of conversion or such earlier date as the mutual company may establish with the consent of the Commissioner. A person insured under a group policy is not an eligible member. A person whose policy becomes effective after the governing body adopts the plan but before the plan's effective date is not an eligible member but shall have those rights established under § 4980 of this title.

(7) "Foreign mutual insurer" means a mutual insurer domiciled in a jurisdiction other than this State.

(8) "Mutual company" means a mutual insurer that is seeking to convert to a stock insurer under this chapter, including a captive insurance company (notwithstanding § 6916 of this title) that is incorporated as a nonstock corporation and including a foreign mutual insurer that has applied to redomesticate to this State with an intent to file an application to convert from mutual to stock form under this chapter.

(9) a. "Mutual holding company" means:

1. A nonstock corporation resulting from a reorganization of a mutual insurer under this chapter; or

2. A nonstock corporation resulting from a reorganization of a mutual insurer under the laws of any other jurisdiction, which subsequently redomesticated to Delaware by conversion under § 265 of Title 8 or any other lawful method, or a Delaware nonstock corporation that is the immediate successor thereto; or

3. A Delaware nonstock corporation surviving or resulting from a merger or consolidation with a nonstock corporation that resulted from a reorganization of a mutual insurer under the laws of any other jurisdiction.

b. A mutual holding company may convert to stock form under this chapter, and shall be subject to the provisions of this chapter and to any other provisions of this title applicable to insurance holding companies, except as otherwise provided in this chapter. It is the policy of this chapter to enable and facilitate such a conversion of a mutual holding company to stock form, and this chapter shall be interpreted accordingly. The certificate of incorporation of a mutual holding company shall include provisions setting forth the following:

1. That it is a mutual holding company under this chapter;

2. That the mutual holding company may hold not less than a majority of the shares of voting stock of a converted stock company or intermediate holding company, which in turn holds, directly or indirectly, all of the voting stock of a converted stock company;

3. That it is not authorized to issue any capital stock except pursuant to a conversion in accordance with the provisions of this chapter;

4. That its members shall have the rights specified in this chapter and its certificate of incorporation and bylaws; and

5. That its assets shall be subject to inclusion in the estate of the converted company in any rehabilitation or insolvency proceedings initiated by the Commissioner.

(10) "Participating policy" means a policy that grants a holder the right to receive dividends if, as and when declared by the mutual company.

(11) "Person" means an individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a trust, an unincorporated organization, a similar entity, or a combination of the foregoing acting in concert.

(12) "Plan of conversion" or "plan" means a plan adopted by a mutual company's governing body to convert the mutual company into a stock company in accordance with the requirements of this chapter.

(13) "Policy" means an insurance policy, including an annuity contract.

(14) "Standby investor" means any person that has agreed in writing to purchase all or a portion of the capital stock to be sold in a conversion that is not subscribed by eligible members.

(15) "Stock company" means a stock insurer that meets all of the current requirements for admission to do business as a domestic Delaware insurer.

(16) "Voting member" means a member who is an eligible member and is also a member of the mutual insurer as of a date not more than 90 days prior to the date of the meeting at which the plan shall be voted upon by members.

(77 Del. Laws, c. 466, § 2; 78 Del. Laws, c. 313, § 1.)

§ 4973. Adoption of plan of conversion.

(a) No plan of conversion shall become effective unless the mutual company seeking to convert to a stock company shall have adopted, by the affirmative vote of not less than $^{2}/_{3}$ of its governing body and otherwise in accordance with law, a plan of conversion consistent with the requirements of §§ 4975, 4976 and 4977, or of § 4978, of this title. At any time before approval of a plan by the Commissioner, the mutual company, by the affirmative vote of not less than a majority of its governing body, may amend or withdraw the plan.

(b) With respect to a domestic mutual company that exists as of October 17, 2010, no plan of conversion may be adopted pursuant to subsection (a) of this section unless the policyholders of the domestic mutual company shall have previously elected to subject the domestic mutual company to the provisions of this chapter at a separate meeting convened for such purpose. In connection with such meeting, the domestic mutual company shall provide its policyholders with substantially the same information as is required by the provisions of § 4974(b) of this title.

(c) Before a mutual company's eligible members may vote on approval of a plan, a mutual company whose governing body has adopted a plan shall file all of the following documents with the Commissioner within 90 days after adoption of the plan together with the application fee specified herein:

(1) The plan of conversion, including the independent evaluation of pro forma market value required by § 4975(d) of this title.

(2) The form of notice required by subsection (f) of this section.

(3) The form of proxy to be solicited from eligible members pursuant to subsection (g) of this section.

(4) The form of notice required by § 4980 of this title to persons whose policies are issued after adoption of the plan but before its effective date.

(5) The proposed certificate of incorporation and bylaws of the converted stock company.

(6) The acquisition of control statement, as required by § 5003 of this title.

(7) The application shall be accompanied by an application fee equal to the greater of:

a. $100,000; or

b. An amount equal to $^{1}/_{10}$ of 1% of the estimated pro forma market value of the converted stock company as determined in accordance with § 4975(d) of this title.

If such value is expressed as a range of values, the application fee shall be based upon the midpoint of the range. For good cause shown, the Commissioner may waive the application fee in whole or in part, or permit a portion of the application fee to be deferred until completion of the conversion.

(8) Such other information as the Commissioner may request. Upon filing of the foregoing documents with the Commissioner, the mutual company shall send to eligible members a notice advising eligible members of the adoption and filing of the plan, their ability to provide the Commissioner and the mutual company with comments on the plan within 30 days of the date of such notice, and procedure therefore.

(d) The Commissioner shall immediately give written notice to the mutual company of any decision and, in the event of disapproval, a statement in detail of the reasons for the decision. The Commissioner shall approve the plan if the Commissioner finds each of the following:

(1) The plan complies with this chapter.

(2) The plan will not prejudice the interests of the members.

(3) The plan's method of allocating subscription rights is fair and equitable.

(e) The Commissioner may retain, at the mutual company's expense, any qualified expert not otherwise a part of the Commissioner's staff, including counsel and financial advisors, to assist in reviewing the plan and the independent evaluation of the pro forma market value required under § 4975(d) of this title.

(f) The Commissioner may order a hearing on whether the terms of the plan comply with this chapter after giving written notice by mail or publication to the mutual company and other interested persons, all of whom have the right to appear at the hearing.

(g) All voting members shall be sent notice of the members' meeting to vote on the plan. The notice shall briefly but fairly describe the proposed conversion plan, shall inform the voting member of the voting member's right to vote upon the plan, and shall be sent to each voting member's last known address, as shown on the mutual company's records. If the meeting to vote upon the plan is held during the mutual company's annual meeting of policyholders, only a combined notice of meeting is required.

(h) The plan shall be voted upon by voting members and shall be adopted upon receiving the affirmative vote of at least $^{2}/_{3}$ of the votes cast by voting members at the meeting. Voting members entitled to vote upon the proposed plan may vote in person or by proxy. The number of votes each voting member may cast shall be determined by the mutual company's bylaws. If the bylaws are silent, each voting member may cast one vote.

(i) The certificate of incorporation of the converted stock company shall be considered at the meeting of the voting members called for the purpose of adopting the plan of conversion and shall require for adoption the affirmative vote of at least $^{2}/_{3}$ of the votes cast by voting members.

(j) *Documents to be filed following approval.* — Within 30 days after the voting members have approved the plan in accordance with the requirements of this section, the converted stock company shall file the following documents with the Commissioner:

(1) The minutes of the meeting of the voting members at which the plan was approved.

(2) The certificate of incorporation and bylaws of the converted stock company.

(77 Del. Laws, c. 466, § 2; 78 Del. Laws, c. 313, § 2.)

§ 4974. Redomestication and conversion.

(a) A foreign mutual insurer or foreign mutual holding company that has filed an application for redomestication may file an application for conversion under this chapter promptly after completion of the redomestication or upon such earlier date as the Commissioner may permit, but in no event prior to the approval of the redomestication by the members of the foreign mutual insurer or foreign mutual holding company if such a member vote is required under the laws of the state of domicile of the foreign mutual insurer or foreign mutual holding company. A redomestication application shall contain such information as the Commissioner may require. If the redomestication is approved by the state of domicile of the foreign mutual insurer or foreign mutual holding company and the members of the foreign mutual insurer or foreign mutual holding company, to the extent required, then no redomestication application of a foreign mutual insurer or foreign mutual holding company will be denied solely because the applicant has indicated its intention to avail itself of the provisions of this chapter.

(b) In addition to any requirements imposed by the existing state of domicile with respect to approval of redomestication by its voting members, a foreign mutual insurer that files an application for redomestication under this section also shall provide to its voting members a comparison of the method of mutual to stock conversion in its existing state of domicile and the methods of mutual to stock conversion established by this chapter.

(c) Any order approving the redomestication of a foreign mutual insurer or foreign mutual holding company may contain such terms and conditions as the Commissioner shall require.

(d) Any foreign mutual insurer or foreign mutual holding company that redomesticates under the provisions of this section, within 10 days of the date of redomestication, shall adopt resolutions ratifying any previously adopted plan of conversion and file such resolutions as an amendment to the application for conversion. The Commissioner may deem any failure to file such ratifying resolutions as a withdrawal of the application for conversion.

(e) Nothing contained in this chapter is intended or shall be deemed to supersede or conflict with the requirements of the state of domicile of any foreign mutual insurer or foreign mutual holding company.

(f) Except to the extent specifically provided by this section, a plan of conversion shall be adopted as required by § 4973 of this title and shall be consistent with the requirements of §§ 4975, 4976, and 4977, or of § 4978, of this title.

(77 Del. Laws, c. 466, § 2; 78 Del. Laws, c. 313, § 3.)

§ 4975. Required provisions of plan of conversion.

(a) The following provisions shall be included in the plan:

(1) The reasons for proposed conversion.

(2) The effect of conversion on existing policies, including all of the following:

a. A provision that all policies in force on the effective date of conversion continue to remain in force under the terms of the policies, except that the following rights, to the extent they existed in the mutual company, shall be extinguished on the effective date of the conversion:

1. Any voting rights of the policyholders provided under the policies.

2. Except as provided under paragraph (a)(2)b. of this section, any right to share in the surplus of the mutual company, unless such right is expressly provided for under the provisions of the existing policy.

3. Any assessment provisions provided for under certain types of policies.

b. Except as provided in paragraph (a)(2)c. of this section, a provision that holders of participating policies in effect on the date of conversion continue to have a right to receive dividends as provided in the participating policies, if any.

c. Except for the mutual company's life policies, participating guaranteed renewable accident and health policies, and participating guaranteed renewable noncancelable accident and health policies, a provision that upon the renewal date of a participating policy, the converted stock company may issue the insured a nonparticipating policy as a substitute for the participating policy. Nothing contained herein shall be construed to permit the substitution, during the term of a policy, of a nonexperience rated policy for an experience rated policy.

(3) The grant of subscription rights to eligible members, including both of the following:

a. A provision that each eligible member is to receive, without payment, nontransferable subscription rights to purchase the capital stock of the converted stock company and that, in the aggregate, all eligible members shall have the right, prior to the right of any other party, to purchase 100% of the capital stock of the converted stock company, exclusive of any shares of capital stock required to be sold or distributed to the holders of surplus notes, if any, and capital stock purchased by the company's tax-qualified employee stock benefit plan that is in excess of the total price of the capital stock established under subsection (d) of this section, as permitted by § 4977(c) of this title. As an alternative to subscription rights in the converted stock company, the plan may provide that each eligible member is to receive, without payment, nontransferable subscription rights to purchase a portion of the capital stock of one of the following:

1. A corporation or entity organized for the purpose of purchasing and holding all the stock of the converted stock company; provided however, that the Commissioner may, in the Commissioner's discretion, require that such corporation or entity be incorporated or formed in this State;

2. A stock insurer owned by the mutual company into which the mutual company will be merged; or

3. An unaffiliated stock insurer or other corporation or entity that will purchase all the stock of the converted stock company.

For purposes of any plan, the transfer of subscription rights from: (i) an individual to such individual and his or her spouse or children or to a trust or other estate or wealth planning entity established for the benefit of such individual, his or her spouse or children, (ii) an individual to such individual's joint or individual IRA account, or other tax-qualified retirement plan, (iii) an entity to the shareholders, partners or members of such entity, or (iv) the holder of such rights to the mutual insurance company or its proposed holding company, shall not be deemed an unpermitted transfer for purposes of this chapter.

b. A provision that the subscription rights shall be allocated in whole shares among the eligible members using a fair and equitable formula. The formula need not allocate subscription rights to eligible members on a pro rata basis based on premium payments or contributions to surplus, but may take into account how the different classes of policies of the eligible members contributed to the surplus of the mutual company or any other factors that may be fair or equitable. In accordance with § 4973(e) of this title, the Commissioner may retain an independent consultant to assist in the determination that the allocation of subscription rights is fair and equitable.

(b) The plan shall provide a fair and equitable means for allocating shares of capital stock in the event of an oversubscription to shares by eligible members exercising subscription rights received under paragraph (a)(3) of this section.

(c) The plan shall provide that any shares of capital stock not subscribed to by eligible members exercising subscription rights received under paragraph (a)(3) of this section shall be sold in a public offering or to another corporation or entity that is participating in the conversion plan, as provided in paragraph (a)(3)a. of this section. If the number of shares of capital stock not subscribed by eligible members is so small in number or other factors exist that:

(1) Do not warrant the time or expense of a public offering, or

(2) Warrant the participation of standby investors to facilitate completion of the conversion,

the plan of conversion may provide for sale of the unsubscribed shares through a private placement or other alternative method approved by the Commissioner that is fair and equitable to eligible members.

(d) The plan shall set the dollar amount of the capital stock for which subscription rights must be granted pursuant to paragraph (a)(3) of this section equal to the estimated pro forma market value of the converted stock company based upon an independent evaluation by a qualified expert. This pro forma market value may be that value that is estimated to be necessary to attract full subscription for the shares, as indicated by the independent evaluation, and may be stated as a range of pro forma market value.

(e) The plan shall set the purchase price per share of capital stock equal to any reasonable amount. However, the minimum subscription amount required of any eligible member cannot exceed $500, but the plan may provide that the minimum number of shares any person may purchase pursuant to the plan is 25 shares. The purchase price per share at which capital stock is offered to persons who are not eligible members may be greater than but not less than the purchase price per share at which capital stock is offered to eligible members.

(f) The plan shall provide that any person or group of persons acting in concert shall not acquire, in the public offering or pursuant to the exercise of subscription rights, more than 5% of the capital stock of the converted stock company or the stock of another corporation that is participating in the conversion plan, as provided in paragraph (a)(3)a. of this section, except with the approval of the Commissioner. This limitation does not apply to any entity that is to purchase 100% of the capital stock of the converted stock company as part of the plan of conversion approved by the Commissioner or to any person that acts as a standby investor of the capital stock of the converted stock company for an amount equal to 10% or more of the capital stock of the converted stock company, provided that in each case such purchase by a standby investor of 10% or more of the capital stock of the converted stock company is approved by the Commissioner in accordance with the provisions of Delaware law following the filing of an acquisition of control statement pursuant to § 5003 of this title.

(g) The plan shall provide that no director or officer or person acting in concert with a director or officer of the mutual company shall acquire any capital stock of the converted stock company or the stock of another corporation that is participating in the conversion plan, as provided in paragraph (a)(3)a. of this section, for 3 years after the effective date of the plan, except through a broker-dealer, without the permission of the Commissioner. This provision does not prohibit the directors and officers from:

(1) Making block purchases of 1% or more of the outstanding common stock other than through a broker-dealer if approved in writing by the Department;

(2) Exercising subscription rights received under the plan; or

(3) Participating in a stock benefit plan permitted by § 4977(c) of this title, or approved by shareholders pursuant to § 4982(b) of this title.

(h) The plan shall provide that no director or officer may sell stock purchased pursuant to this section, or § 4977(a) of this title within 1 year after the effective date of the conversion, except that nothing contained in this section shall be deemed to restrict a transfer of stock by such director or officer if the stock is the stock of a corporation that is participating in the conversion plan as provided in paragraph (a)(3)a.3. of this section and has a class of stock registered under the Securities Exchange Act of 1934, as amended (15 U.S.C. § 78a et seq.), or if the transfer is to the spouse or minor children of such director or officer, or a to a trust or other estate or wealth planning entity established for the benefit of such director or officer, or the spouse or minor children of such director or officer.

(i) The plan shall provide that the rights of a holder of a surplus note to participate in the conversion, if any, shall be governed by the terms of the surplus note.

(j) The plan shall provide that, without the prior approval of the Commissioner, no converted stock company, or any corporation participating in the conversion plan pursuant to paragraph (a)(3)a.1. or (a)(3)a.2. of this section, shall, for a period of 3 years from the date of the completion of the conversion, repurchase any of its capital stock from any person, except that this restriction shall not apply to either:

(1) A repurchase on a pro rata basis pursuant to an offer made to all shareholders of the converted stock company, or any corporation participating in the conversion plan pursuant to paragraph (a)(3)a.1. or (a)(3)a.2. of this section; or

(2) A purchase in the open market by a tax-qualified, or nontax-qualified employee stock benefit plan in an amount reasonable and appropriate to fund the plan.

(77 Del. Laws, c. 466, § 2; 70 Del. Laws, c. 186, § 1; 78 Del. Laws, c. 313, § 4.)

§ 4976. Closed block of business for participating life policies.

(a) A plan that is adopted by a mutual company that is a life insurance company which issues participating life policies shall provide that participating life policies in force on the effective date of the conversion shall be operated by the converted stock company for dividend purposes as a closed block of participating business, except that any and all classes of group participating policies may be excluded from the closed block.

(b) The plan shall provide that sufficient assets of the mutual company shall be allocated for the benefit of the closed block of business so that the assets, together with the revenue from the closed block of business, are sufficient to support the closed block, including, but not limited to, the payment of claims, expenses, taxes, and any dividends that are provided for under the terms of the participating policies, with appropriate adjustments in the dividends for experience changes. The plan shall be accompanied by an opinion of a qualified actuary, or an appointed actuary, who meets the standards set forth in the insurance laws or regulations of this State for the submission of actuarial opinions as to the adequacy of reserves or assets. The opinion shall relate to the adequacy of the assets allocated in support of the closed

block of business. The actuarial opinion shall be based on methods of analysis deemed appropriate for those purposes by the Actuarial Standards Board.

(c) The amount of assets allocated for the benefit of the closed block shall be based upon the mutual life insurance company's last annual statement, updated to the last day of the quarter immediately preceding the effective date of the conversion.

(d) The converted stock company shall keep a separate accounting for the closed block and shall make and include in the annual statement to be filed with the Commissioner each year a separate statement showing the gains, losses, and expenses properly attributable to the closed block.

(e) The assets and liabilities allocated to the closed block may be periodically reviewed by the Commissioner or the Commissioner's designee. The converted stock company shall bear the cost of any such review. If, as a result of such review, the Commissioner determines that the assets allocated to the closed block are insufficient to support the remaining policies in the closed block, the Commissioner may issue an order directing the converted stock company to allocate additional assets to the closed block sufficient to support the remaining policies in the closed block and the converted stock company shall comply with such order within 30 days of the date thereof. If, as a result of such review, or as a result of a review initiated by the converted stock company and accepted by the Commissioner, assets allocated to the closed block are in excess of the amount necessary to support the remaining policies, then upon application made to the Commissioner by the converted stock company, the Commissioner may issue an order permitting such excess assets in the closed block to revert to the benefit of the converted stock company.

(f) The Commissioner may waive the requirement for establishing a closed block of business if, in the Commissioner's discretion, it is in the best interests of policyholders to do so. The Commissioner may waive from inclusion in the closed block of participating policies those participating policies for which there is no expectation of dividends being paid if, in the Commissioner's discretion, it is fair and equitable to do so.

(77 Del. Laws, c. 466, § 2.)

§ 4977. Optional provisions of plan of conversion.

(a) The plan may provide that the directors, officers, and employees of the mutual company shall receive, without payment, nontransferable subscription rights to purchase capital stock of the converted stock company or the stock of another corporation that is participating in the conversion plan, as provided in § 4975(a)(3)a. of this title. These subscription rights shall be allocated among the directors, officers, and employees by a fair and equitable formula and shall be subordinate to the subscription rights of eligible members. Nothing contained in this chapter shall require the subordination of subscription rights received by directors and officers in their capacity as eligible members, if any.

(b) The aggregate total number of shares that may be purchased by directors and officers of the mutual company in their capacity under subsection (a) of this section and in their capacity as eligible members under § 4975(a)(3)a. of this title shall not exceed 35% of the total number of shares to be issued for a mutual company if total assets of the mutual company are less than $50,000,000 or 25% of the total number of shares to be issued for a mutual company if total assets of the mutual company are more than $500,000,000. For mutual companies with total assets of or between $50,000,000 and $500,000,000, the percentage of the total number of shares that may be purchased shall be interpolated.

(c) The plan may allocate to a tax-qualified employee benefit plan nontransferable subscription rights to purchase up to 10% of the capital stock of the converted stock company or the stock of another corporation that is participating in the conversion plan, as provided in § 4975(a)(3)a. of this title. A tax-qualified employee benefit plan is entitled to exercise subscription rights granted under this subsection regardless of the total number of shares purchased by other persons.

(d) The plan may provide that the other classes of subscribers approved by the Commissioner shall receive, without payment, nontransferable subscription rights to purchase capital stock of the converted stock company or the stock of another corporation that is participating in the conversion plan, as provided in § 4975(a)(3)a. of this title. Other classes of subscribers that may be approved by the Commissioner include, without limitation:

(1) Members of the mutual insurer that became members after the date fixed for establishing eligible members;

(2) Brokers, agents, or other producers or their directors, officers, or employees that represent the mutual insurer;

(3) The shareholders of another corporation that is participating in the conversion plan, as provided in § 4975(a)(3)a. of this title; or

(4) The shareholders of another corporation that is a party to an acquisition, merger, consolidation, or other similar transaction with the mutual insurer.

(e) The plan may provide for the creation of a liquidation account for the benefit of members in the event of voluntary liquidation subsequent to conversion in an amount equal to the surplus of the mutual company, exclusive of the principal amount of any surplus note, on the last day of the quarter immediately preceding the date of adoption of the plan.

(77 Del. Laws, c. 466, § 2.)

§ 4978. Alternative plan of conversion.

(a) The governing body may adopt a plan of conversion that does not rely in whole or in part upon issuing nontransferable subscription rights to members to purchase stock of the converted stock company if the Commissioner finds that the plan does not prejudice the

interests of the members, is fair and equitable, and is not inconsistent with the purpose and intent of this chapter. Subject to a finding of the Commissioner that an alternative plan is fair and equitable and is not inconsistent with the purpose and intent of this chapter, an alternative plan may:

(1) Include the merger of a domestic mutual insurer into a domestic or foreign stock insurer.

(2) Provide for issuing transferable or redeemable subscription rights.

(3) Provide for issuing stock, cash, policyholder credits, or other consideration, or any combination of the foregoing, to policyholders instead of subscription rights.

(4) Provide for partial conversion of the mutual company and formation of a mutual holding company in accordance with subsection (b) of this section.

(5) Set forth another plan containing any other provisions approved by the Commissioner.

(b) The Commissioner may approve a partial conversion and formation of a mutual holding company provided that the mutual insurer is not insolvent or in hazardous financial condition according to information supplied in its most recent annual or quarterly statement filed with the Commissioner or as determined by a financial examination performed by the Commissioner pursuant to § 318 of this title. The Commissioner may retain, at the mutual company's expense, any qualified expert, including counsel and financial advisors, not otherwise a part of the Commissioner's staff to assist in reviewing whether the plan may be approved by the Commissioner.

(c) *Conversion of mutual holding company.* — (1) Any mutual holding company may convert to stock form only in accordance with the provisions of this chapter. Solely for purposes of establishing the process for and enabling and facilitating any conversion of a mutual holding company to stock form, references in this chapter to a mutual company shall be deemed to refer to a mutual holding company and other provisions of this chapter shall be interpreted accordingly.

(2) Any stock issued by a subsidiary insurance company or subsidiary holding company of a mutual holding company to persons other than the parent mutual holding company shall be exchanged for the stock issued by the parent mutual holding company in connection with the conversion of the parent mutual holding company to stock form or any corporation participating in the conversion of the mutual holding company pursuant to § 4975(a)(3)a. of this title. The parent mutual holding company and the subsidiary holding company or insurance company must demonstrate to the satisfaction of the Commissioner that the basis for the exchange is fair and reasonable.

(3) If a subsidiary holding company or insurance company has issued shares to an entity other than the mutual holding company, the conversion of the mutual holding company to stock form may not be consummated unless a majority of the shares issued to the entities other than the mutual holding company vote in favor of the conversion. This requirement applies in addition to any otherwise required policyholder or shareholder votes.

(77 Del. Laws, c. 466, § 2; 78 Del. Laws, c. 313, § 5.)

§ 4979. Effective date of plan.

A plan is effective when the Commissioner has approved the plan, the voting members have approved the plan and adopted the certificate of incorporation of the converted stock company, and the certificate of incorporation is filed in the office of the Secretary of State of this State.

(77 Del. Laws, c. 466, § 2.)

§ 4980. Rights of members whose policies are issued after adoption of plan and before effective date.

(a) All members whose policies are issued after the proposed plan has been adopted by the governing body and before the effective date of the plan shall be sent a written notice regarding the plan upon issuance of such policy.

(b) A member of a life or health insurance company entitled to be sent the notice described in subsection (a) of this section is entitled to rescind the member's policy and receive a full refund of any amounts paid for the policy or contract within 10 days after such member has received the notice. Except as provided in subsection (c) of this section, each member of a property or casualty insurance company entitled to receive the notice provided for in subsection (a) of this section shall be advised of the member's right of cancellation and to a pro rata refund of unearned premiums.

(c) No member of a life or health insurance company, or property or casualty insurance company, who has made or filed a claim under such member's insurance policy shall be entitled to any right to receive any refund under subsection (b) of this section. No person who has exercised the rights provided by subsection (b) of this section shall be entitled to make or file any claim under such person's insurance policy.

(77 Del. Laws, c. 466, § 2.)

§ 4981. Corporate existence.

(a) On the effective date of the conversion, the corporate existence of the mutual company continues in the converted stock company. On the effective date of the conversion, all the assets, rights, franchises, and interests of the mutual company or the mutual holding company in and to every species of property, real, personal, and mixed, and any accompanying things in action, are vested in the converted stock company without any deed or transfer and the converted stock company assumes all the obligations and liabilities of the mutual company or the mutual holding company.

(b) Unless otherwise specified in the plan of conversion, the persons who are directors and officers of the mutual company or the mutual holding company on the effective date of the conversion shall serve as directors and officers of the converted stock company until new directors and officers of the converted stock company are elected pursuant to the certificate of incorporation and bylaws of the converted stock company.

(77 Del. Laws, c. 466, § 2; 78 Del. Laws, c. 313, § 6.)

§ 4982. Conflict of interest.

(a) A director, officer, agent, or employee of the mutual company shall not receive any fee, commission, or other valuable consideration, other than such person's usual regular salary or compensation, for aiding, promoting, or assisting in a conversion under this chapter, except as provided for in the plan approved by the Commissioner. This provision does not prohibit the payment of reasonable fees and compensation to attorneys, accountants, financial advisors, and actuaries for services performed in the independent practice of their professions, even if the attorney, accountant, financial advisor, or actuary is also a director or officer of the mutual company.

(b) For a period of 2 years after the effective date of the conversion, no converted stock company shall implement any nontax-qualified stock benefit plan unless the plan is approved by a majority of votes cast at a duly-convened meeting of shareholders held not less than 6 months after the effective date of the conversion.

(c) All the costs and expenses connected with a plan of conversion shall be paid for or reimbursed by the mutual company or the converted stock company. However, if the plan provides for participation by another corporation or stock company in the plan pursuant to § 4975(a)(3)a. of this title, the corporation or stock company may pay for or reimburse all or a portion of the costs and expenses connected with the plan.

(77 Del. Laws, c. 466, § 2.)

§ 4983. Failure to give notice.

If the mutual company complies substantially and in good faith with the notice requirements of this chapter, the mutual company's failure to send a member the required notice does not impair the validity of any action taken under this chapter.

(77 Del. Laws, c. 466, § 2.)

§ 4984. Limitation on actions.

Any action challenging the validity of or arising out of acts taken or proposed to be taken under this chapter shall be commenced no later than the latter of:

(1) Sixty days after the approval of the plan by the Commissioner; or

(2) Thirty days after notice of the meeting of voting members to approve the plan of conversion is first mailed or delivered to voting members or posted on the mutual company's website.

(77 Del. Laws, c. 466, § 2.)

§ 4985. Mutual company insolvent or in hazardous financial condition.

(a) If a mutual company seeking to convert is insolvent or is in hazardous financial condition according to information supplied in its most recent annual or quarterly statement filed with the Department or as determined by a financial examination performed by the Department pursuant to § 318 of this title, the requirements of this chapter, including notice to and policyholder approval of the plan of conversion, may be waived at the discretion of the Commissioner, if requested by the mutual company. If a waiver under this section is ordered by the Commissioner, the mutual company shall specify in its plan of conversion:

(1) The method and basis for the issuance of the converted stock company's shares of its capital stock to an independent party in connection with an investment by the independent party in an amount sufficient to restore the converted stock company to a sound financial condition.

(2) That the conversion shall be accomplished without granting subscription rights or other consideration to the past, present, or future policyholders.

(b) Nothing contained in this section shall alter or limit the authority of the Commissioner under any of the provisions of law, including, but not limited to, Chapter 59 of this title.

(77 Del. Laws, c. 466, § 2.)

§ 4986. Rules and regulations.

The Commissioner may promulgate rules and regulations to administer and enforce this chapter.

(77 Del. Laws, c. 466, § 2.)

§ 4987. Laws applicable to converted stock company.

(a) No mutual company shall be permitted to convert under this chapter if, as a direct result of the conversion, any person or any affiliate thereof acquires control of the converted stock company, unless that person and such person's affiliates comply with the provisions of § 5003 of this title. For purposes of this subsection, "control" shall have the meaning given to such term in § 5001 of this title.

(b) Except as otherwise specified in this chapter, a stock company converted under this chapter shall have and may exercise all the rights and privileges and shall be subject to all of the requirements and regulations imposed on stock insurers under this chapter and any other laws of this State relating to the regulation and supervision of insurers, but it shall exercise no rights or privileges which other stock insurers may not exercise.

(77 Del. Laws, c. 466, § 2.)

§ 4988. Commencement of business as a stock insurer.

No mutual company shall have the power to engage in the business of insurance as a stock company until it complies with all provisions of this chapter.

(77 Del. Laws, c. 466, § 2.)

§ 4989. Amendment of policies.

A mutual company, by endorsement or rider approved by the Commissioner and sent to the policyholder, may simultaneously with or at any time after the adoption of a plan of conversion amend any outstanding insurance policy for the purpose of extinguishing the right of the holder of any such policy to share in the surplus of the mutual company. However, this amendment shall be null and void if the plan of conversion is not submitted to the Commissioner or, if submitted, is disapproved by the Commissioner or, if approved by the Commissioner, is not approved by the eligible members on or before the first anniversary of its approval by the Commissioner.

(77 Del. Laws, c. 466, § 2.)

§ 4990. Prohibition on acquisitions of control.

Except as otherwise specifically provided in § 4975 of this title, from the date a plan of conversion is adopted by the governing body of a mutual company until 3 years after the effective date of the plan of conversion, no person shall directly or indirectly offer to acquire, make any announcement to acquire or acquire in any manner, including making a filing with the Department for such acquisition under a statute or regulation of this State, the beneficial ownership of 10% or more of a class of a voting security of the converted stock company or of a person which controls the voting securities of the converted stock company, unless the converted stock company or a person who controls the voting securities of the converted stock company consents to such acquisition and such acquisition is otherwise approved by the Commissioner.

(77 Del. Laws, c. 466, § 2.)

§ 4991. Applicability to existing mutual insurers.

(a) Except as provided in subsection (b) of this section, this chapter shall apply to all mutual insurers.

(b) Section 4933 of this title as in effect prior to October 17, 2010, is hereby repealed, except as set forth in the next sentence. Section 4933 of this title as in effect on October 16, 2010, shall apply to any mutual insurer that is a domestic mutual company as of such date that has not submitted a written notice to the Commissioner under subsection (c) of this section.

(c) Any mutual insurer that is a domestic mutual company as of the date immediately prior to the enactment of this chapter that otherwise would be subject to the application of this chapter, § 4933 of this title as in effect on such date may elect to become subject to the application of this chapter instead by submitting to the Commissioner a written notice to that effect.

(77 Del. Laws, c. 466, § 2.)

Part I
Insurance
Chapter 50
Insurance Holding Company System Registration

§ 5001. Definitions.

For purposes of this chapter:

(1) *"Affiliate."* — An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through 1 or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(2) *"Commissioner."* — The term "Commissioner" shall mean the Insurance Commissioner, the Commissioner's deputies, or the Insurance Department, as appropriate.

(3) *"Control."* — The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 10 percent or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by § 5004(k) of this title that control does not exist in fact. The Commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(4) *"Enterprise risk."* — The term "enterprise risk" shall mean any activity, circumstance, event or series of events, involving 1 or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including, but not limited to, anything that would cause the insurer's risk-based capital to fall into company action level as set forth in § 5803 of this title or would cause the insurer to be in hazardous financial condition as set forth in Section 3 of Department of Insurance Regulation 304 — Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition [18 DE Admin. Code 304-3.0].

(5)

"Group capital calculation instructions" means the group capital calculation instructions adopted by the NAIC and as amended, from time to time, by the NAIC.

(6) *"Group-wide supervisor."* — The "group-wide supervisor" is the regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is determined or acknowledged by the Commissioner under § 5015 of this title to have sufficient significant contacts with the internationally active insurance group.

(7) *"Insurance holding company system."* — An "insurance holding company system" consists of 2 or more affiliated persons, 1 or more of which is an insurer.

(8) *"Insurer."* — The term "insurer" shall have the same meaning as set forth in § 102 of this title, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(9) *"Person."* — A "person" is an individual, a corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert, but shall not include any joint venture partnership exclusively engaged in owning, managing, leasing or developing real or tangible personal property.

(10) *"NAIC"* means National Association of Insurance Commissioners.

(11) *"NAIC liquidity stress test framework"* means the NAIC publication which includes a history of the NAIC's development of regulatory liquidity stress testing, the scope criteria applicable for a specific data year, and the liquidity stress test instructions and reporting templates for a specific data year, as adopted by the NAIC, and as amended from time to time by the NAIC, in accordance with the procedures adopted by the NAIC.

(12) *"Internationally active insurance group."* — An "internationally active insurance group" is an insurance holding company system that meets all of the following criteria:

a. Includes an insurer registered under § 5004 of this title.

b. Has premiums written in at least 3 countries.

c. Has gross premiums written outside the United States that are at least 10% of total gross written premiums.

d. Based on a 3-year rolling average, has total assets of at least $50 billion or total gross written premiums of at least $10 billion.

(13) *"Scope criteria"* means the designated exposure bases, along with minimum magnitudes thereof for the specified data year, used to establish a preliminary list of insurers considered scoped into the NAIC liquidity stress test framework for that data year.

(14) *"Securityholder."* — A "securityholder" of a specified person is one who owns any security of such person, including common stock, preferred stock, debt obligations and any other security convertible into or evidencing the right to acquire any of the foregoing.

(15) *"Subsidiary."* — A "subsidiary" of a specified person is an affiliate controlled by such person directly or indirectly through 1 or more intermediaries.

(16) *"Voting security."* — The term "voting security" shall include any security convertible into or evidencing a right to acquire a voting security.

(18 Del. C. 1953, § 5002; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 197, § 1; 60 Del. Laws, c. 616, § 3; 68 Del. Laws, c. 325, § 1; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 388, § 1; 80 Del. Laws, c. 118, § 1; 83 Del. Laws, c. 272, § 1.)

§ 5002. Subsidiaries of insurers.

Any domestic insurer, either by itself or in cooperation with 1 or more persons, may organize or acquire 1 or more subsidiaries as otherwise permitted under this title. Such subsidiaries may conduct any kind of business or businesses and their authority to do so shall not be limited by reason of the fact that they are subsidiaries of a domestic insurer.

(68 Del. Laws, c. 325, § 1; 79 Del. Laws, c. 388, § 1.)

§ 5003. Acquisition of control of or merger with domestic insurer.

(a) *Filing requirements.* — No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities, or seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the consummation thereof, such person would, directly or indirectly (or by conversion or by exercise of any right to acquire) be in control of such insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time any such offer, request or invitation is made or any such agreement is entered into, or prior to the acquisition of such securities if no offer or agreement is involved, such person has filed with the Commissioner and has sent to such insurer, a statement containing the information required by this section and such offer, request, invitation, agreement or acquisition has been approved by the Commissioner in the manner hereinafter prescribed.

For purposes of this section, any controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer, in any manner, shall file with the Commissioner, with a copy to the insurer, confidential notice of its proposed divestiture at least 30 days prior to the cessation of control. The Commissioner shall determine those instances in which the party or parties seeking to divest or to acquire a controlling interest in an insurer, will be required to file for and obtain approval of the transaction. The information shall remain confidential until the conclusion of the transaction unless the Commissioner, in the Commissioner's discretion, determines that confidential treatment will interfere with enforcement of this section. If the statement referred to in the above paragraph of this subsection (a) is otherwise filed, this paragraph shall not apply.

With respect to a transaction subject to this section, the acquiring person must also file a pre-acquisition notification with the Commissioner, which shall contain the information set forth in § 5003A of this title 30 days prior to the proposed effective date of the acquisition. A failure to file the notification may result in penalties specified in § 5003A of this title.

For purposes of this section, a domestic insurer shall include any person controlling a domestic insurer unless such person, as determined by the Commissioner, is either directly or through its affiliates primarily engaged in business other than the business of insurance. For the purposes of this section, "person" shall not include any securities broker holding, in the usual and customary brokers function, less than 20 percent of the voting securities of an insurance company or of any person which controls an insurance company.

(b) *Content of statement.* — The statement to be filed with the Commissioner hereunder shall be made under oath or affirmation and shall contain the following information:

(1) The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in subsection (a) of this section is to be effected (hereinafter called "acquiring party"), and

a. If such person is an individual, the acquiring party's principal occupation and all offices and positions held during the past 5 years, and any conviction of crimes other than minor traffic violations during the past 10 years;

b. If such person is not an individual, a report of the nature of its business operations during the past 5 years or for such lesser period as such person and any predecessors thereof shall have been in existence; an informative description of the business intended to be done by such person and such person's subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of such person, or who perform or will perform functions appropriate to such positions. Such list shall include for each such individual the information required by paragraph (b)(1)a. of this section.

(2) The source, nature and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction wherein funds were or are to be obtained for any such purpose (including any pledge of the insurer's stock, or the stock of any of its subsidiaries or controlling affiliates), and the identity of persons furnishing such consideration; provided however, that where a source of such consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential, if the person filing such statement so requests.

(3) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding 5 fiscal years of each such acquiring party (or for such lesser period as such acquiring party and any predecessors thereof shall have been in existence), and similar unaudited information as of a date not earlier than 90 days prior to the filing of the statement.

(4) Any plans or proposals which each acquiring party may have to liquidate such insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management.

(5) The number of shares of any security referred to in subsection (a) of this section which each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement or acquisition referred to in subsection (a) of this section, and a statement as to the method by which the fairness of the proposal was arrived at.

(6) The amount of each class of any security referred to in subsection (a) of this section which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party.

(7) A full description of any contracts, arrangements or understandings with respect to any security referred to in subsection (a) of this section in which any acquiring party is involved, including, but not limited to, transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements or understandings have been entered into.

(8) A description of the purchase of any security referred to in subsection (a) of this section during the 12 calendar months preceding the filing of the statement, by any acquiring party, including the dates of purchase, names of the purchasers, and consideration paid or agreed to be paid therefore.

(9) A description of any recommendations to purchase any security referred to in subsection (a) of this section made during the 12 calendar months preceding the filing of the statement, by any acquiring party, or by anyone based upon interviews or at the suggestion of such acquiring party.

(10) Copies of all tender offers for, requests, or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in subsection (a) of this section, and (if distributed) of additional soliciting material relating thereto.

(11) The term of any agreement, contract or understanding made with or proposed to be made with any broker-dealer as to solicitation of securities referred to in subsection (a) of this section for tender, and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.

(12) An agreement by the person required to file the statement referred to in subsection (a) of this section that it will provide the annual report, specified in § 5004(*l*)(1) of this title, for so long as control exists.

(13) An acknowledgement by the person required to file the statement referred to in subsection (a) of this section that the person and all subsidiaries within its control in the insurance holding company system will provide information to the Commissioner upon request as necessary to evaluate enterprise risk to the insurer.

(14) Such additional information as the Commissioner may by rule or regulation prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest. If the person required to file the statement referred to in subsection (a) of this section is a partnership, limited partnership, syndicate or other group, the Commissioner may require that the information called for by paragraphs (b)(1) through (12) of this section shall be given with respect to each partner of such partnership or limited partnership, each member of such syndicate or group, and each person who controls such partner or member. If any such partner, member or person is a corporation or the person required to file the statement referred to in subsection (a) of this section is a corporation, the Commissioner may require that the information called for by paragraphs (b)(1) through (12) of this section shall be given with respect to such corporation, each officer and director of such corporation, and each person who is directly or indirectly the beneficial owner of more than 10 percent of the outstanding voting securities of such corporation.

If any material change occurs in the facts set forth in the statement filed with the Commissioner and sent to such insurer pursuant to this section, an amendment setting forth such change, together with copies of all documents and other material relevant to such change, shall be filed with the Commissioner and sent to such insurer within 2 business days after the person learns of such change.

(c) *Alternative filing materials. —* If any offer, request, invitation, agreement or acquisition referred to in subsection (a) of this section is proposed to be made by means of a registration statement under the Securities Act of 1933 [15 U.S.C. § 77a et seq.] or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934 [15 U.S.C. § 78a et seq.], or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in subsection (a) of this section may utilize such documents in furnishing the information called for by that statement.

(d) *Approval by Commissioner: Hearings. —* (1) The Commissioner shall approve any merger or other acquisition of control referred to in subsection (a) of this section unless, after a public hearing thereon, the Commissioner finds that:

a. After the change of control, the domestic insurer referred to in subsection (a) of this section would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

b. The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this State or tend to create a monopoly therein. In applying the competitive standard in this paragraph:

1. The informational requirements of § 5003A(c)(1) of this title and the standards of § 5003A(d)(2) of this title shall apply;

2. The merger or other acquisition shall not be disapproved if the Commissioner finds that any of the situations meeting the criteria provided by § 5003A(d)(3) of this title exist; and

3. The Commissioner may condition the approval of the merger or other acquisition on the removal of the basis of disapproval within a specified period of time;

c. The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders;

d. The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest;

e. The competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control; or

f. The acquisition is likely to be hazardous or prejudicial to the insurance buying public.

(2) The public hearing referred to in paragraph (d)(1) of this section shall be held within 45 days after the statement required by subsection (a) of this section is filed, and at least 20 days' notice thereof shall be given by the Commissioner to the person filing the statement.

Not less than 7 days' notice of such public hearing shall be given by the person filing the statement to the insurer and to such other persons as may be designated by the Commissioner. The Commissioner shall make a determination within 30 days after the conclusion of such hearing. At such hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected thereby shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and in connection therewith shall be entitled to conduct discovery proceedings in the same manner as is presently allowed in the Superior Court of this State. All discovery proceedings shall be concluded not later than 3 days prior to the commencement of the public hearing.

If the proposed acquisition of control will require the approval of more than 1 Commissioner, the public hearing referred to in paragraph (d)(1) of this section may be held on a consolidated basis upon request of the person filing the statement referred to in subsection (a) of this section. Such person shall file the statement referred to in subsection (a) of this section with the National Association of Insurance Commissioners (NAIC) within 5 days of making the request for a public hearing. A Commissioner may opt out of a consolidated hearing, and shall provide notice to the applicant of the opt-out within 10 days of the receipt of the statement referred to in subsection (a) of this section. A hearing conducted on a consolidated basis shall be public and shall be held within the United States before the Commissioners of the states in which the insurers are domiciled. Such Commissioners shall hear and receive evidence. A Commissioner may attend such hearing in person or by telecommunication.

(3) The Commissioner may retain at the acquiring person's expense any attorneys, actuaries, accountants and other experts not otherwise a part of the Commissioner's staff as may be reasonably necessary to assist the Commissioner in reviewing the proposed acquisition of control.

(e) *Exemptions.* — The provisions of this section shall not apply to:

(1) Any transaction which is subject to the provisions of Chapter 49 of this title dealing with the merger or consolidation of 2 or more insurers.

(2) Any offer, request, invitation, agreement or acquisition which the Commissioner by order shall exempt therefrom as:

a. Not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer; or

b. Otherwise not comprehended within the purposes of this section.

(f) *Violations.* — The following shall be violations of this section:

(1) The failure to file any statement, amendment or other material required to be filed pursuant to subsection (a) or (b) of this section; or

(2) The effectuation or any attempt to effectuate an acquisition of control of, or merger with, a domestic insurer unless the Commissioner has given approval thereto.

(g) *Jurisdiction, consent to service of process.* — The courts of this State are hereby vested with jurisdiction over every person not resident, domiciled or authorized to do business in this State who files a statement with the Commissioner under this section, and over all actions involving such person arising out of violations of this section, and each such person shall be deemed to have performed acts equivalent to and constituting an appointment by such a person of the Commissioner to be the person's true and lawful attorney upon whom may be served all lawful process in any action, suit or proceeding arising out of violations of this section. Copies of all such lawful process shall be served on the Commissioner and transmitted by registered or certified mail by the Commissioner to such person at the person's last known address.

(68 Del. Laws, c. 325, § 1; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 388, § 1; 80 Del. Laws, c. 118, § 1; 83 Del. Laws, c. 272, § 2; 84 Del. Laws, c. 42, § 1.)

§ 5003A. Acquisitions involving insurers not otherwise covered.

(a) *Definitions.* — The following definitions shall apply for the purposes of this section only:

(1) "Acquisition" means any agreement, arrangement or activity the consummation of which results in a person acquiring directly or indirectly the control of another person, and includes but is not limited to the acquisition of voting securities, the acquisition of assets, bulk reinsurance and mergers.

(2) An "involved insurer" includes an insurer which either acquires or is acquired, is affiliated with an acquirer or acquired or is the result of a merger.

(b) *Scope.* — (1) Except as exempted in paragraph (b)(2) of this section, this section applies to any acquisition in which there is a change in control of an insurer authorized to do business in this State.

(2) This section shall not apply to the following:

a. A purchase of securities solely for investment purposes so long as such securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this State. If a purchase of securities results in a presumption of control under § 5001(3) of this title, it is not solely for investment purposes unless the commissioner of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and such disclaimer action or affirmative finding is communicated by the domiciliary commissioner to the Commissioner of this State;

b. The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if pre-acquisition notification is filed with the Commissioner in accordance with paragraph (c)(1) of this section 30 days prior to the proposed effective date of the acquisition. However, such pre-acquisition notification is not required for exclusion from this section if the acquisition would otherwise be excluded from this section by any other subparagraph of this paragraph;

c. The acquisition of already affiliated persons;

d. An acquisition if, as an immediate result of the acquisition:

1. In no market would the combined market share of the involved insurers exceed 5 percent of the total market;

2. There would be no increase in any market share; or

3. In no market would:

A. The combined market share of the involved insurers exceed 12 percent of the total market, and

B. The market share increases by more than 2 percent of the total market.

For the purpose of this paragraph (b)(2)d.3., a market means direct written insurance premium in this State for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this State;

e. An acquisition for which a pre-acquisition notification would be required pursuant to this section due solely to the resulting effect on the ocean marine insurance line of business;

f. An acquisition of an insurer whose domiciliary commissioner affirmatively finds that such insurer is in failing condition; there is a lack of feasible alternative to improving such condition; the public benefits of improving such insurer's condition through the acquisition exceed the public benefits that would arise from not lessening competition; and such findings are communicated by the domiciliary commissioner to the Commissioner of this State.

(c) *Pre-acquisition notification, waiting period.* — An acquisition covered by subsection (b) of this section may be subject to an order pursuant to subsection (e) of this section unless the acquiring person files a pre-acquisition notification and the waiting period has expired.

The acquired person may file a pre-acquisition notification. The Commissioner shall give confidential treatment to information submitted under this subsection in the same manner as provided in § 5007 of this title.

(1) The pre-acquisition notification shall be in such form and contain such information as prescribed by the National Association of Insurance Commissioners relating to those markets which, under paragraph (b)(2)d. of this section, cause the acquisition not to be exempted from the provisions of this section. The Commissioner may require such additional material and information as the Commissioner deems necessary to determine whether the proposed acquisition, if consummated, would violate the competitive standard of subsection (d) of this section. The required information may include an opinion of an economist as to the competitive impact of the acquisition in this State accompanied by a summary of the education and experience of such person indicating the person's ability to render an informed opinion.

(2) The waiting period required shall begin on the date of receipt by the Commissioner of a pre-acquisition notification and shall end on the earlier of the thirtieth day after the date of such receipt, or termination of the waiting period by the Commissioner. Prior to the end of the waiting period, the Commissioner on a one-time basis may require the submission of additional needed information relevant to the proposed acquisition, in which event the waiting period shall end on the earlier of the thirtieth day after receipt of such additional information by the Commissioner or termination of the waiting period by the Commissioner.

(d) *Competitive standard.* — (1) The Commissioner may enter an order under paragraph (e)(1) of this section with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in this State or tend to create a monopoly therein or if the insurer fails to file adequate information in compliance with subsection (c) of this section.

(2) In determining whether a proposed acquisition would violate the competitive standard of paragraph (d)(1) of this section, the Commissioner shall consider the following:

a. Any acquisition covered under subsection (b) of this section involving 2 or more insurers competing in the same market is prima facie evidence of violation of the competitive standards:

1. If the market is highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
4%	4% or more
10%	2% or more
15%	1% or more

2. Or, if the market is not highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
5%	5% or more
10%	4% or more
15%	3% or more
19%	1% or more

A highly concentrated market is one in which the share of the 4 largest insurers is 75 percent or more of the market. Percentages not shown in the tables are interpolated proportionately to the percentages that are shown. If more than 2 insurers are involved, exceeding the total of the 2 columns in the table is prima facie evidence of violation of the competitive standard in paragraph (d)(1) of this section. For the purpose of this paragraph (d)(2)a., the insurer with the largest share of the market shall be deemed to be Insurer A.

b. There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the 2 largest to the 8 largest, has increased by 7 percent or more of the market over a period of time extending from any base year 5 to 10 years prior to the acquisition up to the time of the acquisition. Any acquisition or merger covered under subsection (b) of this section involving 2 or more insurers competing in the same market is prima facie evidence of violation of the competitive standard in paragraph (d)(1) of this section if:

1. There is a significant trend toward increased concentration in the market;

2. One of the insurers involved is 1 of the insurers in a grouping of such large insurers showing the requisite increase in the market share; and

3. Another involved insurer's market is 2 percent or more.

c. For the purposes of subsection (d)(2) of this section:

1. The term "insurer" includes any company or group of companies under common management, ownership or control;

2. The term "market" means the relevant product and geographical markets. In determining the relevant product and geographical markets, the Commissioner shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the National Association of Insurance Commissioners and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, such line being that used in the annual statement required to be filed by insurers doing business in this State, and the relevant geographical market is assumed to be this State;

3. The burden of showing prima facie evidence of violation of the competitive standard rests upon the Commissioner.

d. Even though an acquisition is not prima facie violative of the competitive standard under paragraphs (d)(2)a. and b. of this section, the Commissioner may establish the requisite anticompetitive effect based upon other substantial evidence. Even though an acquisition is prima facie violative of the competitive standard under paragraphs (d)(2)a. and b. of this section, a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this paragraph include, but are not limited to, the following: market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry, and ease of entry and exit into the market.

(3) An order may not be entered under paragraph (e)(1) of this section if:

a. The acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from such economies exceed the public benefits which would arise from not lessening competition; or

b. The acquisition will substantially increase the availability of insurance, and the public benefits of such increase exceed the public benefits which would arise from not lessening competition.

(e) *Orders and penalties.* — (1) a. If an acquisition violates the standards of this section, the Commissioner may enter an order:

1. Requiring an involved insurer to cease and desist from doing business in this State with respect to the line or lines of insurance involved in the violation; or

2. Denying the application of an acquired or acquiring insurer for a license to do business in this State.

b. Such an order shall not be entered unless:

1. There is a hearing;

2. Notice of such hearing is issued prior to the end of the waiting period and not less than 15 days prior to the hearing; and

3. The hearing is concluded and the order is issued no later than 60 days after the end of the waiting period.

Every order shall be accompanied by a written decision of the Commissioner setting forth the Commissioner's findings of fact and conclusions of law.

c. An order entered under this paragraph shall not become final earlier than 30 days after it is issued, during which time the involved insurer may submit a plan to remedy the anticompetitive impact of the acquisition within a reasonable time. Based upon such plan or other information, the Commissioner shall specify the conditions, if any, under the time period during which the aspects of the acquisition causing a violation of the standards of this section would be remedied and the order vacated or modified.

d. An order pursuant to this paragraph shall not apply if the acquisition is not consummated.

(2) Any person who violates a cease and desist order of the Commissioner under paragraph (e)(1) of this section and while such order is in effect may, after notice and hearing and upon order of the Commissioner, be subject at the discretion of the Commissioner to any 1 or more of the following:

a. A monetary penalty of not more than $10,000 for every day of violation; and/or

b. Suspension or revocation of such person's license.

(3) Any insurer or other person who fails to make any filing required by this section, and who also fails to demonstrate a good faith effort to comply with any such filing requirement, shall be subject to a fine of not more than $50,000.

(f) *Inapplicable provisions.* — Sections 5009(b), (c) and 5011 of this title do not apply to acquisitions covered under subsection (b) of this section.

(68 Del. Laws, c. 325, § 1; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 388, § 1.)

§ 5004. Registration of insurers.

(a) *Registration.* — Every insurer which is authorized to do business in this State and which is a member of an insurance holding company system shall register with the Commissioner, except a foreign insurer subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained in:

(1) This section;

(2) Section 5005(a)(1) and (b) of this title; and

(3) Either § 5005(a)(2) of this title; or a provision such as the following:

Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within 15 days after the end of the month in which it learns of each such change or addition. Any insurer which is subject to registration under this section shall register within 15 days after it becomes subject to registration, and annually thereafter by June 1 of each year for the previous calendar year, unless the Commissioner for good cause shown extends the time for registration, and then within such extended time. The Commissioner may require any insurer authorized to do business in the State which is a member of a holding company system, and which is not subject to registration under this section, to furnish a copy of the registration statement, the summary specified in subsection (c) of this section or other information filed by such insurance company with the insurance regulatory authority of domiciliary jurisdiction.

(b) *Information and form required.* — Every insurer subject to registration shall file the registration statement with the Commissioner on a form and in a format prescribed by the National Association of Insurance Commissioners, which shall contain the following current information:

(1) The capital structure, general financial condition, ownership and management of the insurer and any person controlling the insurer;

(2) The identity and relationship of every member of the insurance holding company system;

(3) The following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between such insurer and its affiliates:

a. Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

b. Purchases, sales or exchange of assets;

c. Transactions not in the ordinary course of business;

d. Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

e. All management agreements, service contracts and all cost-sharing arrangements;

f. Reinsurance agreements;

g. Dividends and other distributions to shareholders; and

h. Consolidated tax allocation agreements;

(4) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;

(5) If requested by the Commissioner, the insurer shall include financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include but are not limited to annual audited financial statements filed with the U.S. Securities and Exchange Commission (SEC) pursuant to the Securities Act of 1933 [15 U.S.C. § 77a et seq.], as amended, or the Securities Exchange Act of 1934 [15 U.S.C. § 78a et seq.], as amended. An insurer required to file financial statements pursuant to this paragraph may satisfy the request by providing the Commissioner with the most recently filed parent corporation financial statements that have been filed with the SEC;

(6) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the Commissioner;

(7) Statements that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures; and

(8) Any other information required by the Commissioner by rule or regulation.

(c) *Summary of changes to registration statement.* — All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

(d) *Materiality.* — No information need be disclosed on the registration statement filed pursuant to subsection (b) of this section if such information is not material for the purposes of this section. Unless the Commissioner by rule, regulation or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, investments, or guarantees involving $^{1}/_{2}$ of 1 percent or less of an insurer's admitted assets as of December 31 next preceding shall not be deemed material for purposes of this section.

(e) *Reporting of dividends to shareholders.* — (1) Subject to § 5005(b) of this title, each registered insurer shall provide notice to the Commissioner of all dividends and other distributions to shareholders within 5 business days following the declaration thereof and at least 10 days prior to the payment thereof.

(2) The Commissioner shall promptly consider the information set forth in the notice under paragraph (e)(1) of this section. In the Commissioner's consideration of the information, the Commissioner shall apply the factors set forth in § 5005(c) of this title.

(f) *Information of insurers.* — Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurer, where such information is reasonably necessary to enable the insurer to comply with the provisions of this chapter.

(g) *Termination of registration.* — The Commissioner shall terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.

(h) *Consolidated filing.* — The Commissioner may require or allow 2 or more affiliated insurers subject to registration hereunder to file a consolidated registration statement.

(i) *Alternative registration.* — The Commissioner may allow an insurer which is authorized to do business in this State and which is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under subsection (a) of this section and to file all information and material required to be filed under this section.

(j) *Exemptions.* — The provisions of this section shall not apply to any insurer, information or transaction if and to the extent that the Commissioner by rule, regulation or order shall exempt the same from the provisions of this section.

(k) *Disclaimer.* — Any person may file with the Commissioner a disclaimer of affiliation with any authorized insurer or such a disclaimer may be filed by such insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between such person and such insurer as well as the basis for disclaiming such affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the Commissioner, within 30 days following receipt of a complete disclaimer, notifies the filing party the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer has been granted by the Commissioner, or if the disclaimer is deemed to have been approved.

(*l*) *Enterprise risk filings.* — (1) The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report shall, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The first enterprise risk report is not required until October 3, 2014, unless the Commissioner for good cause shown extends the time for filing, and then within such extended time. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the NAIC, with a copy to the Commissioner upon request.

(2) Group capital calculation. Except as provided below, the ultimate controlling person of every insurer subject to registration shall concurrently file with the registration an annual group capital calculation as directed by the lead state commissioner. The report shall be completed in accordance with the NAIC group capital calculation instructions, which may permit the lead state commissioner to allow a controlling person that is not the ultimate controlling person to file the group capital calculation. The report shall be filed with the lead

state commissioner of the insurance holding company system as determined by the Commissioner in accordance with the procedures within the Financial Analysis Handbook adopted by the NAIC. All of the insurance holding company systems described below are exempt from filing the group capital calculation:

a. An insurance holding company system that has only 1 insurer within its holding company structure, that only writes business and is only licensed in its domestic state, and assumes no business from any other insurer.

b. An insurance holding company system that is required to perform a group capital calculation specified by the United States Federal Reserve Board. The lead state commissioner shall request the calculation from the Federal Reserve Board under the terms of information sharing agreements in effect. If the Federal Reserve Board cannot share the calculation with the lead state commissioner, the insurance company holding system is not exempt from the group capital calculation filing.

c. An insurance holding company system whose non-U.S. group-wide supervisor is located within a reciprocal jurisdiction as described in § 911(6) of this title that recognizes the U.S. state regulatory approach to group supervision and group capital.

d. An insurance holding company system that meets both of the following:

1. That provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program, either directly or indirectly through the group-wide supervisor, who has determined such information is satisfactory to allow the lead state to comply with the NAIC group supervision approach, as detailed by the NAIC Financial Analysis Handbook.

2. Whose non-U.S. group-wide supervisor that is not in a reciprocal jurisdiction recognizes and accepts, as specified by the commissioner in regulation, the group capital calculation as the world-wide group capital assessment for U.S. insurance groups who operate in that jurisdiction.

e. Notwithstanding the provisions of paragraphs (*l*)(2)c. and d. of this section, a lead state commissioner shall require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system where, after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace.

f. Notwithstanding the exemptions from filing the group capital calculation stated in paragraphs (*l*)(2)a. through d. of this section, the lead state commissioner has the discretion to exempt the ultimate controlling person from filing the annual group capital calculation or to accept a limited group capital filing or report in accordance with criteria as specified by the commissioner in regulation.

g. If the lead state commissioner determines that an insurance holding company system no longer meets 1 or more of the requirements for an exemption from filing the group capital calculation under this section, the insurance holding company system shall file the group calculation at the next annual filing date unless given an extension by the lead state commissioner based on reasonable grounds shown.

(3) *Liquidity stress test. —*

The ultimate controlling person of every insurer subject to registration and also scoped into the NAIC liquidity stress test framework shall file the results of a specific year's liquidity stress test. The filing shall be made to the lead state insurance commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the NAIC.

a. The NAIC liquidity stress test framework includes scope criteria applicable to a specific data year. These scope criteria are reviewed at least annually by the Financial Stability Task Force or its successor. Any change to the NAIC liquidity stress test framework or to the data year for which the scope criteria are to be measured shall be effective on January 1 of the year following the calendar year when such changes are adopted. Insurers meeting at least 1 threshold of the scope criteria are considered scoped into the NAIC liquidity stress test framework for the specified data year unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should not be scoped into the NAIC liquidity stress test framework for that data year. Similarly, insurers that do not trigger at least 1 threshold of the scope criteria are considered scoped out of the NAIC liquidity stress test framework for the specified data year, unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force, or its successor, determines the insurer should be scoped into the NAIC liquidity stress test framework for that data year.

Regulators wish to avoid having insurers scoped in and out of the NAIC liquidity stress test framework on a frequent basis. The lead state insurance commissioner, in consultation with the Financial Stability Task Force or its successor, will assess this concern as part of the determination for an insurer.

b. The performance of, and filing of the results from, a specific year's liquidity stress test shall comply with the NAIC liquidity stress test framework's instructions and reporting templates for that year and any lead state insurance commissioner determinations, in consultation with the Financial Stability Task Force or its successor, provided within the NAIC liquidity stress test framework.

(m) *Violations. —* The failure to file a registration statement or any summary of the registration statement or enterprise risk filing thereto required by this section within the time specified for such filing shall be a violation of this section.

(18 Del. C. 1953, § 5003; 56 Del. Laws, c. 380, § 1; 59 Del. Laws, c. 197, § 1; 60 Del. Laws, c. 616, § 4a; 67 Del. Laws, c. 223, § 35; 68 Del. Laws, c. 325, § 1; 69 Del. Laws, c. 132, § 1; 79 Del. Laws, c. 388, § 1; 83 Del. Laws, c. 272, § 3.)

§ 5005. Standards and management of an insurer within an insurance holding company system.

(a) *Transactions within an insurance holding company system.* — (1) Transactions within an insurance holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

a. The terms shall be fair and reasonable.

b. Agreements for cost-sharing services and management shall include such provisions as required by regulation issued by the Commissioner.

c. Charges or fees for services performed shall be reasonable.

d. Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied.

e. The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.

f. The insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

g. If an insurer subject to this chapter is deemed by the Commissioner to be in a hazardous financial condition, as set forth in § 3 of Department of Insurance Regulation 304 (18 DE Admin. Code 304-3.0), or a condition that would be grounds for supervision, conservation, or a delinquency proceeding, then the Commissioner may require the insurer to secure and maintain either a deposit, held by the Commissioner, or a bond, as determined by the insurer at the insurer's discretion, for the protection of the insurer for the duration of the contracts or agreements, or the existence of the condition for which the Commissioner required the deposit or bond.

In determining whether a deposit or a bond is required, the Commissioner should consider whether concerns exist with respect to the affiliated person's ability to fulfill the contracts or agreements if the insurer were to be put into liquidation. Once the insurer is deemed to be in a hazardous financial condition or a condition that would be grounds for supervision, conservation, or a delinquency proceeding, and a deposit or bond is necessary, the Commissioner has discretion to determine the amount of the deposit or bond, not to exceed the value of the contracts or agreements in any 1 year, and whether such deposit or bond should be required for a single contract, multiple contracts or a contract only with a specific person(s).

h. All records and data of the insurer held by an affiliate are and remain the property of the insurer, are subject to control of the insurer, are identifiable, and are segregated or readily capable of segregation, at no additional cost to the insurer, from all other persons' records and data. This includes all records and data that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records, or similar records within the possession, custody, or control of the affiliate. At the request of the insurer, the affiliate shall provide that the receiver can obtain a complete set of all records of any type that pertain to the insurer's business; obtain access to the operating systems on which the data is maintained; obtain the software that runs those systems either through assumption of licensing agreements or otherwise; and restrict the use of the data by the affiliate if it is not operating the insurer's business. The affiliate shall provide a waiver of any landlord lien or other encumbrance to give the insurer access to all records and data in the event of the affiliate's default under a lease or other agreement; and

i. Premiums or other funds belonging to the insurer that are collected by or held by an affiliate are the exclusive property of the insurer and are subject to the control of the insurer. Any right of offset in the event an insurer is placed into receivership shall be subject to Chapter 59 of this title.

(2) The following transactions involving a domestic insurer and any person in its insurance holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, which are subject to any materiality standards contained in paragraphs (a)(2)a. through e. of this section, may not be entered into unless the insurer has notified the Commissioner in writing of its intention to enter into such transaction at least 30 days prior thereto, or such shorter period as the Commissioner may permit, and the Commissioner has not disapproved it within such period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported, within 30 days after a termination of a previously filed agreement, to the Commissioner for determination of the type of filing required, if any.

a. Sales, purchases, exchanges, loans or extensions of credit, guarantees, or investments, provided such transactions are equal to or exceed:

1. With respect to nonlife insurers, the lesser of 3 percent of the insurer's admitted assets or 25 percent of surplus as regards policyholders;

2. With respect to life insurers, 3 percent of the insurer's admitted assets,

Each as of December 31 next preceding;

b. Loans or extensions of credit to any person who is not an affiliate, where the insurer makes such loans or extensions of credit with the agreement or understanding that the proceeds of such transactions, in whole or in substantial part, are to be used to make

loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit provided such transactions are equal to or exceed:

1. With respect to nonlife insurers, the lesser of 3 percent of the insurer's admitted assets or 25 percent of surplus as regards policyholders;

2. With respect to life insurers, 3 percent of the insurer's admitted assets, as of December 31 next preceding;

c. Reinsurance agreements or modifications thereto, including:

1. All reinsurance pooling agreements;

2. Agreements in which the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities in any of the next 3 years, equals or exceeds 5 percent of the insurer's surplus as regards policyholders, as of December 31 next preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of such assets will be transferred to 1 or more affiliates of the insurer;

d. All management agreements, service contracts, tax allocation agreements, and all cost-sharing arrangements; and

e. Any material transactions, specified by regulation, which the Commissioner determines may adversely affect the interests of the insurer's policyholders.

Nothing herein contained shall be deemed to authorize or permit any transactions which, in the case of an insurer not a member of the same insurance holding company system, would be otherwise contrary to law.

(3) A domestic insurer may not enter into transactions which are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the Commissioner determines that such separate transactions were entered into over any 12-month period for such purpose, the Commissioner may exercise the authority under § 5010 of this title.

(4) The Commissioner, in reviewing transactions pursuant to paragraph (a)(2) of this section shall consider whether the transactions comply with the standards set forth in paragraph (a)(1) of this section and whether they may adversely affect the interests of policyholders.

(5) The Commissioner shall be notified within 30 days of any investment of the domestic insurer in any 1 corporation if the total investment in such corporation by the insurance holding company system exceeds 10 percent of such corporation's voting securities.

(6) Supervision, seizure, conservatorship or receivership proceedings.

a. Any affiliate that is party to an agreement or contract with a domestic insurer that is subject to § 5004(b)(3)e. of this title shall be subject to the jurisdiction of any supervision, seizure, conservatorship, or receivership proceedings against the insurer and to the authority of any supervisor, conservator, rehabilitator, or liquidator for the insurer appointed pursuant to Chapter 59 of this title for the purpose of interpreting, enforcing, and overseeing the affiliate's obligations under the agreement or contract to perform services for the insurer that are either of the following:

1. An integral part of the insurer's operations, including, but not limited to management, administrative, accounting, data processing, marketing, underwriting, claims handling, investment, or any other similar functions.

2. Essential to the insurer's ability to fulfill its obligations under insurance policies.

b. The Commissioner may require that an agreement or contract pursuant to § 5004(b)(3)e. of this title for the provision of services described in paragraphs (a)(6)a.1. and 2. of this section specify that the affiliate consents to the jurisdiction as set forth in this § 5005(a)(6) of this title.

(b) *Dividends and other distributions.* — Except as otherwise provided by law, a domestic insurer may not declare or pay a dividend or other distribution from any source other than earned surplus without the Commissioner's prior approval. For purposes of this section, "earned surplus" means an amount equal to the unassigned funds of an insurer as set forth in the most recent annual statement of the insurer submitted to the Commissioner including all or part of the surplus arising from unrealized capital gains or revaluation of assets.

No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until:

(1) Thirty days after the Commissioner has received notice of the declaration thereof and has not within such period disapproved such payment; or

(2) The Commissioner shall have approved such payment within such 30-day period.

For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding 12 months exceeds the greater of:

(1) Ten percent of such insurer's surplus as regards policyholders as of December 31 next preceding; or

(2) The net gain from operations of such insurer, if such insurer is a life insurer, or the net income, if such insurer is not a life insurer, not including realized capital gains, for the 12-month period ending December 31 next preceding, but shall not include pro rata distributions of any class of the insurer's own securities.

Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the Commissioner's approval thereof, and such declaration shall confer no rights upon shareholders until:

(1) The Commissioner has approved the payment of such a dividend or distribution; or

(2) The Commissioner has not disapproved such payment within the 30-day period referred to above.

(c) *Adequacy of surplus.* — For purposes of this chapter, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

(1) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria;

(2) The extent to which the insurer's business is diversified among the several lines of insurance;

(3) The number and size of risks insured in each line of business;

(4) The extent of the geographical dispersion of the insurer's insured risks;

(5) The nature and extent of the insurer's reinsurance program;

(6) The quality, diversification and liquidity of the insurer's investment portfolio;

(7) The recent past and projected future trend in the size of the insurer's surplus as regards policyholders;

(8) The surplus as regards policyholders maintained by other comparable insurers in respect to the factors enumerated above;

(9) The adequacy of the insurer's reserves;

(10) The quality and liquidity of investments in affiliates. The Commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the Commissioner's judgment such investment so warrants; and

(11) The quality of the insurer's earnings and the extent to which the reported earnings of the insurer include extraordinary items.

(d) *Departmental practices.* — The Commissioner shall review, at least 1 time each year, the dividends paid by each domestic insurer to determine whether dividends paid by the insurer are reasonable in relation to the following:

(1) The adequacy of the level or surplus as regards policyholders of the insurer remaining after the payment of dividends; and

(2) The quality of the earnings of the insurer and the extent to which the reported earnings of the insurer include extraordinary items, such as surplus relief, reinsurance transactions and reserve destrengthening.

The Commissioner may issue an order to limit or disallow the payment of ordinary dividends by a domestic insurer if the Commissioner finds the insurer to be presently or potentially financially distressed or troubled.

(60 Del. Laws, c. 616, §§ 4b, 5, 6; 68 Del. Laws, c. 325, § 1; 69 Del. Laws, c. 132, §§ 2, 3; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 388, § 1; 83 Del. Laws, c. 272, § 4; 84 Del. Laws, c. 233, § 40.)

§ 5006. Examination.

(a) *Power of Commissioner.* — Subject to the limitation contained in this section and in addition to the powers which the Commissioner has under Chapter 3 of this title relating to the examination of insurers, the Commissioner shall have the power to examine any insurer registered under § 5004 of this title and its affiliates to ascertain the financial condition of such insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

(b) *Access to books and records.* — (1) The Commissioner may order any insurer registered under § 5004 of this title to produce such records, books, or other information papers in the possession of the insurer or its affiliates as are reasonably necessary to determine compliance with this chapter.

(2) To determine compliance with this chapter, the Commissioner may order any insurer registered under § 5004 of this title to produce information not in the possession of the insurer if the insurer can obtain access to such information pursuant to contractual relationships, statutory obligations, or through other reasonable means. In the event the insurer cannot obtain the information requested by the Commissioner, the insurer shall provide the Commissioner a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of information. Whenever it appears to the Commissioner that the detailed explanation is without merit, the Commissioner may require, after notice and hearing, the insurer to pay a penalty of $500 for each day's delay, or may suspend or revoke the insurer's license.

(c) *Use of consultants.* — The Commissioner may retain at the registered insurer's expense such attorneys, actuaries, accountants and other experts not otherwise a part of the Commissioner's staff as shall be reasonably necessary to assist in the conduct of the examination under subsection (a) of this section. Any persons so retained shall be under the direction and control of the Commissioner and shall act in a purely advisory capacity.

(d) *Expenses.* — Each registered insurer producing for examination records, books and papers pursuant to subsection (a) of this section shall be liable for and shall pay the expense of such examination in accordance with § 326 of this title.

(e) *Compelling production.* — In the event the insurer fails to comply with an order, the Commissioner shall have the power to examine the affiliates to obtain the information. The Commissioner shall have the power to issue subpoenas, to administer oaths, and to examine under oath any person, in accordance with § 326 of this title, for purposes of determining compliance with this section. Upon the failure

or refusal of any person to obey a subpoena, the Commissioner may petition the Superior Court, and upon a proper showing, the Court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court. Every person shall be obliged to attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the state. He or she shall be entitled to the same fees and mileage, if claimed, as a witness in Superior Court, which fees, mileage, and actual expense, if any, necessarily incurred in securing the attendance of witnesses, and their testimony, shall be itemized and charged against, and be paid by, the company being examined.

(68 Del. Laws, c. 325, § 1; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 388, § 1; 81 Del. Laws, c. 145, § 1.)

§ 5007. Confidential treatment.

(a) Documents, materials or other information in the possession or control of the Department that are obtained by or disclosed to the Commissioner or any other person in the course of an examination or investigation made pursuant to § 5006 of this title and all information reported or provided to the Department pursuant to § 5003(b)(12) and (13), § 5003(e)(2), § 5003A, § 5004, § 5005, or § 5015 of this title are recognized by this State as being proprietary and to contain trade secrets, and shall be confidential by law; shall not be subject subpoena, shall not be subject to this State's Freedom of Information Act laws (Chapter 100 of Title 29), and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties. The Commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer to which it pertains unless the Commissioner, after giving the insurer and its affiliates who would be affected thereby, notice and opportunity to be heard, determines that the interest of policyholders, shareholders or the public will be served by the publication thereof, in which event the Commissioner may publish all or any part in such manner as may be deemed appropriate.

(1) For purposes of the information reported and provided to the Commissioner pursuant to § 5004(*l*)(2) of this title, the Commissioner shall maintain the confidentiality of the group capital calculation and group capital ratio produced within the calculation and any group capital information received from an insurance holding company supervised by the Federal Reserve Board or any U.S. group wide supervisor.

(2) For purposes of the information reported and provided to the Commissioner pursuant to § 5004(*l*)(3) of this title, the Commissioner shall maintain the confidentiality of the liquidity stress test results and supporting disclosures and any liquidity stress test information received from an insurance holding company supervised by the Federal Reserve Board and non-U.S. group wide supervisors.

(b) Neither the Commissioner nor any person who received documents, materials or other information while acting under the authority of the Commissioner or with whom such documents, materials or other information are shared pursuant to this chapter shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (a) of this section.

(c) In order to assist in the performance of the Commissioner's duties, the Commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection (a) of this section, including proprietary and trade secret documents and materials with other state, federal and international regulatory agencies, with the NAIC, with any third-party consultants designated by the Commissioner, and with state, federal, and international law-enforcement authorities, including members of any supervisory college described in § 5014 of this title; provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material or other information, and has verified in writing the legal authority to maintain confidentiality.

(2) Notwithstanding paragraph (c)(1) of this section above, the Commissioner may only share confidential and privileged documents, material, or information reported pursuant to § 5004(*l*)(1) of this title with Commissioners of states having statutes or regulations substantially similar to subsection (a) of this section and who have agreed in writing not to disclose such information.

(3) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, including proprietary and trade secret information, from the NAIC and from regulatory and law-enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

(4) Shall enter into written agreements with the NAIC and any third-party consultant designated by the Commissioner governing sharing and use of information provided pursuant to this chapter consistent with this subsection that shall:

a. Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant designated by the Commissioner pursuant to this chapter, including procedures and protocols for sharing by the NAIC with other state, federal or international regulators. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the documents, materials, or other information and has verified in writing the legal authority to maintain such confidentiality.

b. Specify that ownership of information shared with the NAIC or a third-party consultant designated by the Commissioner pursuant to this chapter remains with the Commissioner and the NAIC's or third-party consultant's use of the information is subject to the direction of the Commissioner.

c. Excluding documents, material or information reported pursuant to § 5004(*l*)(3) of this title, prohibit the NAIC or third-party consultant designated by the Commissioner from storing the information shared pursuant to this chapter in a permanent database after the underlying analysis is completed.

d. Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third-party consultant designated by the Commissioner pursuant to this chapter is subject to a request or subpoena to the NAIC or a third-party consultant designated by the Commissioner for disclosure or production.

e. Require the NAIC or a third-party consultant designated by the Commissioner to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or third-party consultant designated by the Commissioner may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant designated by the Commissioner pursuant to this chapter.

f. For documents, materials, or information reporting pursuant to § 5004(*l*)(3) of this title, in the case of an agreement involving a third-party consultant, provide for notification of the identity of the consultant to the applicable insurer.

(d) The sharing of information by the Commissioner pursuant to this chapter shall not constitute a delegation of regulatory authority or rulemaking and the Commissioner is solely responsible for the administration, execution and enforcement of the provisions of this chapter.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (c) of this section.

(f) Documents or other information in the possession or control of the NAIC or a third-party consultant designated by the Commissioner pursuant to this chapter shall be confidential by law, shall not be subject to subpoena, shall not be subject to this State's Freedom of Information Act laws (Chapter 100 of Title 29), and shall not be subject to discovery or admissible in evidence in any private civil action.

(g) The group capital calculation and resulting group capital ratio required under § 5004(*l*)(2) of this title and the liquidity stress test along with its results and supporting disclosures required under § 5004(*l*)(3) of this title are regulatory tools for assessing group risks and capital adequacy and group liquidity risks, respectively, and are not intended as a means to rank insurers or insurance holding company systems generally. Therefore, except as otherwise may be required under the provisions of this chapter, the making, publishing, disseminating, circulating or placing before the public, or causing directly or indirectly to be made, published, disseminated, circulated or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station or any electronic means of communication available to the public, or in any other way as an advertisement, announcement or statement containing a representation or statement with regard to the group capital calculation, group capital ratio, the liquidity stress test results, or supporting disclosures for the liquidity stress test of any insurer or any insurer group, or of any component derived in the calculation by any insurer, broker, or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; provided, however, that if any materially false statement with respect to the group capital calculation, resulting group capital ratio, an inappropriate comparison of any amount to an insurer's or insurance group's group capital calculation or resulting group capital ratio, liquidity stress test result, supporting disclosures for the liquidity stress test, or an inappropriate comparison of any amount to an insurer's or insurance group's liquidity stress test result or supporting disclosures is published in any written publication and the insurer is able to demonstrate to the Commissioner with substantial proof the falsity of such statement or the inappropriateness, as the case may be, then the insurer may publish announcements in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(60 Del. Laws, c. 616, § 7; 68 Del. Laws, c. 325, § 1; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 388, § 1; 80 Del. Laws, c. 118, § 1; 83 Del. Laws, c. 272, § 5.)

§ 5008. Rules and regulations.

The Commissioner may, upon notice and opportunity for all interested persons to be heard, issue such rules, regulations and orders as shall be necessary to carry out the provisions of this chapter.

(68 Del. Laws, c. 325, § 1.)

§ 5009. Injunctions, prohibitions against voting securities; sequestration of voting securities.

(a) *Injunctions.* — Whenever it appears to the Commissioner that any insurer or any director, officer, employee or agent thereof has committed or is about to commit a violation of this chapter or of any rule, regulation or order issued by the Commissioner hereunder, the Commissioner may apply to the Chancery Court for an order enjoining such insurer or such director, officer, employee or agent thereof from violating or continuing to violate this chapter or any such rule, regulation or order, and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors and shareholders or the public may require.

(b) *Voting of securities; when prohibited.* — No security which is the subject of any agreement or arrangement regarding acquisition, or which is acquired or to be acquired, in contravention of the provisions of this chapter or of any rule, regulation or order issued by the Commissioner hereunder may be voted at any shareholder's meeting, or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though such securities were not issued and outstanding; but no action taken at any such meeting shall be invalidated by the voting of such securities, unless the action would materially affect control of the insurer or unless the courts of this State have so ordered. If an insurer or the Commissioner has reason to believe that

any security of the insurer has been or is about to be acquired in contravention of the provisions of this chapter or of any rule, regulation or order issued by the Commissioner hereunder; the insurer or the Commissioner may apply to the Chancery Court to enjoin any offer, request, invitation, agreement or acquisition made in contravention of § 5003 of this title or any rule, regulation or order issued by the Commissioner thereunder to enjoin the voting of any security so acquired, to void any vote of such security already cast at any meeting of shareholders and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditor and shareholders or the public may require.

(c) *Sequestration of voting securities.* — In any case where a person has acquired or is proposing to acquire any voting securities in violation of this chapter or any rule, regulation or order issued by the Commissioner hereunder, the Chancery Court may, on such notice as the Court deems appropriate, upon the application of the insurer or the Commissioner seize or sequester any voting securities of the insurer owned directly or indirectly by such person, and issue such order with respect thereto as may be appropriate to effectuate the provisions of this chapter.

Notwithstanding any other provisions of law, for the purposes of this chapter the sites of the ownership of the securities of domestic insurers shall be deemed to be in this State.

(68 Del. Laws, c. 325, § 1.)

§ 5010. Sanctions.

(a) Any insurer failing, without just cause, to file any registration statement as required in this chapter shall be required, after notice and hearing, to pay a penalty of $500 for each day's delay, to be recovered by the Commissioner of Insurance and the penalty so recovered shall be paid into the General Revenue Fund of this State. The maximum penalty under this section is $25,000. The Commissioner may reduce the penalty if the insurer demonstrates to the Commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

(b) Every director or officer of an insurance holding company system who knowingly violates, participates in, or assents to, or who knowingly shall permit any of the officers or agents of the insurer to engage in transactions or make investments which have not been properly reported or submitted pursuant to § 5004(a) or § 5005(a)(2) or (b) of this title, or which violate this chapter, shall pay, in their individual capacity, a civil forfeiture of not more than $2,000 per violation, after notice and hearing before the Commissioner. In determining the amount of the civil forfeiture, the Commissioner shall take into account the appropriateness of the forfeiture with respect to the gravity of the violation, the history of previous violations, and such other matters as justice may require.

(c) Whenever it appears to the Commissioner that any insurer subject to this chapter or any director, officer, employee or agent thereof has engaged in any transaction or entered into a contract which is subject to § 5005 of this title and which would not have been approved had such approval been requested, the Commissioner may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and hearing, the Commissioner may also order the insurer to void any such contracts and restore the status quo if such action is in the best interest of the policyholders, creditors or the public.

(d) Whenever it appears to the Commissioner that any insurer or any director, officer, employee or agent thereof has committed a wilful violation of this chapter, the Commissioner may cause criminal proceedings to be instituted by the Superior Court against such insurer or the responsible director, officer, employee or agent thereof. Any insurer which wilfully violates this chapter may be fined not more than $50,000. Any individual who wilfully violates this chapter may be fined in an individual capacity not more than $25,000 or be imprisoned for not more than 1 to 3 years, or both.

(e) Any officer, director or employee of an insurance holding company system who wilfully and knowingly subscribes to or makes or causes to be made any false statements, false reports or false filings with the intent to deceive the Commissioner in the performance of the Commissioner's duties under this chapter, upon conviction thereof, shall be imprisoned for not more than 2 years, or fined $50,000 or both. Any fines imposed shall be paid by the officer, director or employee in an individual capacity.

(f) Whenever it appears to the Commissioner that any person has committed a violation of § 5003 of this title and which prevents the full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with Chapter 59 of this title.

(60 Del. Laws, c. 616, § 8; 68 Del. Laws, c. 325, § 1; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 388, § 1.)

§ 5011. Receivership.

Whenever it appears to the Commissioner that any person has committed a violation of this chapter which so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, shareholders or the public, then the Commissioner may proceed as provided in Chapter 59 of this title to take possession of the property of such domestic insurer and to conduct the business thereof.

(68 Del. Laws, c. 325, § 1.)

§ 5012. Recovery.

(a) If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under such order shall have a right to recover on behalf of the insurer:

(1) From any parent corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions (other than distributions of shares of the same class of stock) paid by the insurer on its capital stock; or

(2) Any payment in the form of a bonus, termination settlement or extraordinary lump sum salary adjustment made by the insurer or its subsidiary(s) to a director, officer or employee.

Where the distribution or payment pursuant to paragraph (a)(1) or (2) of this section is made at any time during the 1 year preceding the petition for liquidation, conservation or rehabilitation, as the case may be, subject to the limitations of subsections (b), (c) and (d) of this section.

(b) No such distribution shall be recoverable if the parent or affiliate shows that when paid, such distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that such distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(c) Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time such distributions were paid shall be liable up to the amount of distributions or payments under subsection (a) of this section such person received. Any person who otherwise controlled the insurer at the time such distributions were declared shall be liable up to the amount of distributions the person would have received if they had been paid immediately. If 2 or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(d) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.

(e) To the extent that any person liable under subsection (c) of this section is insolvent or otherwise fails to pay claims due from it pursuant to such subsection, its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from such parent corporation or holding company or person who otherwise controlled it.

(68 Del. Laws, c. 325, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5013. Revocation, suspension or nonrenewal of insurer's license.

Whenever it appears to the Commissioner that any person has committed a violation of this chapter which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the Commissioner may, after giving notice and an opportunity to be heard, determine to suspend, revoke or refuse to renew such insurer's license or authority to do business in this State for such period as the Commissioner finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusions of law.

(60 Del. Laws, c. 616, § 8; 68 Del. Laws, c. 325, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5014. Supervisory colleges.

(a) *Power of Commissioner.* — With respect to any insurer registered under § 5004 of this title, and in accordance with subsection (c) of this section below, the Commissioner shall also have the power to participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance by the insurer with this chapter. The powers of the Commissioner with respect to supervisory colleges include, but are not limited to, the following:

(1) Initiating the establishment of a supervisory college;

(2) Clarifying the membership and participation of other supervisors in the supervisory college;

(3) Clarifying the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor;

(4) Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and processes for information sharing; and

(5) Establishing a crisis management plan.

(b) *Expenses.* — Each registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the Commissioner's participation in a supervisory college in accordance with subsection (c) of this section below, including reasonable travel expenses. For purposes of this section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates, and the Commissioner may establish a regular assessment to the insurer for the payment of these expenses.

(c) *Supervisory college.* — In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management and governance processes, and as part of the examination of individual insurers in accordance with § 5006 of this title, the Commissioner may participate in a supervisory college with other regulators charged with supervision of the insurer or its affiliates, including other state, federal and international regulatory agencies. The Commissioner may enter into agreements in accordance with § 5007(c) of this title providing the basis for cooperation between the Commissioner and the other regulatory agencies, and the activities of the supervisory college. Nothing in this section shall delegate to the supervisory college the authority of the Commissioner to regulate or supervise the insurer or its affiliates within its jurisdiction.

(79 Del. Laws, c. 388, § 1.)

§ 5015. Group-wide supervision of internationally active insurance group.

(a) The Commissioner is authorized to act as the group-wide supervisor for any internationally active insurance group in accordance with the provisions of this section. However, the Commissioner may otherwise acknowledge another regulatory official as the group-wide supervisor where the internationally active insurance group:

(1) Does not have substantial insurance operations in the United States;

(2) Has substantial insurance operations in the United States, but not in this State; or

(3) Has substantial insurance operations in the United States and this State, but the Commissioner has determined pursuant to the factors set forth in subsections (b) and (f) of this section that the other regulatory official is the appropriate group-wide supervisor.

An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the Commissioner make a determination or acknowledgement as to a group-wide supervisor pursuant to this section.

(b) In cooperation with other state, federal, and international regulatory agencies, the Commissioner will identify a single group-wide supervisor for an internationally active insurance group. The Commissioner may determine that the Commissioner is the appropriate group-wide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in this State. However, the Commissioner may acknowledge that a regulatory official from another jurisdiction is the appropriate group-wide supervisor for the internationally active insurance group. The Commissioner shall consider the following factors when making a determination or acknowledgement under this subsection:

(1) The place of domicile of the insurers within the internationally active insurance group that hold the largest share of the group's written premiums, assets, or liabilities;

(2) The place of domicile of the top-tiered insurer or insurers in the insurance holding company system of the internationally active insurance group;

(3) The location of the executive offices or largest operational offices of the internationally active insurance group;

(4) Whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the Commissioner determines to be:

a. Substantially similar to the system of regulation provided under the laws of this State; or

b. Otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials;

(5) Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the Commissioner with reasonably reciprocal recognition and cooperation.

However, a commissioner identified under this section as the group-wide supervisor may determine that it is appropriate to acknowledge another supervisor to serve as the group-wide supervisor. The acknowledgement of the group-wide supervisor shall be made after consideration of the factors listed in paragraphs (b)(1) through (5) of this section above, and shall be made in cooperation with and subject to the acknowledgement of other regulatory officials involved with supervision of members of the internationally active insurance group, and in consultation with the internationally active insurance group.

(c) Notwithstanding any other provision of law, when another regulatory official is acting as the group-wide supervisor of an internationally active insurance group, the Commissioner shall acknowledge that regulatory official as the group-wide supervisor. However, in the event of a material change in the internationally active insurance group that results in:

(1) The internationally active insurance group's insurers domiciled in this State holding the largest share of the group's premiums, assets, or liabilities; or

(2) This State being the place of domicile of the top-tiered insurer or insurers in the insurance holding company system of the internationally active insurance group,

the Commissioner shall make a determination or acknowledgement as to the appropriate group-wide supervisor for such an internationally active insurance group pursuant to subsection (b) of this section.

(d) Pursuant to § 5006 of this title, the Commissioner is authorized to collect from any insurer registered pursuant to § 5004 of this title all information necessary to determine whether the Commissioner may act as a group-wide supervisor of an internationally active insurance group or if the Commissioner may acknowledge another regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to group-wide supervision by the Commissioner, the Commissioner shall notify the insurer registered pursuant to § 5004 of this title and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group shall have not less than 30 days to provide the Commissioner with additional information pertinent to the pending determination. The Commissioner shall publish in the Delaware Administrative Code and on its Internet website the identity of internationally active insurance groups that the Commissioner has determined are subject to group-wide supervision by the Commissioner.

(e) If the Commissioner is the group-wide supervisor for an internationally active insurance group, the Commissioner is authorized to engage in any of the following group-wide supervision activities:

(1) Assess the enterprise risks within the internationally active insurance group to ensure that:

a. The material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management; and

b. Reasonable and effective mitigation measures are in place.

(2) Request from any member of an internationally active insurance group subject to the Commissioner's supervision, information necessary and appropriate to assess enterprise risk, including, but not limited to, information about the members of the internationally active insurance group regarding:

a. Governance, risk assessment and management;

b. Capital adequacy; and

c. Material intercompany transactions.

(3) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of such internationally active insurance group that are engaged in the business of insurance.

(4) Communicate with other state, federal, and international regulatory agencies for members within the internationally active insurance group and share relevant information subject to the confidentiality provisions of § 5007 of this title, through supervisory colleges as set forth in § 5014 of this title or otherwise.

(5) Enter into agreements with or obtain documentation from any insurer registered under § 5004 of this title, any member of the internationally active insurance group, and any other state, federal, and international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the Commissioner's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled in this State is doing business in this State or is otherwise subject to jurisdiction in this State.

(6) Other group-wide supervision activities, consistent with the authorities and purposes enumerated above, as considered necessary by the Commissioner.

(f) If the Commissioner acknowledges that another regulatory official from a jurisdiction that is not accredited by the National Association of Insurance Commissioners (NAIC) is the group-wide supervisor, the Commissioner is authorized to reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor, provided that:

(1) The Commissioner's cooperation is in compliance with the laws of this State; and

(2) The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the Commissioner's activities as a group-wide supervisor for other internationally active insurance groups where applicable. Where such recognition and cooperation is not reasonably reciprocal, the Commissioner is authorized to refuse recognition and cooperation.

(g) The Commissioner is authorized to enter into agreements with or obtain documentation from any insurer registered under § 5004 of this title, any affiliate of the insurer, and other state, federal and international regulatory agencies for members of the internationally active insurance group that provide the basis for or otherwise clarify a regulatory official's role as group-wide supervisor.

(h) The Commissioner may promulgate regulations necessary for the administration of this section.

(i) A registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the Commissioner's participation in the administration of this section, including the engagement of attorneys, actuaries and any other professionals and all reasonable travel expenses.

(80 Del. Laws, c. 118, § 1.)

§ 5016. Conflict with other laws.

All laws and parts of laws of this State inconsistent with this chapter are hereby superseded with respect to matters covered by this chapter.

(68 Del. Laws, c. 325, § 1; 80 Del. Laws, c. 118, § 1.)

Part I
Insurance

Chapter 51
Insider Trading in Domestic Insurer Securities

§ 5101. Scope of chapter.

This chapter shall apply only with respect to securities issued by domestic stock insurers.

(18 Del. C. 1953, § 5101; 56 Del. Laws, c. 380, § 1.)

§ 5102. "Equity security" defined.

The term "equity security" when used in this chapter means any stock or similar security or any security convertible, with or without consideration, into such a security or carrying any warrant or right to subscribe to or purchase such a security, or any such warrant or right, or any other security which the Commissioner deems to be of similar nature and considers necessary or appropriate, by such rules and regulations as the Commissioner may prescribe in the public interest or for the protection of investors, to treat as an equity security.

(18 Del. C. 1953, § 5102; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5103. Statement of ownership.

Every person who is directly or indirectly the beneficial owner of more than 10 percent of any class of any equity security of a domestic stock insurer or who is a director or an officer of such insurer shall file with the Commissioner within 10 days after such person becomes such beneficial owner, director or officer a statement, in such form as the Commissioner may prescribe, of the amount of all equity securities of such insurer of which such person is the beneficial owner and, within 10 days after the close of each calendar month thereafter if there has been a change in such ownership during such month, shall file with the Commissioner a statement, in such form as the Commissioner may prescribe, indicating such person's ownership at the close of the calendar month and such changes in such person's ownership as have occurred during such calendar month.

(18 Del. C. 1953, § 5103; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5104. Recovery of profits.

(a) For the purpose of preventing the unfair use of information which may have been obtained by such beneficial owner, director or officer by reason of such person's relationship to such insurer, any profit realized by such person from any purchase and sale or any sale and purchase of any equity security of such insurer within any period of less than 6 months, unless such security was acquired in good faith in connection with a debt previously contracted, shall inure to and be recoverable by the insurer, irrespective of any intention on the part of such beneficial owner, director or officer in entering into such transaction of holding the security purchased or of not repurchasing the security sold for a period exceeding 6 months.

(b) Suit to recover such profit may be instituted in any court of competent jurisdiction by the insurer or by the owner of any security of the insurer in the name and in behalf of the insurer if the insurer shall fail or refuse to bring such suit within 60 days after request or shall fail diligently to prosecute the same thereafter, but no such suit shall be brought more than 2 years after the date such profit was realized.

(c) This section shall not be construed to cover any transaction where such beneficial owner was not such both at the time of the purchase and sale or the sale and purchase of the security involved or any transaction or transactions which the Commissioner by rules and regulations may exempt as not comprehended within the purpose of this section.

(18 Del. C. 1953, § 5104; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5105. Unlawful sale of securities.

No such beneficial owner, director or officer, directly or indirectly, shall sell any equity security of such insurer if the person selling the security or principal:

(1) Does not own the security sold; or

(2) If owning the security does not deliver it against such sale within 20 days thereafter or does not within 5 days after such sale deposit it in the mails or other usual channels of transportation; but no person shall be deemed to have violated this section if such person proves that, notwithstanding the exercise of good faith, was unable to make such delivery or deposit within such time, or that to do so would cause undue inconvenience or expense.

(18 Del. C. 1953, § 5105; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5106. Excepted securities; dealers.

(a) Section 5104 of this title shall not apply to any purchase and sale and § 5105 of this title shall not apply to any sale, of an equity security of a domestic stock insurer not then or theretofore held by such insurer in an investment account by a dealer in the ordinary

course of business and incident to the establishment or maintenance by such dealer of a primary or secondary market (otherwise than on an exchange as defined in the Securities Exchange Act of 1934 [15 U.S.C. § 78a et seq.]) for such security.

(b) The Commissioner may, by such rules and regulations as the Commissioner deems necessary or appropriate in the public interest, define and prescribe terms and conditions with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

(18 Del. C. 1953, § 5106; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5107. Arbitrage transactions.

Sections 5103, 5104 and 5105 of this title shall not apply to foreign or domestic arbitrage transactions unless made in contravention of such rules and regulations as the Commissioner may adopt in order to carry out the purposes of this chapter.

(18 Del. C. 1953, § 5107; 56 Del. Laws, c. 380, § 1.)

§ 5108. Registered or closely held securities.

Sections 5103, 5104 and 5105 of this title shall not apply to equity securities of a domestic stock insurer if:

(1) Such securities shall be registered or shall be required to be registered, pursuant to § 12 of the Securities Exchange Act of 1934, as amended [15 U.S.C. § 78l]; or if

(2) Such domestic stock insurer shall not have any class of its equity securities held of record by 100 or more persons on the last business day of the year next preceding the year in which equity securities of the insurer would be subject to the provisions of §§ 5103, 5104 and 5105 of this title except for the provisions of this clause.

(18 Del. C. 1953, § 5108; 56 Del. Laws, c. 380, § 1.)

§ 5109. Rules and regulations.

The Commissioner may make such rules and regulations as may be necessary for the execution of the functions vested in the Commissioner by this chapter and may for such purpose classify domestic stock insurers, securities and other persons or matters within the Commissioner's jurisdiction. No provision of §§ 5103, 5104 and 5105 of this title imposing any liability shall apply to any act done or omitted in good faith in conformity with any rule or regulation of the Commissioner, notwithstanding that such rule or regulation may, after such act or omission, be amended or rescinded or determined by judicial or other authority to be invalid for any reason.

(18 Del. C. 1953, § 5109; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

Part I
Insurance

Chapter 53
Mutual Assessment Property Insurers

§ 5301. Scope of chapter; definition.

(a) This chapter shall apply only to domestic mutual fire insurers heretofore and now doing business on the assessment premium plan.

(b) For the purposes of this chapter an insurer "doing business on the assessment premium plan" is one which depends in whole or substantial part upon special or regular assessments levied upon its members, either prior to or after a loss, for the payment of losses and expenses. This provision shall not be deemed to prevent any such insurer from collecting from each member such initial amount as it may deem proper prior to or at the time of the effectuation of the member's insurance and shall not be deemed to prohibit the acquisition, accumulation and maintenance of surplus or unallocated funds.

(18 Del. C. 1953, § 5301; 56 Del. Laws, c. 380, § 1.)

§ 5302. Continuation of existing insurers.

(a) All such insurers holding subsisting certificates of authority from the Commissioner immediately prior to November 1, 1968, may continue to be so authorized so long as qualified therefor under this title.

(b) No new such insurers shall be formed or be newly authorized after November 1, 1968.

(18 Del. C. 1953, § 5302; 56 Del. Laws, c. 380, § 1.)

§ 5303. Insuring powers.

(a) Such insurers shall have power to insure only real property and personal property incidental to such real property against the perils of fire, lightning and windstorm, together with perils customarily included under extended coverages.

(b) The maximum amount of insurance which the insurer shall retain on any 1 subject of insurance, after deduction of applicable reinsurance, shall not exceed 10% of its admitted assets or $5,000, whichever is the larger amount. For the purposes of this subsection a "subject of insurance" shall have the meaning ascribed in § 909 (limits of risk) of this title.

(18 Del. C. 1953, § 5303; 56 Del. Laws, c. 380, § 1.)

§ 5304. Reinsurance.

Such an insurer may cede reinsurance to any insurer authorized to transact property insurance in this State other than on the assessment premium plan. An insurer doing business on the assessment premium plan shall not accept reinsurance from other insurers.

(18 Del. C. 1953, § 5304; 56 Del. Laws, c. 380, § 1.)

§ 5305. Records.

Every such insurer, through its president and secretary, shall keep or cause to be kept accurate records and accounts of its transactions. The books, files and records of the insurer shall be located at its principal place of business in this State or at such place in this State as may be expressly authorized by the insurer's board of directors with notice thereof in writing to the Commissioner. The books, files and records of the insurer shall be available for inspection by the insurer's directors and officers and by the Commissioner at all reasonable times.

(18 Del. C. 1953, § 5305; 56 Del. Laws, c. 380, § 1.)

§ 5306. Subject to other provisions.

(a) Such insurers shall be subject to all reasonably applicable provisions of this title except provisions requiring the possession, maintenance or deposit of surplus.

(b) Such insurers shall expressly be subject to the following provisions of Chapter 49 of this title (Organization and Corporate Powers, Procedures of Domestic Stock and Mutual Insurers):

(1) Section 4903 (general corporation statutes, applicability);

(2) Section 4904 (insurance business exclusive);

(3) Section 4911 (membership in mutual);

(4) Section 4912 (bylaws of mutual insurers);

(5) Section 4913 (minutes of corporate meetings);

(6) Section 4919 (change of directors, officers; notice);

(7) Section 4920 (prohibited pecuniary interest of officials);

(8) Section 4921 (management and exclusive agency contracts);

(9) Section 4926 (payment of taxes; exoneration);

(10) Sections 4934 through 4942 (merger, consolidation of mutual insurers);

(11) Section 4944 (bulk reinsurance); and

(12) Section 4945 (mutual member’s share of assets on liquidation).

(18 Del. C. 1953, § 5306; 56 Del. Laws, c. 380, § 1.)

Part I
Insurance
Chapter 55
Mutual Benefit Associations

§ 5501. Scope of chapter; provisions exclusive.

(a) This chapter applies only to domestic mutual benefit associations as defined in § 5502 of this title.

(b) This title shall not apply to such associations unless contained or referred to in this chapter.

(18 Del. C. 1953, § 5501; 56 Del. Laws, c. 380, § 1.)

§ 5502. "Mutual benefit association" defined.

As used in this chapter:

(1) "Association" means a mutual benefit association as defined in this section.

(2) "Mutual benefit association" means a corporation, society, order or association which has no capital stock, which issues certificates of membership providing for payment of benefits in case of sickness, disability or death of its members and which accumulates funds by the collection of fees or dues from its members, at either stated or irregular intervals, with which to discharge its liabilities on its membership certificates and with which to pay the administrative expenses, but fraternal benefit societies as defined in Chapter 62 of this title shall not be deemed to be mutual benefit associations.

(18 Del. C. 1953, § 5502; 56 Del. Laws, c. 380, § 1.)

§ 5503. Exempt associations.

A mutual benefit association whose membership is confined to employees or former employees of common carriers engaged in interstate commerce or any association which administers 2 or more such associations is not subject to the provisions of this chapter.

(18 Del. C. 1953, § 5503; 56 Del. Laws, c. 380, § 1.)

§ 5504. Incorporation; prerequisites.

The Secretary of State shall not file a certificate of incorporation for any mutual benefit association unless accompanied by a certificate duly signed by the Commissioner setting forth that a deposit of $25,000 has been made with the Commissioner in cash or approved securities, that conformity has been made with all of the requirements of this chapter and that the certificate of incorporation so presented for filing is in substantial compliance with the provisions of the insurance laws of this State. The deposit shall constitute a guaranty fund hereinafter mentioned.

(18 Del. C. 1953, § 5504; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5505. Certificate of authority required; foreign operations.

(a) No association shall directly or indirectly issue any certificate of membership without being so authorized by a valid and subsisting certificate of authority issued to it by the Commissioner.

(b) No association shall issue any certificate of membership in any other state or foreign country unless it holds a valid and subsisting certificate of authority issued to it by the Commissioner.

(18 Del. C. 1953, § 5505; 56 Del. Laws, c. 380, § 1.)

§ 5506. Certificate of authority — Application.

(a) No certificate of authority shall be issued to any association unless it files with the Commissioner:

(1) A certified copy of its certificate of incorporation or charter;

(2) A copy of its constitution and bylaws;

(3) A copy of all forms of certificates of membership which it proposes to issue;

(4) A certified statement that it has a membership of at least 500 persons or that it has at least 500 bona fide applications for membership accompanied by the initial payments;

(5) Such other information respecting its business or affairs as may be required by the Commissioner.

(b) At the time of application for certificate of authority the association shall deposit with the Commissioner a guaranty fund as required under § 5509 of this title.

(18 Del. C. 1953, § 5506; 56 Del. Laws, c. 380, § 1.)

§ 5507. Certificate of authority — Issuance; renewal.

(a) The Commissioner shall issue a certificate of authority to every mutual benefit association complying with this chapter upon payment of the fee therefor in the amount specified in § 5520 of this title.

(b) The certificate of authority shall be valid until the March 1 next following its issuance. So long as the association is qualified therefor the Commissioner shall, upon payment of the fee for renewal specified in § 5520 of this title, annually on March 1 renew the certificate of authority for the ensuing year.

(18 Del. C. 1953, § 5507; 56 Del. Laws, c. 380, § 1.)

§ 5508. Certificate of authority — Revocation.

The Commissioner shall forthwith revoke the certificate of authority of an association if, from an examination of the affairs of the association or for other cause and after notice to the association and a hearing before the Commissioner, the Commissioner finds that as to the association any 1 or more of the following grounds exist:

(1) It is insolvent, or its assets are not sufficient for carrying on its business;

(2) Its condition is such as to render its further proceeding hazardous to its certificate holders or to the public, notwithstanding any special provision granted in its charter or certificate of incorporation;

(3) It is fraudulently conducted; or

(4) It has violated or failed to comply with this chapter.

(18 Del. C. 1953, § 5508; 56 Del. Laws, c. 380, § 1.)

§ 5509. Guaranty fund.

(a) Each mutual benefit association before receiving a certificate of authority shall deposit with the Commissioner $25,000 in cash and/or securities approved by the Commissioner.

(b) The deposit shall constitute a guaranty fund and shall remain in trust with the Commissioner to answer any default of the association.

(c) While not in default the association may collect the interest, dividends and profits upon the deposited securities and from time to time substitute therefor other securities of equally good character and value, subject to the approval of the Commissioner.

(d) The deposit shall not be withdrawn by the association except as hereinafter provided. The Commissioner may make withdrawals from the fund upon the order of any court of record of this State issued upon a final judgment to pay any claim reduced to final judgment by such court in an action by any member or beneficiary based upon a certificate of membership. In the event of such withdrawal the association shall replace the amount withdrawn within 6 months thereafter.

(e) If the association determines to discontinue its business, it shall make written application to the Commissioner for withdrawal of its guaranty fund. Within 3 months after receipt of the application, the Commissioner shall determine the financial affairs and condition of the association; and if the Commissioner finds that its books and records are in proper order and that it has no liabilities outstanding, the Commissioner shall cancel the association's certificate of authority and deliver to the association or its assigns all moneys and/or securities then held in the deposited guaranty fund to the association's credit.

(18 Del. C. 1953, § 5509; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5510. Benefit fund.

(a) Every association shall deposit in a bank or trust company approved by the Commissioner a sum not less than 50% of all dues collected by the association or by any agent thereof on all certificates of membership. This shall constitute a benefit fund for the sole purpose of payment of claims arising under certificates of membership, for the payments to the guaranty fund maintained with the Commissioner and for the payment of legal expenses incurred in adjusting and defending claims.

(b) If after an examination of the financial affairs of the association the Commissioner determines that 50% of all dues collected is insufficient to properly maintain the benefit fund, the Commissioner may require the association to deposit a larger percentage of its dues to the credit of the benefit fund.

(18 Del. C. 1953, § 5510; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5511. Investments.

An association may invest its funds in such investments as are eligible for investment of the funds of domestic life insurers under Chapter 13 (Investments) of this title.

(18 Del. C. 1953, § 5511; 56 Del. Laws, c. 380, § 1.)

§ 5512. Annual statement.

(a) Each association shall annually on or before March 1 file with the Commissioner its financial statement on forms furnished by the Commissioner and subscribed and sworn to by its president and secretary or in their absence by 2 of its principal officers. The statement shall show the association's financial condition and total membership at the close of business on the December 31 next preceding.

(b) The Commissioner shall annually, in December, furnish to each association then holding a certificate of authority, 2 or more blanks in the form adopted for such annual statements.

(18 Del. C. 1953, § 5512; 56 Del. Laws, c. 380, § 1.)

§ 5513. Examination of association — Timing; responsibility.

(a) The Commissioner shall examine the affairs of each association as to its financial condition at least once in 3 years. The commissioner shall also make an examination of any such association whenever the commissioner deems it prudent or advisable to do so.

(b) The examination shall be made by the Commissioner personally or by a deputy or other accredited representative of the Commissioner, and all proper charges incurred in making such examination, inclusive of expert assistance, shall be paid by the association examined except that the expenses of such examination shall not exceed $25 per day plus traveling expenses incurred.

(18 Del. C. 1953, § 5513; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5514. Examination of association — Access to books and records; witnesses.

For the purpose of the examination under § 5513 of this title, the person making the examination shall have free access to all the books and papers of the association relating to its business and to the books and papers of any of its agents and may summon and qualify as witnesses under oath and examine the directors, officers, agents and employees of the association and any other persons in relation to its affairs, transactions and conditions.

(18 Del. C. 1953, § 5514; 56 Del. Laws, c. 380, § 1.)

§ 5515. Examination of association — Refusal to permit; revocation of certificate of authority.

The refusal of any association to submit to and provide for the examination under § 5513 of this title or to exhibit its books and records for inspection shall be presumptive evidence that it has violated this chapter, and its certificate of authority shall forthwith be revoked by the Commissioner, and it shall be subject to the penalties prescribed and imposed by this chapter.

(18 Del. C. 1953, § 5515; 56 Del. Laws, c. 380, § 1.)

§ 5516. Domestic associations; situs of business; reports and fees.

Any mutual benefit association organized under the general corporation law of this State with its principal office situated in this State shall be regarded as doing business in this State regardless of whether or not its membership is acquired from residents of this State, other states, District of Columbia or territories of the United States and shall make the reports required to the Commissioner and pay all of the fees prescribed in this chapter.

(18 Del. C. 1953, § 5516; 56 Del. Laws, c. 380, § 1.)

§ 5517. Certificate of membership — Approval; terms.

(a) No certificate of membership providing for sick, accident and/or death benefits to members or their beneficiaries, as hereinafter provided, shall be issued by any association unless the form of the same shall first be filed with and approved by the Commissioner.

(b) A certificate of membership, among other conditions not contrary to the provisions of this chapter, may specify the diseases for which limited benefits may be paid in sickness or death and may also specify the causes of personal injuries, or death therefrom, for which no benefits will be paid.

(c) A certificate of membership may also restrict the payment of any benefit for sickness, accident and/or death that occurs within a specified time after the issuance of such certificate to the refund of all dues paid by the members or their beneficiaries less the expense of carrying the same on the books of the association, and the payment of such refund shall fully liquidate all claims of a member against the association by reason of such certificate of membership.

(d) A certificate of membership may also limit the time which shall elapse before any benefits are payable and may be paid within reasonable limitations approved by the Commissioner.

(18 Del. C. 1953, § 5517; 56 Del. Laws, c. 380, § 1.)

§ 5518. Certificate of membership — Limitations on benefits.

No certificate of membership issued by any association shall provide for death benefits in excess of $100,000 or sickness or accident disability benefits in excess of $1,000 per week. No association shall issue more than 1 of each of the above types of certificates of membership to any 1 person.

(18 Del. C. 1953, § 5518; 56 Del. Laws, c. 380, § 1; 57 Del. Laws, c. 154; 66 Del. Laws, c. 388, § 1; 76 Del. Laws, c. 206, § 1.)

§ 5519. Agreement between association and members; binding effect.

The certificate of membership, the certificate of incorporation and any amendments thereto, the bylaws of the association and the provisions of this chapter shall constitute an agreement between the association as a whole or the membership thereof and the members and shall be binding on their respective beneficiaries.

(18 Del. C. 1953, § 5519; 56 Del. Laws, c. 380, § 1.)

§ 5520. Fees; costs; in lieu of provision.

(a) Each association shall pay to the Commissioner fees and costs as follows:

(1) For issuance of original certificate of authority $25

(2) For each annual renewal thereof 25

(3) For filing of annual statement 25

(4) For filing, reviewing and approval of the form of certificates of membership, the actual expenses incurred by the Department in connection therewith, as determined by the Commissioner.

(b) The fees and costs hereinabove provided shall be for the use of the State and shall be in lieu of all other taxes, levies, assessments or contributions, except taxes on real property.

(18 Del. C. 1953, § 5520; 56 Del. Laws, c. 380, § 1.)

§ 5521. Merger; reinsurance; transfers with other associations.

Every association may merge, insure, reinsure or accept the transfer of membership or funds with any other like association under such reasonable rules and regulations for the protection of members as the Commissioner prescribes.

(18 Del. C. 1953, § 5521; 56 Del. Laws, c. 380, § 1.)

§ 5522. Dissolution.

Upon the withdrawal of its guaranty fund deposit as provided in § 5509(e) of this title, the directors or governing body of the association shall forthwith cause the association to be dissolved in accordance with the applicable laws of this State and shall file proper evidence of such dissolution with the Commissioner.

(18 Del. C. 1953, § 5522; 56 Del. Laws, c. 380, § 1.)

§ 5523. Penalties.

(a) Any corporation, society, order or association which shall organize and/or transact the business of a mutual benefit association in this State contrary to the provisions of this chapter or any mutual benefit association which shall directly or indirectly transact such business in this State without having a valid and unrevoked certificate of authority therefor, agreeable to the provisions of this chapter, shall be fined not more than $1,000. Any officer, manager or agent of such corporation, society, order or association or mutual benefit association wilfully violating or failing to observe or comply with the provisions of this chapter shall be punishable under this section.

(b) Any mutual benefit association or any officer, manager or agent thereof neglecting or refusing to comply with or violating this chapter, the penalty for which neglect, refusal or violation is not otherwise specified, shall be fined not more than $200.

(18 Del. C. 1953, § 5523; 56 Del. Laws, c. 380, § 1.)

§ 5524. Other provisions applicable.

The following additional chapters of this title shall also apply as to mutual benefit associations to the extent so applicable and not inconsistent with the express provisions of this chapter and the reasonable implications of such express provisions:

(1) Chapter 1 (General Definitions and Provisions);

(2) Chapter 3 (The Insurance Commissioner);

(3) Chapter 13 (Investments);

(4) Chapter 15 (Administration of Deposits);

(5) Chapter 23 (Unfair Practices in the Insurance Business);

(6) Chapter 59 (Rehabilitation and Liquidation).

(18 Del. C. 1953, § 5524; 56 Del. Laws, c. 380, § 1.)

Part I
Insurance
Chapter 56
Travel Insurance

§ 5601. Short title.

This chapter shall be known as the “Delaware Travel Insurance Act.”

(84 Del. Laws, c. 40, § 6.)

§ 5602. Scope and purposes.

(a) The purpose of this chapter is to promote the public welfare by creating a comprehensive legal framework within which travel insurance may be sold in this State.

(b) The requirements of this chapter shall apply to travel insurance that covers any resident of this State, and is sold solicited, negotiated, or offered in this State, and policies and certificates that are delivered or issued for delivery in this State. It shall not apply to cancellation fee waivers or travel assistance services, except as expressly provided herein.

(c) All other applicable provisions of this State’s insurance laws shall continue to apply to travel insurance except that the specific provisions of this chapter shall supersede any general provisions of law that would otherwise be applicable to travel insurance.

(84 Del. Laws, c. 40, § 6.)

§ 5603. Definitions.

For purposes of this chapter:

(1) “Aggregator site” means a website that provides access to information regarding insurance products from more than 1 insurer, including product and insurer information, for use in comparison shopping.

(2) “Blanket travel insurance” means a policy of travel insurance issued to any eligible group providing coverage for specific classes of persons defined in the policy with coverage provided to all members of the eligible group without a separate charge to individual members of the eligible group.

(3) “Cancellation fee waiver” means a contractual agreement between a supplier of travel services and its customer to waive some or all of the nonrefundable cancellation fee provisions of the supplier’s underlying travel contract with or without regard to the reason for the cancellation or form of reimbursement. A “cancellation fee waiver” is not insurance.

(4) “Commissioner” means as defined in § 102 of this title.

(5) Solely for the purposes of travel insurance, “eligible group” means 2 or more persons who are engaged in a common enterprise, or have an economic, educational, or social affinity or relationship, including any of the following:

a. Any entity engaged in the business of providing travel or travel services, including: tour operators, lodging providers, vacation property owners, hotels and resorts, travel clubs, travel agencies, property managers, cultural exchange programs, and common carriers or the operator, owner, or lessor of a means of transportation of passengers, including airlines, cruise lines, railroads, steamship companies, and public bus carriers, wherein with regard to any particular travel or type of travel or travelers, all members or customers of the group must have a common exposure to risk attendant to such travel.

b. Any college, school, or other institution of learning, covering students, teachers, employees, or volunteers.

c. Any employer covering any group of employees, volunteers, contractors, board of directors, dependents, or guests.

d. Any sports team, camp, or sponsor thereof, covering participants, members, campers, employees, officials, supervisors, or volunteers.

e. Any religious, charitable, recreational, educational, or civic organization, or branch thereof, covering any group of members, participants, or volunteers.

f. Any financial institution or financial institution vendor, or parent holding company, trustee, or agent of or designated by 1 or more financial institutions or financial institution vendors, including accountholders, credit card holders, debtors, guarantors, or purchasers.

g. Any incorporated or unincorporated association, including labor unions, having a common interest, constitution and bylaws, and organized and maintained in good faith for purposes other than obtaining insurance for members or participants of such association covering its members.

h. Any trust or the trustees of a fund established, created or maintained for the benefit of and covering members, employees or customers, of 1 or more associations meeting the requirements of paragraph (5)g. of this section, subject to the Commissioner’s permitting the use of a trust and the State’s premium tax provisions in § 5604 of this title.

i. Any entertainment production company covering any group of participants, volunteers, audience members, contestants, or workers.

j. Any volunteer fire department, ambulance, rescue, police, court, or any first aid, civil defense, or other such volunteer group.

k. Preschools, daycare institutions for children or adults, and senior citizen clubs.

l. Any automobile or truck rental or leasing company covering a group of individuals who may become renters, lessees, or passengers defined by their travel status on the rented or leased vehicles. The common carrier, the operator, owner, or lessor of a means of transportation, or the automobile or truck rental or leasing company, is the policyholder under a policy to which this section applies.

m. Any other group where the Commissioner has determined that the members are engaged in a common enterprise, or have an economic, educational, or social affinity or relationship, and that issuance of the policy would not be contrary to the public interest.

(6) "Fulfillment materials" means documentation sent to the purchaser of a travel protection plan confirming the purchase and providing the travel protection plan's coverage and assistance details.

(7) "Group travel insurance" means travel insurance issued to any eligible group.

(8) "Limited lines travel insurance producer" means as defined in § 1771 of this title.

(9) "Offer and disseminate" means as defined in § 1771 of this title.

(10) "Primary certificate holder", for purposes of § 5604 of this title, means an individual person who elects and purchases travel insurance under a group policy.

(11) "Primary policyholder", for purposes of § 5604 of this title, means an individual person who elects and purchases individual travel insurance.

(12) "Travel administrator" means a person who directly or indirectly underwrites, collects charges, collateral or premiums from, or adjusts or settles claims on residents of this State, in connection with travel insurance, except that a person shall not be considered a travel administrator if that person's only actions that would otherwise cause it to be considered a travel administrator are among any of the following:

a. A person working for a travel administrator to the extent that the person's activities are subject to the supervision and control of the travel administrator.

b. An insurance producer selling insurance or engaged in administrative and claims-related activities within the scope of the producer's license.

c. A travel retailer offering and disseminating travel insurance and registered under the license of a limited lines travel insurance producer in accordance with § 1772 of this title.

d. An individual adjusting or settling claims in the normal course of that individual's practice or employment as an attorney-at-law and who does not collect charges or premiums in connection with insurance coverage.

e. A business entity that is affiliated with a licensed insurer while acting as a travel administrator for the direct and assumed insurance business of an affiliated insurer.

(13) "Travel assistance services" means noninsurance services for which the consumer is not indemnified based on a fortuitous event, and where providing the service does not result in transfer or shifting of risk that would constitute the business of insurance. Travel assistance services include: security advisories; destination information; vaccination and immunization information services; travel reservation services; entertainment; activity and event planning; translation assistance; emergency messaging; international legal and medical referrals; medical case monitoring; coordination of transportation arrangements; emergency cash transfer assistance; medical prescription replacement assistance; passport and travel document replacement assistance; lost luggage assistance; concierge services; and any other service that is furnished in connection with planned travel. Travel assistance services are not insurance and not related to insurance.

(14) "Travel insurance" means as defined in § 1702 of this title.

(15) "Travel protection plans" means plans that provide 1 or more of the following: travel insurance; travel assistance services; and cancellation fee waivers.

(16) "Travel retailer" means as defined in § 1771 of this title.

(84 Del. Laws, c. 40, § 6; 84 Del. Laws, c. 514, § 40.)

§ 5604. Premium tax.

(a) A travel insurer shall pay premium tax, as provided in § 702 of this title, on travel insurance premiums paid by any of the following:

(1) An individual primary policyholder who is a resident of this State.

(2) A primary certificate holder who is a resident of this State who elects coverage under a group travel insurance policy.

(3) A blanket travel insurance policyholder that is a resident in, or has its principal place of business or the principal place of business of an affiliate or subsidiary that has purchased blanket travel insurance in this State for eligible blanket group members, subject to any apportionment rules which apply to the insurer across multiple taxing jurisdictions or that permit the insurer to allocate premium on an apportioned basis in a reasonable and equitable manner in those jurisdictions.

(b) A travel insurer shall:

(1) Document the state of residence or principal place of business of the policyholder or certificate- holder.

(2) Report as premium only the amount allocable to travel insurance and not any amounts received for travel assistance services or cancellation fee waivers.

(84 Del. Laws, c. 40, § 6.)

§ 5605. Travel protection plans.

Travel protection plans may be offered for 1 price for the combined features that the travel protection plan offers in this State if:

(1) The travel protection plan clearly discloses to the consumer, at or prior to the time of purchase, that it includes travel insurance, travel assistance services, and cancellation fee waivers as applicable, and provides information and an opportunity, at or prior to the time of purchase, for the consumer to obtain additional information regarding the features and pricing of each; and

(2) The fulfillment materials shall:

a. Describe and delineate the travel insurance, travel assistance services, and cancellation fee waivers in the travel protection plan.

b. Include the travel insurance disclosures and the contact information for persons providing travel assistance services, and cancellation fee waivers, as applicable.

(84 Del. Laws, c. 40, § 6.)

§ 5606. Sales practices.

(a) All persons offering travel insurance to residents of this State are subject to the Unfair Trade Practices Act at §§ 2301 et seq. of this title except as otherwise provided in this section. In the event of a conflict between this chapter and other provisions of this title regarding the sale and marketing of travel insurance and travel protection plans, the provisions of this chapter shall control.

(b) *Illusory travel insurance.* —

Offering or selling a travel insurance policy that could never result in payment of any claims for any insured under the policy is an unfair trade practice under § 2301 et seq. of this title.

(c) *Marketing.* — (1) All documents provided to consumers prior to the purchase of travel insurance, including sales materials, advertising materials, and marketing materials, shall be consistent with the travel insurance policy itself, including forms, endorsements, policies, rate filings, and certificates of insurance.

(2) For travel insurance policies or certificates that contain pre-existing condition exclusions, information and an opportunity to learn more about the pre-existing condition exclusions shall be provided any time prior to the time of purchase, and in the coverage's fulfillment materials.

(3) The fulfillment materials and the information described in § 1772(2)a.1-4 of this title shall be provided to a policyholder or certificate holder as soon as practicable, following the purchase of a travel protection plan. Unless the insured has either started a covered trip or filed a claim under the travel insurance coverage, a policyholder or certificate holder may cancel a policy or certificate for a full refund of the travel protection plan price from the date of purchase of a travel protection plan until at least:

a. Fifteen days following the date of delivery of the travel protection plan's fulfillment materials by postal mail; or

b. Ten days following the date of delivery of the travel protection plan's fulfillment materials by means other than postal mail.

For the purposes of this section, "delivery" means handing fulfillment materials to the policyholder or certificate holder or sending fulfillment materials by postal mail or electronic means to the policyholder or certificate holder.

(4) The company shall disclose in the policy documentation and fulfillment materials whether the travel insurance is primary or secondary to other applicable coverage.

(5) Where travel insurance is marketed directly to a consumer through an insurer's website or by others through an aggregator site, it shall not be an unfair trade practice or other violation of law where an accurate summary or short description of coverage is provided on the web page, so long as the consumer has access to the full provisions of the policy through electronic means.

(d) *Opt out.* —

No person offering, soliciting, or negotiating travel insurance or travel protection plans on an individual or group basis may do so by using negative option or opt out, which would require a consumer to take an affirmative action to deselect coverage, such as unchecking a box on an electronic form, when the consumer purchases a trip.

(e) It shall be an unfair trade practice to market blanket travel insurance coverage as free.

(f) Where a consumer's destination jurisdiction requires insurance coverage, it shall not be an unfair trade practice to require that a consumer choose between the following options as a condition of purchasing a trip or travel package:

(1) Purchasing the coverage required by the destination jurisdiction through the travel retailer or limited lines travel insurance producer supplying the trip or travel package.

(2) Agreeing to obtain and provide proof of coverage that meets the destination jurisdiction's requirements prior to departure.

(84 Del. Laws, c. 40, § 6.)

§ 5607. Travel administrators.

(a) Notwithstanding any other provisions of this title, no person shall act or represent itself as a travel administrator for travel insurance in this State unless that person meets at least 1 of the following criteria:

(1) Is a licensed property and casualty insurance producer in this State for activities permitted under that producer license.

(2) Holds a valid managing general agent license in this State.

(3) Holds a valid third-party administrator license in this State.

(b) A travel administrator and its employees are exempt from the adjuster licensing requirements of § 1703 of this title for travel insurance it administers.

(c) An insurer is responsible for the acts of a travel administrator administering travel insurance underwritten by the insurer, and is responsible for ensuring that the travel administrator maintains all books and records relevant to the insurer to be made available by the travel administrator to the Commissioner upon request.

(84 Del. Laws, c. 40, § 6.)

§ 5608. Policy.

(a) Notwithstanding any other provision of this title, travel insurance shall be classified and filed for purposes of rates and forms under an inland marine line of insurance, provided, however, that travel insurance that provides coverage for sickness, accident, disability or death occurring during travel, either exclusively, or in conjunction with related coverages of emergency evacuation or repatriation of remains, may be filed under either an accident and health line of insurance or an inland marine line of insurance.

(b) Eligibility and underwriting standards for travel insurance may be developed and provided based on travel protection plans designed for individual or identified marketing or distribution channels, provided those standards also meet this State’s underwriting standards for inland marine.

(84 Del. Laws, c. 40, § 6.)

§ 5609. Regulations.

The Commissioner may promulgate regulations to implement the provisions of this chapter.

(84 Del. Laws, c. 40, § 6.)

Part I
Insurance
Chapter 57
Reciprocal Insurers

§ 5701. “Reciprocal” insurance defined.

“Reciprocal” insurance is that resulting from an interchange among persons, known as subscribers, of reciprocal agreements of indemnity, the interchange being effectuated through an attorney-in-fact common to all such persons.

(18 Del. C. 1953, § 5701; 56 Del. Laws, c. 380, § 1.)

§ 5702. Scope of chapter; existing insurers.

(a) All authorized reciprocal insurers shall be governed by those sections of this chapter not expressly made applicable to domestic reciprocals.

(b) Existing authorized reciprocal insurers shall, after November 1, 1968, comply with this chapter and shall make such amendments to their subscribers’ agreement, power of attorney, policies and other documents and accounts and perform such other acts as may be required for such compliance.

(18 Del. C. 1953, § 5702; 56 Del. Laws, c. 380, § 1.)

§ 5703. Insuring powers of reciprocals.

(a) A reciprocal insurer may, upon qualifying therefor as provided for by this title, transact any kind or kinds of insurance defined by this title, other than life or title insurances.

(b) Such an insurer may purchase reinsurance upon the risk of any subscriber and may grant reinsurance as to any kind of insurance it is authorized to transact directly.

(18 Del. C. 1953, § 5703; 56 Del. Laws, c. 380, § 1.)

§ 5704. Name; suits.

A reciprocal insurer shall:

(1) Have and use a business name. The name shall include the word “reciprocal” or “interinsurer” or “interinsurance” or “exchange” or “underwriters” or “underwriting” or “association.”

(2) Sue and be sued in its own name.

(18 Del. C. 1953, § 5704; 56 Del. Laws, c. 380, § 1.)

§ 5705. Attorney; attorney, subscribers and reciprocal insurer a single entity.

(a) “Attorney,” as used in this chapter, refers to the attorney-in-fact of a reciprocal insurer. The attorney may be an individual, firm or corporation.

(b) The attorney of a foreign reciprocal insurer, which insurer is duly authorized to transact insurance in this State, shall not, by virtue of discharge of its duties as such attorney with respect to the insurer’s transactions in this State, be thereby deemed to be doing business in this State within the meaning of any laws of this State applying to foreign persons, firms or corporations.

(c) The subscribers and the attorney-in-fact comprise a reciprocal insurer and a single entity for the purposes of Chapter 7 of this title as to all operations under the insurer’s certificate of authority.

(18 Del. C. 1953, § 5705; 56 Del. Laws, c. 380, § 1.)

§ 5706. Organization of reciprocal insurer.

(a) Twenty-five or more persons domiciled in this State may organize a domestic reciprocal insurer and make application to the Commissioner for a certificate of authority to transact insurance.

(b) (1) The proposed attorney shall fulfill the requirements of and shall execute and file with the Commissioner when applying for a certificate of authority, a declaration setting forth:

a. The name of the insurer;

b. The location of the insurer’s principal office, which shall be the same as that of the attorney and shall be maintained within this State;

c. The kinds of insurance proposed to be transacted;

d. The names and addresses of the original subscribers;

e. The designation and appointment of the proposed attorney and a copy of the power of attorney;

f. The names and addresses of the officers and directors of the attorney, if a corporation, or of its members, if a firm;

g. The powers of the subscribers’ advisory committee and the names and terms of office of the members thereof;

h. That all moneys paid to the reciprocal shall, after deducting therefrom any sum payable to the attorney, be held in the name of the insurer and for the purposes specified in the subscribers' agreement;

i. A statement that each of the original subscribers has in good faith applied for insurance of a kind proposed to be transacted and that the insurer has received from each such subscriber the full premium or premium deposit required for the policy applied for, for a term of not less than 6 months at an adequate rate therefor, filed with and approved by the Commissioner;

j. A statement of the financial condition of the insurer, a schedule of its assets and a statement that the surplus as required by § 511 of this title is on hand; and

k. A copy of each policy, endorsement and application form it then proposes to issue or use.

(2) The declaration shall be acknowledged by the attorney in the manner required for the acknowledgment of deeds.

(18 Del. C. 1953, § 5706; 56 Del. Laws, c. 380, § 1.)

§ 5707. Certificate of authority.

(a) The certificate of authority of a reciprocal insurer shall be issued to its attorney in the name of the insurer.

(b) The Commissioner may refuse, suspend or revoke the certificate of authority, in addition to other grounds therefor, for failure of the attorney to comply with any applicable provision of this title.

(18 Del. C. 1953, § 5707; 56 Del. Laws, c. 380, § 1.)

§ 5708. Power of attorney.

(a) The rights and powers of the attorney of a reciprocal insurer shall be as provided in the power of attorney given it by the subscribers.

(b) The power of attorney must set forth:

(1) The powers of the attorney;

(2) The general services to be performed by the attorney;

(3) The maximum amount to be deducted from advance premiums or deposits to be paid to the attorney and the general items of expense in addition to losses to be paid by the insurer; and

(4) Except as to nonassessable policies, a provision for a contingent several liability of each subscriber in a specified amount which amount shall be not less than 1 nor more than 10 times the premium or premium deposit stated in the policy.

(c) The power of attorney may:

(1) Provide for the right of substitution of the attorney and revocation of the power of attorney and rights thereunder;

(2) Impose such restrictions upon the exercise of the power as are agreed upon by the subscribers;

(3) Provide for the exercise of any right reserved to the subscribers directly or through their advisory committee; and

(4) Contain other lawful provisions deemed advisable.

(d) The terms of any power of attorney or agreement collateral thereto shall be reasonable and equitable, and no such power or agreement shall be used or be effective in this State until approved by the Commissioner.

(18 Del. C. 1953, § 5708; 56 Del. Laws, c. 380, § 1.)

§ 5709. Modifications.

Modifications of the terms of the subscribers' agreement or of the power of attorney of a domestic reciprocal insurer shall be made jointly by the attorney and the subscribers' advisory committee. No such modification shall be effective retroactively nor as to any insurance contract issued prior thereto.

(18 Del. C. 1953, § 5709; 56 Del. Laws, c. 380, § 1.)

§ 5710. Attorney's bond.

(a) Concurrently with the filing of the declaration provided for in § 5706 of this title, the attorney of a domestic reciprocal insurer shall file with the Commissioner a bond in favor of this State for the benefit of all persons damaged as a result of breach by the attorney of the conditions of the attorney's bond as set forth in subsection (b) hereof. The bond shall be executed by the attorney and by an authorized corporate surety and shall be subject to the Commissioner's approval.

(b) The bond shall be in the penal sum of $25,000, aggregate in form, conditioned that the attorney will faithfully account for all moneys and other property of the insurer coming into the attorney's hands and that such attorney will not withdraw or appropriate to his or her own use from the funds of the insurer any moneys or property to which he or she is not entitled under the power of attorney.

(c) The bond shall provide that it is not subject to cancellation unless 30 days' advance notice in writing of cancellation is given both the attorney and the Commissioner.

(18 Del. C. 1953, § 5710; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5711. Deposit in lieu of bond.

In lieu of the bond required under § 5710 of this title, the attorney may maintain on deposit, through the office of the Commissioner, a like amount in cash or in value of securities qualified under this title as insurers' investments and subject to the same conditions as the bond.

(18 Del. C. 1953, § 5711; 56 Del. Laws, c. 380, § 1.)

§ 5712. Action on bond.

Action on the attorney's bond or to recover against any such deposit made in lieu thereof may be brought at any time by 1 or more subscribers suffering loss through a violation of its conditions or by a receiver or liquidator of the insurer. Amounts recovered on the bond shall be deposited in and become part of the insurer's funds. The total aggregate liability of the surety shall be limited to the amount of the penalty of such bond.

(18 Del. C. 1953, § 5712; 56 Del. Laws, c. 380, § 1.)

§ 5713. Service of process; judgment.

(a) Legal process shall be served upon a domestic reciprocal insurer by serving the insurer's attorney at the attorney's principal offices or by serving the Commissioner as the insurer's process agent under §§ 524 and 525 of this title.

(b) Any judgment based upon legal process so served shall be binding upon each of the insurer's subscribers as their respective interests may appear but in an amount not exceeding their respective contingent liabilities, if any, the same as though personal service of process was had upon each such subscriber.

(18 Del. C. 1953, § 5713; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5714. Contributions to insurer.

The attorney or other parties may advance to a domestic reciprocal insurer upon reasonable terms such funds as it may require from time to time in its operations. Sums so advanced shall not be treated as a liability of the insurer and, except upon liquidation of the insurer, shall not be withdrawn or repaid except out of the insurer's realized earned surplus in excess of its minimum required surplus. No such withdrawal or repayment shall be made without the advance approval of the Commissioner. This section does not apply to bank loans or to other loans made upon security.

(18 Del. C. 1953, § 5714; 56 Del. Laws, c. 380, § 1.)

§ 5715. Financial condition; method of determining.

In determining the financial condition of a reciprocal insurer, the Commissioner shall apply the following rules:

(1) The Commissioner shall charge as liabilities the same reserves as are required of incorporated insurers issuing nonassessable policies on a reserve basis.

(2) The surplus deposits of subscribers shall be allowed as assets, except that any premium deposits delinquent for 90 days shall first be charged against such surplus deposit.

(3) The surplus deposits of subscribers shall not be charged as a liability.

(4) All premium deposits delinquent less than 90 days shall be allowed as assets.

(5) An assessment levied upon subscribers and not collected shall not be allowed as an asset.

(6) The contingent liability of subscribers shall not be allowed as an asset.

(7) The computation of reserves shall be based upon premium deposits other than membership fees and without any deduction for expenses and the compensation of the attorney.

(18 Del. C. 1953, § 5715; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5716. Subscribers.

Individuals, partnerships and corporations of this State may make application, enter into agreement for and hold policies or contracts in or with and be a subscriber of any domestic, foreign or alien reciprocal insurer. Any corporation now or hereafter organized under the laws of this State shall, in addition to the rights, powers, and franchises specified in its articles of incorporation, have full power and authority as a subscriber to exchange insurance contracts through such reciprocal insurer. The right to exchange such contracts is hereby declared to be incidental to the purposes for which such corporations are organized and to be as fully granted as the rights and powers expressly conferred upon such corporations. Government or governmental agencies, state or political subdivisions thereof, boards, associations, estates, trustees or fiduciaries are authorized to exchange nonassessable reciprocal interinsurance contracts with each other and with individuals, partnerships and corporations to the same extent that individuals, partnerships and corporations are herein authorized to exchange reciprocal interinsurance contracts. Any officer, representative, trustee, receiver or legal representative of any such subscriber shall be recognized as acting for or on its behalf for the purpose of such contract but shall not be personally liable upon such contract by reason of acting in such representative capacity.

(18 Del. C. 1953, § 5716; 56 Del. Laws, c. 380, § 1.)

§ 5717. Subscribers' advisory committee.

(a) The advisory committee of a domestic reciprocal insurer exercising the subscribers' rights shall be selected under such rules as the subscribers adopt.

(b) Not less than $^{2}/_{3}$ of such committee shall be subscribers other than the attorney or any person employed by, representing or having a financial interest in the attorney.

(c) The committee shall:

(1) Supervise the finances of the insurer;

(2) Supervise the insurer's operations to such extent as to assure conformity with the subscribers' agreement and power of attorney;

(3) Procure the audit of the accounts and records of the insurer and of the attorney at the expense of the insurer; and

(4) Have such additional powers and functions as may be conferred by the subscribers' agreement.

(18 Del. C. 1953, § 5717; 56 Del. Laws, c. 380, § 1.)

§ 5718. Subscribers' liability generally.

(a) The liability of each subscriber, other than as to a nonassessable policy, for the obligations of the reciprocal insurer shall be an individual, several and proportionate liability, and not joint.

(b) Except as to a nonassessable policy, each subscriber shall have a contingent assessment liability, in the amount provided for in the power of attorney or in the subscribers' agreement, for payment of actual losses and expenses incurred while the subscriber's policy was in force. Such contingent liability may be at the rate of not less than 1 nor more than 10 times the premium or premium deposit stated in the policy, and the maximum aggregate thereof shall be computed in the manner set forth in § 5722 of this title.

(c) Each assessable policy issued by the insurer shall contain a statement of the contingent liability set in type of the same prominence as the insuring clause.

(18 Del. C. 1953, § 5718; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5719. Subscribers' liability on judgment.

(a) No action shall lie against any subscriber upon any obligation claimed against the insurer until a final judgment has been obtained against the insurer and remains unsatisfied for 30 days.

(b) Any such judgment shall be binding upon each subscriber only in such proportion as the subscriber's interests may appear and in amount not exceeding the subscriber's contingent liability, if any.

(18 Del. C. 1953, § 5719; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5720. Assessments.

(a) Assessments may from time to time be levied upon subscribers of a domestic reciprocal insurer liable therefor under the terms of their policies by the attorney upon approval in advance by the subscribers' advisory committee and the Commissioner or by the Commissioner in liquidation of the insurer.

(b) Each subscriber's share of a deficiency for which an assessment is made which shall not exceed in any event the subscriber's aggregate contingent liability as computed in accordance with § 5722 of this title, shall be computed by applying to the premium earned on the subscriber's policy or policies during the period to be covered by the assessment, the ratio of the total deficiency to the total premiums earned during such period upon all policies subject to the assessment.

(c) In computing the earned premiums for the purposes of this section, the gross premium received by the insurer for the policy shall be used as a base, deducting therefrom solely charges not recurring upon the renewal or extension of the policy.

(d) No subscriber shall have an offset against any assessment for which such subscriber is liable on account of any claim for unearned premium or losses payable.

(18 Del. C. 1953, § 5720; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5721. Time limit for assessments.

Every subscriber of a domestic reciprocal insurer having contingent liability shall be liable for and shall pay his or her share of any assessment, as computed and limited in accordance with this chapter, if:

(1) While his or her policy is in force or within 1 year after its termination, he or she is notified by either the attorney or the Commissioner of his or her intentions to levy such assessment, or

(2) An order to show cause why a receiver, conservator, rehabilitator or liquidator of the insurer should not be appointed is issued while his or her policy is in force or within 1 year after its termination.

(18 Del. C. 1953, § 5721; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5722. Aggregate or contingent liability.

No 1 policy or subscriber as to such policy shall be assessed or charged with an aggregate or contingent liability as to obligations incurred by a domestic reciprocal insurer in any 1 calendar year in excess of the amount provided for in the power of attorney or in the subscribers' agreement, computed solely upon premium earned on such policy during that year.

(18 Del. C. 1953, § 5722; 56 Del. Laws, c. 380, § 1.)

§ 5723. Nonassessable policies.

(a) If a reciprocal insurer has a surplus of assets over all liabilities at least equal to the minimum capital stock and surplus required to be maintained by a domestic stock insurer authorized to transact like kinds of insurance, upon application of the attorney and as approved by

the subscribers' advisory committee, the Commissioner shall issue his or her certificate authorizing the insurer to extinguish the contingent liability of subscribers under its policies then in force in this State and to omit provisions imposing contingent liability in all policies delivered or issued for delivery in this State for so long as all such surplus remains unimpaired.

(b) Upon impairment of such surplus, the Commissioner shall forthwith revoke the certificate. Such revocation shall not render subject to contingent liability any policy then in force and for the remainder of the period for which the premium has theretofore been paid, but, after such revocation, no policy shall be issued or renewed without providing for contingent assessment liability of the subscriber.

(c) The Commissioner shall not authorize a domestic reciprocal insurer so to extinguish the contingent liability of any of its subscribers or in any of its policies to be issued unless it qualified to and does extinguish such liability of all its subscribers and in all such policies for all kinds of insurance transacted by it. Except, that if required by the laws of another state in which the insurer is transacting insurance as an authorized insurer, the insurer may issue policies providing for the contingent liability of such of its subscribers as may acquire such policies in such state and need not extinguish the contingent liability applicable to policies theretofore in force in such state.

(18 Del. C. 1953, § 5723; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5724. Subscribers' share in assets.

Upon the liquidation of a domestic reciprocal insurer, its assets remaining after discharge of its indebtedness and policy obligations, the return of any contributions of the attorney or other persons to its surplus and the return of any unused premium, savings or credits then standing on subscribers' accounts shall be distributed to its subscribers who were such within the 12 months prior to the last termination of its certificate of authority, according to such reasonable formula as the Commissioner may approve.

(18 Del. C. 1953, § 5724; 56 Del. Laws, c. 380, § 1.)

§ 5725. Merger or conversion.

(a) A domestic reciprocal insurer upon affirmative vote of not less than $^{2}/_{3}$ of its subscribers who vote on such merger, pursuant to due notice and the approval of the Commissioner of the terms therefor, may merge with another reciprocal insurer or be converted to a stock or mutual insurer.

(b) Such a stock or mutual insurer shall be subject to the same capital or surplus requirements and shall have the same rights as a like domestic insurer transacting like kinds of insurance.

(c) The Commissioner shall not approve any plan for such merger or conversion which is inequitable to subscribers, or which, if for conversion to a stock insurer, does not give each subscriber preferential right to acquire stock of the proposed insurer proportionate to each subscriber's interest in the reciprocal insurer as determined in accordance with § 5724 of this title and a reasonable length of time within which to exercise such right.

(18 Del. C. 1953, § 5725; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5726. Impaired reciprocals.

(a) If the assets of a domestic reciprocal insurer are at any time insufficient to discharge its liabilities, other than any liability on account of funds contributed by the attorney or others, and to maintain the required surplus, its attorney shall forthwith make up the deficiency or levy an assessment upon the subscribers for the amount needed to make up the deficiency but subject to the limitation set forth in the power of attorney or policy.

(b) If the attorney fails to make up such deficiency or to make the assessment within 30 days after the Commissioner orders such attorney to do so or if the deficiency is not fully made up within 60 days after the date the assessment was made, the insurer shall be deemed insolvent and shall be proceeded against as authorized by this title.

(c) If liquidation of such an insurer is ordered, an assessment shall be levied upon the subscribers for such an amount, subject to limits as provided by this chapter, as the Commissioner determines to be necessary to discharge all liabilities of the insurer, exclusive of any funds contributed by the attorney or other persons but including the reasonable cost of the liquidation.

(18 Del. C. 1953, § 5726; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

Part I
Insurance
Chapter 58
Risk-Based Capital (RBC)
Subchapter I
Risk-Based Capital (RBC) for Insurers [For severability of this subchapter, see 70 Del. Laws, c. 234, § 2]

§ 5801. Definitions [For severability of this subchapter, see 70 Del. Laws, c. 234, § 2].

As used in this chapter, these terms shall have the following meanings:

(1) "Adjusted RBC Report" means an RBC report which has been adjusted by the Commissioner in accordance with § 5802(e) of this title.

(2) "Corrective order" means an order issued by the Commissioner specifying corrective actions which the Commissioner has determined are required.

(3) "Domestic insurer" means any insurance company domiciled in this State, except insurers not doing business with citizens or residents of the United States or organized or located within the United States.

(4) "Foreign insurer" means any insurance company which is licensed to do business in this State under § 516 of this title, but is not domiciled in this State.

(5) "Life and/or health insurer" means any insurance company licensed under § 516 of this title, or a licensed property and casualty insurer writing only accident and health insurance.

(6) "NAIC" means the National Association of Insurance Commissioners.

(7) "Negative trend" means, with respect to a life and/or health insurer, negative trend over a period of time, as determined in accordance with the Trend Test Calculation included in the RBC Instructions.

(8) "Property and casualty insurer" means any insurance company licensed under § 516 of this title, but shall not include monoline mortgage guaranty insurers, financial guaranty insurers and title insurers.

(9) "RBC instructions" means the RBC report including risk-based capital instructions adopted by the NAIC; as such, RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(10) "RBC level" means an insurer's Company Action Level RBC, Regulatory Action Level RBC, Authorized Control Level RBC, or Mandatory Control Level RBC where:

a. "Company Action Level RBC" means, with respect to any insurer, the product of 2.0 and its Authorized Control Level RBC;

b. "Regulatory Action Level RBC" means the product of 1.5 and its Authorized Control Level RBC;

c. "Authorized Control Level RBC" means the number determined under the risk-based capital formula in accordance with the RBC Instructions;

d. "Mandatory Control Level RBC" means the product of .70 and the Authorized Control Level RBC.

(11) "RBC plan" means a comprehensive financial plan containing the elements specified in § 5803(b) of this title. If the Commissioner rejects the RBC Plan, and it is revised by the insurer, with or without the Commissioner's recommendation, the plan shall be called the revised RBC plan.

(12) "RBC report" means the report required in § 5802 of this title.

(13) "Total adjusted capital" means the sum of:

a. An insurer's statutory capital and surplus; and

b. Such other items, if any, as the RBC instructions may provide.

(70 Del. Laws, c. 234, § 1; 79 Del. Laws, c. 425, § 2.)

§ 5802. RBC reports [For severability of this subchapter, see 70 Del. Laws, c. 234, § 2].

(a) Every domestic insurer shall, on or prior to each March 1 (the "filing date"), prepare and submit to the Commissioner a report of its RBC levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, every domestic insurer shall file its RBC report:

(1) With the NAIC in accordance with the RBC instructions; and

(2) With the insurance commissioner in any state in which the insurer is authorized to do business, if the insurance commissioner has notified the insurer of its request in writing, in which case the insurer shall file its RBC report not later than the later of:

a. Fifteen days from the receipt of notice to file its RBC report with that state; or

b. The filing date.

(b) A life and health insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account and may adjust for the covariance between:

(1) The risk with respect to the insurer's assets;

(2) The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(3) The interest rate risk with respect to the insurer's business; and

(4) All other business risks and such other relevant risks as are set forth in the RBC instructions;

determined in each case by applying the factors in the manner set forth in the RBC instructions.

(c) A property and casualty insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account and may adjust for the covariance between:

(1) Asset risk;

(2) Credit risk;

(3) Underwriting risk; and

(4) All other business risks and such other relevant risks as are set forth in the RBC instructions;

determined in each case by applying the factors in the manner set forth in the RBC instructions.

(d) An excess of capital over the amount produced by the risk-based capital requirements contained in this chapter and the formulas, schedules and instructions referenced in this chapter is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the RBC levels required by this chapter. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this chapter.

(e) If a domestic insurer files an RBC report which in the judgment of the Commissioner is inaccurate, then the Commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC report as so adjusted is referred to as an "adjusted RBC report."

(70 Del. Laws, c. 234, § 1; 79 Del. Laws, c. 425, § 2.)

§ 5803. Company Action Level Event [For severability of this subchapter, see 70 Del. Laws, c. 234, § 2].

(a) "Company Action Level Event" means any of the following events:

(1) The filing of an RBC report by an insurer which indicates that:

a. The insurer's total adjusted capital is greater than or equal to its Regulatory Action Level RBC but less than its Company Action Level RBC; or

b. If a life insurer, health insurer, or a fraternal benefit society, the insurer or society has total adjusted capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0 and has a negative trend; or

c. If a property and casualty insurer, the insurer has total adjusted capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the Property and Casualty RBC instructions.

(2) The notification by the Commissioner to the insurer of an adjusted RBC report that indicates an event in paragraph (a)(1) of this section, provided the insurer does not challenge the adjusted RBC report under § 5807 of this title; or

(3) If, pursuant to § 5807 of this chapter, an insurer challenges an adjusted RBC report that indicates the event in paragraph (a)(1) of this section, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(b) In the event of a Company Action Level Event, the insurer shall prepare and submit to the Commissioner an RBC plan which shall:

(1) Identify the conditions which contribute to the Company Action Level Event;

(2) Contain proposals of corrective actions which the insurer intends to take and would be expected to result in the elimination of the Company Action Level Event;

(3) Provide projections of the insurer's financial results in the current year and at least the 4 succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital and/or surplus. (The projections for both new and renewal business might include separate projections for each major line of business and separate identification of each significant income, expense and benefit component);

(4) Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(5) Identify the quality of, and problems associated with, the insurer's business including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(c) The RBC plan shall be submitted:

(1) Within 45 days of the Company Action Level Event; or

(2) If the insurer challenges an adjusted RBC report pursuant to § 5807 of this title, within 45 days after notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(d) Within 60 days after the submission by an insurer of an RBC plan to the Commissioner, the Commissioner shall notify the insurer whether the RBC plan shall be implemented or is, in the judgment of the Commissioner, unsatisfactory. If the Commissioner determines the RBC plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC plan satisfactory, in the judgment of the Commissioner. Upon notification from the Commissioner, the insurer shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the Commissioner, and shall submit the revised RBC plan to the Commissioner:

(1) Within 45 days after the notification from the Commissioner; or

(2) If the insurer challenges the notification from the Commissioner under § 5807 of this title, within 45 days after a notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(e) In the event of a notification by the Commissioner to an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the Commissioner may at the Commissioner's discretion, subject to the insurer's right to a hearing under § 5807 of this title, specify in the notification that the notification constitutes a Regulatory Action Level Event.

(f) Every domestic insurer that files an RBC plan or revised RBC plan with the Commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

(1) Such state has an RBC provision substantially similar to § 5808(a) of this title; and

(2) The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

a. Fifteen days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

b. The date on which the RBC plan or revised RBC plan is filed under subsections (c) and (d) of this section.

(70 Del. Laws, c. 234, § 1; 78 Del. Laws, c. 329, § 1; 79 Del. Laws, c. 425, § 2; 80 Del. Laws, c. 384, § 1.)

§ 5804. Regulatory Action Level Event [For severability of this subchapter, see 70 Del. Laws, c. 234, § 2].

(a) "Regulatory Action Level Event" means, with respect to any insurer, any of the following events:

(1) The filing of an RBC report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its Authorized Control Level RBC but less than its Regulatory Action Level RBC;

(2) The notification by the Commissioner to an insurer of an adjusted RBC report that indicates the event in paragraph (a)(1) of this section, provided the insurer does not challenge the adjusted RBC report under § 5807 of this title;

(3) If, pursuant to § 5807 of this title, the insurer challenges an adjusted RBC report that indicates the event in paragraph (a)(1) of this section, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge;

(4) The failure of the insurer to file an RBC report by the filing date, unless the insurer has provided an explanation for such failure which is satisfactory to the Commissioner and has cured the failure within 10 days after the filing date;

(5) The failure of the insurer to submit an RBC plan to the Commissioner within the time period set forth in § 5803(c) of this title;

(6) Notification by the Commissioner to the insurer that:

a. The RBC plan or revised RBC plan submitted by the insurer is, in the judgment of the Commissioner, unsatisfactory; and

b. Such notification constitutes a Regulatory Action Level Event with respect to the insurer, provided the insurer has not challenged the determination under § 5807 of this title;

(7) If, pursuant to § 5807 of this title, the insurer challenges a determination by the Commissioner under paragraph (a)(6) of this section, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected such challenge;

(8) Notification by the Commissioner to the insurer that the insurer has failed to adhere to its RBC plan or revised RBC plan, but only if such failure has a substantial adverse effect on the ability of the insurer to eliminate the Company Action Level Event in accordance with its RBC plan or revised RBC plan and the Commissioner has so stated in the notification, provided the insurer has not challenged the determination under § 5807 of this title; or

(9) If, pursuant to § 5807 of this title, the insurer challenges a determination by the Commissioner under paragraph (a)(8) of this section, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the challenge.

(b) In the event of a Regulatory Action Level Event the Commissioner shall:

(1) Require the insurer to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(2) Perform such examination or analysis as the Commissioner deems necessary of the assets, liabilities and operations of the insurer including a review of its RBC plan or revised RBC plan; and

(3) Subsequent to the examination or analysis, issue an order specifying such corrective actions as the Commissioner shall determine are required (a "corrective order").

(c) In determining corrective actions, the Commissioner may take into account such factors as are deemed relevant with respect to the insurer based upon the Commissioner's examination or analysis of the assets, liabilities and operations of the insurer, including, but not limited to, the results of any sensitivity test undertaken pursuant to the RBC Instructions. The RBC plan or revised RBC plan shall be submitted:

(1) Within 45 days after the occurrence of the Regulatory Action Level Event;

(2) If the insurer challenges an adjusted RBC report pursuant to § 5807 of this title, and the challenge is not frivolous in the judgment of the Commissioner within 45 days after the notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge; or

(3) If the insurer challenges a revised RBC plan pursuant to § 5807 of this title, and the challenge is not frivolous in the judgment of the Commissioner, within 45 days after the notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(d) The Commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the Commissioner to review the insurer's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations of the insurer and formulate the corrective order with respect to the insurer. The fees, costs and expenses relating to consultants shall be borne by the affected insurer or such other party as directed by the Commissioner.

(70 Del. Laws, c. 234, § 1; 79 Del. Laws, c. 425, § 2.)

§ 5805. Authorized Control Level Event [For severability of this subchapter, see 70 Del. Laws, c. 234, § 2].

(a) "Authorized Control Level Event" means any of the following events:

(1) The filing of an RBC report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its Mandatory Control Level RBC but less than its Authorized Control Level RBC;

(2) The notification by the Commissioner to the insurer of an adjusted RBC report that indicates the event in paragraph (a)(1) of this section, provided the insurer does not challenge the adjusted RBC report under § 5807 of this title;

(3) If, pursuant to § 5807 of this title, the insurer challenges an adjusted RBC report that indicates the event in paragraph (a)(1) of this section, notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge;

(4) The failure of the insurer to respond, in a manner satisfactory to the Commissioner, to a corrective order (provided the insurer has not challenged the corrective order under § 5807 of this title); or

(5) If the insurer has challenged a corrective order under § 5807 of this title, and the Commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the Commissioner, to the corrective order subsequent to rejection or modification by the Commissioner.

(b) In the event of an Authorized Control Level Event with respect to an insurer, the Commissioner shall:

(1) Take such actions as are required under § 5804 of this title, regarding an insurer with respect to which a Regulatory Action Level Event has occurred; or

(2) If the Commissioner deems it to be in the best interests of the policyholders and creditors of the insurer and of the public, take such actions as are necessary to cause the insurer to be placed under regulatory control under Chapter 59 of this title. In the event the Commissioner takes such actions, the Authorized Control Level Event shall be deemed sufficient grounds for the Commissioner to take action under Chapter 59 of this title, and the Commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in Chapter 59 of this title. In the event the Commissioner takes actions under this paragraph pursuant to an adjusted RBC report, the insurer shall be entitled to such protections as are afforded to insurers under the provisions of Chapter 59 of this title pertaining to summary proceedings.

(70 Del. Laws, c. 234, § 1; 79 Del. Laws, c. 425, § 2.)

§ 5806. Mandatory Control Level Event [For severability of this subchapter, see 70 Del. Laws, c. 234, § 2].

(a) "Mandatory Control Level Event" means any of the following events:

(1) The filing of an RBC report which indicates that the insurer's total adjusted capital is less than its Mandatory Control Level RBC;

(2) Notification by the Commissioner to the insurer of an adjusted RBC report that indicates the event in paragraph (a)(1) of this section, provided the insurer does not challenge the adjusted RBC report under § 5807 of this title; or

(3) If, pursuant to § 5807 of this title, the insurer challenges an adjusted RBC report that indicates the event in paragraph (a)(1) of this section, notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(b) In the event of a Mandatory Control Level Event:

(1) With respect to a life insurer, the Commissioner shall take such actions as are necessary to place the insurer under regulatory control under Chapter 59 of this title. In the event the Mandatory Control Level Event shall be deemed sufficient grounds for the Commissioner to take action under Chapter 59 of this title, the Commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in Chapter 59 of this title. If the Commissioner takes actions pursuant to an adjusted RBC report, the insurer shall be entitled to the protections of Chapter 59 to this title pertaining to summary proceedings. Notwithstanding any of the foregoing, the Commissioner may forgo action for up to 90 days after the Mandatory Control Level Event if the Commissioner finds there is a reasonable expectation that the Mandatory control Level Event may be eliminated within the 90-day period.

(2) With respect to a property and casualty insurer, the Commissioner shall take such actions as are necessary to place the insurer under regulatory control under Chapter 59 of this title, or, in the case of an insurer which is writing no business and which is running-

off its existing business, may allow the insurer to continue its run-off under the supervision of the Commissioner. In either event, the Mandatory Control Level Event shall be deemed sufficient grounds for the Commissioner to take action under Chapter 59 of this title and the Commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in Chapter 59 of this title. If the Commissioner takes actions pursuant to an adjusted RBC report, the insurer shall be entitled to the protections of Chapter 59 of this title pertaining to summary proceedings. Notwithstanding any of the foregoing, the Commissioner may forgo action for up to 90 days after the Mandatory Control Level Event if the Commissioner finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the 90-day period.

(70 Del. Laws, c. 234, § 1; 79 Del. Laws, c. 425, § 2.)

§ 5807. Hearings [For severability of this subchapter, see 70 Del. Laws, c. 234, § 2].

Upon:

(1) Notification to an insurer by the Commissioner of an adjusted RBC report; or

(2) Notification to an insurer by the Commissioner that:

a. The insurer's RBC plan or revised RBC plan is unsatisfactory; and

b. Such notification constitutes a Regulatory Action Level Event with respect to such insurer; or

(3) Notification to any insurer by the Commissioner that the insurer has failed to adhere to its RBC plan or revised RBC plan and that such failure has a substantial adverse effect on the ability of the insurer to eliminate the Company Action Level Event with respect to the insurer in accordance with its RBC plan or revised RBC plan; or

(4) Notification to an insurer by the Commissioner of a corrective order with respect to the insurer,

the insurer shall have the right to a departmental hearing, on the record, at which the insurer may challenge any determination or action by the Commissioner. The insurer shall notify the Commissioner of its request for a hearing within 5 days after the notification by the Commissioner under paragraph (1), (2), (3) or (4) of this section. Upon receipt of the insurer's request for a hearing, the Commissioner shall set a date for the hearing, which date shall be no less than l0 nor more than 30 days after the date of the insurer's request.

(70 Del. Laws, c. 234, § 1; 79 Del. Laws, c. 425, § 2.)

§ 5808. Confidentiality, prohibition on announcements, prohibition on use in ratemaking [For severability of this subchapter, see 70 Del. Laws, c. 234, § 2].

(a) All RBC reports (to the extent the information therein is not required to be set forth in a publicly available annual statement schedule) and RBC plans (including the results or report of any examination or analysis of an insurer performed pursuant hereto and any corrective order issued by the Commissioner pursuant to examination or analysis) with respect to any domestic insurer or foreign insurer which are filed with the Commissioner constitute information that might be damaging to the insurer if made available to its competitors, and therefore shall be kept confidential by the Commissioner. This information shall not be made public and/or be subject to subpoena, other than by the Commissioner and then only for the purpose of enforcement actions taken by the Commissioner pursuant to this chapter or any other provision of the insurance laws of this State.

(b) Neither the Commissioner nor any person who received documents, materials or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection (a) of this section.

(c) In order to assist in the performance of the Commissioner's duties, the Commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection (a) of this section, with other state, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal and international law-enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(2) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law-enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(3) May enter into agreements governing sharing and use of information consistent with this subsection.

(d) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (c) of this section.

(e) It is the judgment of the General Assembly that the comparison of an insurer's total adjusted capital to any of its RBC levels is a regulatory tool which may indicate the need for possible corrective action with respect to the insurer, and is not intended as a means to rank insurers generally. Therefore, except as otherwise required under the provisions of this chapter, the making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any

radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC levels of any insurer, or of any component derived in the calculation, by any insurer, agent, broker or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; provided, however, that if any materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its RBC levels (or any of them) or an inappropriate comparison of any other amount to the insurers RBC levels is published in any written publication and the insurer is able to demonstrate to the Commissioner with substantial proof the falsity of such statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(f) It is the further judgment of the General Assembly that the RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans are intended solely for use by the Commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers and shall not be used by the Commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the Commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance which an insurer or any affiliate is authorized to write.

(70 Del. Laws, c. 234, § 1; 78 Del. Laws, c. 329, § 1; 79 Del. Laws, c. 425, § 2.)

§ 5809. Supplemental provisions, rules, exemption [For severability of this subchapter, see 70 Del. Laws, c. 234, § 2].

(a) The provisions of this chapter are supplemental to any other provisions of the laws of this State, and shall not preclude or limit any other powers or duties of the Commissioner under such laws, including, but not limited to, Chapter 59 of this title.

(b) The Commissioner may adopt reasonable rules necessary for the implementation of this chapter.

(c) The Commissioner may exempt from the application of this chapter any domestic property and casualty insurer which:

(1) Writes direct business only in this State;

(2) Writes direct annual premiums of $2,000,000 or less; and

(3) Assumes no reinsurance in excess of 5 percent of direct premium written.

(d) The provisions of this chapter shall not apply to any domestic insurer transacting insurance in foreign countries only, as defined in § 103 of this title; and negotiation and issuance of insurance on objects of insurance resident, located or to be performed in such foreign jurisdictions, and changes in, communications concerning, and collection of premiums and payment of proceeds on insurance so issued, shall not be deemed to constitute the transaction of insurance in any such state.

(70 Del. Laws, c. 234, § 1; 79 Del. Laws, c. 425, § 2.)

§ 5810. Foreign insurers [For severability of this subchapter, see 70 Del. Laws, c. 234, § 2].

(a) Any foreign insurer shall, upon the written request of the Commissioner, submit to the Commissioner an RBC report as of the end of the calendar year just ended the later of:

(1) The date an RBC report would be required to be filed by a domestic insurer under this chapter; or

(2) Fifteen days after the request is received by the foreign insurer.

(b) Any foreign insurer shall, at the written request of the Commissioner, promptly submit to the Commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

(c) In the event of a Company Action Level Event, Regulatory Action Level Event or Authorized Control Level Event with respect to any foreign insurer as determined under the RBC statute applicable in the state of domicile of the insurer (or, if no RBC statute is in force in that state, under the provisions of this chapter), if the insurance commissioner of the state of domicile of the foreign insurer fails to require the foreign insurer to file an RBC plan in the manner specified under that state's RBC statute (or, if no RBC statute is in force in that state, under § 5803 of this title), the Commissioner may require the foreign insurer to file an RBC plan with the Commissioner. In such event, the failure of the foreign insurer to file an RBC plan with the Commissioner shall be grounds to order the insurer to cease and desist from writing new insurance business in this State.

(d) In the event of a Mandatory Control Level Event with respect to any foreign insurer, if no domiciliary receiver has been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer, the Commissioner may make application to the Court of Chancery permitted under Chapter 59 of this title with respect to the liquidation of property of foreign insurers found in this State, and the occurrence of the Mandatory Control level Event shall be considered adequate grounds for the application.

(70 Del. Laws, c. 234, § 1; 79 Del. Laws, c. 425, § 2.)

§ 5811. Immunity [For severability of this subchapter, see 70 Del. Laws, c. 234, § 2].

There shall be no liability on the part of, and no cause of action shall arise against, the Commissioner or the Insurance Department or its employees or agents for any action taken by them in the performance of their powers and duties under this chapter.

(70 Del. Laws, c. 234, § 1; 79 Del. Laws, c. 425, § 2.)

§ 5812. Notices [For severability of this subchapter, see 70 Del. Laws, c. 234, § 2].

All notices by the Commissioner to an insurer which may result in regulatory action hereunder shall be effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission shall be effective upon the insurer's receipt of such notice.

(70 Del. Laws, c. 234, § 1; 79 Del. Laws, c. 425, § 2.)

§ 5813. Phase-in provision [For severability of this subchapter, see 70 Del. Laws, c. 234, § 2].

For RBC reports required to be filed insurers with respect to 1994, the following requirements shall apply in lieu of the provisions of §§ 5803, 5804, 5805 and 5806 of this title:

(1) In the event of a Company Action Level Event with respect to a domestic insurer, the Commissioner shall take no regulatory action hereunder.

(2) In the event of a Regulatory Action Level Event under § 5804(a)(1), (2) or (3) of this title the Commissioner shall take the actions required under § 5803 of this title.

(3) In the event of a Regulatory Action Level Event under § 5804(a)(4), (5), (6), (7), (8) or (9) of this title or an Authorized Control Level Event, the Commissioner shall take the actions required under § 5804 of this title with respect to the insurer.

(4) In the event of a Mandatory Control Level Event with respect to an insurer, the Commissioner shall take the actions required under § 5805 of this title with respect to the insurer.

(70 Del. Laws, c. 234, § 1; 79 Del. Laws, c. 425, § 2.)

Subchapter II
Risk-Based Capital (RBC) for Health Organizations

§ 5820. Definitions.

As used in this chapter, the following terms shall have the respective meanings hereinafter set forth, unless the context shall otherwise require:

(1) "*Adjusted RBC report.*" — The term "adjusted RBC report" means an RBC report which has been adjusted by the Commissioner in accordance with § 5821(d) of this title.

(2) "*Corrective order.*" — The term "corrective order" means an order issued by the Commissioner specifying corrective actions which the Commissioner has determined are required.

(3) "*Domestic health organization.*" — The term "domestic health organization" means a health organization domiciled in this State.

(4) "*Foreign health organization.*" — The term "foreign health organization" means a health organization that is licensed to do business in this State under this title but is not domiciled in this State.

(5) "*Health organization.*" — The term "health organization" means a health maintenance organization, limited health service organization, health service corporation, dental or vision plan, hospital, medical and dental indemnity or service corporation or other managed care organization licensed under this title. This definition does not include an organization that is licensed as either a life and/or health insurer or a property and casualty insurer under § 516 of this title and that is otherwise subject to either the life and/or health or property and casualty RBC requirements.

(6) "*NAIC.*" — The term "NAIC" means the National Association of Insurance Commissioners.

(7) "*RBC instructions.*" — The term "RBC instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as these RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(8) "*RBC level.*" — The term "RBC level" means a health organization's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

a. "Authorized control level RBC" means the number determined under the risk based capital formula in accordance with the RBC instructions;

b. "Company action level RBC" means, with respect to any health organization, the product of 2.0 and its authorized control level RBC;

c. "Mandatory control level RBC" means the product of .70 and the authorized control level RBC;

d. "Regulatory action level RBC" means the product of 1.5 and its authorized control level RBC.

(9) "*RBC plan.*" — The term "RBC plan" means a comprehensive financial plan containing the elements specified in § 5822(b) of this title. If the Commissioner rejects the RBC plan, and it is revised by the health organization, with or without the Commissioner's recommendation, the plan shall be called the "revised RBC plan."

(10) "*RBC report.*" — The term "RBC report" means the report required in § 5821 of this title.

(11) "*Total adjusted capital.*" — The term "total adjusted capital" means the sum of:

a. A health organization's statutory capital and surplus (i.e., net worth) as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under this title; and

b. Such other items, if any, as the RBC instructions may provide.

(79 Del. Laws, c. 425, § 3.)

§ 5821. RBC reports.

(a) A domestic health organization shall, on or prior to each March 1 or the required annual statement filing date if later (the "filing date"), prepare and submit to the Commissioner a report of its RBC levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, a domestic health organization shall file its RBC report:

(1) With the NAIC in accordance with the RBC instructions; and

(2) With the insurance commissioner in any state in which the health organization is authorized to do business, if the insurance commissioner has notified the health organization of its request in writing, in which case the health organization shall file its RBC report not later than the later of:

a. Fifteen days from the receipt of notice to file its RBC report with that state; or

b. The filing date.

(b) A health organization's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account (and may adjust for the covariance between) determined in each case by applying the factors in the manner set forth in the RBC instructions.

(1) Asset risk;

(2) Credit risk;

(3) Underwriting risk; and

(4) All other business risks and such other relevant risks as are set forth in the RBC instructions.

(c) An excess of capital (i.e. net worth) over the amount produced by the risk-based capital requirements contained in this subchapter II and the formulas, schedules and instructions referenced in this subchapter II is desirable in the business of health insurance. Accordingly, health organizations should seek to maintain capital above the RBC levels required by this subchapter II. Additional capital is used and useful in the insurance business and helps to secure a health organization against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this subchapter II.

(d) If a domestic health organization files an RBC report that in the judgment of the Commissioner is inaccurate, then the Commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the health organization of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC report as so adjusted is referred to as an "adjusted RBC report."

(79 Del. Laws, c. 425, § 3.)

§ 5822. Company action level event.

(a) "Company action level event" means any of the following events:

(1) The filing of an RBC report by a health organization that indicates that the health organization's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC, if a health organization has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the health RBC instructions;

(2) Notification by the Commissioner to the health organization of an adjusted RBC report that indicates an event in paragraph (a)(1) of this section, provided the health organization does not challenge the adjusted RBC report under § 5826 of this title; or

(3) If, pursuant to § 5826 of this title, a health organization challenges an adjusted RBC report that indicates the event in paragraph (a)(1) of this section, the notification by the Commissioner to the health organization that the Commissioner has, after a hearing, rejected the health organization's challenge.

(b) In the event of a company action level event, the health organization shall prepare and submit to the Commissioner an RBC plan that shall:

(1) Identify the conditions that contribute to the company action level event;

(2) Contain proposals of corrective actions that the health organization intends to take and that would be expected to result in the elimination of the company action level event;

(3) Provide projections of the health organization's financial results in the current year and at least the 2 succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

(4) Identify the key assumptions impacting the health organization's projections and the sensitivity of the projections to the assumptions; and

(5) Identify the quality of, and problems associated with, the health organization's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(c) The RBC plan shall be submitted

(1) Within 45 days of the company action level event; or

(2) If the health organization challenges an adjusted RBC report pursuant to § 5826 of this title, within 45 days after notification to the health organization that the Commissioner has, after a hearing, rejected the health organization's challenge.

(d) Within 60 days after the submission by a health organization of an RBC plan to the Commissioner, the Commissioner shall notify the health organization whether the RBC plan shall be implemented or is, in the judgment of the Commissioner, unsatisfactory. If the Commissioner determines the RBC plan is unsatisfactory, the notification to the health organization shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC plan satisfactory, in the judgment of the Commissioner. Upon notification from the Commissioner, the health organization shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the Commissioner, and shall submit the revised RBC plan to the Commissioner:

(1) Within 45 days after the notification from the Commissioner; or

(2) If the health organization challenges the notification from the Commissioner under § 5826 of this title, within 45 days after a notification to the health organization that the Commissioner has, after a hearing, rejected the health organization's challenge.

(e) In the event of a notification by the Commissioner to a health organization that the health organization's RBC plan or revised RBC plan is unsatisfactory, the Commissioner may at the Commissioner's discretion, subject to the health organization's right to a hearing under § 5826 of this title, specify in the notification that the notification constitutes a regulatory action level event.

(f) Every domestic health organization that files an RBC plan or revised RBC plan with the Commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the health organization is authorized to do business if:

(1) The state has an RBC provision substantially similar to § 5827(a) of this title; and

(2) The insurance commissioner of that state has notified the health organization of its request for the filing in writing, in which case the health organization shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

a. Fifteen days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

b. The date on which the RBC plan or revised RBC plan is filed under subsections (c) and (d) of this section.

(79 Del. Laws, c. 425, § 3.)

§ 5823. Regulatory action level event.

(a) "Regulatory action level event" means, with respect to a health organization, any of the following events:

(1) The filing of an RBC report by the health organization that indicates that the health organization's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(2) Notification by the Commissioner to a health organization of an adjusted RBC report that indicates the event in paragraph (a)(1) of this section, provided the health organization does not challenge the adjusted RBC report under § 5826 of this title;

(3) If, pursuant to § 5826 of this title, the health organization challenges an adjusted RBC report that indicates the event in paragraph (a)(1) of this section, the notification by the Commissioner to the health organization that the Commissioner has, after a hearing, rejected the health organization's challenge;

(4) The failure of the health organization to file an RBC report by the filing date, unless the health organization has provided an explanation for the failure that is satisfactory to the Commissioner and has cured the failure within 10 days after the filing date;

(5) The failure of the health organization to submit an RBC plan to the Commissioner within the time period set forth in § 5822(c) of this title;

(6) Notification by the Commissioner to the health organization that:

a. The RBC plan or revised RBC plan submitted by the health organization is, in the judgment of the Commissioner, unsatisfactory; and

b. Notification constitutes a regulatory action level event with respect to the health organization, provided the health organization has not challenged the determination under § 5826 of this title;

(7) If, pursuant to § 5826 of this title, the health organization challenges a determination by the Commissioner under paragraph (a)(6) of this section, the notification by the Commissioner to the health organization that the Commissioner has, after a hearing, rejected the challenge;

(8) Notification by the Commissioner to the health organization that the health organization has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the health organization to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the Commissioner has so stated in the notification, provided the health organization has not challenged the determination under § 5826 of this title; or

(9) If, pursuant to § 5826 of this title, the health organization challenges a determination by the Commissioner under paragraph (a)(8) of this section, the notification by the Commissioner to the health organization that the Commissioner has, after a hearing, rejected the challenge.

(b) In the event of a regulatory action level event the Commissioner shall:

(1) Require the health organization to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(2) Perform such examination or analysis as the Commissioner deems necessary of the assets, liabilities and operations of the health organization including a review of its RBC plan or revised RBC plan; and

(3) Subsequent to the examination or analysis, issue an order specifying such corrective actions as the Commissioner shall determine are required (a "corrective order").

(c) In determining corrective actions, the Commissioner may take into account factors the Commissioner deems relevant with respect to the health organization based upon the Commissioner's examination or analysis of the assets, liabilities and operations of the health organization, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(1) Within 45 days after the occurrence of the regulatory action level event;

(2) If the health organization challenges an adjusted RBC report pursuant to § 5826 of this title and the challenge is not frivolous in the judgment of the Commissioner, within 45 days after the notification to the health organization that the Commissioner has, after a hearing, rejected the health organization's challenge; or

(3) If the health organization challenges a revised RBC plan pursuant to § 5826 of this title and the challenge is not frivolous in the judgment of the Commissioner, within 45 days after the notification to the health organization that the Commissioner has, after a hearing, rejected the health organization's challenge.

(d) The Commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the Commissioner to review the health organization's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations (including contractual relationships) of the health organization and formulate the corrective order with respect to the health organization. The fees, costs and expenses relating to consultants shall be borne by the affected health organization or such other party as directed by the Commissioner.

(79 Del. Laws, c. 425, § 3.)

§ 5824. Authorized control level event.

(a) "Authorized control level event" means any of the following events:

(1) The filing of an RBC report by the health organization that indicates that the health organization's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(2) The notification by the Commissioner to the health organization of an adjusted RBC report that indicates the event in paragraph (a)(1) of this section, provided the health organization does not challenge the adjusted RBC report under § 5826 of this title;

(3) If, pursuant to § 5826 of this title, the health organization challenges an adjusted RBC report that indicates the event in paragraph (a)(1) of this section, notification by the Commissioner to the health organization that the Commissioner has, after a hearing, rejected the health organization's challenge;

(4) The failure of the health organization to respond, in a manner satisfactory to the Commissioner, to a corrective order (provided the health organization has not challenged the corrective order under § 5826 of this title); or

(5) If the health organization has challenged a corrective order under § 5826 of this title and the Commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the health organization to respond, in a manner satisfactory to the Commissioner, to the corrective order subsequent to rejection or modification by the Commissioner.

(b) In the event of an authorized control level event with respect to a health organization, the Commissioner shall:

(1) Take such actions as are required under § 5823 of this title regarding a health organization with respect to which a regulatory action level event has occurred; or

(2) If the Commissioner deems it to be in the best interests of the policyholders and creditors of the health organization and of the public, take such actions as are necessary to cause the health organization to be placed under regulatory control under Chapter 59 of this title. In the event the Commissioner takes such actions, the authorized control level event shall be deemed sufficient grounds for the Commissioner to take action under Chapter 59 of this title, and the Commissioner shall have the rights, powers and duties with respect to the health organization as are set forth Chapter 59 of this title. In the event the Commissioner takes actions under this paragraph pursuant to an adjusted RBC report, the health organization shall be entitled to such protections as are afforded to health organizations under the provisions of Chapter 59 of this title pertaining to summary proceedings.

(79 Del. Laws, c. 425, § 3.)

§ 5825. Mandatory control level event.

(a) "Mandatory control level event" means any of the following events:

(1) The filing of an RBC report which indicates that the health organization's total adjusted capital is less than its mandatory control level RBC;

(2) Notification by the Commissioner to the health organization of an adjusted RBC report that indicates the event in paragraph (a)(1) of this section, provided the health organization does not challenge the adjusted RBC report under § 5826 of this title; or

(3) If, pursuant to § 5826 of this title, the health organization challenges an adjusted RBC report that indicates the event in paragraph (a)(1) of this section, notification by the Commissioner to the health organization that the Commissioner has, after a hearing, rejected the health organization's challenge.

(b) In the event of a mandatory control level event, the Commissioner shall take such actions as are necessary to place the health organization under regulatory control under Chapter 59 of this title. In that event, the mandatory control level event shall be deemed sufficient grounds for the Commissioner to take action Chapter 59 of this title, and the Commissioner shall have the rights, powers and duties with respect to the health organization as are set forth in Chapter 59 of this title. If the Commissioner takes actions pursuant to an adjusted RBC report, the health organization shall be entitled to the protections of Chapter 59 of this title pertaining to summary proceedings. Notwithstanding any of the foregoing, the Commissioner may forego action for up to 90 days after the mandatory control level event if the Commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period.

(79 Del. Laws, c. 425, § 3.)

§ 5826. Hearings.

Upon the occurrence of any of the following events, the health organization shall have the right to a confidential departmental hearing, on a record, at which the health organization may challenge any determination or action by the Commissioner. The health organization shall notify the Commissioner of its request for a hearing within 5 days after the notification by the Commissioner under paragraph (1), (2), (3) or (4) of this section. Upon receipt of the health organization's request for a hearing, the Commissioner shall set a date for the hearing, which shall be no less than 10 nor more than 30 days after the date of the health organization's request. The events include:

(1) Notification to a health organization by the Commissioner of an adjusted RBC report;

(2) Notification to a health organization by the Commissioner that:

a. The health organization's RBC plan or revised RBC plan is unsatisfactory; and

b. Notification constitutes a regulatory action level event with respect to the health organization;

(3) Notification to a health organization by the Commissioner that the health organization has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the health organization to eliminate the company action level event with respect to the health organization in accordance with its RBC plan or revised RBC plan; or

(4) Notification to a health organization by the Commissioner of a corrective order with respect to the health organization.

(79 Del. Laws, c. 425, § 3.)

§ 5827. Confidentiality; prohibition on announcements, prohibition on use in ratemaking.

(a) All RBC reports (to the extent the information is not required to be set forth in a publicly available annual statement schedule) and RBC plans (including the results or report of any examination or analysis of a health organization performed pursuant to this statute and any corrective order issued by the Commissioner pursuant to examination or analysis) with respect to a domestic health organization or foreign health organization that are in the possession or control of the Department of Insurance shall be confidential by law and privileged, shall not be subject to this State's Freedom of Information Act, § 10001 et seq. of Title 29, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties.

(b) Neither the Commissioner nor any person who received documents, materials or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection (a) of this section.

(c) In order to assist in the performance of the Commissioner's duties, the Commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection (a) of this section, with other state, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal and international law-enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(2) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law-enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(3) May enter into agreements governing sharing and use of information consistent with this subsection.

(d) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in paragraph (c)(3) of this section.

(e) It is the judgment of the General Assembly that the comparison of a health organization's total adjusted capital to any of its RBC levels is a regulatory tool which may indicate the need for corrective action with respect to the health organization, and is not intended

as a means to rank health organizations generally. Therefore, except as otherwise required under the provisions of this subchapter II, the making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over a radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC levels of any health organization, or of any component derived in the calculation, by any health organization, agent, broker or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; provided, however, that if any materially false statement with respect to the comparison regarding a health organization's total adjusted capital to its RBC levels (or any of them) or an inappropriate comparison of any other amount to the health organizations' RBC levels is published in any written publication and the health organization is able to demonstrate to the Commissioner with substantial proof the falsity of the statement, or the inappropriateness, as the case may be, then the health organization may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(f) It is the further judgment of the General Assembly that the RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans are intended solely for use by the Commissioner in monitoring the solvency of health organizations and the need for possible corrective action with respect to health organizations and shall not be used by the Commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the Commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that a health organization or any affiliate is authorized to write.

(79 Del. Laws, c. 425, § 3.)

§ 5828. Supplemental provisions; rules; exemption.

(a) The provisions of this subchapter II are supplemental to any other provisions of the laws of this State, and shall not preclude or limit any other powers or duties of the Commissioner under such laws, including, but not limited to, Chapter 59 of this title and 18 DE Admin. Code 304.

(b) The Commissioner may adopt reasonable rules necessary for the implementation of this subchapter II.

(c) The Commissioner may exempt from the application of this subchapter II a domestic health organization that:

(1) Writes direct business only in this State;

(2) Assumes no reinsurance in excess of 5% of direct premium written; and

(3) Writes direct annual premiums for comprehensive medical business of $2,000,000 or less; or

(4) Is a limited health service organization that covers less than 2,000 lives.

(79 Del. Laws, c. 425, § 3.)

§ 5829. Foreign health organizations.

(a) (1) A foreign health organization shall, upon the written request of the Commissioner, submit to the Commissioner an RBC report as of the end of the calendar year just ended the later of:

a. The date an RBC report would be required to be filed by a domestic health organization under this subchapter II; or

b. Fifteen days after the request is received by the foreign health organization.

(2) A foreign health organization shall, at the written request of the Commissioner, promptly submit to the Commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

(b) In the event of a company action level event, regulatory action level event or authorized control level event with respect to a foreign health organization as determined under the RBC statute applicable in the state of domicile of the health organization (or, if no RBC statute is in force in that state, under the provisions of this subchapter II), if the insurance commissioner of the state of domicile of the foreign health organization fails to require the foreign health organization to file an RBC plan in the manner specified under that state's RBC statute (or, if no RBC statute is in force in that state, under § 5822 of this title), the Commissioner may require the foreign health organization to file an RBC plan with the Commissioner. In such event, the failure of the foreign health organization to file an RBC plan with the Commissioner shall be grounds to order the health organization to cease and desist from writing new insurance business in this State.

(c) In the event of a mandatory control level event with respect to a foreign health organization, if no domiciliary receiver has been appointed with respect to the foreign health organization under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign health organization, the Commissioner may make application to the Court of Chancery permitted under Chapter 59 of this title with respect to the liquidation of property of foreign health organizations found in this State, and the occurrence of the mandatory control level event shall be considered adequate grounds for the application.

(79 Del. Laws, c. 425, § 3.)

§ 5830. Immunity.

There shall be no liability on the part of, and no cause of action shall arise against, the Commissioner or the Insurance Department or its employees or agents for any action taken by them in the performance of their powers and duties under this subchapter II.

(79 Del. Laws, c. 425, § 3.)

§ 5831. Severability clause.

If any provision of this subchapter II, or its application to any person or circumstance, is held invalid, that determination shall not affect the provisions or applications of this subchapter II that can be given effect without the invalid provision or application, and to that end the provisions of this subchapter II are severable.

(79 Del. Laws, c. 425, § 3.)

§ 5832. Notices.

All notices by the Commissioner to a health organization that may result in regulatory action under this subchapter II shall be effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission shall be effective upon the health organization’s receipt of notice.

(79 Del. Laws, c. 425, § 3.)

Part I
Insurance
Chapter 59
Rehabilitation and Liquidation
Subchapter I
General Provisions

§ 5901. Definitions [For application of this section, see 79 Del. Laws, c. 207, § 3].

For the purpose of this chapter:

(1) *"Impairment" or "insolvency." —*

The capital of a stock insurer or the surplus of a mutual or reciprocal insurer shall be deemed to be impaired, and the insurer shall be deemed to be insolvent, when such insurer is not possessed of assets at least equal to all liabilities and required reserves together with its total issued and outstanding capital stock, if a stock insurer, or the minimum surplus if a mutual or reciprocal insurer, required by this title to be maintained for the kind or kinds of insurance it is then authorized to transact.

(2) "Insurer" means any person, firm, corporation, association or aggregation of persons doing an insurance business and subject to the insurance supervisory authority of or to liquidation, rehabilitation, reorganization or conservation by the Commissioner or the equivalent insurance supervisory official of another state.

(3) "Delinquency proceeding" means any proceeding commenced against an insurer pursuant to this chapter for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer.

(4) "State" means any state of the United States and also the District of Columbia and the Commonwealth of Puerto Rico.

(5) "Foreign country" means territory not in any state.

(6) "Domiciliary state" means the state in which an insurer is incorporated or organized or, in the case of an insurer incorporated or organized in a foreign country, the state in which such insurer, having become authorized to do business in such state, has at the commencement of delinquency proceedings the largest amount of its assets held in trust and assets held on deposit for the benefit of its policyholders or policyholders and creditors in the United States, and any such insurer is deemed to be domiciled in such state.

(7) "Ancillary state" means any state other than a domiciliary state.

(8) "Reciprocal state" means any state other than this State in which in substance and effect the provisions of the Uniform Insurers Liquidation Act, as defined in § 5920 of this title, are in force, including the provisions requiring that the Commissioner of Insurance or equivalent insurance supervisory official be the receiver of a delinquent insurer.

(9) "General assets" means all property, real, personal or otherwise, not specifically mortgaged, pledged, deposited or otherwise encumbered for the security or benefit of specified persons or a limited class or classes of persons, and as to such specifically encumbered property, the term includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and assets held on deposit for the security or benefit of all policyholders or all policyholders and creditors in the United States shall be deemed general assets.

(10) "Preferred claim" means any claim with respect to which the law of the state or of the United States accords priority of payments from the general assets of the insurer.

(11) "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons but not including any general assets.

(12) "Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow or otherwise but not including special deposit claim or claims against general assets. The term also includes claims which more than 4 months prior to the commencement of delinquency proceedings in the state of the insurer's domicile have become liens upon specific assets by reason of judicial process.

(13) "Receiver" means receiver, liquidator, rehabilitator or conservator as the context may require.

(14) "Affiliate" shall have the same meaning as set forth in § 5001 of this title.

(15) "Commodity contract" means any of the following:

a. A contract for the purchase or sale of a commodity for future delivery on, or subject to the rules of, a board of trade designated as a contract market by the commodity futures trading commission under the federal Commodity Exchange Act, 7 U.S.C. § 1 et seq., or a board of trade outside the United States.

b. An agreement that is subject to regulation under § 23 of the federal Commodity Exchange Act [7 U.S.C. § 26] and that is commonly known to the commodities trade as a margin account, margin contract, leverage account or leverage contract.

c. An agreement or transaction that is subject to regulation under § 6c(b) of the federal Commodity Exchange Act [7 U.S.C. § 13a-1] and that is commonly known to the commodities trade as a commodity option.

d. Any combination of the agreements or transactions referred to in this paragraph.

e. Any option to enter into an agreement or transaction referred to in this paragraph.

(16) "Creditor" or "claimant" is a person having any claim against an insurer, whether the claim is matured or not, liquidated or unliquidated, secured or unsecured, absolute, fixed or contingent.

(17) "Formal delinquency proceeding" means any conservation, rehabilitation or liquidation proceeding; provided, however, that the term "formal delinquency proceeding" shall not include a supervision under § 5942 of this title.

(18) "Forward contract" shall have the meaning set forth in the Federal Deposit Insurance Act, 12 U.S.C. § 1821(e)(8)(D), as amended from time to time.

(19) "Netting agreement" means:

a. A contract or agreement (including terms and conditions incorporated by reference therein), including a master agreement (which master agreement, together with all schedules, confirmations, definitions and addenda thereto and transactions under any thereof, shall be treated as 1 netting agreement), that documents one or more transactions between the parties to the agreement for or involving 1 or more qualified financial contracts and that provides for the netting, liquidation, setoff, termination, acceleration or close out under or in connection with 1 or more qualified financial contracts or present or future payment or delivery obligations or payment or delivery entitlements thereunder (including liquidation or close-out values relating to such obligations or entitlements) among the parties to the netting agreement;

b. Any master agreement or bridge agreement for 1 or more master agreements described in paragraph (19)a. of this section; or

c. Any security agreement or arrangement or other credit enhancement or guarantee or reimbursement obligation related to any contract or agreement described in paragraph (19)a. or b. of this section; provided that any contract or agreement described in paragraph (19)a. or b. of this section relating to agreements or transactions that are not qualified financial contracts shall be deemed to be a netting agreement only with respect to those agreements or transactions that are qualified financial contracts.

(20) "Qualified financial contract" means any commodity contract, forward contract, repurchase agreement, securities contract, swap agreement and any similar agreement that the commissioner determines by regulation, rule or order to be a qualified financial contract for the purposes of this chapter.

(21) "Repurchase agreement" shall have the meaning set forth in the Federal Deposit Insurance Act, 12 U.S.C. § 1821(e)(8)(D), as amended from time to time. The term repurchase agreement also applies to a reverse repurchase agreement.

(22) "Securities contract" shall have the meaning set forth in the Federal Deposit Insurance Act, 12 U.S.C. § 1821(e)(8)(D), as amended from time to time.

(23) "Swap agreement" shall have the meaning set forth in the Federal Deposit Insurance Act, 12 U.S.C. § 1821(e)(8)(D), as amended from time to time.

(24) "Transfer" shall include the sale and every other and different mode, direct or indirect, of disposing of or of parting with property or with an interest therein, including a setoff, or with the possession thereof or of fixing a lien upon property or upon an interest therein, absolutely or conditionally, voluntarily or involuntarily, by or without judicial proceedings. The retention of a security title in property delivered to an insurer and foreclosure of the insurer's equity of redemption shall be deemed a transfer suffered by the insurer.

(25) "Federal home loan bank" or "FHLBank" shall mean a bank as defined in 12 U.S.C. § 1422(1)(A).

(26) "Federal Home Loan Bank Act" or "FHLBank Act" shall mean 12 U.S.C. § 1421 et seq.

(27) "Insurer-member" means an insurer that is a member of a federal home loan bank.

(18 Del. C. 1953, § 5901; 56 Del. Laws, c. 380, § 1; 78 Del. Laws, c. 29, § 2; 79 Del. Laws, c. 207, § 2; 83 Del. Laws, c. 272, § 1.)

§ 5902. Jurisdiction of delinquency proceedings; venue; change of venue; exclusiveness of remedy; appeal.

(a) The Court of Chancery shall have original jurisdiction of delinquency proceedings under this chapter, and any court with jurisdiction is authorized to make all necessary or proper orders to carry out the purposes of this chapter.

(b) The venue of delinquency proceedings against a domestic insurer shall be in the county of the insurer's principal place of business. The venue of such proceedings against foreign and alien insurers shall be in any county in this State selected by the Commissioner for the purpose.

(c) At any time after the commencement of a proceeding under this chapter the Commissioner may apply to the court for an order changing the venue of and removing the proceeding to any other county of this State in which the Commissioner deems that such proceeding may be most economically and efficiently conducted.

(d) Delinquency proceedings pursuant to this chapter shall constitute the sole and exclusive method of liquidating, rehabilitating, reorganizing or conserving an insurer, and no court shall entertain a petition for the commencement of such proceedings unless the same has been filed in the name of the State on the relation of the Commissioner.

(e) An appeal shall lie to the Supreme Court from an order granting or refusing rehabilitation, liquidation or conservation and from every order in delinquency proceedings having the character of a final order as to the particular portion of the proceedings embraced therein.

(18 Del. C. 1953, § 5902; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5903. Commencement of delinquency proceedings.

The Commissioner shall commence any such proceedings by application to the court for an order directing the insurer to show cause why the Commissioner should not have the relief prayed for. On the return of such order to show cause and after a full hearing, the court shall either deny the application or grant the application, together with such other relief as the nature of the case and the interests of the policyholders, creditors, stockholders, members, subscribers or the public may require.

(18 Del. C. 1953, § 5903; 56 Del. Laws, c. 380, § 1.)

§ 5904. Injunctions [For application of this section, see 79 Del. Laws, c. 207, § 3].

(a) Upon application by the Commissioner for such an order to show cause, or at any time thereafter, the court may without notice issue an injunction restraining the insurer, its officers, directors, stockholders, members, subscribers, agents and all other persons from the transaction of its business or the waste or disposition of its property until the further order of the court.

(b) The court may at any time during a proceeding under this chapter issue such other injunctions or orders as may be deemed necessary to prevent interference with the Commissioner or the proceeding or waste of the assets of the insurer or the commencement or prosecution of any actions or the obtaining of preferences, judgments, attachments or other liens or the making of any levy against the insurer or against its assets or any part thereof.

(c) Notwithstanding any other provision of law, no bond shall be required of the Commissioner as a prerequisite for the issuance of any injunction or restraining order pursuant to this section.

(d) Notwithstanding subsection (a) of this section above, or any other provision of this chapter to the contrary, the commencement of a delinquency proceeding with respect to an insurer-member shall not operate as a stay, injunction or prohibition of the exercise by an FHLBank of its rights regarding collateral pledged by such insurer-member.

(18 Del. C. 1953, § 5904; 56 Del. Laws, c. 380, § 1; 79 Del. Laws, c. 207, § 2.)

§ 5904A. Proceedings against bank insurance division.

(a) The Commissioner may in the Commissioner's discretion forthwith take possession of the business and property, including the books and records, of any division of a bank or trust company acting as an insurer whenever it shall appear that such division:

(1) Is conducting its business in an unauthorized or unsafe manner;

(2) Is in an unsound or unsafe condition to transact its business; or

(3) Cannot with safety and expediency continue business as a result of any cause whatsoever.

(b) The Commissioner may require an examination of a bank or trust company, which bank or trust company has established and operates a division pursuant to § 767 of Title 5, by the Bank Commissioner as authorized under § 122 of Title 5, and a report of such examination shall be furnished to the Commissioner pursuant to § 124 of Title 5.

(c) After taking possession of the division of a bank or trust company acting as an insurer, the Commissioner shall take such steps to conserve or rehabilitate the business and property of such division as the Commissioner deems practicable or desirable, or if in the judgment of the Commissioner such conservation or rehabilitation is not practicable or desirable, the Commissioner may proceed to liquidate such business and property. All proceedings of the Commissioner for the conservation, rehabilitation, or liquidation of a division of a bank or trust company acting as an insurer shall be in accordance with the provisions of this title applicable to the conservation, rehabilitation or liquidation of insurers by the Commissioner.

(67 Del. Laws, c. 223, § 38; 70 Del. Laws, c. 186, § 1.)

§ 5905. Grounds for rehabilitation; domestic insurers.

The Commissioner may apply to the court for an order appointing the Commissioner as receiver of and directing the Commissioner to rehabilitate a domestic insurer upon one or more of the following grounds, if the insurer:

(1) Is impaired or insolvent or is in unsound condition or in such condition or using such methods and practices in the conduct of its business as to render its further transaction of insurance presently or prospectively hazardous to its policyholders;

(2) Has refused to submit any of its books, records, accounts or affairs to reasonable examination by the Commissioner;

(3) Has concealed or removed records or assets;

(4) Has failed to comply with an order of the Commissioner to make good an impairment of capital or surplus or both;

(5) Has transferred or attempted to transfer substantially its entire property or business or has entered into any transaction the effect of which is to merge substantially its entire property or business in that of any other insurer without having first obtained the written approval of the Commissioner;

(6) Has wilfully violated its charter or certificate of incorporation or any law of this State;

(7) Has an officer, director or manager who has refused to be examined under oath concerning its affairs, for which purposes the Commissioner is hereby authorized to conduct and to enforce by all appropriate and available means any such examination under oath in any other state or territory of the United States in which any such officer, director or manager may then presently be to the full extent permitted by the laws of such other state or territory, this special authorization considered;

(8) Has been or is the subject of an application for the appointment of a receiver, trustee, custodian or sequestrator of the insurer or its property otherwise than pursuant to the provisions of this title, but only if such appointment has been made or is imminent and its effect is or would be to oust the courts of this State of jurisdiction hereunder;

(9) Has consented to such an order through a majority of the directors, stockholders, members or subscribers; and

(10) Has failed to pay a final judgment rendered against it in this State upon any insurance contract issued or assumed by it within 30 days after the judgment became final or within 30 days after the time for taking an appeal has expired or within 30 days after dismissal of an appeal before final termination, whichever date is the later.

(18 Del. C. 1953, § 5905; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5906. Grounds for liquidation.

The Commissioner may apply to the court for an order appointing the Commissioner as receiver (if the Commissioner appointment as receiver shall not be then in effect) and directing the Commissioner to liquidate the business of a domestic insurer or of the United States branch of an alien insurer having trusteed assets in this State, regardless of whether or not there has been a prior order directing the Commissioner to rehabilitate such insurer, upon any of the grounds specified in § 5905 of this title or if such insurer:

(1) Has ceased transacting business for a period of 1 year, or

(2) Is an insolvent insurer and has commenced voluntary liquidation or dissolution or attempts to commence or prosecute any action or proceeding to liquidate its business or affairs or to dissolve its corporate charter or to procure the appointment of a receiver, trustee, custodian or sequestrator under any law except this title.

(18 Del. C. 1953, § 5906; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5907. Grounds for conservation; foreign insurers.

The Commissioner may apply to the court for an order appointing the Commissioner as receiver or ancillary receiver and directing him or her to conserve the assets within this State, of a foreign insurer upon any of the following grounds:

(1) Upon any of the grounds specified in § 5905 or § 5906 of this title, or

(2) Upon the ground that its property has been sequestrated in its domiciliary sovereignty or in any other sovereignty.

(18 Del. C. 1953, § 5907; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5908. Grounds for conservation — Alien insurers.

The Commissioner may apply to the court for an order appointing the Commissioner as receiver or ancillary receiver and directing the Commissioner to conserve the assets within this State of any alien insurer upon any of the following grounds:

(1) Upon any of the grounds specified in § 5905 or § 5906 of this title;

(2) Upon the ground that the insurer has failed to comply within the time designated by the Commissioner with an order made by the Commissioner to make good an impairment of its trusteed funds; or

(3) Upon the ground that the property of the insurer has been sequestrated in its domiciliary sovereignty or elsewhere.

(18 Del. C. 1953, § 5908; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5909. Grounds for ancillary liquidation; foreign insurers.

The Commissioner may apply to the court for an order appointing the Commissioner as ancillary receiver of and directing the Commissioner to liquidate the business of a foreign insurer having assets, business or claims in this State upon the appointment in the domiciliary state of such insurer of a receiver, liquidator, conservator, rehabilitator or other officer by whatever name called for the purpose of liquidating the business of such insurer.

(18 Del. C. 1953, § 5909; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5910. Order of rehabilitation; termination.

(a) An order to rehabilitate a domestic insurer shall direct the Commissioner forthwith to take possession of the property of the insurer and to conduct the business thereof and to take such steps toward removal of the causes and conditions which have made rehabilitation necessary as the court may direct.

(b) If at any time the Commissioner deems that further efforts to rehabilitate the insurer would be useless, the Commissioner may apply to the court for an order of liquidation.

(c) The Commissioner or any interested person upon due notice to the Commissioner at any time may apply to the court for an order terminating the rehabilitation proceedings and permitting the insurer to resume possession of its property and the conduct of its business, but, no such order shall be made or entered except when, after a hearing, the Court has determined that the purposes of the proceeding have been fully accomplished.

(18 Del. C. 1953, § 5910; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5911. Order of liquidation; domestic insurers; insolvent insurer's assets.

(a) An order to liquidate the business of a domestic insurer shall direct the Commissioner forthwith to take possession of the property of the insurer, to liquidate its business, to deal with the insurer's property and business in the Commissioner's own name as Insurance

Commissioner or in the name of the insurer, as the court may direct, and to give notice to all creditors who may have claims against the insurer to present such claims.

(b) The Commissioner may apply for and secure an order dissolving the corporate existence of a domestic insurer or the United States branch of an alien insurer domiciled in this State upon the Commissioner's application for an order of liquidation of such insurer or at any time after such order has been granted. The court may order dissolution of the corporation upon petition by the Commissioner upon or after the granting of a liquidation order. If the dissolution has not previously been ordered, it shall be effected by operation of law upon the discharge of the liquidator if the insurer is insolvent. However, dissolution may be ordered by the court upon the discharge of the liquidator if the insurer is under a liquidation order for some other reason. Notwithstanding the above, upon application by the Commissioner and following notice as prescribed by the court and a hearing, the court may sell the corporation as an entity, together with any of its licenses to do business, despite the entry of an order of liquidation. The sale may be made on terms and conditions the court deems appropriate. The court may permit the sale of such corporate existence upon or after the granting of a liquidation order. The proceeds from the sale of the corporation shall become a part of the general assets of the estate in liquidation, and the corporate entity and its licenses shall thereafter be free and clear from the claims or interest of all claimants, creditors, policyholders and stockholders of the corporation under liquidation. If permission to sell the corporation is not granted prior to discharge of the liquidator, the court shall order dissolution of the corporation if the insurer is insolvent, and the court may order dissolution of the corporation if the insurer is under a liquidation order for some other reason.

(c) (1) Within 120 days of a final determination of insolvency of a company, the Commissioner shall apply for a proposed order to disburse assets out of such company's marshalled assets, from time to time as such assets become available to the Delaware Insurance Guaranty Association and to any entity or person performing a similar function in another jurisdiction having substantially the same provisions of law.

(2) Such proposed order shall at least include provision for:

a. Reserving amounts for the payment of expenses to administration and the payment of claims of secured creditors (to the extent the value of the security held) and claims falling within the priorities established in §§ 5915-5919, 5924-5927 and 5929 of this title;

b. Disbursement of the assets marshalled to date and subsequent disbursements of assets as they become available;

c. Equitable allocation disbursements to the Delaware Insurance Guaranty Association and similar entities entitled thereto;

d. The securing by the Commissioner as receiver in each of the associations entitled to disbursement pursuant to this section of an agreement to return to the receiver such assets previously disbursed as may be required to pay claims of secured creditors and claims falling within the priorities established in §§ 5915-5919, 5924-5927 and 5929 of this title in accordance with such priorities. No bond shall be required of any such association;

e. A full report to be made by the association to the receiver accounting for all assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on such assets and any matter as the court may direct.

(3) The Commissioner's proposed order shall provide for disbursements to the Delaware Insurance Guaranty Association and any entity or person performing a similar function in another jurisdiction in amounts estimated at least equal to the claim payments made or to be made thereby for which such associations could assert a claim against the Commissioner as receiver, and shall further provide that if the assets available for disbursement from time to time do not equal nor exceed the amount of such claim payments made or to be made by the Delaware Insurance Guaranty Association in a similar entity in another jurisdiction, then disbursements shall be in the amount of available assets.

(4) Notice of such proposed order shall be given to the Delaware Insurance Guaranty Association and the commissioners of insurance of each state and the District of Columbia. Any such notice shall be deemed to have been given when deposited in the United States certified mails, first-class postage prepaid, at least 30 days prior to the submission of such application to the court. Action on the proposed order may be taken by the court provided the above required notice has been given and provided further that the Commissioner's proposed order complies with paragraphs (c)(2)a. and d. of this section.

(18 Del. C. 1953, § 5911; 56 Del. Laws, c. 380, § 1; 61 Del. Laws, c. 129, § 1; 70 Del. Laws, c. 186, § 1; 70 Del. Laws, c. 195, § 1.)

§ 5912. Order of conservation or ancillary liquidation of foreign or alien insurers.

(a) An order to conserve the assets of a foreign or alien insurer shall require the Commissioner forthwith to take possession of the property of the insurer within this State and to conserve it, subject to the further direction of the court.

(b) An order to liquidate the assets in this State of a foreign insurer shall require the Commissioner forthwith to take possession of the property of the insurer within this State and to liquidate it subject to the orders of the court and with due regard to the rights and powers of the domiciliary receiver, as provided in this chapter.

(18 Del. C. 1953, § 5912; 56 Del. Laws, c. 380, § 1.)

§ 5913. Conduct of delinquent proceedings against domestic and alien insurers.

(a) Whenever under this chapter a receiver is to be appointed in delinquency proceedings for an insurer, the court shall appoint the Commissioner as such receiver. The court shall order the Commissioner forthwith to take possession of the assets of the insurer and to administer the same under the orders of the court.

(b) As a domiciliary receiver, the Commissioner shall be vested by operation of law with the title to all of the property, contracts and rights of action and all of the books and records of the insurer, wherever located, as of the date of entry of the order directing the Commissioner to rehabilitate or liquidate a domestic insurer or to liquidate the United States branch of an alien insurer domiciled in this State, and the Commissioner shall have the right to recover the same and reduce the same to possession, except that ancillary receivers in reciprocal states shall have, as to assets located in their respective states, the rights and powers which are herein prescribed for ancillary receivers appointed in this State as to assets located in this State.

(c) The filing or recording of the order directing possession to be taken, or a certified copy thereof, in any office where instruments affecting title to property are required to be filed or recorded shall impart the same notice as would be imparted by a deed, bill of sale or other evidence of title duly filed or recorded.

(d) The Commissioner as domiciliary receiver shall be responsible for the proper administration of all assets coming into the Commissioner's possession or control. The court may at any time require a bond from the Commissioner or the Commissioner's deputies if deemed desirable for the protection of such assets.

(e) Upon taking possession of the assets of an insurer, the domiciliary receiver shall, subject to the direction of the court, immediately proceed to conduct the business of the insurer or to take such steps as are authorized by this chapter for the purpose of rehabilitating, liquidating or conserving the affairs or assets of the insurer.

(f) In connection with delinquency proceedings, the Commissioner may appoint 1 or more special deputy commissioners to act for the Commissioner, and the Commissioner may employ such counsel, clerks and assistants as necessary. The compensation of the special deputies, counsel, clerks or assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the receiver, subject to the approval of the court, and shall be paid out of the funds or assets of the insurer. Within the limits of duties imposed upon them, special deputies shall possess all the powers given to and, in the exercise of those powers, shall be subject to all of the duties imposed upon the receiver with respect to such proceedings.

(18 Del. C. 1953, § 5913; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5914. Conduct of delinquency proceedings against foreign insurers.

(a) Whenever under this chapter an ancillary receiver is to be appointed in delinquency proceedings for an insurer not domiciled in this State, the court shall appoint the Commissioner as ancillary receiver. The Commissioner shall file a petition requesting the appointment on the grounds set forth in § 5909 of this title:

(1) If the Commissioner finds that there are sufficient assets of the insurer located in this State to justify the appointment of an ancillary receiver, or

(2) If 10 or more persons resident in this State having claims against such insurer file a petition with the Commissioner requesting the appointment of such ancillary receiver.

(b) The domiciliary receiver for the purpose of liquidating an insurer domiciled in a reciprocal state shall be vested by operation of law with the title to all of the property, contracts and rights of action and all of the books and records of the insurer located in this State, and such receiver shall have the immediate right to recover balances due from local agents and to obtain possession of any books and records of the insurer found in this State. The domiciliary receiver shall also be entitled to recover the other assets of the insurer located in this State, except that upon the appointment of an ancillary receiver in this State, the ancillary receiver shall during the ancillary receivership proceedings have the sole right to recover such other assets. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this State and shall pay the necessary expenses of the proceedings. All remaining assets shall promptly transfer to the domiciliary receiver. Subject to the foregoing provisions, the ancillary receiver and the ancillary receiver's deputies shall have the same powers and be subject to the same duties with respect to the administration of such assets as a receiver of an insurer domiciled in this State.

(c) The domiciliary receiver of an insurer domiciled in a reciprocal state may sue in this State to recover any assets of such insurer to which the domiciliary receiver may be entitled under the laws of this State.

(18 Del. C. 1953, § 5914; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5915. Claims of nonresidents against domestic insurers.

(a) In a delinquency proceeding begun in this State against a domestic insurer, claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, or with the domiciliary receiver. All such claims must be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings.

(b) (1) Controverted claims belonging to claimants residing in reciprocal states may either:

a. Be proved in this State; or

b. If ancillary proceedings have been commenced in such reciprocal states may be proved in those proceedings.

(2) In the event a claimant elects to prove a claim in ancillary proceedings, if notice of the claim and opportunity to appear and be heard is afforded the domiciliary receiver of this State, as provided in § 5916 of this title with respect to ancillary proceedings in this State, the final allowance of such claim by the courts in the ancillary state shall be accepted in this State as conclusive as to

its amount and shall also be accepted as conclusive as to its priority, if any, against special deposits or other security located within the ancillary state.

(18 Del. C. 1953, § 5915; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5916. Claims against foreign insurers.

(a) In a delinquency proceeding in a reciprocal state against an insurer domiciled in that state, claimants against such insurer who reside within this State may file claims either with the ancillary receiver, if any, appointed in this State or with the domiciliary receiver. All such claims must be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings.

(b) (1) Controverted claims belonging to claimants residing in this State may either:

a. Be proved in the domiciliary state as provided by the law of that state; or

b. If ancillary proceedings have been commenced in this State, be proved in those proceedings.

(2) In the event that any such claimant elects to prove a claim in this State, such claimant shall file a claim with the ancillary receiver and shall give notice in writing to the receiver in the domiciliary state, either by registered or certified mail or by personal service at least 40 days prior to the date set for hearing. The notice shall contain a concise statement of the amount of the claim, the facts on which the claim is based and the priorities asserted, if any. If the domiciliary receiver within 30 days after the giving of such notice shall give notice in writing to the ancillary receiver and to the claimant, either by registered or certified mail or by personal service, of the domiciliary receiver's intention to contest such claim, the domiciliary receiver shall be entitled to appear or to be represented in any proceeding in this State involving adjudication of the claim. The final allowance of the claim by the courts of this State shall be accepted as conclusive as to its amount and shall also be accepted as conclusive as to its priority, if any, against special deposits or other security located within this State.

(18 Del. C. 1953, § 5916; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5917. Form of claim; notice; hearing.

(a) All claims against an insurer against which delinquency proceedings have been begun shall set forth in reasonable detail the amount of the claim or the basis upon which such amount can be ascertained, the facts upon which the claim is based and the priorities asserted, if any. All such claims shall be verified by the affidavit of the claimant or someone authorized to act on the claimant's behalf and having knowledge of the facts and shall be supported by such documents as may be material thereto.

(b) All claims filed in this State shall be filed with the receiver, whether domiciliary or ancillary, in this State on or before the last date for filing as specified in this chapter.

(c) Within 10 days of the receipt of any claim or within such further period as the court may fix for good cause shown, the receiver shall report the claim to the court, specifying in such report the receiver's recommendation with respect to the action to be taken thereon. Upon receipt of such report, the court shall fix a time for hearing the claim and shall direct that the claimant or the receiver, as the court shall specify, shall give such notice as the court shall determine to such persons as shall appear to the court to be interested therein. All such notices shall specify the time and place of the hearing and shall concisely state the amount and nature of the claim, the priorities asserted, if any, and the recommendation of the receiver with reference thereto.

(d) At the hearing, all persons interested shall be entitled to appear and the court shall enter an order allowing, allowing in part, or disallowing the claim. Any such order shall be deemed to be an appealable order.

(18 Del. C. 1953, § 5917; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5918. Priority of certain claims.

(a) In a delinquency proceeding against an insurer domiciled in this State, claims owing to residents of ancillary states shall be preferred claims if like claims are preferred under the laws of this State. All such claims owing to residents or nonresidents shall be given equal priority of payment from general assets regardless of where such assets are located.

(b) In a delinquency proceeding against an insurer domiciled in a reciprocal state, claims owing to residents of this State shall be preferred if like claims are preferred by the laws of that state.

(c) The owners of special deposit claims against an insurer for which a receiver is appointed in this or any other state shall be given priority against their several special deposits in accordance with the provisions of the statutes governing the creation and maintenance of such deposits. If there is a deficiency in any such deposit so that the claims secured thereby are not fully discharged therefrom, the claimants may share in the general assets, but such sharing shall be deferred until general creditors and also claimants against other special deposits who have received smaller percentages from their respective special deposits have been paid percentages of their claims equal to the percentage paid from the special deposit.

(d) The owner of a secured claim against an insurer for which a receiver has been appointed in this or any other state may surrender his or her security and file a claim as a general creditor, or the claim may be discharged by resort to the security, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors. If the amount of the deficiency has been adjudicated in ancillary proceedings as provided in this chapter or if it has been adjudicated by a court of

competent jurisdiction in proceedings in which the domiciliary receiver has had notice and opportunity to be heard, such amounts shall be conclusive, otherwise, the amount shall be determined in the delinquency proceeding in the domiciliary state.

(e) The priority of distribution of claims from the insurer's general assets shall be in accordance with the order in which each class of claims is herein set forth. Every claim in each class shall be paid in full or adequate funds retained for such payment before the members of the next class shall receive any payment. No subclasses shall be established within any class. No claim by a shareholder, policyholder or other creditor shall be permitted to circumvent the priority classes through the use of equitable remedies. The order of distribution shall be:

(1) *Class I.* — The costs and expenses of administration expressly approved by the receiver, including but not limited to the following:

a. The receiver's actual and necessary costs of taking possession of the insurer, preserving or recovering the assets of the insurer, and otherwise complying with this chapter;

b. Reasonable compensation for all services rendered at the request of and on behalf of the receiver, or that receiver's appointed deputy receiver or receivers, in the liquidation by the receivership's employees and its retained attorneys, accountants, actuaries, claims adjusters, expert witnesses and other consultants; and

c. All expenses incurred by the Department in supervising the receivership proceedings of the insurer;

(2) *Class II.* — The reasonable and necessary administrative expenses of the Delaware Insurance Guaranty Association or the Delaware Life and Health Insurance Guaranty Association or as the case may be, and any similar organization in another state. If the receiver determines that the assets of the estate will be sufficient to pay all Class I claims in full, Class II claims shall be paid currently, provided that the receiver shall secure from each of the associations receiving disbursements pursuant to this section an agreement to return to the receiver such disbursement, together with investment income actually earned on such disbursement, as may be required to pay Class I claims.

(3) *Class III.* — Claims by policyholders, beneficiaries and insureds, including the federal or any state or local government if such government is a named policyholder, beneficiary or insured under the policy, arising from and within the coverage of and not in excess of the applicable limits of insurance policies, insurance contracts and funding agreements issued by the company; liability claims, including liability claims of the federal or any state or local government, against insureds which claims are within the coverage of and not in excess of the applicable limits of insurance policies, insurance contracts and funding agreements issued by the company, including claims for reasonable attorneys" fees incurred by the policyholder to defend against the liability claim if such attorneys" fees are covered under the policy, but only to the extent covered; policyholder's claims for refunds of unearned premium; and claims of the Delaware Insurance Guaranty Association or the Delaware Life and Health Insurance Guaranty Association, as the case may be, and any similar organization in another state for coverage of policy benefits as required by statute; provided, however, that this paragraph shall not apply to the following claims:

a. Claims arising under reinsurance contracts, including any claims for reinsurance premium due;

b. Claims of insurers, insurance pools or underwriting associations for contribution, indemnity or subrogation, equitable or otherwise.

Interest shall not be allowed or paid on Class III claims, except that the value assigned to Class III claims arising from valid preliquidation judgments, other than judgments by default or collusion, may include prejudgment and postjudgment interest up to the date of liquidation if such interest is required by law or contract.

(4) *Class IV.* — Taxes owed to the United States and other debts owed to the United States which by the laws of the United States are entitled to priority over the claims in Classes V through IX below and which claims of the United States are not already included in Class III above.

(5) *Class V.* — Claims of employees, other than officers or directors, of the insurer for compensation actually owing to such employees for services rendered to the insurer within 3 months prior to the commencement of a proceeding against the insurer under this chapter but not exceeding $1,000 for each employee. Such priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of such employees.

(6) *Class VI.* — Claims of general creditors including, but not limited to, claims of ceding and assuming insurers in their capacity as such, and claims of insurers, insurance pools or underwriting associations for contribution, indemnity or subrogation, equitable or otherwise. This class shall include any claims of the guaranty associations, federal or any state or local government to the extent such claims are not otherwise included in Class II, Class III, Class IV or Class V in paragraphs (e)(2) through (5) of this section.

(7) *Class VII.* — Claims which would otherwise qualify for classification under the classes enumerated above, but which are not filed with the receiver on or before the bar date and which are not excused from such bar date by the liquidation court.

(8) *Class VIII.* — Surplus or contribution notes, or similar obligations.

(9) *Class IX.* — The claims of shareholders or other owners arising out of such capacity.

(18 Del. C. 1953, § 5918; 56 Del. Laws, c. 380, § 1; 64 Del. Laws, c. 193, § 1; 70 Del. Laws, c. 186, § 1; 72 Del. Laws, c. 400, § 1; 80 Del. Laws, c. 268, § 4.)

§ 5919. Attachment and garnishment of assets.

During the pendency of delinquency proceedings in this or any reciprocal state, no action or proceeding in the nature of an attachment, garnishment or execution shall be commenced or maintained in the courts of this State against the delinquent insurer or its assets. Any

lien obtained by any such action or proceeding within 4 months prior to the commencement of any such delinquency proceeding or at any time thereafter shall be void as against any rights arising in such delinquency proceeding.

(18 Del. C. 1953, § 5919; 56 Del. Laws, c. 380, § 1.)

§ 5920. Uniform Insurers Liquidation Act.

(a) Section 5901(2)-(13) inclusive, together with §§ 5902, 5903 and 5913-5920 of this title constitute and may be referred to as the Uniform Insurers Liquidation Act.

(b) The Uniform Insurers Liquidation Act shall be so interpreted and construed as to effectuate its general purpose to make uniform the law of those states that enact it. To the extent that its provisions when applicable conflict with other provisions of this chapter, the provisions of such act shall control.

(18 Del. C. 1953, § 5920; 56 Del. Laws, c. 380, § 1.)

§ 5921. Deposit of moneys collected.

The moneys collected by the Commissioner in a proceeding under this chapter shall be from time to time deposited in 1 or more state or national banks, savings banks or trust companies, and in the case of the insolvency or voluntary or involuntary liquidation of any such depositary which is an institution organized and supervised under the laws of this State, such deposits shall be entitled to priority of payment on an equality with any other priority given by the banking laws of this State. The Commissioner may in his or her discretion deposit such moneys or any part thereof in a national bank or trust company as a trust fund.

(18 Del. C. 1953, § 5921; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5922. Exemption from fees.

The Commissioner shall not be required to pay any fee to any public officer in this State for filing, recording, issuing a transcript or certificate authenticating any paper or instrument pertaining to the exercise by the Commissioner of any of the powers or duties conferred upon the Commissioner under this chapter, whether or not such paper or instrument is executed by the Commissioner or the Commissioner's deputies, employees or attorneys of record and whether or not it is connected with the commencement of any action or proceeding by or against the Commissioner or with the subsequent conduct of such action or proceeding.

(18 Del. C. 1953, § 5922; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5923. Borrowing on pledge of assets.

For the purpose of facilitating the rehabilitation, liquidation, conservation or dissolution of an insurer pursuant to this chapter, the Commissioner may, subject to the approval of the court, borrow money and execute, acknowledge and deliver notes or other evidences of indebtedness therefor and secure the repayment of the same by the mortgage, pledge, assignment, transfer in trust or hypothecation of any or all of the property, whether real, personal or mixed, of such insurer; and the Commissioner, subject to the approval of the court, shall have power to take any and all other action necessary and proper to consummate any such loan and to provide for the repayment thereof. The Commissioner shall be under no obligation personally or in an official capacity to repay any loan made pursuant to this section.

(18 Del. C. 1953, § 5923; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5924. Date rights fixed on liquidation.

The rights and liabilities of the insurer and of its creditors, policyholders, stockholders, members, subscribers and all other persons interested in its estate shall, unless otherwise directed by the court, be fixed as of the date on which the order directing the liquidation of the insurer is filed in the office of the clerk of the court which made the order, subject to the provisions of this chapter with respect to the rights of claimants holding contingent claims.

(18 Del. C. 1953, § 5924; 56 Del. Laws, c. 380, § 1.)

§ 5925. Voidable transfers [For application of this section, see 79 Del. Laws, c. 207, § 3].

(a) Any transfer of or lien upon the property of an insurer which is made or created within 4 months prior to the granting of an order to show cause, under this chapter, with the intent of giving to any creditor a preference or of enabling the creditor to obtain a greater percentage of such creditor's debt than any other creditor of the same class and which is accepted by such creditor having reasonable cause to believe that such preference will occur, shall be voidable.

(b) Every director, officer, employee, stockholder, member, subscriber and any other person acting on behalf of such insurer who shall be concerned in any such act or deed and every person receiving thereby any property of such insurer of the benefit thereof shall be personally liable therefor and shall be bound to account to the Commissioner.

(c) The Commissioner, as receiver in any proceeding under this chapter, may avoid any transfer of or lien upon the property of an insurer which any creditor, stockholder, subscriber or member of such insurer might have avoided and may recover the property so transferred unless such person was a bona fide holder for value prior to the date of the entering of an order to show cause under this chapter. Such property or its value may be recovered from anyone who has received it except a bona fide holder for value as herein specified.

(d) (1) Notwithstanding subsection (a) of this section above, or any other provision of this chapter to the contrary, the receiver for an insurer-member subject to a delinquency proceeding shall not void a transfer made to an FHLBank in the ordinary course of business and in compliance with the advance agreement with such FHLBank. The receiver shall not void a redemption or repurchase of any stock or equity securities made by the FHLBank within 4 months of the commencement of the delinquency proceedings or which received prior approval of the receiver. However, a transfer may be avoided under subsection (c) of this section if the transfer was made with actual intent to hinder, delay or defraud the insurer-member, a receiver appointed for the insurer-member or existing or future creditors.

(2) Following the appointment of a receiver for an insurer-member and upon request of the receiver, the FHLBank shall, within 10 days of such request, provide a process and establish timing for:

a. The release of collateral that exceeds the lending value (as determined in accordance with the advance agreement with the FHLBank) required to support secured obligations remaining after any repayment of advances;

b. The release of any collateral remaining in the FHLBank's possession following repayment of all outstanding secured obligations in full;

c. The payment of fees and the operation of deposits and other accounts with the FHLBank; and

d. The possible redemption or repurchase of FHLBank stock or excess stock of any class that an insurer-member is required to own.

(3) Upon the request of the receiver for an insurer-member, the FHLBank shall provide any available options for such insurer-member to renew or restructure an advance to defer associated prepayment fees, to the extent that market conditions, the terms of the advance outstanding to the insurer-member, the applicable policies of the FHLBank and compliance with the FHLBank Act and corresponding regulations permit.

(4) Nothing in § 5904(d) of this title or this subsection shall affect the receiver's rights pursuant to 12 C.F.R. § 1266.4 regarding advances to an insurer-member in delinquency proceedings.

(18 Del. C. 1953, § 5925; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 207, § 2.)

§ 5926. Priority of claims for compensation.

Repealed by 72 Del. Laws, c. 400, § 2, effective July 6, 2000. For present law, see §§ 4211(b) and 5918(e) of this title.

§ 5927. Offsets.

(a) In all cases of mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this chapter, such credits and debts shall be set off and the balance only shall be allowed or paid, except as provided in subsection (b) of this section below.

(b) No offset shall be allowed in favor of any such person where:

(1) The obligation of the insurer to such person would not at the date of the entry of any liquidation order or otherwise, as provided in § 5924 of this title, entitle such person to share as a claimant in the assets of the insurer; or

(2) The obligation of the insurer to such person was purchased by or transferred to such person with a view of its being used as an offset; or

(3) The obligation of such person is to pay an assessment levied against the members of a mutual insurer or against the subscribers of a reciprocal insurer or is to pay a balance upon the subscription to the capital stock of a stock insurer.

(18 Del. C. 1953, § 5927; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5928. Allowance of certain claims.

(a) No contingent and unliquidated claim shall share in a distribution of the assets of an insurer which has been adjudicated to be insolvent by an order made pursuant to this chapter, except that such claim shall be considered, if properly presented, and may be allowed to share where:

(1) Such claim becomes absolute against the insurer on or before the last day for filing claims against the assets of such insurer; or

(2) There is a surplus and the liquidation is thereafter conducted upon the basis that such insurer is solvent.

(b) Where an insurer has been so adjudicated to be insolvent, any person who has a cause of action against an insured of such insurer under a liability insurance policy issued by such insurer shall have the right to file a claim in the liquidation proceeding, regardless of the fact that such claim may be contingent, and such claim may be allowed:

(1) If it may be reasonably inferred from the proof presented upon such claim that such person would be able to obtain a judgment upon such cause of action against such insured;

(2) If such person shall furnish suitable proof, unless the court for good cause shown shall otherwise direct, that no further valid claim against such insurer arising out of that person's cause of action other than those already presented can be made; and

(3) If the total liability of such insurer to all claimants arising out of the same act of its insured shall be no greater than its maximum liability would be were it not in liquidation.

(c) No judgment against such an insured taken after the date of entry of the liquidation order shall be considered in the liquidation proceedings as evidence of liability or of the amount of damages, and no judgment against an insured taken by default or by collusion

prior to the entry of the liquidation order shall be considered as conclusive evidence in the liquidation proceedings, either of the liability of such insured to such person upon such cause of action or of the amount of damages to which such person is therein entitled.

(d) No claim of any secured claimant shall be allowed at a sum greater than the difference between the value of the claim without security and the value of the security itself as of the date of the entry of the order of liquidation or such other date set by the court for determining rights and liabilities as provided in § 5924 of this title unless the claimant surrenders the security to the Commissioner, in which event the claim shall be allowed in the full amount for which it is valued.

(18 Del. C. 1953, § 5928; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5929. Order of insolvency; time to file claims.

(a) If, upon the entry of an order of liquidation under this chapter or at any time thereafter during liquidation proceedings the insurer is not clearly solvent, the court shall, upon hearing after such notice it deems proper, make and enter an order adjudging the insurer to be insolvent.

(b) After the entry of the order of insolvency, regardless of any prior notice that may have been given to creditors, the Commissioner shall notify all persons who may have claims against the insurer to file such claims with the Commissioner, at a place and within the time specified in the notice, or such claims shall be forever barred. The time specified in the notice shall be as fixed by the court for filing of claims and which shall be not less than 6 months after the entry of the order of insolvency. The notice shall be given in such manner and for such reasonable period of time as may be ordered by the court.

(18 Del. C. 1953, § 5929; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5930. Report and petition for assessment.

Within 3 years after the date of the entry of an order of rehabilitation or liquidation of a domestic mutual insurer or a domestic reciprocal insurer, the Commissioner may make and file a report and petition to the court setting forth:

(1) The reasonable value of the assets of the insurer;

(2) The liabilities of the insurer to the extent thus far ascertained by the Commissioner;

(3) The aggregate amount of the assessment, if any, which the Commissioner deems reasonably necessary to pay all claims, the costs and expenses of the collection of the assessments and the costs and expenses of the delinquency proceedings in full;

(4) Any other information relative to the affairs or property of the insurer that the Commissioner deems material.

(18 Del. C. 1953, § 5930; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5931. Order and levy of assessments.

(a) Upon the filing and reading of the report and petition provided for in § 5930 of this title, the court, ex parte, may order the Commissioner to assess all members or subscribers of the insurer who may be subject to such an assessment, in such an aggregate amount as the court finds reasonably necessary to pay all valid claims as may be timely filed and proved in the delinquency proceedings, together with the costs and expenses of levying and collecting assessments and the costs and expenses of the delinquency proceedings in full. Any such order shall require the Commissioner to assess each such member or subscriber for such member or subscriber's proportion of the aggregate assessment, according to such reasonable classification of such members or subscribers and formula as may be made by the Commissioner and approved by the court.

(b) The court may order additional assessments upon the filing and reading of any amendment or supplement to the report and petition referred to in subsection (a) of this section above, if such amendment or supplement is filed within 3 years after the date of the entry of the order of rehabilitation or liquidation.

(c) After the entry of the order to levy and assess members or subscribers of an insurer referred to in subsection (a) or (b) of this section above, the Commissioner shall levy and assess members or subscribers in accordance with the order.

(d) The total of all assessments against any member or subscriber with respect to any policy, whether levied pursuant to this chapter or pursuant to any other provision of this title, shall be for no greater amount than that specified in the policy or policies of the member or subscriber and as limited under this title, except as to any policy which was issued at a rate of premium below the minimum rate lawfully permitted for the risk insured, in which event the assessment against any such policyholder shall be upon the basis of the minimum rate for such risk.

(e) No assessment shall be levied against any member or subscriber with respect to any nonassessable policy issued in accordance with this title.

(18 Del. C. 1953, § 5931; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5932. Assessment prima facie correct; notice; payment; proceedings to collect.

(a) Any assessment of a subscriber or member of an insurer made by the Commissioner, pursuant to the order of court fixing the aggregate amount of the assessment against all members or subscribers and approving the classification and formula made by the Commissioner under § 5931(a) of this title, shall be prima facie correct.

(b) Each member or subscriber shall be notified of the amount of assessment to be paid by written notice mailed to the address of the member or subscriber last of record with the insurer. Failure of the member or subscriber to receive the notice so mailed, within the time specified therein or at all, shall be no defense in any proceeding to collect the assessment.

(c) If any such member or subscriber fails to pay the assessment within the period specified in the notice, which period shall not be less than 20 days after mailing, the Commissioner may obtain an order in the delinquency proceedings requiring the member or subscriber to show cause at a time and place fixed by the court why judgment should not be entered against such member or subscriber for the amount of the assessment together with all costs, and a copy of the order and a copy of the petition therefor shall be served upon the member or subscriber within the time and in the manner designated in the order.

(d) If the subscriber or member after due service of a copy of the order and petition referred to in subsection (c) of this section above is made:

(1) Fails to appear at the time and place specified in the order, judgment shall be entered against such subscriber or member as prayed for in the petition; or

(2) Appears in the manner and form required by law in response to the order, the court shall hear and determine the matter and enter a judgment in accordance with its decision.

(e) The Commissioner may collect any such assessment through any other lawful means.

(18 Del. C. 1953, § 5932; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 5933. Qualified financial contracts.

(a) Notwithstanding any other provision of this chapter to the contrary, including any other provision of this chapter permitting the modification of contracts, or other law of a state, no person shall be stayed, enjoined or prohibited from exercising any of the following:

(1) A contractual right to terminate, liquidate, accelerate or close out, or cause the termination, liquidation, acceleration or close out of obligations, under or in connection with any netting agreement or qualified financial contract with an insurer because of any of the following:

a. The insolvency, financial condition or default of the insurer at any time, provided that the right is enforceable under applicable law other than this chapter; or

b. The commencement of a formal delinquency proceeding under this chapter;

(2) Any right under a pledge, security, collateral, reimbursement or guarantee agreement or arrangement or any other similar security arrangement or other credit enhancement relating to 1 or more netting agreements or qualified financial contracts; or

(3) Subject to any provision of § 5927(b) of this title, any right to set off or net out any termination value, payment amount or other transfer obligation arising under or in connection with 1 or more netting agreements or qualified financial contracts where the counterparty or its guarantor is organized under the laws of the United States or a state or a foreign jurisdiction approved by the Securities Valuation Office of the National Association of Insurance Commissioners as eligible for netting.

(4) If a counterparty to a master netting agreement or a qualified financial contract with an insurer subject to a formal delinquency proceeding under this chapter terminates, liquidates, closes out or accelerates the agreement or contract, damages shall be measured as of the date or dates of termination, liquidation, close out or acceleration. The amount of a claim for damages shall be actual direct compensatory damages calculated in accordance with subsection (f) of this section.

(b) Upon termination of a netting agreement or qualified financial contract, the net or settlement amount, if any, owed by a nondefaulting party to an insurer against which an application or petition has been filed under this chapter shall be transferred to or on the order of the receiver for the insurer, even if the insurer is the defaulting party, notwithstanding any walkaway clause in the netting agreement or qualified financial contract. For purposes of this subsection, the term "walkaway clause" means a provision in a netting agreement or a qualified financial contract that, after calculation of a value of a party's position or an amount due to or from 1 of the parties in accordance with its terms upon termination, liquidation or acceleration of the netting agreement or qualified financial contract, either does not create a payment obligation of a party or extinguishes a payment obligation of a party in whole or in part solely because of the party's status as a nondefaulting party. Any limited 2-way payment or first method provision in a netting agreement or qualified financial contract with an insurer that has defaulted shall be deemed to be a full 2-way payment or second method provision as against the defaulting insurer. Any such net or settlement amount shall, except to the extent it is subject to 1 or more secondary liens or encumbrances or rights of netting or setoff, be a general asset of the insurer.

(c) In making any transfer of a netting agreement or qualified financial contract of an insurer subject to a formal delinquency proceeding under this chapter, the receiver shall do either of the following:

(1) Transfer to 1 party (other than an insurer subject to a proceeding under this chapter) all netting agreements and qualified financial contracts between a counterparty or any affiliate of such counterparty and the insurer that is the subject of the formal delinquency proceeding, including all of the following:

a. All rights and obligations of each party under each such netting agreement and qualified financial contract; and

b. All property, including any guarantees or other credit enhancement, securing any claims of each party under each such netting agreement and qualified financial contract; or

(2) Transfer none of the netting agreements, qualified financial contracts, rights, obligations or property referred to in paragraph (c)(1) of this section (with respect to the counterparty and any affiliate of such counterparty).

(d) If a receiver for an insurer makes a transfer of 1 or more netting agreements or qualified financial contracts, then the receiver shall use its best efforts to notify any person who is a party to the netting agreements or qualified financial contracts of the transfer by 12:00 noon (the receiver's local time) on the business day following the transfer. For purposes of this subsection, "business day" means a day other than a Saturday, Sunday or any day on which either the New York Stock Exchange or the Federal Reserve Bank of New York is closed.

(e) Notwithstanding any other provision of this chapter to the contrary, a receiver shall not avoid a transfer of money or other property arising under or in connection with a netting agreement or qualified financial contract (or any pledge, security, collateral or guarantee agreement or any other similar security arrangement or credit support document relating to a netting agreement or qualified financial contract) that is made before the commencement of a formal delinquency proceeding under this chapter. However, a transfer may be avoided under § 5925(c) of this title if the transfer was made with actual intent to hinder, delay or defraud the insurer, a receiver appointed for the insurer or existing or future creditors.

(f) (1) In exercising the rights of disaffirmance or repudiation of a receiver with respect to any netting agreement or qualified financial contract to which an insurer is a party, the receiver for the insurer shall either:

a. Disaffirm or repudiate all netting agreements and qualified financial contracts between a counterparty or any affiliate of the counterparty and the insurer that is the subject of the proceeding; or

b. Disaffirm or repudiate none of the netting agreements and qualified financial contracts referred to in paragraph (f)(1)a. of this section (with respect to the person or any affiliate of the person).

(2) Notwithstanding any other provision of this chapter, any claim of a counterparty against the estate arising from the receiver's disaffirmance or repudiation of a netting agreement or qualified financial contract that has not been previously affirmed in the liquidation or immediately preceding conservation or rehabilitation case shall be determined and shall be allowed or disallowed as if the claim had arisen before the date of the filing of the petition for liquidation or, if a conservation or rehabilitation proceeding is converted to a liquidation proceeding, as if the claim had arisen before the date of the filing of the petition for conservation or rehabilitation. The amount of the claim shall be the actual direct compensatory damages determined as of the date of the disaffirmance or repudiation of the netting agreement or qualified financial contract. The term "actual direct compensatory damages" does not include punitive or exemplary damages, damages for lost profit or lost opportunity or damages for pain and suffering, but does include normal and reasonable costs of cover or other reasonable measures of damages utilized in the derivatives, securities or other market for the contract and agreement claims.

(g) The term "contractual right" as used in this section includes any right, whether or not evidenced in writing, arising under statutory or common law, a rule or bylaw of a national securities exchange, national securities clearing organization or securities clearing agency, a rule or bylaw or a resolution of the governing body of a contract market or its clearing organization, or under law merchant.

(h) The provisions of this section shall not apply to persons who are affiliates of the insurer that is the subject of the formal delinquency proceeding, unless the Commissioner has previously approved the application of this section to a particular affiliate, which approval may not be unreasonably or arbitrarily withheld.

(i) All rights of counterparties under this chapter shall apply to netting agreements and qualified financial contracts entered into on behalf of the general account or separate accounts if the assets of each separate account are available only to counterparties to netting agreements and qualified financial contracts entered into on behalf of that separate account.

(78 Del. Laws, c. 29, § 3.)

Subchapter II
Summary Proceedings

§ 5941. Commissioner's summary orders.

(a) Whenever the Commissioner has reasonable cause to believe, and determines, after a hearing, held as prescribed in subsection (c) of this section, that any insurer has committed or engaged in any act, practice or transaction that would subject it to formal delinquency proceedings under this chapter, the Commissioner may make and serve upon the insurer and any other persons involved such orders, including an order suspending the business of an insurer, as are reasonably necessary to correct, eliminate or remedy such conduct, condition or ground.

(b) If the conditions of subsection (a) of this section, other than notice and hearing, are satisfied and if the Commissioner has reasonable grounds to believe that irreparable harm to the property or business of the insurer or to the interests of its policy or certificate holders, creditors or the public may occur unless the Commissioner issues with immediate effect the orders described in subsection (a) of this section, the Commissioner may make and serve such orders without notice and before hearing, simultaneously serving upon the insurer notice of hearing under subsection (c) of this section.

(c) The notice of hearing under subsection (a) or (b) of this section and the summary order issued under subsection (a) or (b) of this section shall be served pursuant to the applicable rules of civil or administrative procedure. The notice of hearing under subsection (a) of this section shall state the time and place of hearing and the conduct, condition or ground upon which the Commissioner would base

the order; the notice of hearing under subsection (b) of this section shall state the time and place of hearing. Unless mutually agreed between the Commissioner and the insurer, the hearing shall occur not more than 15 days after notice is served. The Commissioner shall not publicize such hearings and shall hold all hearings in summary proceedings privately unless the insurer requests a public hearing, in which case the hearing shall be public.

(d) Any suspension order made by the Commissioner under subsection (a) of this section shall prohibit issuance of policies, transfers of property and payments of moneys without prior written approval of the Commissioner. Notice of such suspension shall be given, by first class mail within 15 days thereof, by the suspended organization to those who were creditors, policyholders, members and certificate holders at the date of suspension. Notice of such suspension shall be given, within 15 days thereof, by the Commissioner to creditors, policyholders, members and certificate holders by advertising the same by 1 publication in a newspaper of general circulation in the county where the suspended organization has its principal office. From the date of such suspension on the ground that the insurer is insolvent or is in such condition that its further transaction of business will be hazardous financially to its policyholders, creditors or the public, no action at law or equity shall be commenced or prosecuted, nor shall any judgment be entered against nor shall any execution or attachment be issued or prosecuted against the suspended insurer, or against its property, in any court in the State; provided, that if such suspension order is vacated by the Chancery Court for the reason that the suspended insurer is no longer insolvent or in such condition that its further transaction of business will be hazardous to its policyholders or to its creditors or to the public, these restraints upon legal process regarding the insurer shall thereafter cease to be operative.

(e) If the Commissioner issues a summary order before a hearing under this section, the insurer may at any time waive the Commissioner's hearing and apply for immediate judicial relief by means of any remedy afforded by law without first exhausting administrative remedies.

(f) If any person has violated any order issued under this section which as to that person was then still in effect, he or she shall be liable to pay a civil penalty imposed by the Chancery Court not to exceed $10,000.

(g) The Commissioner may apply to the Chancery Court for such restraining orders, preliminary and permanent injunctions and other orders as may be deemed necessary and proper to enforce a summary order.

(64 Del. Laws, c. 420, § 2; 70 Del. Laws, c. 186, § 1.)

§ 5942. Commissioner's supervision.

(a) If upon examination or at any other time the Commissioner has reasonable cause to believe, and determines, that an insurer has committed, engaged in or is about to engage in any act, practice or transaction that would subject it to formal delinquency proceedings under this chapter, or if such insurance company gives its consent, then the Commissioner shall upon determination notify the insurer of the determination and furnish to the insurer an order or orders containing a written list of the Commissioner's requirements to abate the Commissioner's determination. If the Commissioner, after a hearing held as provided in § 5941(c) of this title, makes a further determination to supervise, the Commissioner shall issue an order to the insurer notifying it that it is under the supervision of the Commissioner and that the Commissioner is applying and effecting this section. The Commissioner may issue an order under this section without a hearing under the conditions provided under § 5941(b) of this title, and shall simultaneously serve upon the insurer notice of a hearing to be held in accordance with § 5941(c) of this title, and, in such event, the insurer may file an appeal in accordance with § 5941(e) of this title. Such insurer shall comply with the lawful requirements of the Commissioner and, if placed under an order of supervision, shall have 90 days from the date of service of such order within which to comply with the requirements of the Commissioner. In the event of such insurer's failure to comply within such time, the Commissioner may institute proceedings in the Chancery Court to have a rehabilitator or liquidator appointed under this chapter or issue an order extending an existing order of supervision. Such order extending any existing order shall be issued prior to the end of each 90-day period, unless otherwise agreed to by the insurer.

(b) The Commissioner may appoint a supervisor to supervise such insurer and may provide that the insurer may not do any of the following acts, during the period of supervision, without the prior written approval of the Commissioner or the supervisor:

(1) Dispose of, convey or encumber any of its assets or its business in force;

(2) Withdraw any of its bank accounts;

(3) Lend any of its funds;

(4) Invest any of its funds;

(5) Transfer any of its property;

(6) Incur any debt, obligation or liability;

(7) Merge or consolidate with another company; or

(8) Enter into any new reinsurance contract or treaty.

(c) In the event that any person, subject to this chapter, shall violate any valid order of the Commissioner issued under this section and, as a result, the net worth of the insurer shall be reduced or the insurer shall otherwise suffer loss, said person shall become personally liable to the insurer for the amount of any such reduction or loss. The Commissioner or supervisor is authorized to bring an action on behalf of the insurer in the Chancery Court to recover the amount of the reduction or loss together with any costs.

(64 Del. Laws, c. 420, § 2; 70 Del. Laws, c. 186, § 1.)

§ 5943. Seizure order.

(a) Upon the filing by the Commissioner in the Chancery Court of a petition alleging:

(1) Any ground that would justify a court order for a formal delinquency proceeding against an insurer under this chapter, and

(2) That the interests of policyholders, creditors or the public will be endangered by delay, and

(3) Setting out the order deemed necessary by the Commissioner,

the Court may issue forthwith, ex parte and without a hearing, the requested order which shall direct the Commissioner to take possession and control of all or a part of the property, books, accounts, documents and other records of an insurer and of the premises occupied by it for the transaction of its business, and until further order of the Court enjoin the insurer and its officers, managers, agents and employees from disposition of its property and from transaction of its business except with the written consent of the Commissioner.

(b) The Court shall specify in the order what its duration shall be, which shall be such time as the Court deems necessary for the Commissioner to ascertain the condition of the insurer. Such initial duration or any extension thereof shall not exceed 90 days. On motion of either party or on its own motion, the Court may from time to time hold such hearings as it deems desirable after such notice as it deems appropriate, and may extend, shorten or modify the terms of the seizure order. The Court shall vacate the seizure order if the Commissioner fails to commence a formal proceeding under this subchapter prior to the expiration of a seizure order or any extension thereof. An order of the Court pursuant to a formal proceeding under this subchapter shall ipso facto vacate the seizure order.

(c) Entry of a seizure order under this section shall not constitute an anticipatory breach of any contract of the insurer.

(d) An insurer subject to an ex parte order of the Chancery Court issued under this section may petition the Court at any time after the issuance of such order for a hearing and review of the order, and the Court shall grant such a hearing and review within 10 days of the filing of such petition.

(64 Del. Laws, c. 420, § 2.)

§ 5944. Conduct of hearings.

(a) The Chancery Court may hold all hearings in summary proceedings and judicial review thereof privately in chambers, and shall do so on request of the insurer proceeded against.

(b) In all summary proceedings and judicial reviews thereof, all records of the insurer, other documents and all Insurance Department files and court records and papers, so far as they pertain to or are a part of the record of the summary proceedings, shall be and remain confidential except as is necessary to obtain compliance therewith, unless and until the Chancery Court, after hearing arguments from the parties in chambers, shall order otherwise or unless the insurer requests that the matter be made public. Until such court order, all papers filed with the Clerk of the Chancery Court shall be held by the Clerk in a confidential file.

(c) Any person having possession or custody of and refusing to deliver any of the property, books, accounts, documents or other records of or relating to an insurer against which a seizure order or a summary order has been issued by the Commissioner or by the Chancery Court may be fined not more than $10,000 or sentenced to undergo imprisonment for not more than 1 year, or both.

(64 Del. Laws, c. 420, § 2; 70 Del. Laws, c. 186, § 1.)

Part I
Insurance

Chapter 61
Prohibition of Rescissions Based Upon Post-Claims Underwriting

§ 6101. Rescissions based upon post-claims underwriting barred.

Unless approval is granted pursuant to § 6102 of this title, no insurer may rescind, cancel or limit any health insurance policy, contract, evidence of coverage or certificate that provides coverage of the types specified in § 6103 of this title on the basis of written information submitted on, with or omitted from an insurance application by the insured if the insurer failed to complete medical underwriting and resolve all reasonable medical questions related to the written information submitted on, with or omitted from the insurance application before issuing the policy, contract, evidence of coverage or certificate. No insurer may rescind, cancel or limit any such health insurance policy, contract, evidence of coverage or certificate once the enrollee is covered under such plan or coverage involved, except this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or who makes an intentional misrepresentation of a material fact, as prohibited by the terms of the plan or coverage, and such omission materially affects the risk or the hazard assumed by the insurer or health care center. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and except as permitted under applicable federal, state or local laws.

(77 Del. Laws, c. 471, § 1.)

§ 6102. Approval of rescission.

An insurer shall apply for approval of such rescission, cancellation or limitation by submitting such written information to the Insurance Commissioner on an application in such appropriate form as the Commissioner prescribes. Such insurer shall provide a copy of the application for such approval to the insured or the insured's representative. Not later than 7 business days after receipt of the application for such approval, the insured or the insured's representative shall have an opportunity to respond and submit relevant information to the Commissioner with respect to such application. Not later than 15 business days after the submission of information by the insured or the insured's representative, the Commissioner shall issue a written decision on such application. The Commissioner shall approve such rescission, cancellation or limitation if the Commissioner finds that:

(1) The written information submitted on or with the insurance application was false at the time such application was made and the insured or such insured's representative knew or should have known of the falsity therein, and such submission materially affects the risk or the hazard assumed by the insurer or health care center; or

(2) The information omitted from the insurance application was knowingly omitted by the insured or such insured's representative, or the insured or such insured's representative should have known of such omission, and such omission materially affects the risk or the hazard assumed by the insurer or health care center. Such decision shall be mailed to the insured, the insured's representative, if any, and the insurer.

(77 Del. Laws, c. 471, § 1.)

§ 6103. Affected health insurance policies.

As used in this chapter, "health insurance policy, contract, evidence of coverage or certificate" means insurance providing benefits due to illness or injury, resulting in loss of life, loss of earnings, or expenses incurred, and includes the following types of coverage:

(1) Basic hospital expense coverage;

(2) Basic medical-surgical expense coverage;

(3) Hospital confinement indemnity coverage;

(4) Major medical expense coverage; or

(5) Hospital or medical service plan contract.

(77 Del. Laws, c. 471, § 1.)

§ 6104. Authority of Insurance Commissioner to promulgate regulations.

The Insurance Commissioner may promulgate regulations to implement the provisions of this chapter.

(77 Del. Laws, c. 471, § 1.)

Part I
Insurance
Chapter 62
Fraternal Benefit Societies
Subchapter I
Structure and Purpose

§ 6201. Fraternal benefit societies.

Any incorporated society, order or supreme lodge, without capital stock, including one exempted under the provisions of § 6237(a)(2) of this title, whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government and which provides benefits in accordance with this chapter, is hereby declared to be a fraternal benefit society.

(70 Del. Laws, c. 533, § 1.)

§ 6202. Lodge system.

(a) A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated or admitted in accordance with its laws, rules and ritual. Subordinate lodges shall be required by the laws of the society to hold regular meetings at least once in each month in furtherance of the purposes of the society.

(b) A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required of such children, nor shall they have a voice or vote in the management of the society.

(70 Del. Laws, c. 533, § 1.)

§ 6203. Representative form of government.

A society has a representative form of government when:

(1) It has a supreme governing body constituted in 1 of the following ways:

a. *Assembly.* —

The supreme governing body is an assembly composed of delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail. The elected delegates shall constitute a majority in number and shall not have less than $^{2}/_{3}$ of the votes and not less than the number of votes required to amend the society's laws. The assembly shall be elected and shall meet at least once every 4 years and shall elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws.

b. *Direct election.* —

The supreme governing body is a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's laws. A society may provide for election of the board by mail. Each term of a board member may not exceed 4 years. Vacancies on the board between elections may be filled in the manner prescribed by the society's laws. Those persons elected to the board shall constitute a majority in number and not less than the number of votes required to amend the society's laws. A person filling the unexpired term of an elected board member shall be considered to be an elected member. The board shall meet at least quarterly to conduct the business of the society.

(2) The officers of the society are elected either by the supreme governing body or by the board of directors;

(3) Only benefit members are eligible for election to the supreme governing body and the board of directors; and

(4) Each voting member shall have 1 vote; no vote may be cast by proxy.

(70 Del. Laws, c. 533, § 1.)

§ 6204. Terms used.

Whenever used in this chapter:

(1) "Benefit contract" shall mean the agreement for provision of benefits authorized by § 6216 of this title, as that agreement is described in § 6219(a) of this title.

(2) "Benefit member" shall mean an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract.

(3) "Certificate" shall mean the document issued as written evidence of the benefit contract.

(4) "Commissioner" shall mean the Commissioner of Insurance of this State.

(5) "Laws" shall mean the society's certificate of incorporation, constitution and bylaws, however designated.

(6) “Lodge” shall mean subordinate member units of the society, known as camps, courts, councils, branches or by any other designation.

(7) “Premiums” shall mean premiums, rates, dues or other required contributions by whatever name known, which are payable under the certificate.

(8) “Rules” shall mean all rules, regulations or resolutions adopted by the supreme governing body or board of directors, which are intended to have general application to the members of the society.

(9) “Society” shall mean fraternal benefit society, unless otherwise indicated.

(70 Del. Laws, c. 533, § 1.)

§ 6205. Purposes and powers.

(a) A society shall operate for the benefit of members and their beneficiaries by:

(1) Providing benefits as specified in § 6216 of this title; and

(2) Operating for 1 or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic or religious purposes for the benefit of its members which may also be extended to others.

Such purposes may be carried out directly by the society or indirectly through subsidiary corporations or affiliated organizations.

(b) Every society shall have the power to adopt laws and rules for the government of the society, the admission of its members and the management of its affairs. It shall have the power to change, alter, add to or amend such laws and rules and shall have such other powers as are necessary and incidental to carrying into effect the objects and purposes of the society.

(70 Del. Laws, c. 533, § 1.)

Subchapter II

Membership

§ 6206. Qualifications for membership.

(a) A society shall specify in its laws or rules:

(1) Eligibility standards for each and every class of membership provided, that if benefits are provided on the lives of children, the minimum age for adult membership shall be set at not less than age 15 and not greater than age 21;

(2) The process for admission to membership for each membership class; and

(3) The rights and privileges of each membership class, provided that only benefit members shall have the right to vote on the management of the insurance affairs of the society.

(b) A society may also admit social members who shall have no voice or vote in the management of the insurance affairs of the society

(c) Membership rights in the society are personal to the member and are not assignable.

(70 Del. Laws, c. 533, § 1.)

§ 6207. Location of office, meetings, communications to members, grievance procedures.

(a) The principal office of any domestic society shall be located in this State. The meetings of its supreme governing body may be held in any state, district, province or territory wherein such society has at least 1 subordinate lodge, or in such other location as determined by the supreme governing body, and all business transacted at such meetings shall be as valid in all respects as if such meetings were held in this State. The minutes of the proceedings of the supreme governing body and of the board of directors shall be in the English language.

(b) (1) A society may provide in its laws for an official publication in which any notice, report or statement required by law to be given to members, including notice of election, may be published. Such required reports, notices and statements shall be printed conspicuously in the publication. If the records of a society show that 2 or more members have the same mailing address, an official publication mailed to 1 member is deemed to be mailed to all members at the same address unless a member requests a separate copy.

(2) Not later than June 1 of each year, a synopsis of the society’s annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed, shall be printed and mailed to each benefit member of the society or, in lieu thereof, such synopsis may be published in the society’s official publication.

(c) A society may provide in its laws or rules for grievance or complaint procedures for members.

(70 Del. Laws, c. 533, § 1.)

§ 6208. No personal liability.

(a) The officers and members of the supreme governing body or any subordinate body of a society shall not be personally liable for any benefits provided by a society.

(b) Any person may be indemnified and reimbursed by any society for expenses reasonably incurred by, and liabilities imposed upon, such person in connection with or arising out of any action, suit or proceeding, whether civil, criminal, administrative or investigative, or threat thereof, in which the person may be involved by reason of the fact that he or she is or was a director, officer, employee or agent

of the society or of any firm, corporation or organization which he or she served in any capacity at the request of the society. A person shall not be so indemnified or reimbursed:

(1) In relation to any matter in such action, suit or proceeding as to which he or she shall finally be adjudged to be or have been guilty of breach of a duty as a director, officer, employee or agent of the society; or

(2) In relation to any matter in such action, suit or proceeding, or threat thereof, which has been made the subject of a compromise settlement, unless in either such case the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in addition, in a criminal action or proceeding, had no reasonable cause to believe that his or her conduct was unlawful.

The determination whether the conduct of such person met the standard required in order to justify indemnification and reimbursement, in relation to any matter described in paragraph (b)(1) or (2) of this section, may only be made by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to such action, suit or proceeding or by a court of competent jurisdiction. The termination of any action, suit or proceeding by judgment, order, settlement, conviction or upon a plea of no contest as to such person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification and reimbursement. The foregoing right of indemnification and reimbursement shall not be exclusive of other rights to which such person may be entitled as a matter of law and shall inure to the benefit of his or her heirs, executors and administrators.

(c) A society shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee or agent of the society or who is or was serving at the request of the society as a director, officer, employee or agent of any other firm, corporation or organization against any liability asserted against such person and incurred by him or her in any such capacity or arising out of his or her status as such, whether or not the society would have the power to indemnify the person against such liability under this section.

(d) No director, officer, employee, member or volunteer of a society serving without compensation shall be liable and no cause of action may be brought for damages resulting from the exercise of judgment or discretion in connection with the duties or responsibilities of such person for the society unless such act or omission involved wilful or wanton misconduct.

(70 Del. Laws, c. 186, § 1; 70 Del. Laws, c. 533, § 1.)

§ 6209. Waiver.

The laws of the society may provide that no subordinate body nor any of its subordinate officers or members shall have the power or authority to waive any of the provisions of the laws of the society. Such provision shall be binding on the society and every member and beneficiary of a member.

(70 Del. Laws, c. 533, § 1.)

Subchapter III

Governance

§ 6210. Organization.

A domestic society organized on or after January 1, 1997, shall be formed as follows:

(1) Seven or more citizens of the United States, a majority of whom are citizens of this State, who desire to form a fraternal benefit society shall form a corporation without capital stock, the governing body of which is elected and the powers of which are not more liberal than as provided in this chapter and the name of which shall not so closely resemble the name of any society or insurance company then licensed in Delaware as to be confusing.

(2) Its certificate of incorporation, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications therefor and circulars to be issued by the society, the names, residences and official titles of all the officers, trustees, directors or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme governing body, which election shall be held not later than 1 year from the date of issuance of the permanent certificate of authority and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within 1 year, shall be filed with the Commissioner, who may require such further information as the Commissioner deems necessary. The bond with sureties approved by the Commissioner shall be in such amount, not less than $300,000, nor more than $1,500,000, as required by the Commissioner. All documents filed are to be in the English language. If the purposes of the society conform to the requirements of this chapter and all provisions of the law have been complied with, the Commissioner shall so certify, retain and file the certificate of incorporation and shall furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as hereinafter provided.

(3) No preliminary certificate of authority granted under the provisions of this section shall be valid after 1 year from its date or after such further period, not exceeding 1 year, as may be authorized by the Commissioner upon cause shown, unless the 500 applicants hereinafter required have been secured and the organization has been completed as herein provided. The charter and all other proceedings thereunder shall become null and void in 1 year from the date of the preliminary certificate of authority or at the

expiration of the extended period, unless the society shall have completed its organization and received a certificate of authority to do business as hereinafter provided.

(4) Upon receipt of a preliminary certificate of authority from the Commissioner, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than 1 regular monthly premium in accordance with its table of rates and shall issue to each such applicant a receipt for the amount so collected. No society shall incur any liability other than for the return of such advance premium, nor issue any certificate, nor pay, allow, or offer or promise to pay or allow any benefit to any person until:

a. Actual bona fide applications for benefits have been secured on not less than 500 applicants, and any necessary evidence of insurability has been furnished to and approved by the society;

b. At least 10 subordinate lodges have been established into which the 500 applicants have been admitted;

c. There has been submitted to the Commissioner, under oath of the president or secretary or corresponding officer of the society, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted and premiums therefor; and

d. It shall have been shown to the Commissioner, by sworn statement of the treasurer or corresponding officer of such society, that at least 500 applicants have each paid in cash at least 1 regular monthly premium as herein provided, which premiums in the aggregate shall amount to at least $150,000. Said advance premiums shall be held in trust during the period of organization and if the society has not qualified for a certificate of authority within 1 year, as herein provided, such premiums shall be returned to said applicants.

(5) The Commissioner may make such examination and require such further information as the Commissioner deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the Commissioner shall issue to the society a certificate of authority to that effect and that the society is authorized to transact business pursuant to the provisions of this chapter. The certificate of authority shall be prima facie evidence of the existence of the society at the date of such certificate. The Commissioner shall cause a record of such certificate of authority to be made. A certified copy of such record may be given in evidence with like effect as the original certificate of authority.

(6) Any incorporated society authorized to transact business in this State on January 1, 1997, shall not be required to reincorporate.

(70 Del. Laws, c. 533, § 1.)

§ 6211. Amendments to laws.

(a) A domestic society may amend its laws in accordance with the provisions thereof by action of its supreme governing body at any regular or special meeting thereof or, if its laws so provide, by referendum. Such referendum may be held in accordance with the provisions of its laws by the vote of the voting members of the society, by the vote of delegates or representatives of voting members or by the vote of local lodges. A society may provide for voting by mail. No amendment submitted for adoption by referendum shall be adopted unless, within 6 months from the date of submission thereof, a majority of the members voting shall have signified their consent to such amendment by 1 of the methods herein specified.

(b) No amendment to the laws of any domestic society shall take effect unless approved by the Commissioner, who shall approve such amendment if the Commissioner finds that it has been duly adopted and is not inconsistent with any requirement of the laws of this State or with the character, objects and purposes of the society. Unless the Commissioner shall disapprove any such amendment within 60 days after the filing of same, such amendment shall be considered approved. The approval or disapproval of the Commissioner shall be forwarded in writing and mailed to the secretary or corresponding officer of the society at its principal office. In case the Commissioner disapproves such amendment, the reasons therefor shall be stated in such written notice.

(c) Within 90 days from the approval thereof by the Commissioner, all such amendments or a synopsis thereof shall be furnished to all members of the society either by mail or by publication in full in the official publication of the society. The affidavit of any officer of the society or of anyone authorized by it to mail any amendments or synopsis thereof, stating facts which show that same have been duly addressed and mailed, shall be prima facie evidence that such amendments or synopsis thereof have been furnished the addressee.

(d) Every foreign or alien society authorized to do business in this State shall file with the Commissioner a duly certified copy of all amendments of or additions to its laws within 90 days after the enactment of same.

(e) Printed copies of the laws, as amended, certified by the secretary or corresponding officer of the society shall be prima facie evidence of the legal adoption thereof.

(70 Del. Laws, c. 533, § 1.)

§ 6212. Institutions.

(a) A society may create, maintain and operate or may establish organizations to operate not-for-profit institutions to further the purposes permitted by § 6205(a)(2) of this title. Such institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held or leased by the society for this purpose shall be reported in every annual statement but shall not be allowed as an admitted asset of such society.

(b) No society shall own or operate funeral homes or undertaking establishments.

(70 Del. Laws, c. 533, § 1.)

§ 6213. Reinsurance.

(a) A domestic society may, by a reinsurance agreement, cede any individual risk or risks in whole or in part to an insurer (other than another fraternal benefit society) having the power to make such reinsurance and authorized to do business in this State, or if not so authorized, one which is approved by the Commissioner, but no such society may reinsure substantially all of its insurance in force without the written permission of the Commissioner. It may take credit for the reserves on such ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability to a ceding society for reinsurance made, ceded, renewed or otherwise becoming effective after January 1, 1997, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contract or contracts reinsured without diminution because of the insolvency of the ceding society.

(b) Notwithstanding the limitation in subchapter I of this chapter, a society may reinsure the risks of another society in a consolidation or merger approved by the Commissioner under § 6214 of this title.

(70 Del. Laws, c. 533, § 1.)

§ 6214. Consolidations and mergers.

(a) A domestic society may consolidate or merge with any other society by complying with the provisions of this section and the applicable provisions of the statutes of this State governing the merger or consolidation of nonstock corporations. It shall file with the Commissioner:

(1) A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;

(2) A sworn statement by the president and secretary or corresponding officers of each society showing the financial condition thereof on a date fixed by the Commissioner, but not earlier than December 31 next preceding the date of the contract;

(3) A certificate of such officers, duly verified by their respective oaths, that the consolidation or merger has been approved by a $^{2}/_{3}$ vote of the supreme governing body of each society, such vote being conducted at a regular or special meeting of each such body, or, if the society's laws so permit, by mail; and

(4) Evidence that at least 60 days prior to the action of the supreme governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in the official publication of each society.

(b) If the Commissioner finds that the contract is in conformity with the provisions of this section, that the financial statements are correct and that the consolidation or merger is just and equitable to the members of each society, the Commissioner shall approve the contract and issue a certificate to such effect. Upon such approval, the contract shall be in full force and effect unless any society which is a party to the contract is incorporated under the laws of any other state or territory. In such event the consolidation or merger shall not become effective unless and until it has been approved as provided by the laws of such state or territory and a certificate of such approval is filed with the Commissioner of this State, or, if the laws of such state or territory contain no such provision, then the consolidation or merger shall not become effective unless and until it has been approved by the Commissioner of Insurance of such state or territory and a certificate of such approval is filed with the Commissioner of this State.

(c) Upon the consolidation or merger becoming effective as herein provided, all the rights, franchises and interests of the consolidated or merged societies in and to every species of property, real, personal or mixed, and things in action thereunto belonging, shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument, except that conveyances of real property may be evidenced by proper deeds and the title to any real estate or interest therein, vested under the laws of this State in any of the societies consolidated or merged, shall not revert or be in any way impaired by reason of the consolidation or merger, but shall vest absolutely in the society resulting from or remaining after such consolidation or merger.

(d) The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document stating that such notice or document has been duly addressed and mailed shall be prima facie evidence that such notice or document has been furnished the addressees.

(70 Del. Laws, c. 533, § 1.)

§ 6215. Conversion of fraternal benefit society into a mutual life insurance company.

Any domestic fraternal benefit society may be converted and licensed as a mutual life insurance company by compliance with all the applicable requirements of § 4905 of this title. A plan of conversion shall be prepared in writing by the board of directors setting forth in full the terms and conditions of conversion. The affirmative vote of $^{2}/_{3}$ of all members of the supreme governing body at a regular or special meeting shall be necessary for the approval of such plan. No such conversion shall take effect unless and until approved by the Commissioner who may give such approval if the Commissioner finds that the proposed change is in conformity with the requirements of law and not prejudicial to the certificate holders of the society.

(70 Del. Laws, c. 533, § 1.)

Subchapter IV
Contractual Benefits

§ 6216. Benefits.

(a) A society may provide the following contractual benefits in any form:

(1) Death benefits;

(2) Endowment benefits;

(3) Annuity benefits;

(4) Temporary or permanent disability benefits;

(5) Hospital, medical or nursing benefits;

(6) Monument or tombstone benefits to the memory of deceased members; and

(7) Such other benefits as authorized for life insurers and which are not inconsistent with this chapter.

(b) A society shall specify in its rules those persons who may be issued or covered by the contractual benefits in subsection (a) of this section, consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person.

(70 Del. Laws, c. 533, § 1.)

§ 6217. Beneficiaries.

(a) The owner of a benefit contract shall have the right at all times to change the beneficiary or beneficiaries in accordance with the laws or rules of the society unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

(b) A society may make provision for the payment of funeral benefits to the extent of such portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member, provided the portion so paid shall not exceed the sum of $500 dollars.

(c) If, at the death of any person insured under a benefit contract, there is no lawful beneficiary to whom the proceeds shall be payable, the amount of such benefit, except to the extent that funeral benefits may be paid as hereinbefore provided, shall be payable to the personal representative of the deceased insured; provided, that if the owner of the certificate is other than the insured, such proceeds shall be payable to such owner.

(70 Del. Laws, c. 533, § 1.)

§ 6218. Benefits not attachable.

No money or other benefit, charity, relief or aid to be paid, provided or rendered by any society shall be liable to attachment, garnishment or other process or to be seized, taken, appropriated or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary, or any other person who may have a right thereunder, either before or after payment by the society.

(70 Del. Laws, c. 533, § 1.)

§ 6219. The benefit contract.

(a) Every society authorized to do business in this State shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided thereby. The certificate, together with any riders or endorsements attached thereto, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant and all amendments to each thereof shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

(b) Any changes, additions or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate shall bind the owner and the beneficiaries and shall govern and control the benefit contract in all respects the same as though such changes, additions or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition or amendment shall destroy or diminish benefits which the society contracted to give the owner as of the date of issuance.

(c) Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

(d) A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired, its board of directors or corresponding body may require that there shall be paid by the owner to the society the amount of the owner’s equitable proportion of such deficiency as ascertained by its board, and that if the payment is not made either:

(1) It shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates; or

(2) In lieu of or in combination with paragraph (1) of this subsection, the owner may accept a proportionate reduction in benefits under the certificate.

The society may specify the manner of the election and which alternative is to be presumed if no election is made.

(e) Copies of any of the documents mentioned in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.

(f) No certificate shall be delivered or issued for delivery in this State unless a copy of the form has been filed with and approved by the Commissioner in the manner provided for like policies issued by life and disability insurers in this State. Every life, accident and sickness, health or disability insurance certificate and every annuity certificate issued on or after January 1, 1988, must be filed with and approved by the Commissioner and shall meet the standard contract provision requirements not inconsistent with this chapter for like policies issued by life and disability insurers in this State, except that a society may provide for a grace period for payment of premiums of 1 full month in its certificates. The certificate shall also contain a provision stating the amount of premiums which are payable under the certificate and a provision reciting or setting forth the substance of any section of the society's laws or rules in force at the time of issuance of the certificate which, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium. Any filing made hereunder shall be deemed approved unless disapproved within 60 days from the date of such filing.

(g) Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control of ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer and may provide in all other respects for the regulation, government and control of such certificates and all rights, obligations and liabilities incident thereto and connected therewith. Ownership rights prior to such transfer shall be specified in the certificate.

(h) A society may specify the terms and conditions on which benefit contracts may be assigned.

(70 Del. Laws, c. 533, § 1.)

§ 6220. Nonforfeiture benefits, cash surrender values, certificate loans and other options.

(a) For certificates issued prior to January 1, 1988, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall comply with the provisions of law applicable immediately prior to January 1, 1997.

(b) For certificates issued on or after January 1, 1988, for which reserves are computed on the Commissioner's 1941 Standard Ordinary Mortality Table, the Commissioner's 1941 Standard Industrial Table or the Commissioner's 1958 Standard Ordinary Mortality Table or the Commissioner's 1980 Standard Mortality Table, or any more recent table made applicable to life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall not be less than the corresponding amount ascertained in accordance with the laws of this State applicable to life insurers issuing policies containing like benefits based upon such tables.

(70 Del. Laws, c. 533, § 1.)

Subchapter V

Financial

§ 6221. Investments.

A society shall invest its funds only in such investments as are authorized by the laws of this State for the investment of assets of life insurers and subject to the limitations thereon. Any foreign or alien society permitted or seeking to do business in this State which invests its funds in accordance with the laws of the state, district, territory, country or province in which it is incorporated shall be held to meet the requirements of this subchapter for the investment of funds.

(70 Del. Laws, c. 533, § 1.)

§ 6222. Funds.

(a) All assets shall be held, invested and disbursed for the use and benefit of the society and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment on the surrender of any part thereof, except as provided in the benefit contract.

(b) A society may create, maintain, invest, disburse and apply any special fund or funds necessary to carry out any purpose permitted by the laws of such society.

(c) A society may, pursuant to resolution of its supreme governing body, establish and operate 1 or more separate accounts and issue contracts on a variable basis, subject to law regulating life insurers establishing such accounts and issuing such contracts. To the extent the society deems it necessary in order to comply with any applicable federal or state laws or any rules issued thereunder, the society may adopt special procedures for the conduct of the business and affairs of a separate account, may, for persons having beneficial interests therein, provide special voting and other rights, including, without limitation, special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants and selection of a committee to manage the business and affairs of the account and may issue contracts on a variable basis to which § 6219(b) and (d) of this title shall not apply.

(70 Del. Laws, c. 533, § 1.)

§ 6223. Exemptions; application of other code provisions.

(a) Except as herein provided, societies shall be governed by this chapter and shall be exempt from all other provisions of the insurance laws of this State, not only in governmental relations with this State, but for every other purpose. No law hereafter enacted shall apply to them, unless they be expressly designated therein.

(b) Societies shall also be subject to §§ 505 to 509, inclusive, 523, 529, 530, 532, 1101, 1102, 1105, 1108 and 1127 to 1130, inclusive, of this title.

(70 Del. Laws, c. 533, § 1; 80 Del. Laws, c. 117, § 2.)

§ 6224. Taxation.

Every society organized or licensed under this chapter is hereby declared to be a charitable and benevolent institution and all of its funds shall be exempt from all and every state, county, district, municipal and school tax other than taxes on real estate and office equipment.

(70 Del. Laws, c. 533, § 1.)

Subchapter VI
Regulation

§ 6225. Valuation.

(a) Standards of valuation for certificates issued prior to January 1, 1988, shall be those provided by the laws applicable immediately prior to January 1, 1997.

(b) The minimum standards of valuation for certificates issued on or after January 1, 1988, shall be based on the following tables:

(1) For certificates of life insurance, the Commissioner's 1941 Standard Ordinary Mortality Table, the Commissioner's 1941 Standard Industrial Mortality Table, the Commissioner's 1958 Standard Ordinary Mortality Table, the Commissioner's 1980 Standard Ordinary Mortality Table or any more recent table made applicable to life insurers; and

(2) For annuity and pure endowment certificates, for total and permanent disability benefits, for accidental death benefits and for noncancelable accident and health benefits, such tables as are authorized for use by life insurers in this State.

All of the above shall be under valuation methods and standards (including interest assumptions) in accordance with the laws of this State applicable to life insurers issuing policies containing like benefits.

(c) The Commissioner may, in his or her discretion, accept other standards for valuation if the Commissioner finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard herein prescribed. The Commissioner may, in his or her discretion, vary the standards of mortality applicable to all benefit contracts on substandard lives or other extra hazardous lives by any society authorized to do business in this State.

(d) Any society, with the consent of the Commissioner of Insurance of the state of domicile of the society and under such conditions, if any, which the Commissioner may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any benefit member shall not be affected thereby.

(70 Del. Laws, c. 533, § 1; 70 Del. Laws, c. 186, § 1.)

§ 6226. Reports.

Reports shall be filed in accordance with the provisions of this section.

(1) Every society transacting business in this State shall annually, on or before March 1, unless for cause shown such time has been extended by the Commissioner, file with the Commissioner a true statement of its financial condition, transactions and affairs for the preceding calendar year and pay the fee set forth in § 701 of this title for filing same. The statement shall be in the general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the Commissioner.

(2) As part of the annual statement herein required, each society shall, on or before the 1st day of March, file with the Commissioner a valuation of its certificates in force on December 31 last preceding, provided the Commissioner may, in the Commissioner's discretion for cause shown, extend the time for filing such valuation for not more than 2 calendar months. Such valuation shall be done in accordance with the standards specified in § 6225 of this title. Such valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

(3) A society neglecting to file the annual statement in the form and within the time provided by this section may be subject to a fine of $100 dollars for each day during which such neglect continues, and its authority to do business in this State may be suspended by the Commissioner while such default continues.

(70 Del. Laws, c. 533, § 1; 70 Del. Laws, c. 186, § 1; 84 Del. Laws, c. 42, § 1; 84 Del. Laws, c. 336, § 4.)

§ 6227. Annual license.

Societies which are now authorized to transact business in this State may continue such business until April 1, 1997. The authority of such societies and all societies hereafter licensed may thereafter be renewed annually, but in all cases to terminate on the next succeeding

April 1. However, a license so issued shall continue in full force and effect until the new license is issued or specifically refused. For each such new license or renewal, the society shall pay the Commissioner the fees set forth in § 701 of this title. A duly certified copy or duplicate of such license shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of this chapter.

(70 Del. Laws, c. 533, § 1; 84 Del. Laws, c. 336, § 5.)

§ 6228. Examination of societies; no adverse publications.

(a) The Commissioner, or any person he or she may appoint, may examine any domestic, foreign or alien society transacting or applying for admission to transact business in this State in the same manner as authorized for examination of domestic, foreign or alien insurers. Requirements of notice and an opportunity to respond before findings are made public, as provided in the laws regulating insurers, shall also be applicable to the examination of societies.

(b) The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be paid by the society examined or whose certificates are valued, upon statements furnished by the Commissioner.

(70 Del. Laws, c. 533, § 1; 70 Del. Laws, c. 186, § 1.)

§ 6229. Foreign or alien society — Admission.

No foreign or alien society shall transact business in this State without a license issued by the Commissioner. Any such society desiring admission to this State shall comply substantially with the requirements and limitations of this chapter applicable to domestic societies. Any such society may be licensed to transact business in this State upon filing with the Commissioner:

(1) A duly certified copy of its chapters of incorporation;

(2) A copy of its bylaws, certified by its secretary or corresponding officer;

(3) A power of attorney to the Commissioner as prescribed in § 6235 of this title;

(4) A statement of its business under oath of its president and secretary or corresponding officers in a form prescribed by the Commissioner, duly verified by an examination made by the supervising insurance official of its home state or other state, territory, province or country, satisfactory to the Commissioner;

(5) Certification from the proper official of its home state, territory, province or country that the society is legally incorporated and licensed to transact business therein;

(6) Copies of its certificate forms; and

(7) Such other information as the Commissioner may deem necessary;

upon a showing that its assets are invested in accordance with the provisions of this chapter.

(70 Del. Laws, c. 533, § 1.)

§ 6230. Injunction — Liquidation — Receivership of domestic society.

(a) When the Commissioner, upon investigation, finds that a domestic society has exceeded its powers, has failed to comply with any provision of this chapter, is not fulfilling its contracts in good faith, has a membership of less than 400 after an existence of 1 year or more or is conducting business fraudulently or in a manner hazardous to its members, creditors or the public, the Commissioner shall notify the society of such deficiency or deficiencies and state in writing the reasons for his or her dissatisfaction. The Commissioner shall simultaneously issue a written notice to the society requiring that the deficiency or deficiencies which exist be corrected. After such notice, the society shall have a 30-day period in which to comply with the Commissioner's request for correction, and if the society fails to comply, the Commissioner shall take such action as is necessary and appropriate under Chapter 59 of this title.

(b) The Commissioner may take such action as is necessary and appropriate under this section with respect to domestic society which shall voluntarily determine to discontinue business.

(70 Del. Laws, c. 533, § 1; 70 Del. Laws, c. 186, § 1.)

§ 6231. Suspension, revocation or refusal of license of foreign or alien society.

(a) When the Commissioner, upon investigation, finds that a foreign or alien society transacting or applying to transact business in this State:

(1) Has exceeded its powers;

(2) Has failed to comply with any of the provisions of this chapter;

(3) Is not fulfilling its contracts in good faith; or

(4) Is conducting its business fraudulently or in a manner hazardous to its members or creditors or the public, the Commissioner shall notify the society of such deficiency or deficiencies and state in writing the reasons for his or her dissatisfaction. The Commissioner shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist are corrected. After such notice, the society shall have a 30-day period in which to comply with the Commissioner's request for correction and if the society fails to comply, the Commissioner shall notify the society of such findings of noncompliance and require the society to show cause, on a date named, why its license should not be suspended, revoked or refused. If on such date, the society does not present good and sufficient

reason why its authority to do business in this State should not be suspended, revoked or refused, the Commissioner may suspend or refuse the license of the society to do business in this State until satisfactory evidence is furnished to the Commissioner that such suspension or refusal should be withdrawn or the Commissioner may revoke the authority of the society to do business in this State.

(b) Nothing contained in this section shall be taken or construed as preventing any such society from continuing in good faith all contracts made in this State during the time such society was legally authorized to transact business herein.

(70 Del. Laws, c. 533, § 1; 70 Del. Laws, c. 186, § 1.)

§ 6232. Injunction.

No application or petition for injunction against any domestic, foreign or alien society or lodge thereof shall be recognized in any court of this State unless made by the Attorney General upon request of the Commissioner.

(70 Del. Laws, c. 533, § 1.)

§ 6233. Licensing of agents.

(a) Agents of societies shall be licensed in accordance with Chapter 17 of this title. Agents licensed prior to January 1, 1997, shall not be required to take a written or other examination.

(b) No examination or license shall be required of any regular salaried officer, employee or member of a licensed society who devotes substantially all of his or her services to activities other than the solicitation of fraternal insurance contracts from the public and who receives for the solicitation of such contracts no commission or other compensation directly dependent upon the amount of business obtained.

(c) Any agent or representative of a society who devotes or intends to devote less than 50% of the agent's or representative's time to solicitation and procurement of insurance contracts for such society shall be exempt from the requirements of subsection (a) of this section. Any person who, in the preceding calendar year, has solicited and procured life insurance contracts on behalf of any society in an amount of insurance in excess of $125,000 or, in the case of any other kind or kinds of insurance which the society might write, on the persons of more than 25 individuals and who has received or will receive a commission or other compensation therefor, shall be presumed to be devoting or intending to devote 50% of the person's time to the solicitation or procurement of insurance contracts for such society.

(70 Del. Laws, c. 533, § 1; 70 Del. Laws, c. 186, § 1.)

§ 6234. Unfair methods of competition and unfair and deceptive acts and practices.

Every society authorized to do business in this State shall be subject to Chapter 23 of this title relating to unfair practices; provided however, that nothing therein shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.

(70 Del. Laws, c. 533, § 1.)

Subchapter VII

Miscellaneous

§ 6235. Service of process.

(a) Every society authorized to do business in this State shall appoint, in writing, the Commissioner and each successor in office to be its true and lawful attorney upon whom all lawful process in any action or proceeding against it shall be served and shall agree, in such writing, that any lawful process against it which is served on such attorney shall be of the same legal force and validity as if served upon the society, and that the authority shall continue in force so long as any liability remains outstanding in this State. Copies of such appointment, certified by the Commissioner, shall be deemed sufficient evidence thereof and shall be admitted in evidence with the same force and effect as the original thereof might be admitted.

(b) Service shall only be made upon the Commissioner or, if absent, upon the person in charge of his or her office. It shall be made in duplicate and shall constitute sufficient service upon the society. When legal process against a society is served upon the Commissioner, the Commissioner shall forthwith forward 1 of the duplicate copies by registered mail, prepaid, directed to the secretary or corresponding officer. No such service shall require a society to file its answer, pleading or defense in less than 30 days from the date of mailing the copy of the service to a society. Legal process shall not be served upon a society except in the manner herein provided.

(c) At the time of serving any process upon the Commissioner, the plaintiff or complainant in the action shall pay to the Commissioner a fee of $2.00.

(70 Del. Laws, c. 533, § 1; 70 Del. Laws, c. 186, § 1.)

§ 6236. Penalties.

(a) A person who shall knowingly or wilfully make any false or fraudulent statement or representation in or relating to any application for membership or for the purpose of obtaining money from or a benefit in any society shall be guilty of a misdemeanor, and upon conviction, be fined not less than $100, nor more than $500, or imprisonment in the county jail not less than 30 days, nor more than 1 year, or both.

(b) Any person who wilfully makes a false or fraudulent statement in any verified report or declaration under oath required or authorized by this chapter or of any material fact or thing contained in a sworn statement concerning the death or disability of an insured for the purpose of procuring payment of a benefit named in the certificate shall be guilty of perjury and shall be subject to the penalties therefor prescribed by law.

(c) Any person who solicits membership for or in any manner assists in procuring membership in any society not licensed to do business in this State shall, upon conviction, be fined not less than $100, nor more than $500.

(d) Any person guilty of a wilful violation of or neglect or refusal to comply with the provisions of this chapter for which a penalty is not otherwise prescribed shall, upon conviction, be subject to the penalties provided by § 106 (general penalty) of this title.

(70 Del. Laws, c. 533, § 1.)

§ 6237. Exemption of certain societies.

(a) Nothing contained in this chapter shall be so construed as to affect or apply to:

(1) Grand or subordinate lodges of societies, orders or associations now doing business in this State which provide benefits exclusively through local or subordinate lodges;

(2) Orders, societies or associations which admit to membership only persons engaged in 1 or more crafts or hazardous occupations, in the same or similar lines of business and the ladies societies or ladies auxiliaries to such orders, societies or associations;

(3) Domestic societies which limit their membership to employees of a particular city or town, designated firm, business house or corporation which provide for a death benefit of not more than $400 or disability benefits of not more than $350 to any person in any 1 year, or both;

(4) Domestic societies or associations of a purely religious, charitable or benevolent description which provide for a death benefit of not more than $400 or for disability benefits of not more than $350 to any 1 person in any 1 year, or both.

(b) Any such society or association described in paragraph (a)(3) or (4) of this section which provides for death or disability benefits for which benefit certificates are issued and any such society or association included in paragraph (a)(4) of this section which has more than 1,000 members shall not be exempted from the provisions of this chapter but shall comply with all requirements thereof.

(c) No society which, by the provisions of this section, is exempt from the requirements of this chapter, except any society described in paragraph (a)(2) of this section, shall give or allow or promise to give or allow to any person any compensation for procuring new members.

(d) Every fraternal benefit society heretofore organized and incorporated and which provides exclusively for benefits in case of death or disability resulting solely from accident and which does not obligate itself to pay natural death or sick benefits shall have all of the privileges and be subject to all the applicable provisions and regulations of this chapter, except that the privileges thereof relating to medical examination, valuations of benefit certificates and incontestability shall not apply to such society.

(e) The Commissioner may require from any society or association, by examination or otherwise, such information as will enable the Commissioner to determine whether such society or association is exempt from the provisions of this chapter.

(f) Societies exempted under the provisions of this chapter shall also be exempt from all other provisions of the insurance laws of this State.

(70 Del. Laws, c. 533, § 1.)

§ 6238. Review.

All decisions and findings of the Commissioner made under this chapter shall be subject to review as set forth in Chapter 3 of this title and in Chapter 101 of Title 29.

(70 Del. Laws, c. 533, § 1.)

Part I
Insurance
Chapter 63
Health Service Corporations

§ 6301. Provisions exclusive.

Health service corporations now or hereafter incorporated in this State shall be governed by this chapter, shall be exempt from all other provisions of this title, except as herein expressly provided, and no insurance law hereafter enacted shall be deemed to apply to such corporations unless they be specifically referred to therein.

(18 Del. C. 1953, § 6301; 56 Del. Laws, c. 380, § 1.)

§ 6302. Health service corporation defined.

"Health service corporation" means a nonprofit corporation, without capital stock, organized under the laws of this State for the purpose of establishing, maintaining and operating plans to provide hospital, physicians' or related health services, or indemnity therefor, for such persons as become members or subscribers of any plan of such corporation.

(18 Del. C. 1953, § 6302; 56 Del. Laws, c. 380, § 1.)

§ 6303. Limited application.

This chapter, other than § 6301 of this title, shall not apply to any corporation operating or maintaining a hospital service plan or medical service plan, participation in which is limited to its employees and the employees of other persons or corporations with which such corporation may have contracted to provide such services. As used in this section, the term "employees" may include members of the families of employees and retired employees.

(18 Del. C. 1953, § 6303; 56 Del. Laws, c. 380, § 1.)

§ 6304. Certificate of authority; when required; application.

(a) No corporation shall engage in the business of a health service corporation without first obtaining a certificate of authority therefor from the Commissioner, except that this provision shall not apply to corporations which are engaged in such business in this State on November 1, 1968.

(b) Application for a certificate of authority as a health service corporation shall be made on forms supplied by the Commissioner and containing such information as the Commissioner shall reasonably deem necessary. The application shall be accompanied by a filing fee of $25 and copies of the following documents:

(1) Certificate of incorporation;

(2) Bylaws;

(3) Forms of all proposed contracts between the applicant and participating hospitals, physicians and other providers of health services showing the terms under which services are to be furnished to subscribers or members;

(4) Forms of all proposed contracts and optional riders to be offered for subscribers or members;

(5) Tables of rates to be charged for each such contract or rider or a statement of the rating formulas to be used in lieu of fixed rates;

(6) Financial statement of the corporation, including the amounts of contributions paid or agreed to be paid to the corporation for working capital and the name or names of each contributor and the terms of each contribution;

(7) A statement of the areas in which the corporation proposes to operate; and

(8) A list of the names and addresses of the members of the board of directors or other governing body of the corporation and its principal officers.

(c) Every corporation engaging in the business of a health service corporation pursuant to the exception stated in subsection (a) of this section above, shall, within 30 days after November 1, 1968, file with the Commissioner copies of all the documents referred to in paragraphs (b)(1)-(8) of this section, above, and pay therewith a filing fee of $25.

(18 Del. C. 1953, § 6304; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 6305. Issuance of certificate of authority.

The Commissioner shall issue a certificate of authority to the applicant when it is shown to the Commissioner's satisfaction that:

(1) The applicant is established as a bona fide nonprofit health service corporation;

(2) Arrangements have been made by the applicant reasonably to assure provision of the services covered by its contracts and riders;

(3) The amounts provided as working capital of the corporation are repayable, without interest, only out of operating revenues;

(4) The amount of money actually available for working capital is sufficient to carry on the plan for a period of 2 months from the date of issuance of the certificate of authority.

(18 Del. C. 1953, § 6305; 56 Del. Laws, c. 380, § 1; 70 Del. Laws, c. 186, § 1.)

§ 6306. Filing required for contract or rate changes.

No new or changed contract or rider shall be offered to the public and no new or changed rate or rating formula shall be charged or employed, unless documentation with respect thereto as specified in § 6304(b) of this title is first filed with the Commissioner.

(18 Del. C. 1953, § 6306; 56 Del. Laws, c. 380, § 1.)

§ 6307. Annual report; examination.

(a) Not later than March 1 of each year every such corporation shall file with the Commissioner a statement sworn to by at least 2 of its principal officers, showing its financial condition on the last day of the next preceding calendar year. Such statement shall be in the general form as is currently in general and customary use in the United States for health insurance and may be submitted on standard office-size paper.

(b) The Commissioner may appoint an examiner to examine into the affairs of the corporation. Such person shall have the power of visitation and examination, shall have free access to all the books, papers and documents relating to the business of the corporation and may require the officers, agents or employees thereof, or any other persons, to testify under oath concerning the affairs, transactions and conditions at least every 3 years. Except, that the confidentiality of information relating to the diagnosis and treatment of the members of such corporation shall be strictly maintained by the examiner. The reasonable cost of the examination shall be paid by the corporation upon completion of the examination.

(18 Del. C. 1953, § 6307; 56 Del. Laws, c. 380, § 1; 64 Del. Laws, c. 322, § 1; 69 Del. Laws, c. 343, § 1.)

§ 6308. Suspension or revocation of authority to do business.

The Commissioner may, after hearing, suspend or revoke the right to do business or the certificate of authority for any of the following causes:

(1) If the corporation is no longer qualified therefor under this chapter;

(2) For a violation by the corporation of a provision of this chapter; or

(3) Upon any applicable ground under this chapter or any of the chapters specified in § 6309 of this title for which the certificate of authority of an insurer may be suspended or revoked.

(18 Del. C. 1953, § 6308; 56 Del. Laws, c. 380, § 1.)

§ 6309. Other provisions applicable.

(a) Such corporations shall be subject to this chapter and to the following chapters of this title, to the extent applicable and not in conflict with the express provisions of this chapter:

(1) Chapter 1 (General Definitions and Provisions).

(2) Chapter 3 (The Insurance Commissioner).

(3) Chapter 23 (Unfair Practices in the Insurance Business).

(4) Chapter 25 (Rates and Rating Organizations).

(5) Subchapter II of Chapter 58 (Risk-Based Capital (RBC) for Health Organizations).

(6) Chapter 59 (Rehabilitation and Liquidation).

(7) Chapter 34 (Medicare Supplement Insurance Minimum Standards).

(8) Chapter 36 (Individual Health Insurance Minimum Standards).

(b) Such corporations shall also be subject to §§ 3349A, 3365, 3565A and 3571G of this title.

(18 Del. C. 1953, § 6309; 56 Del. Laws, c. 380, § 1; 60 Del. Laws, c. 388, §§ 5, 6; 63 Del. Laws, c. 262, § 4; 64 Del. Laws, c. 142, § 3; 78 Del. Laws, c. 276, § 3; 79 Del. Laws, c. 425, § 4; 79 Del. Laws, c. 435, § 3.)

§ 6310. Affiliations involving health service corporations.

(a) (1) With respect to any proposed change of control affiliation or transaction between:

a. A health service corporation licensed under this chapter; and

b. Any insurer that administers a Children's Health Insurance Program buy-in program ("the insurer"),

the Commissioner shall not approve the transaction or affiliation unless the affiliation will result in the Delaware-licensed health service corporation offering an insurance plan with the same benefits and eligibility criteria as the Delaware program created under § 9909(j) of Title 16.

(2) The specific premiums to be initially charged under this section shall be approved by the Commissioner as part of the approval for the transaction or affiliation required by this section, with the analysis required by Chapter 25 of this title and the premiums charged in other regions whose CHIP buy-in programs are administered by the insurer being factors in the Commissioner's decision.

(3) The plan offered pursuant to this section shall offer to subscribers the same network of health-care providers that is offered to subscribers of the Delaware-licensed entity's standard health insurance plan.

(b) For purposes of this section, a "change of control affiliation or transaction" is any affiliation or transaction that will ultimately result in any change in effective control of a health service corporation, either as described by the applicant or as determined by the Commissioner.

(c) The obligation imposed under subsection (a) of this section shall exist until such time that the Commissioner finds that a subsequent change in ownership or governance of the affected Delaware health service corporation has negated the change of control affiliation or transaction that triggered the insurer's obligation under subsection (a) of this section, or until such time that the Commissioner determines that the program has been effectively replaced by federal law, or until such time as the Commissioner determines that the program has become unviable due to insufficient enrollment or unsustainable financial losses. For purposes of this subsection, "unsustainable financial losses" shall require a demonstration of an actual medical loss ratio greater than 90% for each of 2 completed program years in a 3-program-year period.

(d) For purposes of this section, a "children's health insurance buy-in program" is a state program that allows children who would otherwise be ineligible to participate in the State's CHIP program by virtue of income to nevertheless participate in the program by paying a monthly premium.

(e) For purposes of this section, "CHIP program" means the federal Children's Health Insurance Program.

(f) Future adjustments to premiums for any Delaware CHIP buy-in program created pursuant to this section shall be subject to Chapter 25 of this title, with premiums charged in other regions whose CHIP buy-in programs are administered by the insurer being a factor considered under § 2503(a)(3) of this title.

(g) Any program created pursuant to this section shall be actuarially separated from a health service corporation's other insurance plans, and shall not affect the premiums approved by the Commissioner pursuant to Chapter 25 of this title for those other plans.

(h) The Insurance Commissioner shall provide a report to the Controller General regarding any rate-setting proceeding relating to any CHIP buy-in program created by this section. Such report shall include any request with respect to rates made by the relevant carrier, any analysis performed by the Insurance Commissioner, and the Insurance Commissioner's ultimate decision with an explanation for that decision. This requirement shall also apply to the initial premium setting required by paragraph (a)(2) of this section. The report shall be furnished within 30 days of a final decision by the Commissioner with respect to any rate.

(78 Del. Laws, c. 58, § 1.)

§ 6311. Reserves and surplus; holding company standards.

(a) Any approval by the Commissioner of a change of control of a health service corporation shall be governed under the provisions of Chapter 50 of this title and shall be subject to conditions that ensure compliance with this section. Chapter 50 of this title shall also govern the ongoing affiliation of a health service corporation following a change of control, but only to the extent that the provisions thereof are not inconsistent with any more stringent provision of this title or conditions imposed by the Commissioner in connection with approval of such change of control.

(b) If a health service corporation regulated under this chapter proposes to enter into a transaction in which it will become controlled by another entity, the Insurance Commissioner shall place conditions upon any approval of the change of control intended to preserve that amount, determined in accordance with Delaware law, that constitutes the surplus or reserves of the health service corporation. Such conditions shall include, without limitation, requiring:

(1) Review and approval by the Department of Insurance of any change in the certificate of incorporation of the health service corporation;

(2) Review and approval by the Department of Insurance of any individual expenditure or transfer of funds or coordinated series of expenditures or transfers of funds by the health service corporation in excess of $500,000 to the controlling entity or any affiliate of such controlling entity, which review and approval shall assess the commercial reasonableness of the proposed expenditure or transfer;

(3) A majority of the board of directors of the health service corporation to consist of persons not employed by the health service corporation or any of its affiliates who are residents of Delaware and have been so for at least 5 years prior to appointment; and

(4) Recognition of, and consent to, the ability of Insurance Commissioner to seek appropriate relief from the Court of Chancery or other court of appropriate jurisdiction to prevent the entity controlling the health service corporation from improperly using the assets of the health service corporation for the benefit of the controlling entity rather than the benefit of the health service corporation and its subscribers, or otherwise violating the terms of this section, Chapter 50 of this title, or any agreement between the health service corporation and the controlling entity or affiliate thereof.

(c) Any conditions placed on approval will be enforced by the Insurance Commissioner in accordance with applicable provisions of this title. Whenever approval must be obtained from the Commissioner for any activity described in this section, simultaneous notice thereof shall be provided to the Department of Justice.

(d) A health service corporation in dissolution shall, after the discharge of all obligations, distribute all remaining assets to the foundation created under § 2533 of Title 29.

(e) Terms used in this section shall have the same meaning as defined in Chapter 50 of this title.

(78 Del. Laws, c. 109, § 2.)

Part I
Insurance
Chapter 64
Regulation of Managed Care Organizations

§ 6401. Legislative intent.

It is the intent of the General Assembly in enacting this chapter to provide that the Insurance Commissioner regulate managed care organizations, including financial solvency, established or operated in this State. It is the intent of the General Assembly that such organizations be subject only to the provisions of this chapter, including those other chapters of this title expressly included in § 6411 of this title, and no insurance law hereinafter enacted shall be deemed to apply to managed care organizations unless they are specifically referred to therein.

(63 Del. Laws, c. 382, § 1; 66 Del. Laws, c. 124, §§ 1, 2; 71 Del. Laws, c. 229, §§ 1, 2; 75 Del. Laws, c. 362, § 2.)

§ 6402. Short title.

This chapter shall be known and may be cited as the "Delaware Managed Care Organization Act" or the "Delaware MCO Act."

(63 Del. Laws, c. 382, § 1; 66 Del. Laws, c. 124, § 7; 71 Del. Laws, c. 229, § 8; 75 Del. Laws, c. 362, § 2.)

§ 6403. Definitions.

As used in this chapter, unless the context clearly indicates a different meaning, the following words and phrases shall have the meaning ascribed to them in this section:

(1) "Basic health services" means a range of services including at least the following: usual physician services, hospitalization, laboratory, x-ray, emergency and preventive services and out-of-area coverage.

(2) "Certified managed care organization" means a managed care organization which has been issued a certificate of authority under this title.

(3) "Department" means the Delaware Department of Insurance.

(4) "Health-care services" means any service included in the furnishing to any individual of medical or dental care, or hospitalization or incidental to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing or healing human illness, injury or physical disability.

(5) "Managed care organization" means a public or private organization, organized under the laws of any state, which:

a. Makes health-care services, including at least the basic health services defined in paragraph (1) of this section above, available to enrolled participants;

b. Is primarily compensated (except for copayment) for the provision of basic health-care services to enrolled participants on a predetermined periodic rate basis; and

c. Provides physicians' services.

The organization may also arrange for health-care services on a prepayment or other financial basis.

(63 Del. Laws, c. 382, § 1; 66 Del. Laws, c. 124, § 1, 3-5; 71 Del. Laws, c. 229, §§ 1, 3; 72 Del. Laws, c. 441, § 1; 75 Del. Laws, c. 362, § 2.)

§ 6404. Certificate of authority; when required; application and issuance.

(a) No person shall establish, operate or engage in the business of a managed care organization or enter this State for the purpose of enrolling persons in a managed care organization without first obtaining a certificate of authority from the Insurance Commissioner. A foreign corporation shall not be eligible to apply for such certificate of authority unless it has first qualified to do business in this State as a foreign corporation pursuant to § 371 of Title 8.

(b) Application for a certificate of authority as a managed care organization shall be made on forms promulgated by the Insurance Commissioner and shall contain such information as the Commissioner shall by regulation require. The application shall be accompanied by copies of any documents which the Insurance Commissioner shall by regulation require and copies of the following documents:

(1) Certificate of incorporation;

(2) Bylaws;

(3) A list of the names and addresses of the members of the board of directors or other governing body of the corporation and its principal officers;

(4) A statement of the geographic areas in which the managed care organization proposes to operate;

(5) A statement describing how the managed care organization shall operate, including its anticipated enrollment, its basic health services, its personnel, the proposed method of marketing and a financial plan which includes a projection of operating results for the first 3 years of operation;

(6) A statement identifying the states where the managed care organization is authorized to operate, any states where it has pending an application for authorization to operate; and States where it has been cited for a violation of any laws or legislation and an explanation of any such alleged violation, including the status or outcome;

(7) Forms of proposed contracts to be offered for members who enroll on a direct payment or standard group basis;

(8) Tables of rates to be charged for such contracts or statement of the rating formulas to be used in lieu of fixed rates; and

(9) Financial statements showing the applicant's assets, liabilities and sources of financial support; provided that if the applicant's financial affairs are audited by an independent certified public accountant, a copy of the applicant's most recent certified financial statement shall be deemed to satisfy this requirement.

(c) Within 60 days of receipt of an application for issuance of a certificate of authority, the Department shall determine whether the applicant, with respect to health-care services to be furnished:

(1) Has demonstrated the ability to provide such health-care services in a manner assuring availability, accessibility and continuity of services;

(2) Has arrangements for an ongoing health-care quality assurance program concerning health-care processes;

(3) Has the capability to comply with all applicable rules and regulations promulgated by the Department;

(4) Has the capability to provide or arrange for the provision to its enrollees of basic health-care services on a prepaid basis through insurance or otherwise, except to the extent of reasonable requirements of co-payments; and

(5) Has the staff and facilities to directly provide at least half of the outpatient medical care costs of its anticipated enrollees on a prepaid basis.

(d) The Commissioner shall issue a certificate of authority to the applicant when the applicant has shown to the Commissioner's satisfaction that:

(1) The applicant meets or is able to meet the requirements of this title as set forth herein;

(2) Arrangements have been made by the applicant reasonably to assure provision of the services covered by its contracts; and

(3) The applicant is financially responsible and able to meet its obligations to members.

(63 Del. Laws, c. 382, § 1; 66 Del. Laws, c. 124, §§ 1, 6, 7; 70 Del. Laws, c. 186, § 1; 71 Del. Laws, c. 229, §§ 1, 4, 5; 75 Del. Laws, c. 362, § 2.)

§ 6405. Suspension or revocation of certificate of authority.

(a) The Commissioner may, after a hearing, suspend or revoke the certificate of authority of a managed care organization for any of the following causes:

(1) If the managed care organization is no longer qualified therefor under this chapter;

(2) For a violation by the managed care organization of any provision of this chapter;

(3) Upon any applicable ground under this chapter or any of the chapters specified in § 6411 of this title for which the certificate of authority of an insurer may be suspended or revoked;

(4) If the managed care organization is operating in a manner which deviates substantially, in a manner detrimental to its enrollees, from the plan of operation described by it in securing its certificate of authority;

(5) If the managed care organization does not have in effect arrangements to provide the quantity and quality of health-care services required by its enrollees; or

(6) If the continued operation of the managed care organization would be detrimental to the health or well-being of its enrollees needing services.

(b) Proceedings in regard to any hearing held pursuant to this section shall be conducted in accordance with provisions for case decisions as set forth in the Administrative Procedures Act, Chapter 101 of Title 29, and any applicable rules and regulations of the Department. Any decision rendered following a hearing shall set forth the findings of fact and conclusions of the Department as to any violations of this chapter, and shall also set forth the reasons for the Department's choice of any sanction to be imposed. The Department's choice of sanction shall not be disturbed upon appeal, except for abuse of discretion.

(c) Suspension of a certificate of authority pursuant to this section shall not prevent a managed care organization from continuing to serve all its enrollees as of the date the Department issues a decision imposing suspension, nor shall it preclude thereafter adding as enrollees newborn children or other newly acquired dependents of existing enrollees. Unless otherwise determined by the Department and set forth in its decision, a suspension shall, during the period when it is in effect, preclude all other new enrollments and also all advertising or solicitation on behalf of the managed care organization other than communication, approved by the Department, which are intended to give information as to the effect of the suspension.

(d) In the event that the Department decides to revoke the certificate of authority of a managed care organization, the decision so providing shall specify the time and manner in which its business shall be concluded. In any case, after the Department has issued a decision revoking a certificate of authority, unless stayed in connection with an appeal, the managed care organization shall not conduct any further business except as expressly permitted in the Department's decision and it shall engage only in such activities as are directed by the Department are required to assist its enrollees in securing continued health care coverage.

(63 Del. Laws, c. 382, § 1; 66 Del. Laws, c. 124, §§ 1, 7-9; 71 Del. Laws, c. 229, §§ 1, 6; 75 Del. Laws, c. 362, § 2.)

§ 6406. Annual report.

(a) Every managed care organization shall annually, on or before June 1, file with the Department a report covering the preceding fiscal year.

(b) Such report shall include:

(1) A financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding fiscal year; and

(2) A statement explaining any material change in the information originally submitted pursuant to this title.

(63 Del. Laws, c. 382, § 1; 66 Del. Laws, c. 124, § 7; 71 Del. Laws, c. 229, § 1; 75 Del. Laws, c. 362, § 2.)

§ 6407. Prohibited practices.

(a) No managed care organization or representative thereof may cause or knowingly permit the use of advertising or solicitation which is untrue or misleading.

(b) No managed care organization may cancel or refuse to renew the enrollment of an enrollee solely on the basis of the enrollee's health. This subsection shall not prevent a managed care organization from canceling the enrollment of an enrollee if the enrollee misrepresented the state of the enrollee's health at the time of enrollment. This subsection shall not prevent a managed care organization from canceling or refusing to renew an enrollment for reasons other than an enrollee's health, including without limitation nonpayment of premiums or fraud by the enrollee.

(c) The Department shall have exclusive authority to investigate violations of this section.

(63 Del. Laws, c. 382, § 1; 66 Del. Laws, c. 124, § 7; 70 Del. Laws, c. 186, § 1; 71 Del. Laws, c. 229, § 1; 75 Del. Laws, c. 362, § 2.)

§ 6408. Rules and regulations.

The Department shall have authority to promulgate such reasonable rules and regulations as are necessary to carry out this chapter. Such rules or regulations shall conform to and be promulgated pursuant to the Administrative Procedures Act, Chapter 101 of Title 29.

(63 Del. Laws, c. 382, § 1; 66 Del. Laws, c. 124, § 7; 75 Del. Laws, c. 362, § 2.)

§ 6409. Fees.

Every managed care organization subject to this chapter shall pay the fees set forth in § 701 of this title for filing an application for a certificate of authority and for filing an annual report.

(75 Del. Laws, c. 362, § 2; 84 Del. Laws, c. 336, § 6.)

§ 6410. Provision of professional services.

(a) A managed care organization shall have a medical director. The medical director shall be licensed to practice medicine in Delaware in accordance with § 1702 of Title 24. The medical director's duties shall include, at a minimum, those specified in regulations promulgated by the Department pursuant to the authority granted. The medical director may assign duties to other physicians and nonphysician personnel employed by, or under contract to, the managed care organization, provided, however, that the medical director shall retain responsibility for assigned duties. Any decision to deny a covered service shall be rendered by a physician.

(b) A certified managed care organization may contract with, or employ, any licensed health-care professional to provide health-care services, notwithstanding any statute, rule or regulation to the contrary. No managed care organization delivering health-care services in this State shall engage in a contract with or employ, for the delivery of such services, any person who does not hold a Delaware license to practice the profession for which such person is engaged or employed, if such practice requires a license.

(63 Del. Laws, c. 382, § 1; 66 Del. Laws, c. 124, §§ 7, 11-15; 71 Del. Laws, c. 229, §§ 1, 7; 72 Del. Laws, c. 200, §§ 1, 2; 75 Del. Laws, c. 362, § 2.)

§ 6411. Relationship to other laws.

(a) Managed care organizations shall be subject to this chapter and to the following chapters of this title, as amended from time to time, to the extent applicable and not in conflict with the express provisions of this chapter. For purposes of the following chapters only, a managed care organization shall be treated as a health insurer, and its coverages shall be deemed to be "medical and hospital expense-incurred insurance policies" for purposes of Chapter 25 of this title:

(1) Chapter 1 of this title (General Definitions and Provisions).

(2) Chapter 3 of this title (The Insurance Commissioner).

(3) Chapter 5 of this title (Authorization of Insurers and General Requirements).

(4) Chapter 9 of this title (Kinds of Insurance; Limits of Risk; Reinsurance).

(5) Chapter 11 of this title (Assets and Liabilities).

(6) Chapter 13 of this title (Investments).

(7) Chapter 15 of this title (Administration of Deposits).

(8) Chapter 17 of this title (Licensing of Professional Insurance Personnel).

(9) Chapter 21 of this title (Unauthorized Insurers — Prohibitions, Process and Advertising).

(10) Chapter 23 of this title (Unfair Practices in the Insurance Business).

(11) Chapter 25 of this title (Rates and Rating Organizations).

(12) Chapter 27 of this title (The Insurance Contract).

(13) Chapter 33 of this title (Health Insurance Contracts).

(14) Chapter 34 of this title (Medicare Supplement Insurance Minimum Standards).

(15) Chapter 35 of this title (Group and Blanket Health Insurance).

(16) Chapter 36 of this title (Individual Health Insurance Minimum Standards).

(17) Chapter 50 of this title (Insurance Holding Company System Registration).

(18) Subchapter II of Chapter 58 of this title (Risk-Based Capital (RBC) for Health Organizations).

(19) Chapter 59 of this title (Rehabilitation and Liquidation).

(20) Chapter 44 of this title (Delaware Life and Health Insurance Guaranty Association Act).

(b) A certified managed care organization shall not be deemed to be practicing medicine and the managed care organization shall be exempt from statutes, rules and regulations relating to the practice of medicine. A certified managed care organization shall not be deemed to be practicing any other licensed health-care profession, and the managed care organization shall be exempt from statutes, rules and regulations relating to such professions.

(c) Except as provided in § 6407 of this title, solicitation of enrollees by a certified managed care organization or its employees shall not be construed as a violation of any statute, rule or regulation relating to solicitation or advertising by health professionals.

(63 Del. Laws, c. 382, § 1; 66 Del. Laws, c. 124, §§ 1, 11-15; 69 Del. Laws, c. 404, § 1; 71 Del. Laws, c. 229, §§ 1, 7; 72 Del. Laws, c. 200, §§ 1, 2; 75 Del. Laws, c. 362, § 2; 79 Del. Laws, c. 425, § 5; 82 Del. Laws, c. 113, § 11.)

§ 6412. Confidentiality of health information.

Any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant obtained from such person or from any health-care provider by any managed care organization shall be held in confidence and shall not be disclosed to any person except upon the express consent of the enrollee or applicant, or the enrollee's or applicant's physician, or pursuant to statute or court order for the production of evidence or the discovery thereof, or in the event of claim or litigation between such person and the managed care organization wherein such data or information is pertinent. The communication of such data or information from a health care provider to a managed care organization shall not prevent such data or information from being deemed confidential for purposes of the Delaware Uniform Rules of Evidence.

(63 Del. Laws, c. 382, § 1; 66 Del. Laws, c. 124, § 7; 70 Del. Laws, c. 186, § 1; 71 Del. Laws, c. 229, § 1; 75 Del. Laws, c. 362, § 2.)

§ 6413. Freedom of choice.

In order to promote freedom of choice by employers and others in Delaware who purchase group health-care coverage, it shall be unlawful for any insurer, health service corporation or other person in the business of providing or insuring health-care services or coverage, to offer any insurance or health-care coverage to any person in this State on a basis which would preclude such person from allowing some members of a group to elect to enroll in a certified managed care organization, either by means of an express prohibition or by requiring the same payment regardless of such election; provided, however, that it shall not be unlawful for such persons to offer insurance or coverage on a basis where the rates or cost thereof are calculated according to the number of persons in the group for which such coverage is provided. The Department shall have authority to enforce this section.

(63 Del. Laws, c. 382, § 1; 66 Del. Laws, c. 124, § 7; 71 Del. Laws, c. 229, § 1; 75 Del. Laws, c. 362, § 2.)

§ 6414. Nondisclosure clause.

A managed care organization contract shall contain no provision or nondisclosure clause prohibiting physicians or other health-care providers from giving patients information regarding diagnoses, prognoses and treatment options.

(63 Del. Laws, c. 382, § 1; 66 Del. Laws, c. 124, § 7; 70 Del. Laws, c. 186, § 1; 70 Del. Laws, c. 537, § 3; 71 Del. Laws, c. 229, § 1; 75 Del. Laws, c. 362, § 2.)

§ 6415. Refusal to contract.

A managed care organization shall not refuse to contract with or compensate for covered services an otherwise eligible health-care provider solely because that provider has in good faith communicated with 1 or more of the provider's current, former or prospective

patients regarding the provisions, terms or requirements of the health maintenance organization's products or services as they relate to the needs of that provider's patients.

(63 Del. Laws, c. 382, § 1; 66 Del. Laws, c. 124, § 7; 70 Del. Laws, c. 186, § 1; 70 Del. Laws, c. 537, § 3; 71 Del. Laws, c. 229, § 1; 75 Del. Laws, c. 362, § 2.)

§ 6416. Independent health care appeals program.

(a) There is established the Independent Health Care Appeals Program in the Department of Insurance. The program will include, at a minimum, a final step in the grievance process which provides for a review by an Independent Utilization Review Organization, hereafter referred to as "IURO," as specified in regulations promulgated by the Department pursuant to the authority granted in § 6408 of this title. The purpose of the program is to provide an independent medical necessity or appropriateness of services review of final decisions of carriers to deny, reduce or terminate benefits in the event the final decision is contested by the covered person. For the purpose of this chapter "medical necessity" means the providing of covered health-care services or products that a prudent physician would provide to a patient for the purpose of diagnosing or treating an illness, injury, or disease or its symptoms, in a manner that is:

(1) In accordance with generally accepted standards of medical practice;

(2) Consistent with the symptoms or treatment of the condition; and

(3) Not solely for anyone's convenience.

(b) The appeal review shall include any decisions regarding covered benefits by the covered person's health benefits plan, and any determination by the IURO shall be binding on the health carriers. If the IURO makes a determination in favor of the carrier, it will give rise to a rebuttable presumption to that effect in any subsequent action brought by or on behalf of the covered person with respect to the decision. Should the determination favor the covered person, the health carrier shall have the ability to appeal the issue to Superior Court. In any such instance in which an appeal is taken to the Superior Court, that Court shall, upon receiving notice of the appeal, appoint an independent attorney to defend the determination from which the appeal is taken. The expenses of the appeal to the Superior Court, including the assessment of attorney fees for the attorney appointed by the Court, shall be assessed by the Court against the health carrier. This act will affect "health carriers," defined as any entity subject to insurance laws and regulations of the State.

(c) A covered person may apply to the Independent Health Appeals Program for a review of any decision to deny, reduce or terminate covered benefits if the person has already completed the carrier's internal appeals process and the person contests the final decision by a carrier. Within 4 months of the date the final decision was issued by the carrier, a covered person or the covered person's authorized representative may file a request for an external review with the health carrier. Upon receipt of a request for an external review, the health carrier shall send an electronic copy of the request to the Department.

(d) The Department shall, at the time of the receipt of the request for an external review, assign an IURO from the list of certified IUROs pursuant to this section and shall so inform the health carrier. The IURO shall notify the covered person or the covered person's authorized representative in writing that they have been assigned to conduct an external review. Included in the notice shall be a statement that the covered person or the covered person's authorized representative may submit additional information and supporting documentation that the IURO shall consider when conducting the external review. Such additional information must be submitted within 7 days of receipt of the notification.

(e) Within 7 calendar days after the date on which the health carrier receives notice of the IURO assigned, the heath carrier shall provide to the assigned IURO all documents and information utilized in making the final decision to deny, reduce or terminate benefits, as well as the final written decision from internal appeal.

(f) For cases in which the denial, reduction or termination of benefits by the health carrier is based on grounds other than medical necessity or the appropriateness of services, as defined in this section, review from the final decision of the health carrier, following completion of the health carrier's internal review process, shall be through the Department of Insurance in accordance with the provisions of § 332 of this title.

(g) For cases in which a denial, reduction or termination of benefits should be reviewed by both an IURO and by the Department of Insurance, or where there is ambiguity as to where the review should be conducted, the review shall be conducted by an IURO pursuant to this section.

(72 Del. Laws, c. 441, § 1; 73 Del. Laws, c. 96, § 2; 75 Del. Laws, c. 362, § 2; 78 Del. Laws, c. 226, § 1.)

§ 6417. Appeal reviews; independent utilization review organizations.

(a) The Insurance Commissioner or designee shall certify such organizations that meet the requirements of this section or regulations to be promulgated pursuant to it or shall deem certified any independent review entity meeting standards developed for this purpose by an independent, national accrediting organization. The Department will contract these IUROs.

(b) The Insurance Commissioner or designee shall appoint an IURO on a rotating basis to hear each appeal. The carrier shall be responsible for all costs associated with the appeal regardless of the final ruling, and shall reimburse the Department within 90 days of a final decision for the expenses related to the appeal process. In addition, upon the written request of an MCO, the Insurance Commissioner or designee shall have the discretion to appoint an IURO to conduct a preliminary review to determine if an appeal is clearly without merit. The cost of the preliminary review shall be borne by the MCO.

(c) Regulations promulgated under this section shall include the following requirements:

(1) Expert reviewers assigned by independent review organizations must be physicians or other appropriate health-care practitioners who meet the following minimum requirements:

a. Expert in the treatment of the covered person's medical condition, and knowledgeable about the recommended service or treatment through recent or current actual clinical experience treating patients with the same or similar medical conditions of the covered person.

b. Hold a nonrestricted license in a State of the United States, and for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of review.

c. Have no history of disciplinary action or sanctions (including but not limited to loss of staff privileges or participation restrictions) taken or pending by any hospital, government or regulatory body.

(2) The independent review organization shall submit to the Department the following information:

a. The names of all stockholders and owners of more than 5% of any stock or options, if a publicly held organization.

b. The names of all entities the independent review organization controls or is affiliated with, including the nature and extent of any ownership or control, including the affiliated organization's type of business.

c. The names of all directors, officers and executives of the independent review organization, as well as a statement regarding any relationships the directors, officers and executives may have with any health-care service plan, disability insurer, managed care organization, provider group or board or committee.

(3) Neither the expert reviewer, nor the independent review organization, has any material professional, familial or financial conflict of interest with any of the following:

a. The plan.

b. Any officer, director or management of the plan.

c. The physician, the physician's medical group or the independent practice association proposing the service or treatment.

d. The institution at which the service or treatment would be provided.

e. The development or manufacture of the principal drug, device, procedure or other therapy proposed for the covered person whose treatment is under review.

f. The covered person.

g. National, state or local trade association of health benefit plans or health-care providers.

(4) The independent review organization shall have a quality assurance mechanism in place that ensures the timeliness and quality of the reviews, the qualifications and independence of the experts, and the confidentiality of the medical records and review materials.

a. The Insurance Commissioner or designee shall establish procedures for transmitting the completed application for an appeal review to the independent review entity.

b. The independent review entity shall promptly review the pertinent medical records of the covered person to determine whether the carrier's denial, reduction or termination of benefits deprived the covered person of medically necessary services covered by the person's health benefits plan, based on applicable, generally accepted practice guidelines developed by the federal government, national or professional medical practice societies, boards or associations and any applicable clinical protocols or practice guidelines developed by the carrier. The organization shall complete its review and make its written determination within 45 days of receipt of a completed application for an appeal review. In no event shall appeals involving an imminent, emergent or serious threat to the health of the enrollee, as determined by the treating health-care practitioner, exceed 72 hours. Upon completion of the review, the entity shall state its findings in writing and make a determination of whether the carrier's denial, reduction or termination of benefits deprived the covered person of medically necessary services covered by the person's health benefits plan. If the organization determines that the denial, reduction or termination of benefits deprived the person of medically necessary covered services, it shall send a determination to the covered person and the carrier. The determination shall be binding on the carrier and the carrier shall promptly notify the person what action it intends to take to implement the determination.

c. Coverage for the services required under this section shall be provided subject to the terms and conditions generally applicable to benefits under coverage under the plan. Nothing in this section shall be construed to require the plan to pay for services of a nonparticipating physician that are not otherwise covered pursuant to the evidence of coverage under the plan.

d. The Insurance Commissioner or designee shall require the independent review organization to establish procedures to provide for an expedited review of a carrier's denial, reduction or termination of a benefit decision when a delay in receipt of the services could seriously jeopardize the health or well-being of the covered person.

e. The covered person's medical records provided to the program and the independent utilization review organization and the findings and recommendations of the organization made pursuant to this chapter are confidential and shall be used only by the Department, the organization and the affected carrier for the purposes of this chapter. The medical records and findings and determinations shall not otherwise be divulged or made public so as to disclose the identity of any person to whom they relate and shall not be included under any materials available to public inspection pursuant to Chapter 100 of Title 29.

f. A carrier may at any time determine to provide the requested medical services by so notifying the organization or the Insurance Commissioner or designee, as well as the covered person which notification shall terminate the review process. The cost of a partial review by an IURO shall be borne by the carrier.

(72 Del. Laws, c. 441, § 1; 75 Del. Laws, c. 362, § 2.)

§ 6418. Indemnification and immunity of employees.

(a) An employee of the Department who participates in the program shall not be liable in any action for damages to any person for any action taken within the scope of that employee's function in the program. The Attorney General shall defend the person in any civil suit and the State shall provide indemnification for any damages awarded.

(b) The carrier that is the subject of the review shall not be liable in any action for damages to any person for any action taken to implement a determination of the independent review organization pursuant to this chapter.

(c) Any physician serving on the IURO chosen by the Insurance Commissioner or designee to hear an appeal shall not be liable in any action for damages to any person for any action taken within the scope of that physician's function in the program.

(72 Del. Laws, c. 441, § 1; 70 Del. Laws, c. 186, § 1; 75 Del. Laws, c. 362, § 2.)

§ 6419. Violations; penalties.

(a) A carrier that violates any provision of this chapter shall be liable to a civil penalty of not less than $250 and not greater than $10,000 for each day that the carrier is in violation of the chapter if 10-days notice in writing is given of the intent to levy the penalty and, at the discretion of the Insurance Commissioner or designee, the carrier has 30 days, or such additional time as the Insurance Commissioner or designee shall determine to be reasonable, to remedy the condition which gave rise to the violation and fails to do so within the time allowed.

(b) The Insurance Commissioner or designee may issue an order directing a carrier or a representative of a carrier to cease and desist from engaging in any act or practice in violation of the provisions of this chapter.

(c) Within 20 days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this section have occurred. The hearing shall be conducted pursuant to the Administrative Procedure Act [Chapter 101 of Title 29], and judicial review shall be available as provided therein. This appeal shall not stay the cease and desist order.

(d) In the case of any violation of the provisions of this chapter, if the Insurance Commissioner or designee elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection (b) of this section, the Insurance Commissioner or designee may institute a proceeding to obtain injunctive relief in accordance with the applicable court rules.

(72 Del. Laws, c. 441, § 1; 75 Del. Laws, c. 362, § 2.)

§ 6420. Enforcement; adoption of rules and regulations.

The Insurance Commissioner shall enforce the provisions of this chapter. The Insurance Commissioner shall adopt rules and regulations, pursuant to the Administrative Procedure Act (Chapter 101 of Title 29), necessary to carry out the purposes of this chapter. The regulations shall establish procedures for protections defined in this chapter.

(72 Del. Laws, c. 441, § 1; 75 Del. Laws, c. 362, § 2; 78 Del. Laws, c. 226, § 2.)

Part I
Insurance
Chapter 65
Insurance for the Protection of the State
Subchapter I
General Provisions

§ 6501. Definitions.

As used in this chapter:

(1) "Administrator" means the Insurance Coverage Administrator, hereinafter established by § 6505 of this title.

(2) "The Committee" means the Insurance Coverage Determination Committee, hereinafter established by § 6502 of this title.

(3) "The Fund" means the State Self-Insurance Fund as provided for by subchapter III of this chapter.

(18 Del. C. 1953, § 6501; 57 Del. Laws, c. 187, § 2; 79 Del. Laws, c. 286, § 1.)

§ 6502. Insurance for the protection of the State and the public; determination of coverage.

There is hereby established the Insurance Coverage Determination Committee, which shall be composed of the Secretary of the Department of Human Resources, the State Auditor and the Insurance Commissioner or their designees, during their respective terms of office. The Secretary of the Department of Human Resources or his or her designee shall serve as the Chair of the Committee. The Committee shall from time to time determine the method of insuring, the amount of insurance, and the class of coverage covering any type of risk to which the State may be exposed, including, but not limited to: property insurance, as defined in § 904 of this title; surety insurance, as defined in § 905(a)(1) of this title; casualty insurance, as defined in § 906 of this title; marine and transportation and "wet marine" insurance, as defined in § 907 of this title; title insurance, as defined in § 908 of this title; to be effected and carried by the State or any subdivision thereof, including all school districts, but excluding, however, municipal corporations, counties, and the authorities relating to the crossings of the Delaware River and the Delaware Bay.

(18 Del. C. 1953, § 6502; 57 Del. Laws, c. 187, § 2; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 286, § 2; 81 Del. Laws, c. 66, § 14.)

§ 6503. Forms of coverage.

The Committee shall:

(1) Protect this State from loss to state-owned property;

(2) Protect the public from wrongful actions of state officials and employees and failure or malfunction of state-owned property;

(3) Secure for this State the maximum economic advantage feasible in the operation of its insurance coverage program, including, when deemed appropriate to such end, the utilization of blanket policies, deductible or excess loss insurance, and self-insurance;

(4) Determine such insurance protection as shall be required by the needs of the State and as shall be most economically advantageous to the State by providing for, as they shall deem appropriate, no insurance on small losses, coverage by commercial insurance, coverage by self-insurance or a combination of such methods.

(18 Del. C. 1953, § 6502A; 57 Del. Laws, c. 187, § 2.)

§ 6504. Rules and regulations.

The Insurance Coverage Administrator, with the approval of the Committee, shall promulgate such rules and regulations as shall be necessary to carry out the policy determinations of the Committee in administering the state insurance coverage program, so as to effectively provide coverage for the State whether same be procured from commercial insurance or by self-insurance or a combination of both.

(18 Del. C. 1953, § 6502B; 57 Del. Laws, c. 187, § 2; 79 Del. Laws, c. 286, § 3.)

§ 6505. Establishment of Insurance Coverage Office.

There is hereby established under the direction and supervision of the Secretary of the Department of Human Resources the Insurance Coverage Office, the executive head of which shall be the Insurance Coverage Administrator, who shall serve in the state classified service.

(18 Del. C. 1953, § 6503; 57 Del. Laws, c. 187, § 2; 79 Del. Laws, c. 286, § 4; 81 Del. Laws, c. 66, § 15.)

§ 6506. Qualifications of the Insurance Coverage Administrator.

The Administrator shall be qualified for the office by virtue of the Administrator's education and experience. The Administrator shall not be associated directly or indirectly with any insurance agency, firm or corporation. The Administrator shall be charged with and responsible for the administration of the Insurance Coverage Office as herein provided.

(18 Del. C. 1953, § 6504; 57 Del. Laws, c. 187, § 2; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 286, § 5.)

§ 6507. Salary of the Director of Insurance Coverage [Repealed].

(18 Del. C. 1953, § 6505; 57 Del. Laws, c. 187, § 2; repealed by 79 Del. Laws, c. 286, § 6, eff. July 1, 2014.)

§ 6508. Duties of the Insurance Coverage Office.

The Insurance Coverage Office shall provide:

(1) The placement of all insurance with commercial insurers as directed by the Committee;

(2) The operation of the Self-Insurance Fund, as established in subchapter III of this chapter;

(3) Centralized responsibility for the operation of the state insurance coverage program vested in a single agency with an adequate staff of legal, actuarial and administrative resources;

(4) The establishment and operation of an open bid procedure to be maintained for purchasing new insurance coverage from commercial insurers and renewing existing contracts with such commercial insurers which will permit the free forces of market competition to operate to the benefit of the state insurance coverage program;

(5) The keeping of all policies with commercial insurers and all records necessary and pertinent thereto in some safe and secure place;

(6) The keeping in some safe and secure place of all records, accounts, claims files, statistical studies and other such records and documents necessary and proper in the administration of the self-insurance program, when and if the Committee deems it proper to utilize same;

(7) The periodic preparation of reports as to the commercially procured insurance coverage part of the program which shall present the basic statistical-actuarial data pertaining to the experience of that part of the program and its component parts, which reports shall be public documents;

(8) Provide to the commercial insurance industry such information about bidding procedures as is required by the statutes of this State, so that any qualified commercial insurer may have an opportunity to offer its service to this State in the areas where the Committee has deemed it desirable to procure commercial coverage;

(9) Periodic comprehensive insurance surveys of program needs, and a continuing review of existing commercially procured insurance contracts, as well as analysis of commercial rates in terms of changing economic conditions, and periodic studies of commercial market conditions and developments;

(10) Such special investigations and reports as may be requested by the Committee Chair;

(11) Technical assistance to the volunteer fire departments in the State concerning insurance matters relating to their operations. Such assistance shall be given only at the request of the president of a company; and

(12) The implementation and monitoring of loss prevention activities.

(18 Del. C. 1953, § 6506; 57 Del. Laws, c. 187, § 2; 60 Del. Laws, c. 130, § 1; 79 Del. Laws, c. 286, § 7.)

§ 6509. Insurance by other agencies of the State.

No other agency of this State, for which coverage is herein provided, shall be authorized to place any insurance, any law to the contrary notwithstanding, and all insurance for such agencies shall be placed by and through the Insurance Coverage Office.

(18 Del. C. 1953, § 6507; 57 Del. Laws, c. 187, § 2; 79 Del. Laws, c. 286, § 8.)

§ 6510. Existing insurance contracts.

Existing insurance contracts and any renewals thereof may continue in full force and effect unless and until otherwise provided by the Administrator.

(18 Del. C. 1953, § 6508; 57 Del. Laws, c. 187, § 2; 79 Del. Laws, c. 286, § 9.)

§ 6511. Defense of sovereignty prohibited.

The defense of sovereignty is waived and cannot and will not be asserted as to any risk or loss covered by the state insurance coverage program, whether same be covered by commercially procured insurance or by self-insurance, and every commercially procured insurance contract shall contain a provision to this effect, where appropriate.

(18 Del. C. 1953, § 6509; 57 Del. Laws, c. 187, § 2.)

Subchapter II

Commercial Insurance

§ 6520. Placement of commercial insurance.

When the Administrator shall determine and declare it to be advisable to insure against a certain risk or risks with commercially procured insurance, with the approval of the Committee, then, as to such risk or risks, the Insurance Coverage Office shall provide for the placement of such insurance as shall be necessary with duly accredited and qualified commercial insurers. The purchase of all new insurance policies

and the renewal of all existing policies shall be by open bid procedure under rules and regulations promulgated by the Administrator calculated to permit the free forces of market competition to operate to the economic benefit of the state insurance coverage program.

(18 Del. C. 1953, § 6520; 57 Del. Laws, c. 187, § 2; 79 Del. Laws, c. 286, § 10.)

§ 6521. Payment of premiums on commercial insurance.

The estimated appropriation necessary for commercially procured insurance as authorized by § 6520 of this title for each fiscal year shall be determined by the Insurance Coverage Office and submitted to the Secretary of the Department of Human Resources for review and consideration as part of the annual budget requested by the Department. Upon appropriation by the General Assembly the funds shall be utilized by the Administrator for the payment of premiums for coverages.

(18 Del. C. 1953, § 6521; 57 Del. Laws, c. 187, § 2; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 286, § 10; 81 Del. Laws, c. 66, § 16.)

§ 6522. Administration and records.

The administration of the commercially insured part of the state insurance coverage program shall be the responsibility of the Insurance Coverage Office which shall keep in some safe and secure place all policies of insurance and all records pertaining thereto and such other records, reports, studies, analysis and correspondence as is necessary to effectuate the efficient and economic administration of the program.

(18 Del. C. 1953, § 6522; 57 Del. Laws, c. 187, § 2; 79 Del. Laws, c. 286, § 11.)

Subchapter III

Self-Insurance

§ 6530. Placement of self-insurance.

(a) When the Administrator shall determine and declare it to be advisable to insure against a certain risk or risks through a self-insurance program, then a request shall be made of the General Assembly in an amount equal to anticipated claims and expenses for a Self-Insurance Fund Contingency Account, hereinafter referred to as "the Fund."

(b) The Administrator shall be responsible for the administration of the Fund and the payment of claims and costs.

(c) In the event that the Committee shall elect to procure commercial insurance on risks which are self-insured, they may direct that the initial premium for such commercial policies covering such risk or risks shall be paid from the Fund.

(18 Del. C. 1953, § 6530; 57 Del. Laws, c. 187, § 2; 79 Del. Laws, c. 286, § 12.)

§ 6531. Capitalization of the State Self-Insurance Fund.

(18 Del. C. 1953, § 6531; 57 Del. Laws, c. 187, § 2; 59 Del. Laws, c. 279, § 1; repealed by 79 Del. Laws, c. 286, § 13, eff. July 1, 2014.)

§ 6532. Payment of premium allocations.

The estimated appropriation necessary for each fiscal year shall be determined by the Insurance Coverage Office and submitted to the Secretary of the Department of Human Resources for review and consideration as part of the annual budget requested by the Department. Upon appropriation by the General Assembly, the funds shall be utilized for the purposes of paying coverages.

(18 Del. C. 1953, § 6531A; 57 Del. Laws, c. 187, § 2; 59 Del. Laws, c. 279, § 2; 79 Del. Laws, c. 286, § 14; 81 Del. Laws, c. 66, § 17.)

§§ 6533, 6534. Maximum level of effective capitalization and termination of premium payments; Emergency Back-Up Fund.

Repealed by 59 Del. Laws, c. 279, § 3, effective Mar. 27, 1974.

§ 6535. Administration and custody of the State Self-Insurance Fund.

(18 Del. C. 1953, § 6532; 57 Del. Laws, c. 187, § 2; 63 Del. Laws, c. 142, § 38; repealed by 79 Del. Laws, c. 286, § 15, eff. July 1, 2014.)

§ 6536. Investment of moneys in the Fund.

(18 Del. C. 1953, § 6533; 57 Del. Laws, c. 187, § 2; 63 Del. Laws, c. 142, § 39; repealed by 79 Del. Laws, c. 286, § 16, eff. July 1, 2014.)

§ 6537. Provisions for deductible limits.

The Committee, from time to time, may declare and enforce such deductible limits on any insured risk covering loss to state-owned property, both real, personal and mixed, as it shall deem appropriate.

(18 Del. C. 1953, § 6534; 57 Del. Laws, c. 187, § 2.)

§ 6538. Provisions for reinsurance.

The Committee, from to time, may determine the advisability of purchasing commercial reinsurance contracts as to any risk or risks covered by the Fund and direct the Insurance Coverage Office to place such insurance, in such amount as the Committee shall have determined to be most feasible, in the manner herein provided for the placement of other commercial insurance coverage.

(18 Del. C. 1953, § 6535; 57 Del. Laws, c. 187, § 2; 79 Del. Laws, c. 286, § 17.)

§ 6539. Adjusting claims and paying losses.

The Insurance Coverage Office shall have the responsibility of adjusting all claims and paying all losses in risks covered by the Fund, and shall carry out its duties in conformity with appropriate regulations promulgated for that purpose by the Administrator, which regulations shall be in general conformity with the accepted practice in the commercial insurance industry in such matters, and shall be calculated to provide for prompt, efficient and equitable settlement procedures. The Insurance Coverage Office shall keep such records and files as shall be necessary and proper in its fulfillment of this obligation.

(18 Del. C. 1953, § 6536; 57 Del. Laws, c. 187, § 2; 79 Del. Laws, c. 286, § 18.)

§ 6540. Arbitration of disputes and litigation of claims.

(a) Any dispute between the Insurance Coverage Office and a state agency claimant, which cannot be amicably resolved, shall be referred to arbitration before an arbitrator selected by the Secretary of State. The expense of such arbitration will be borne by the disputants equally. The decision of the arbitrator will be final and binding upon the disputants.

(b) Any dispute between the Insurance Coverage Office and a claimant under the workers' compensation coverage, should same be covered by the Fund, which cannot be amicably resolved, shall be handled in the manner of a claim against a commercial insurer before the Industrial Accident Board with all normal rights of appeal.

(c) Any dispute between the Insurance Coverage Office and a claimant not otherwise covered in subsections (a) and (b) of this section, which cannot be amicably resolved, may be made the subject of litigation in any court of competent jurisdiction in this State.

(18 Del. C. 1953, § 6537; 57 Del. Laws, c. 187, § 2; 71 Del. Laws, c. 84, § 26; 79 Del. Laws, c. 286, § 19.)

§ 6541. Inspections of insured property.

The Insurance Coverage Office shall have available to it the services of the State Fire Marshal and the State Fire Marshal's deputies for the purpose of inspecting self-insured real and personal property of the State, and may call upon the Fire Marshal and State Fire Marshal's deputies to conduct such inspections of such property as are reasonable and necessary to determine the risk involved in insuring same and to provide the basis for requests or suggestions as to how undesirable hazards may be corrected; and the Fire Marshal and the State Fire Marshal's deputies shall cooperate with the Insurance Coverage Office in this regard, conducting such investigations as are requested and reporting the results thereof to the Insurance Coverage Office together with such recommendations as the investigator shall deem to be appropriate.

All state agencies, officials and employees will render full cooperation to the Fire Marshal and the Insurance Coverage Office in these matters and shall promptly correct such hazards as are found to exist, and failure to do so shall be referred to the Secretary of the Department of Human Resources by the Insurance Coverage Office for such remedial executive action as the Governor shall deem appropriate.

(18 Del. C. 1953, § 6538; 57 Del. Laws, c. 187, § 2; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 286, § 20; 81 Del. Laws, c. 66, § 18.)

§ 6542. Independent contractors.

The Administrator shall first employ all resources available in the Insurance Coverage Office, the Insurance Department, the office of the State Fire Marshal, the Justice Department, and the Auditor's Office before retaining independent contractors, but in the event that special expertise is required for the performance of the Administrator's duties not otherwise available or not readily available to the Administrator when required, then the Administrator is authorized and directed to contract for the services of such independent contractors as shall be best equipped to render such services, including, but not limited to, accountants, actuaries, claims adjusters and investigators, attorneys and engineers, which contracts shall be on an ad hoc or per case basis, and for which the Administrator is authorized to make payment by drafts upon the Fund as an administrative expense of the Fund.

(18 Del. C. 1953, § 6539; 57 Del. Laws, c. 187, § 2; 70 Del. Laws, c. 186, § 1; 79 Del. Laws, c. 286, § 21.)

§ 6543. Fidelity bonds.

In the event that the Committee determines and declares it advisable to self-insure the statutory required fidelity bonds of the officials and/or employees of the State or its herein covered subdivisions, and establishes a self-insurance program in that regard, then those provisions of the several statutes of this State requiring that such bonds be with corporate surety are superseded as to such bonds as are covered by such self-insurance program to the extent that said statutes required corporate surety.

(18 Del. C. 1953, § 6540; 57 Del. Laws, c. 187, § 2.)

Part I
Insurance

Chapter 66
Line-of-Duty Death Benefits

§ 6601. Definitions [For application of this section, see 79 Del. Laws, c. 434, § 3].

As used in this chapter:

(1) "College or university" shall mean any nonprofit college in the State which is accredited by the appropriate regional accrediting agency.

(2) "Covered person" is defined as a member of 1 of the following:

a. Enrolled firefighters, auxiliary and volunteer ambulance and rescue company members in good standing, either according to the rules of their Delaware volunteer company, or through their assignment to a municipal fire company;

b. National guardmembers on state duty pursuant to subchapter V of Chapter 1 of Title 20, and National Guard members activated for federal service under Title 10 of the United States Code;

c. Police officers of any jurisdiction of this State or its subdivisions;

d. Correctional officers and probation and parole officers employed by the Department of Correction;

e. State merit system employees who qualify for hazard pay under the state merit system regulations Nos. 5.1041 and 5.1042;

f. Drivers and attendants of ambulances owned or operated by the American Legion or Veterans of Foreign Wars for the benefit of the public; provided, however, that such ambulance drivers and attendants have been certified by the State;

g. The Fire Marshal, the Deputy Fire Marshals, Fire Inspectors, Fire Safety Engineer, and the Director, Senior Instructors and Field Instructors of the Delaware State Fire School;

h. Ambulance drivers and State-certified emergency medical technicians (EMTs) of ambulances owned or operated by ambulance or fire departments, counties, or municipalities for the benefit of the public;

i. Law-enforcement officers of the Department of Natural Resources and Environmental Control;

j. Employees of the Department of Transportation routinely employed in job-related activities upon the state highway system, such as toll operators, construction inspectors, equipment operators, bridge inspectors and maintenance staff, and survey crews;

k. Officers of the State Division of Alcohol, Tobacco, and Marijuana Enforcement;

l. Officers or agents of the State Police Drug Diversion Unit;

m. Officers or agents of the State Police Sex Offender Apprehension and Registration Unit (SOAR);

n. State forest officers and Special Forest Fire Wardens employed by the Department of Agriculture;

o. Paramedics of any jurisdiction of this State or its subdivisions;

p. Justices of the peace constables;

q. Sheriffs and deputy sheriffs;

r. Security officers, bailiffs and legal assistants performing services as bailiffs in the Supreme Court, Superior Court, Court of Chancery, Court of Common Pleas, Family Court and the Justice of the Peace Courts;

s. Employees of the Department of Natural Resources and Environmental Control while serving aboard watercraft and nonscheduled aircraft;

t. Employees of the Delaware Emergency Management Agency while traveling to, returning from or while performing official duties associated with natural, human error or technological emergencies, including all normal and special assignments;

u. Employees of the Department of Natural Resources and Environmental Control Environmental Response Team while traveling to, returning from, or while performing official duties associated with natural, human error, technological or other emergencies, including all normal and special assignments;

v. Agents employed by a state, county or municipal law-enforcement agency engaged in monitoring sex offenders;

w. Constables commissioned pursuant to Chapter 56 of Title 24; or

x. 911 dispatchers, as defined under § 10002 of Title 16.

(3) a. "Death in the line of duty" shall mean any death of a covered person under this chapter, arising out of and in the course of that person's assigned duty, including all normal and special assignments as ordered by that person's superiors or assignments undertaken while acting as a law-enforcement officer under rules, directions or regulations promulgated by the appropriate employing authority, within or outside of normal duty hours; provided, however, that death of a covered person occurring while that person is on active duty shall create a rebuttable presumption that such death was a death in the line of duty and that the burden of proof shall be on the employer to demonstrate by a preponderance of the evidence that such death was not a death in the line of duty.

b. "Death in the line of duty" with respect to enrolled firefighters, auxiliary members and volunteer ambulance and rescue company members as referred to in paragraph (2)a. of this section shall include in addition to other provisions of this section any death occurring while performing assigned duties, or while traveling to or returning from a fire alarm, rescue operation or any other emergency volunteer fire company action; provided, however, that the phrases "traveling to" and "returning from" shall include the time encompassed by the firefighters', auxiliary members' or volunteer ambulance and rescue company members' entrance into their personal vehicle or company emergency vehicle in response to the alarm or emergency call until their first disembarkation from their personal vehicle at their home, place of employment or other location.

c. Death in the line of duty shall not include:

1. Death from natural causes, except that death in the line of duty shall include death proximately resulting from a heart attack, stroke, or vascular rupture if the public safety officer, while on duty, engages in a situation involving nonroutine stressful or strenuous physical activity no more than 24 hours before said heart attack, stroke, or vascular rupture; or

2. Accidental death during travel to and from work, except in emergencies and in cases where a covered person is called upon to perform a duty in the course of such travel; or

3. Death as a result of disobedience to or exceeding of orders or instructions from superiors; or

4. Suicide.

(4) "Dependent children" shall include stepchildren, adopted children and children to whom the deceased stood in loco parentis, if members of the decedent's household at the time of death.

(18 Del. C. 1953, § 6601; 58 Del. Laws, c. 504, § 1; 59 Del. Laws, c. 135, § 1; 60 Del. Laws, c. 132, § 1; 60 Del. Laws, c. 389, § 1; 60 Del. Laws, c. 595, § 1; 63 Del. Laws, c. 71, §§ 1, 2; 63 Del. Laws, c. 453, §§ 1, 2; 65 Del. Laws, c. 2, § 3; 65 Del. Laws, c. 138, §§ 1, 2; 65 Del. Laws, c. 454, § 1; 66 Del. Laws, c. 311, § 1; 67 Del. Laws, c. 54, §§ 1, 2; 68 Del. Laws, c. 179, § 1; 69 Del. Laws, c. 78, § 2; 69 Del. Laws, c. 143, § 1; 69 Del. Laws, c. 300, § 2; 70 Del. Laws, c. 105, § 17; 70 Del. Laws, c. 186, § 1; 74 Del. Laws, c. 250, § 2; 74 Del. Laws, c. 396, § 3; 75 Del. Laws, c. 28, § 1; 76 Del. Laws, c. 402, § 1; 78 Del. Laws, c. 155, § 8; 78 Del. Laws, c. 371, § 1; 79 Del. Laws, c. 200, § 2; 79 Del. Laws, c. 386, § 1; 79 Del. Laws, c. 434, § 1; 83 Del. Laws, c. 454, § 4; 84 Del. Laws, c. 42, § 1; 84 Del. Laws, c. 518, § 1; 85 Del. Laws, c. 518, § 25.)

§ 6602. Payment for beneficiaries; tuition payments; burial expenses.

(a) Upon certification by the Insurance Commissioner that a claim under this chapter has been approved, the State Treasurer shall:

(1) For claims submitted prior to July 1, 1997, pay to the beneficiary or beneficiaries as designated or determined pursuant to § 6603(a) of this title of every covered person who dies in the line of duty an amount totaling $100,000, payable in annual installments with the maximum amount payable in any 1 calendar year being $20,000. For claims submitted on July 1, 1997, through June 30, 2017, pay to the beneficiary or beneficiaries as designated or determined pursuant to § 6603(a) of this title of every covered person who dies in the line of duty an amount totaling $150,000, payable in annual installments with the maximum amount payable in any 1 calendar year being $30,000. For claims submitted on July 1, 2017, and thereafter, pay to the beneficiary or beneficiaries as designated or determined pursuant to § 6603(a) of this title of every covered person who dies in the line of duty an amount totaling $200,000, payable in annual installments with the maximum amount payable in any 1 calendar year being $40,000. For claims submitted on July 1, 2023, and thereafter, pay to the beneficiary or beneficiaries as designated or determined pursuant to § 6603(a) of this title of every covered person who dies in the line of duty an amount totaling $375,000, payable in annual installments with the maximum amount payable in any 1 calendar year being $50,000. Installments shall terminate with the expiration of the beneficiary's eligibility;

(2) Pay, for no more than 4 years, directly to the institution involved, the amount of the tuition of each dependent child of such covered person who dies in the line of duty so long as such child is enrolled in a degree or certificate program at a college or university. The term "tuition" means any amount required for enrollment or attendance of a student. Such term does not include any amount paid directly or indirectly for meals, lodging, transportation, extracurricular activities, supplies, equipment, clothing or personal or family expenses;

(3) Unless any payment has been made pursuant to paragraph (a)(1) of this section, pay to the beneficiary or beneficiaries as designated or determined pursuant to § 6603(b) hereof of a covered person as defined in § 6601(2)a., b. or f. of this title who dies in the line of duty an amount totalling $25,000 payable in annual installments with the maximum amount payable in any 1 calendar year being $5,000. Installments shall terminate with the death of the last surviving beneficiary as determined pursuant to § 6603(b) of this title;

(4) Pay, if neither paragraph (a)(1) nor (3) of this section apply, to the estate of a covered person, as defined in § 6601(2)a., b. or f. of this title, who dies in the line of duty an amount not to exceed $5,000 to be used solely for expenses related to burial of such covered person;

(5) Pay for health insurance for dependent children for covered persons who died in the line-of-duty after January 1, 2004, until said dependent children attain the age of 26 years. Should health insurance be provided by the federal government, Tricare or similar program, for any of these dependent children, the dependent children shall only be eligible for state group health coverage in the event of loss of coverage under the federal health insurance plan.

(b) Notwithstanding any law to the contrary, there shall be no limit on the period of time during which a person may submit a claim for benefits under this chapter.

(18 Del. C. 1953, § 6602; 58 Del. Laws, c. 504, § 1; 63 Del. Laws, c. 71, § 3; 65 Del. Laws, c. 2, §§ 1, 2; 71 Del. Laws, c. 213, § 1; 79 Del. Laws, c. 216, § 1; 79 Del. Laws, c. 434, § 2; 81 Del. Laws, c. 121, § 1; 84 Del. Laws, c. 406, § 1.)

§ 6603. Designation or determination of beneficiary [For application of this section, see 79 Del. Laws, c. 434, § 3].

(a) Each covered person under this chapter shall submit to the person's employing state, county or municipal agency, volunteer fire department or ambulance operator, the name of the beneficiary or beneficiaries and alternate beneficiaries such covered persons wish to receive the payment provided for by § 6602(a)(1) of this title. Beneficiary designation will be submitted to the Insurance Commissioner with the submission of any claim. The covered person may designate that any payment shall be divided among 2 or more beneficiaries as provided by this subsection in any proportion. Only the spouse, children or parents of a covered person shall be eligible beneficiaries to receive payment under § 6602(a)(1) of this title. Should a designated beneficiary or beneficiaries be dead or ineligible, then eligible alternate beneficiaries shall take hereunder in the order indicated by the covered person. Should a covered person not designate a primary or alternate beneficiary or beneficiaries, the following in the order of position of eligibility shall receive the payment:

(1) Spouse, if alive, if not;

(2) Living children, the sum to be divided among the living children equally;

(3) Parents, each parent to take 50 percent if both are living.

(b) Each covered person, as defined in § 6601(2)a., b. or f. of this title, shall, if § 6602(a)(1) of this title and subsection (a) of this section do not apply, submit to such person's employing state, county or municipal agency, volunteer fire department or ambulance operator, the name of the beneficiary or beneficiaries such covered person wishes to receive the payment provided for by § 6602(a)(3) of this title. Beneficiary designations will be submitted to the Insurance Commissioner with the submission of any claim. Only the living parents of such covered person shall be eligible beneficiaries to receive payment under § 6602(a)(3) of this title. The covered person may designate that any payment shall be divided among 2 eligible beneficiaries in any proportion. Should a designated beneficiary be dead, then eligible alternate beneficiaries shall take hereunder as indicated by the covered person. Should the covered person not designate a primary or alternate eligible beneficiary or beneficiaries, the living parents, shall receive the payment, which shall be divided between the living parents equally.

(c) Payments under § 6602(a)(1) of this title in accordance with subsection (a) of this section shall take priority. Any payments pursuant to § 6602(a)(1) of this title and subsection (a) of this section shall preclude the applicability of § 6602(a)(3) of this title and subsection (b) of this section.

(18 Del. C. 1953, § 6603; 58 Del. Laws, c. 504, § 1; 63 Del. Laws, c. 71, § 4; 70 Del. Laws, c. 186, § 1; 71 Del. Laws, c. 213, § 2; 79 Del. Laws, c. 434, § 2.)

§ 6604. Records of agencies.

Every county and local police agency, volunteer and municipal fire department, the Department of Health and Social Services, the National Guard, the Department of Safety and Homeland Security and every organization providing voluntary ambulance service for the public shall, by July 1, 1972, record the names of all members of their organizations who are currently eligible for coverage under this chapter. These organizations shall make appropriate changes to their records when any person not previously eligible becomes eligible, and when 1 previously eligible becomes ineligible. The records will be subject to audit by the Insurance Commissioner.

(18 Del. C. 1953, § 6604; 58 Del. Laws, c. 504, § 1; 74 Del. Laws, c. 110, § 138.)

§ 6605. Administration of Fund; adjudication of claims.

(a) The Insurance Commissioner must receive claims against the Fund under this chapter. The Commissioner must determine the validity of all such claims and determine whether a death resulting in any such claim was in the line of duty under terms set forth in § 6601 of this title. In making such determinations, the Commissioner may seek the guidance of the Attorney General. As administrator of the Fund out of which benefits are paid under this chapter, the State Insurance Coverage Office established under Chapter 65 of this title has standing to contest any claim filed under this chapter, and the Commissioner must consider any such objections when rendering a decision on the validity of any claim.

(b) The Commissioner must hold a hearing on every contested claim, at which hearing the claimant may be represented by counsel. The Commissioner may determine uncontested claims on the papers. For all claims, the Commissioner must receive evidence, make findings, and render a decision. The Commissioner has the power to subpoena witnesses and records and administer oaths and must keep a written or taped record of all testimony given. The Commissioner must state, in writing, the Commissioner's findings and the reasons for the decision.

(c) The Commissioner may issue regulations governing the submission, processing, and adjudication of claims, including regulations governing hearings.

(18 Del. C. 1953, § 6605; 58 Del. Laws, c. 504, § 1; 70 Del. Laws, c. 186, § 1; 85 Del. Laws, c. 116, § 1.)

§ 6606. Appeals.

Any aggrieved claimant may appeal a decision of the Insurance Commissioner to Superior Court, which shall have final appellate jurisdiction under this chapter. Such appeal shall be an appeal on the record. Superior Court may, by rule, set forth the procedure for processing appeals under this chapter.

(18 Del. C. 1953, § 6606; 58 Del. Laws, c. 504, § 1.)

§ 6607. Payments to be diminished by amounts of other benefits.

Repealed by 65 Del. Laws, c. 273, § 1, effective May 28, 1986.

§ 6608. Source of payments under this chapter.

Payments made pursuant to this chapter shall be made from the State Self-Insurance Fund, as provided in Chapter 65 of this title. The General Assembly shall, when necessary, from time to time, provide for the adequate funding to the said Self-Insurance Fund to cover claims under this chapter.

(18 Del. C. 1953, § 6608; 58 Del. Laws, c. 504, § 1.)

§ 6609. Tax exemption for payments.

Payments made under this chapter to a beneficiary shall not be subject to Delaware income taxes or Delaware estate taxes.

(18 Del. C. 1953, § 6609; 58 Del. Laws, c. 504, § 1.)

Part I
Insurance
Chapter 67
Line-of-Duty Disability Benefits to Covered Firefighters

§ 6701. Definitions.

As used in this chapter, the following words and terms have the following meanings:

(1) "Covered firefighters" shall mean enrolled firefighters, ladies auxiliary members, and volunteer ambulance and rescue company members in good standing either according to the rules of their Delaware volunteer fire company or association or through their assignment to a municipal fire company. The use of the masculine gender throughout this chapter in referring to "covered firemen" shall also include the feminine gender where applicable.

(2) "Line of duty," with respect to enrolled firefighters, ladies auxiliary members and volunteer ambulance and rescue company members as defined in paragraph (1) of this section, shall mean while traveling to, performing their assigned duties or returning from, a fire alarm, rescue operation or any other emergency volunteer fire company action; provided, however, that the phrases "traveling to" and "returning from" shall include the time encompassed by the firefighter's, ladies auxiliary members' or volunteer ambulance and rescue company members' entrance into their personal vehicle or company emergency vehicle in response to the alarm or emergency call until their first disembarkation from their personal vehicle at their home, place of employment or other location.

(3) "Permanent disability" shall mean a permanent physical condition arising out of and in the course of actions in the line of duty, but shall not include permanent disability from an injury or disease, which, although aggravated in the line of duty, was not originally sustained in the line of duty; provided, however, that said permanent disability must be sufficient to disable the covered firefighter so that the firefighter is unable to do the work normally required for the job or employment which he or she held at the time he or she was disabled.

(59 Del. Laws, c. 484, § 1; 63 Del. Laws, c. 450, §§ 1, 2; 67 Del. Laws, c. 53, §§ 1, 2; 70 Del. Laws, c. 186, § 1.)

§ 6702. Payment of benefits.

Upon certification by the Commissioner that a claim under this chapter has been approved, the State Treasurer shall pay to a covered firefighter who has been permanently disabled in the line of duty, a benefit of $500 per month, plus $50 per month for each child under the age of 18 years, for so long as such shall remain.

(59 Del. Laws, c. 484, § 1; 70 Del. Laws, c. 186, § 1.)

§ 6703. Physical examinations.

No firefighter shall receive disability benefits under this chapter until he or she has been examined by a duly qualified physician or surgeon, selected by the firefighter or, if not selected by the firefighter, selected by the Commissioner for that purpose. If the firefighter is found to be permanently disabled, he or she shall be entitled to present a claim to the Commissioner. The examining doctor shall prepare a written report which shall be submitted to the Commissioner and shall be part of the records. Any firefighter receiving benefits under this chapter shall be examined periodically by a duly qualified physician or surgeon as required by the Commissioner to determine if such disability has ceased to exist.

(59 Del. Laws, c. 484, § 1; 70 Del. Laws, c. 186, § 1.)

§ 6704. Adjudication of claims.

(a) The Commissioner shall receive claims for disability benefits under this chapter. The Commissioner shall determine the validity of all such claims and determine whether a disability resulting in any such claim was in the line of duty under the terms set forth in § 6701 of this title. In making such determinations, the Commissioner may seek the guidance of the Attorney General. The Commissioner shall hold a hearing on every claim, at which hearing the claimant may be represented by counsel. The Commissioner shall, at the hearing, receive evidence, make findings and render a decision. The Commissioner shall have the power to subpoena witnesses and records and administer oaths and shall keep a written or taped record of all testimony given. The Commissioner shall state, in writing, the findings and the reasons for the decision.

(b) The Commissioner shall issue regulations governing the submission, processing, and adjudication of claims, including regulations governing hearings before him or her.

(c) The Commissioner shall make available the necessary forms for processing claims.

(d) The Commissioner shall insure that on the claim forms supplied to the applicant are spaces wherein the president and company chief, or any other 2 officers designated by the fire company, may, by oath or affirmation, depose the following:

"I, ...(name of officer), do hereby swear/affirm that .....(name of applicant), a member in good standing of the ..... Volunteer Fire Company, did sustain the injury or disease listed herein as the cause of the permanent disability claim, in the circumstances and on the date herein set forth.

(signed) .....

..... (Title of Officer) ”

Notwithstanding this section, the Insurance Commissioner may consider the submission of the above oath or affirmation as meeting the requirements for a hearing on every claim.

(59 Del. Laws, c. 484, § 1; 70 Del. Laws, c. 186, § 1.)

§ 6705. Appeals.

Any aggrieved claimant may appeal a decision of the Commissioner to Superior Court, which shall have final jurisdiction under this chapter. Such appeal shall be an appeal on the record. The Superior Court may, by rule, set forth the procedure for processing appeals under this chapter.

(59 Del. Laws, c. 484, § 1.)

§ 6706. Payments to be diminished by amounts of other benefits.

If any claimant under this chapter is entitled to receive, as a result of the same disability in the line of duty which gave rise to a claim under this chapter, any payment of state, federal, county or municipal funds or insurance proceeds from a policy paid entirely by the state, federal, county or municipal government in the form of a disability benefit, other than that provided for under this chapter, the payment pursuant to this chapter shall be reduced by the amount of such other payment or payments to which the claimant is entitled.

(59 Del. Laws, c. 484, § 1; 70 Del. Laws, c. 186, § 1.)

§ 6707. Source of payments under this chapter.

Payments made pursuant to this chapter shall be made from the State Self-Insurance Fund, as provided in Chapter 65 of this title. The General Assembly shall, when necessary, from time to time, provide for the adequate funding to the said Self-Insurance Fund to cover claims under this chapter.

(59 Del. Laws, c. 484, § 1.)

§ 6708. Exemption from tax and execution.

Payments made for permanent disability under this chapter are hereby exempted from any state, county or municipal tax and shall not be subject to execution or attachment or to any legal process whatsoever and shall be unassignable.

(59 Del. Laws, c. 484, § 1.)

Part I
Insurance

Chapter 67A
Volunteer Firefighters — Funeral Expenses

§ 6701A. Funeral expenses for deceased volunteer firefighters.

(a) The funeral expenses of a deceased member of a volunteer fire company, volunteer fire company ladies auxiliary, or volunteer ambulance and rescue company must be paid in the amount of $7,000.

(b) (1) An individual is eligible for funeral expenses under this chapter if the individual served, in this State, as an active member of a volunteer fire company, volunteer fire company ladies auxiliary, or volunteer ambulance and rescue company for at least 10 years.

(2) The 10 years of service required under paragraph (b)(1) of this section includes years of service as an active member of 1 or more volunteer fire companies, volunteer fire company ladies auxiliaries, or volunteer ambulance and rescue companies in this State.

(c) If an individual eligible for funeral expenses under this chapter was a state employee entitled to a benefit under § 8331 of Title 11, § 8395 of Title 11, § 8846 of Title 11, § 5316 of Title 29, or § 5546 of Title 29, the individual is also eligible for the benefit under this chapter.

(64 Del. Laws, c. 474, § 1; 67 Del. Laws, c. 176, § 1; 70 Del. Laws, c. 186, § 1; 72 Del. Laws, c. 284, § 1; 74 Del. Laws, c. 339, § 1; 85 Del. Laws, c. 215, § 1.)

§ 6702A. Source of payments under this chapter.

Payments made under this chapter must be made from the fund established under subchapter III of Chapter 65 of this title. The General Assembly shall, when necessary, provide adequate funding to the fund to cover claims under this chapter.

(85 Del. Laws, c. 215, § 1.)

§ 6750. Funeral expenses for deceased volunteer firefighters [Transferred].

Transferred to § 6701A of this title by 85 Del. Laws, c. 215, § 1, effective Oct. 1, 2025.

Part I
Insurance
Chapter 67B
Line-of-Duty Disability Policies for Certain Emergency Responders

(83 Del. Laws, c. 123, § 1.)

§ 6701B. Definitions [For application of this section, see 84 Del. Laws, c. 419, § 6].

For purposes of this chapter:

(1) "Active" means either of the following:

a. A paid service member who has worked at least 1,250 hours within the previous 12-month period.

b. A volunteer member with active status as defined by the volunteer member's individual fire or emergency service company.

(2) "Advanced-stage cancer" means a diagnosis by a board certified physician in the medical specialty appropriate for the type of cancer diagnosed that there are 1 or more malignant tumors characterized by the uncontrollable and abnormal growth and spread of malignant cells with invasion of normal tissue and that there is metastasis and:

a. Surgery, radiotherapy, or chemotherapy is medically necessary; or

b. There is a tumor of the prostate, provided that it is treated with radical prostatectomy or external beam therapy; or

c. The member has terminal cancer, their life expectancy is 24 months or less from the date of diagnosis, and will not benefit from, or has exhausted, curative therapy.

(3) "Cancer" means a malignant tumor characterized by the uncontrolled and abnormal growth and spread of malignant cells and invasion of normal tissue. This includes bladder, blood, brain, breast, cervical, esophageal, intestinal, kidney, lymphatic, lung, prostate, rectal, respiratory tract, skin, testicular, and thyroid cancer; leukemia, multiple myeloma; or non-Hodgkin's lymphoma.

(4) "Early-stage cancer" means a diagnosis by a board certified physician in the medical specialty appropriate for the type of cancer involved in that:

a. There is carcinoma in situ such that surgery, radiotherapy, or chemotherapy has been determined to be medically necessary;

b. There are malignant tumors which are treated by endoscopic procedures alone; or

c. There are malignant melanomas.

(5) "Emergency medical technician" ("EMT") means a person trained, and currently certified by the State Fire Prevention Commission, in emergency medical care procedures through a course that meets the objectives of the national scope of practice and maintains Delaware certification, who is faithfully and actually performing service in the State.

(6) "Faithful and actual service" (or any derivative thereof) means participation in the activities of a legally organized volunteer fire, ambulance, or emergency medical service department or company, fire school, or State Fire Marshal, or fire police or paramedic service.

(7) "Fire company" means a company in the State comprised of volunteer firefighters, fire police, paid employees of volunteer fire companies, volunteer ambulance companies, volunteer ambulance company members, paid employees of volunteer ambulance companies, and firefighters who are a part of an all-paid force.

(8) "Fire department" means a department in the State comprised of volunteer firefighters, fire police, paid employees of volunteer fire companies, volunteer ambulance companies, volunteer ambulance company members, paid employees of volunteer ambulance companies, and firefighters who are a part of an all-paid force.

(9) "Fire instructor" means an individual who actively teaches and holds a certificate to teach firefighter training courses, issued by and employed by the Delaware State Fire School.

(10) "Fire marshal" means a person who is an official responsible for enforcing fire regulations or investigating fires in the State under § 6612 of Title 16.

(11) "Fire police" means a member of a fire company who has taken the oath to perform police duties at fires, fire drills, and any emergencies or functions covered by the fire company.

(12) "Fit test" means the self-contained breathing apparatus fit test conducted yearly pursuant to requirements of 29 CFR § 1910.134 for an immediately dangerous to life and health atmosphere.

(13) "Paid firefighter" means a person who has been approved by the Delaware Fire School as a firefighter, as evidenced by an annual fit test, and who is faithfully and actually performing service in the protection of life and property from fire or other emergency, accident, or calamity in connection with which the service of the fire department or company is required.

(14) "Paramedic" means a person who is employed by a "county paramedic service" as defined in § 9802 of Title 16, has been approved by the National Registry of Emergency Medical Technicians or the Commission on Accreditation of Allied Health Education Programs (CAAHEP), maintains Delaware certification, and is faithfully and actually performing service in this State.

(15) "Policy" means a contract between the insurer and the insured which determines the claims which the insurer is legally required to pay based on the benefits outlined in § 6702B of this title.

(16) “Total disability” means a disability caused by cancer, that prevents an eligible member from being able to perform the substantial and material duties under the class in which they have applied for the benefits.

(17) “Volunteer firefighter” means a firefighter who is faithfully and actually performing service in the protection of life and property from fire or other emergency, accident, or calamity in connection with which the service of the fire department or company is required.

(18) “Years of service” means the years that the active member serves. If the active member serves in multiple classifications at the same time, the time will only be counted once.

(83 Del. Laws, c. 123, § 1; 84 Del. Laws, c. 42, § 1; 84 Del. Laws, c. 419, § 5; 84 Del. Laws, c. 514, § 41.)

§ 6702B. Benefits.

A policy shall be purchased by the Insurance Coverage Office on behalf of those who are eligible under § 6703B of this title for the following benefits. Lump sum cash benefit payable after diagnosis from a covered condition as follows:

(1) Early-stage cancer benefit — $5,000.

(2) Advanced-stage cancer benefit — $20,000.

a. The combined total of all lump sum benefits received during a member’s lifetime shall not exceed $40,000.

b. Monthly disability benefits for a period not to exceed 36 months, payable after diagnosis of a covered condition as follows:

1. Class 1 shall be all paid service members who are “active.”

A. The lesser of 60% of monthly salary or $4,000.

B. Such monthly benefit shall be subordinate to any other benefit actually paid to the member solely for such disability from any other source and shall be limited to the difference between the amount of such other paid benefit and the amount specified herein.

2. Class 2 shall be all personnel as described in § 6703B(a) of this title who do not meet the requirement of Class 1.

A. $1,500 per month.

B. Such monthly benefit shall be subordinate to any other benefit actually paid to the member solely for such disability from any other source, not including private insurance purchased solely by the member, and shall be limited to the difference between the amount of such other paid benefit and the amount specified herein.

(83 Del. Laws, c. 123, § 1.)

§ 6703B. Eligibility.

(a) A volunteer or paid firefighter, EMT, paramedic, fire instructor, fire marshal, and fire police will be eligible for coverage under this provision after 3 years of active service.

(b) Any person who was simultaneously a member of more than 1 class at the time of diagnosis shall not be entitled to receive benefits from, or on behalf of, more than 1 such class but is entitled to the higher of the 2 classes.

(c) A covered member of class 1 or class 2 of this provision shall remain eligible for benefits pursuant to § 6702B of this title for 60 months after the formal cessation of the member’s status as an active volunteer firefighter, paid firefighter, EMT, paramedic, fire instructor, fire marshal, or fire police.

(83 Del. Laws, c. 123, § 1.)

§ 6704B. Adjudication of claims.

Claims shall be filed with the insurer by the eligible volunteer or paid firefighter, EMT, paramedic, fire instructor, fire marshal, or fire police covered individual, representative, or estate.

(83 Del. Laws, c. 123, § 1.)

§ 6705B. Appeals.

Any aggrieved claimant may appeal a decision to the Department of Insurance. The Commissioner may hold a hearing on those claims at which time the Commissioner may receive evidence, make findings, and render a decision. If the claimant is not satisfied with the decision of the Commissioner, the claimant may appeal the decision to the Superior Court, which shall have final appellate jurisdiction under this chapter. Such appeal shall be an appeal on the record. Superior Court may, by rule, set forth the procedure for processing appeals under this chapter.

(83 Del. Laws, c. 123, § 1.)

§ 6706B. Payments to be diminished by amounts of other benefits.

If any claimant under the policy is entitled to receive, as a result of a covered disability, any other income, the payment pursuant to the policy shall be reduced by the amount of such other payment or payments to which the claimant is entitled.

(83 Del. Laws, c. 123, § 1.)

§ 6707B. Source of funding and administration of such policy.

(a) Administration of this policy and funding will be through the State Insurance Coverage Office. A separate budget line will be established in which the funds will be transferred from the State Treasurer to the State Insurance Coverage Office, pursuant to § 705(g) of this title, who will be responsible for paying the premium for the policy. In any policy year, should the amounts transferred pursuant to § 705(g) of this title be insufficient to fund the premium for the policy, the Fund as defined in § 6501 of this title will make up the shortfall.

(b) The Insurance Coverage Office will submit a copy of a quarterly stewardship report to the State Fire Commission and the Department of Insurance for their review.

(83 Del. Laws, c. 123, § 1; 84 Del. Laws, c. 512, § 2.)

§ 6708B. Exemption from tax and execution.

Benefits payable under the policy are hereby exempted from any state, county, or municipal tax and shall not be subject to execution or attachment or to any legal process whatsoever and shall be unassignable.

(83 Del. Laws, c. 123, § 1.)

§ 6709B. Statute of limitation

A claimant shall not bring forth a claim or action after 2 years following the time the claimant was diagnosed with a qualifying cancer as defined in § 6701B of this title.

(83 Del. Laws, c. 123, § 1.)

Part I
Insurance
Chapter 68
Health-Care Medical Negligence Insurance and Litigation
Subchapter I
Definitions

§ 6801. Definitions.

For the purpose of this chapter the following terms shall have the following meanings:

(1) “Category of health-care provider” means a type or class of health-care provider for which a separate license is required under Delaware law.

(2) “Commissioner” means the Insurance Commissioner of this State.

(3) “Health care” means any act or treatment performed or furnished, or which should have been performed or furnished, by any health-care provider for, to or on behalf of a patient during the patient’s medical care, treatment or confinement.

(4) “Health-care provider” means a person, corporation, facility or institution licensed by this State pursuant to Title 24, excluding Chapter 11 thereof, or Title 16 to provide health-care or professional services or any officers, employees or agents thereof acting within the scope of their employment; provided, however, that the term “health-care provider” shall not mean or include any nursing service or nursing facility conducted by or for those who rely upon treatment solely by spiritual means in accordance with the creed or tenets of any generally recognized church or religious denomination.

(5) “Informed consent” means the consent of a patient to the performance of health-care services by a health-care provider given after the health-care provider has informed the patient, to an extent reasonably comprehensible to general lay understanding, of the nature of the proposed procedure or treatment and of the risks and alternatives to treatment or diagnosis which a reasonable patient would consider material to the decision whether or not to undergo the treatment or diagnosis.

(6) “Medical negligence” means any tort or breach of contract based on health care or professional services rendered, or which should have been rendered, by a health-care provider to a patient. The standard of skill and care required of every health-care provider in rendering professional services or health care to a patient shall be that degree of skill and care ordinarily employed in the same or similar field of medicine as defendant, and the use of reasonable care and diligence.

(7) “Net direct premiums” means gross direct premiums, subscription dues, assessments, membership fees or other consideration received for or written on: a. Casualty insurance as defined in § 906(a) of this title, including the liability component of multiple peril policies as computed by the Commissioner; b. health insurance as defined in § 903 of this title; and c. health service contracts of health service corporations subject to Chapter 63 of this title, less the amount of any such consideration received which is returned on cancelled policies or contracts, the unabsorbed portion of any deposit premium and the amount returned to policyholders as dividends and similar returns, whether paid in cash or credit in reduction of premiums.

(8) “Patient” means a natural person who receives or should have received health care from a licensed health-care provider under a contract, express or implied.

(9) “Tail coverage” means insurance coverage, under a claims-made medical negligence insurance policy, for an alleged act of medical malpractice that occurred during the effective period of the policy but for which a claim was not made until after the policy was no longer in effect.

(60 Del. Laws, c. 373, § 1; 71 Del. Laws, c. 373, §§ 1, 3; 76 Del. Laws, c. 417, § 1; 84 Del. Laws, c. 393, § 1.)

Subchapter II
Jurisdiction of the Superior Court

§ 6802. Jurisdiction of the Superior Court.

(a) The Superior Court of the State shall have exclusive jurisdiction of civil actions alleging health care medical negligence.

(b) [Repealed.]

(60 Del. Laws, c. 373, § 1; 71 Del. Laws, c. 373, § 3; 84 Del. Laws, c. 393, § 2.)

Subchapter III
Medical Negligence Review Panels [Repealed]

§ 6803. Establishment of medical negligence review panels; purpose [Repealed].

(60 Del. Laws, c. 373, § 1; 71 Del. Laws, c. 373, § 3; repealed by 84 Del. Laws, c. 393, § 3, effective Aug. 29, 2024.)

§ 6804. Composition of panels; chairperson [Repealed].

(60 Del. Laws, c. 373, § 1; 70 Del. Laws, c. 186, § 1; 71 Del. Laws, c. 373, § 3; repealed by 84 Del. Laws, c. 393, § 3, effective Aug. 29, 2024.)

§ 6805. Method of selection of panel members [Repealed].

(60 Del. Laws, c. 373, § 1; 70 Del. Laws, c. 186, § 1; 71 Del. Laws, c. 373, § 3; repealed by 84 Del. Laws, c. 393, § 3, effective Aug. 29, 2024.)

§ 6806. Commissioner to administer process of selection of medical negligence review panel members; rules and regulations of medical negligence review panels [Repealed].

(60 Del. Laws, c. 373, § 1; 71 Del. Laws, c. 373, § 3; repealed by 84 Del. Laws, c. 393, § 3, effective Aug. 29, 2024.)

§ 6807. Evidence; duties of chairperson [Repealed].

(60 Del. Laws, c. 373, § 1; 71 Del. Laws, c. 373, § 3; repealed by 84 Del. Laws, c. 393, § 3, effective Aug. 29, 2024.)

§ 6808. Hearing before panel; procedure [Repealed].

(60 Del. Laws, c. 373, § 1; repealed by 84 Del. Laws, c. 393, § 3, effective Aug. 29, 2024.)

§ 6809. Panel's right to information; access of parties [Repealed].

(60 Del. Laws, c. 373, § 1; repealed by 84 Del. Laws, c. 393, § 3, effective Aug. 29, 2024.)

§ 6810. Panel's appointment and compensation of expert witness [Repealed].

(60 Del. Laws, c. 373, § 1; repealed by 84 Del. Laws, c. 393, § 3, effective Aug. 29, 2024.)

§ 6811. Opinion of panel; time for rendering [Repealed].

(60 Del. Laws, c. 373, § 1; 71 Del. Laws, c. 373, § 3; repealed by 84 Del. Laws, c. 393, § 3, effective Aug. 29, 2024.)

§ 6812. Report of panel admissible in evidence; witnesses; immunity of members [Repealed].

(60 Del. Laws, c. 373, § 1; 71 Del. Laws, c. 373, § 3; repealed by 84 Del. Laws, c. 393, § 3, effective Aug. 29, 2024.)

§ 6813. Compensation of panelists [Repealed].

(68 Del. Laws, c. 383, § 1; 71 Del. Laws, c. 373, § 3; repealed by 84 Del. Laws, c. 393, § 3, effective Aug. 29, 2024.)

§ 6814. Medical negligence review panels in federal court action [Repealed].

(60 Del. Laws, c. 373, § 1; 71 Del. Laws, c. 373, § 3; repealed by 84 Del. Laws, c. 393, § 3, effective Aug. 29, 2024.)

Subchapter IV

Reporting and Review of Claims

§ 6820. Reports; contents; when due.

(a) Every insurance carrier providing medical negligence coverage and who pays any amount for insurance coverage for any medical negligence claim shall file a report with the Commissioner within 60 days following the final disposition by agreement, settlement, order, adjudication, or otherwise of such medical negligence claim against the insurance carrier's insured. Such report shall include the following:

(1) The name of the insured.

(2) A detailed statement of the medical negligence claim asserted against the insured.

(3) A statement detailing the result or final disposition of the claim against the insured, including disclosure of the manner of the resolution or disposition of such claim, the amount ordered, adjudged or agreed to be paid by or on behalf of the insured, the amount paid by such insurance carrier on behalf of the insured as part of that settlement, adjudication or order and the total amount paid by such insurance carrier for attorney's fees, costs and expenses incurred on behalf of the insured.

(b) Except as otherwise required by this section or § 6821 of this title, information reported to the Commissioner shall be kept confidential, shall not be subject to disclosure to the public pursuant to the Freedom of Information Act, Chapter 100 of Title 29, or for any other reason, and shall not be subject to subpoena or any other legal process.

(c) A standard form to be used by insurance carriers making reports pursuant to this section shall be created jointly by the Commissioner and the Board of Medical Licensure and Discipline.

(d) The Commissioner shall, on an annual basis, submit to the General Assembly a report that shall not disclose any personal information but which shall provide the following aggregated statistical information:

(1) The number of separate medical negligence claims resolved or disposed of by agreement, by order, or by adjudication during the immediately preceding calendar year;

(2) The type of medical negligence claim made;

(3) The average amount paid in settlement of each such claim or the average amount ordered to be paid; and

(4) The average amount paid by insurance carriers for attorneys' fees, costs, and expenses incurred in defense of such claims.

Following its submission to the General Assembly, the Commissioner shall make the report submitted pursuant to subsection (d) of this section available to the public and to any medical negligence insurance carrier.

(60 Del. Laws, c. 373, § 1; 71 Del. Laws, c. 373, § 3; 75 Del. Laws, c. 109, § 1; 77 Del. Laws, c. 319, § 1.)

§ 6821. Disciplinary action.

(a) The Commissioner shall forward the name of every health-care provider against whom a settlement is made or judgment is rendered under this chapter to the appropriate agency for licensure or professional registration and examination for review of the fitness of the health-care provider to practice the profession. In each case involving review of a health-care provider's fitness to practice under this chapter, the agency shall have the power, in appropriate cases, to take the following disciplinary action:

(1) Censure, public or private;

(2) Imposition of probation for determinate period;

(3) Suspension of the health-care provider's license for a determinate period;

(4) Revocation of the license; or

(5) In the instance of institutional or corporate providers, the ordering of temporary or permanent cessation of the particular program, procedure or service resulting in the claim or judgment, and/or the ordering, monitoring and evaluation of corrective action necessary to bring such activity into compliance with contemporary standards.

(b) Review of the health-care provider's fitness to practice shall be conducted in accordance with the applicable procedures set forth in Title 16 or 24, or other applicable provisions, and shall include a determination of whether a provider has been shown to be unfit to continue the practice of the profession because of a series of actions presumed to be medical negligence, because of verdicts or settlements against the provider, or because of a single case in which the act or omission is considered to include gross negligence on the provider's part.

(60 Del. Laws, c. 373, § 1; 70 Del. Laws, c. 186, § 1; 71 Del. Laws, c. 373, § 3.)

Subchapter V

Joint Underwriting Association [Repealed]

§ 6830. Temporary Joint Underwriting Association [Repealed].

(60 Del. Laws, c. 373, § 1; 71 Del. Laws, c. 373, § 3; repealed by 84 Del. Laws, c. 393, § 4, effective Aug. 29, 2024.)

§ 6831. Plan of operation [Repealed].

(60 Del. Laws, c. 373, § 1; repealed by 84 Del. Laws, c. 393, § 4, effective Aug. 29, 2024.)

§ 6832. Policy forms and rates [Repealed].

(60 Del. Laws, c. 373, § 1; 71 Del. Laws, c. 373, § 3; repealed by 84 Del. Laws, c. 393, § 4, effective Aug. 29, 2024.)

§ 6833. Stabilization Reserve Fund [Repealed].

(60 Del. Laws, c. 373, § 1; 70 Del. Laws, c. 186, § 1; repealed by 84 Del. Laws, c. 393, § 4, effective Aug. 29, 2024.)

§ 6834. Procedures [Repealed].

(60 Del. Laws, c. 373, § 1; 71 Del. Laws, c. 373, § 3; repealed by 84 Del. Laws, c. 393, § 4, effective Aug. 29, 2024.)

§ 6835. Participation [Repealed].

(60 Del. Laws, c. 373, § 1; repealed by 84 Del. Laws, c. 393, § 4, effective Aug. 29, 2024.)

§ 6836. Directors [Repealed].

(60 Del. Laws, c. 373, § 1; repealed by 84 Del. Laws, c. 393, § 4, effective Aug. 29, 2024.)

§ 6837. Appeals and judicial review [Repealed].

(60 Del. Laws, c. 373, § 1; repealed by 84 Del. Laws, c. 393, § 4, effective Aug. 29, 2024.)

§ 6838. Annual statements [Repealed].

(60 Del. Laws, c. 373, § 1; repealed by 84 Del. Laws, c. 393, § 4, effective Aug. 29, 2024.)

§ 6839. Examinations [Repealed].

(60 Del. Laws, c. 373, § 1; repealed by 84 Del. Laws, c. 393, § 4, effective Aug. 29, 2024.)

§ 6840. Privileged communications [Repealed].

(60 Del. Laws, c. 373, § 1; 70 Del. Laws, c. 186, § 1; repealed by 84 Del. Laws, c. 393, § 4, effective Aug. 29, 2024.)

§ 6841. Public officers or employees [Repealed].

(60 Del. Laws, c. 373, § 1; 70 Del. Laws, c. 186, § 1; repealed by 84 Del. Laws, c. 393, § 4, effective Aug. 29, 2024.)

Subchapter VI

General Provisions

§ 6850. Legal terms as at common law.

Any legal term or word of art used in this chapter, not otherwise defined, shall have such meaning as is consistent with the common law.

(60 Del. Laws, c. 373, § 1.)

§ 6851. Agreement assuring result to be in writing.

No liability shall be imposed upon any health-care provider on the basis of an alleged breach of contract, express or implied, assuring results to be obtained from undertaking or not undertaking any diagnostic or therapeutic procedure in the course of health care, unless such contract is set forth in writing and signed by such health-care provider or by an authorized agent of such health-care provider.

(60 Del. Laws, c. 373, § 1.)

§ 6852. Informed consent.

(a) No recovery of damages based upon a lack of informed consent shall be allowed in any action for medical negligence unless:

(1) The injury alleged involved a nonemergency treatment, procedure or surgery; and

(2) The injured party proved by a preponderance of evidence that the health-care provider did not supply information regarding such treatment, procedure or surgery to the extent customarily given to patients, or other persons authorized to give consent for patients by other licensed health-care providers in the same or similar field of medicine as the defendant.

(b) In any action for medical negligence, in addition to other defenses provided by law, it shall be a defense to any allegation that such health-care provider treated, examined or otherwise rendered professional care to an injured party without his or her informed consent that:

(1) A person of ordinary intelligence and awareness in a position similar to that of the injured party could reasonably be expected to appreciate and comprehend hazards inherent in such treatment;

(2) The injured party assured the health-care provider he or she would undergo the treatment regardless of the risk involved or that he or she did not want to be given the information or any part thereof to which he or she could otherwise be entitled; or

(3) It was reasonable for the health-care provider to limit the extent of his or her disclosures of the risks of the treatment, procedure or surgery to the injured party because further disclosure could be expected to affect, adversely and substantially, the injured party's condition, or the outcome of the treatment, procedure or surgery.

(60 Del. Laws, c. 373, § 1; 70 Del. Laws, c. 186, § 1; 71 Del. Laws, c. 373, §§ 2, 3.)

§ 6853. Affidavit of merit, expert medical testimony.

(a) No health-care negligence lawsuit shall be filed in this State unless the complaint is accompanied by:

(1) An affidavit of merit as to each defendant signed by an expert witness, as defined in § 6854 of this title, and accompanied by a current curriculum vitae of the witness, stating that there are reasonable grounds to believe that there has been health-care medical negligence committed by each defendant. If the required affidavit does not accompany the complaint or if a motion to extend the time to file said affidavit as permitted by paragraph (a)(2) of this section has not been filed with the court, then the Prothonotary or clerk of the court shall refuse to file the complaint and it shall not be docketed with the court. The affidavit of merit and curriculum vitae shall be filed with the court in a sealed envelope which envelope shall state on its face:

"Confidential subject to 18 del. C., section 6853. The contents of this envelope May only be viewed by a judge of the superior court."

Notwithstanding any law or rule to the contrary the affidavit of merit shall be and shall remain sealed and confidential, except as provided in subsection (d) of this section, shall not be a public record and is exempt from Chapter 100 of Title 29.

(2) The court, may, upon timely motion of the plaintiff and for good cause shown, grant a single 60-day extension for the time of filing the affidavit of merit. Good cause shall include, but not be limited to, the inability to obtain, despite reasonable efforts, relevant medical records for expert review.

(3) A motion to extend the time for filing an affidavit of merit is timely only if it is filed on or before the filing date that the plaintiff seeks to extend. The filing of a motion to extend the time for filing an affidavit of merit tolls the time period within which the affidavit must be filed until the court rules on the motion.

(4) The defendant or defendants not required to take any action with respect to the complaint in such cases until 20 days after plaintiff has filed the affidavit or affidavits of merit.

(b) An affidavit of merit shall be unnecessary if the complaint alleges a rebuttable inference of medical negligence, the grounds of which are set forth below in subsection (e) of this section.

(c) *Qualifications of expert and contents of affidavit.* — The affidavit or affidavits of merit shall set forth the expert's opinion that there are reasonable grounds to believe that the applicable standard of care was breached by the named defendant or defendants and that the breach was a proximate cause of injury or injuries claimed in the complaint. An expert signing an affidavit of merit shall be licensed to practice medicine as of the date of the affidavit; and in the 3 years immediately preceding the alleged negligent act has been engaged in the treatment of patients and/or in the teaching/academic side of medicine in the same or similar field of medicine as the defendant or defendants, and the expert shall be Board certified in the same or similar field of medicine if the defendant or defendants is Board certified. The Board Certification requirement shall not apply to an expert that began the practice of medicine prior to the existence of Board certification in the applicable specialty.

(d) Upon motion by the defendant the court shall determine in camera if the affidavit of merit complies with paragraph (a)(1) and subsection (c) of this section. The affidavit of merit shall not be discoverable in any medical negligence action. The affidavit of merit itself, and the fact that an expert has signed the affidavit of merit, shall not be admissible nor may the expert be questioned in any respect about the existence of said affidavit in the underlying medical negligence action or any subsequent unrelated medical negligence action in which that expert is a witness.

(e) No liability shall be based upon asserted negligence unless expert medical testimony is presented as to the alleged deviation from the applicable standard of care in the specific circumstances of the case and as to the causation of the alleged personal injury or death; provided, however, that a rebuttable inference that personal injury or death was caused by negligence shall arise where evidence is presented that the personal injury or death occurred in any 1 or more of the following circumstances:

(1) A foreign object was unintentionally left within the body of the patient following surgery;

(2) An explosion or fire originating in a substance used in treatment occurred in the course of treatment; or

(3) A surgical procedure was performed on the wrong patient or the wrong organ, limb or part of the patient's body.

Except as otherwise provided herein, there shall be no inference or presumption of negligence on the part of a health-care provider.

(60 Del. Laws, c. 373, § 1; 70 Del. Laws, c. 186, § 1; 71 Del. Laws, c. 373, § 3; 74 Del. Laws, c. 148, § 1; 74 Del. Laws, c. 391, § 1; 84 Del. Laws, c. 393, § 5.)

§ 6854. Expert witness.

No person shall be competent to give expert medical testimony as to applicable standards of skill and care unless such person is familiar with the degree of skill ordinarily employed in the field of medicine on which he or she will testify.

(60 Del. Laws, c. 373, § 1; 62 Del. Laws, c. 274, § 1; 70 Del. Laws, c. 186, § 1; 70 Del. Laws, c. 415, § 1.)

§ 6855. Punitive damages.

In any action for medical negligence, punitive damages may be awarded only if it is found that the injury complained of was maliciously intended or was the result of wilful or wanton misconduct by the health-care provider, and may be awarded only if separately awarded by the trier of fact in a separate finding from any finding of compensatory damages which separate finding shall also state the amounts being awarded for each such category of damages. Injuries shall not be considered maliciously intended in instances in which unforeseen damage or injury results from intended medication, manipulation, surgery, treatment or the intended omission thereof, administered or omitted without actual malice or if the intended treatment is applied or omitted by mistake to or for the wrong patient or wrong organ.

(60 Del. Laws, c. 373, § 1; 71 Del. Laws, c. 373, § 3.)

§ 6856. General limitations.

No action for the recovery of damages upon a claim against a health-care provider for personal injury, including personal injury which results in death, arising out of medical negligence shall be brought after the expiration of 2 years from the date upon which such injury occurred; provided, however, that:

(1) Solely in the event of personal injury the occurrence of which, during such period of 2 years, was unknown to and could not in the exercise of reasonable diligence have been discovered by the injured person, such action may be brought prior to the expiration of 3 years from the date upon which such injury occurred, and not thereafter; and

(2) A minor under the age of 6 years shall have until the latter of time for bringing such an action as provided for hereinabove or until the minor's 6th birthday in which to bring an action.

(3) a. Notwithstanding any provision to the contrary, a cause of action based on the sexual abuse of a child patient by a health-care provider may be brought at any time following the commission of the act or acts that constituted the sexual abuse. A civil cause of action for sexual abuse of a child patient by a health-care provider shall be based upon sexual acts which would constitute a criminal offense under the Delaware Code.

b. Through July 13, 2012, a child patient who has been a victim of sexual abuse by a health-care provider which was discovered and reported to a person or legal entity specified in § 1731A of Title 24 or which was unknown to and could not in the exercise of reasonable diligence have been discovered by the child patient or a parent, guardian, and/or next friend of a child patient, and as

a consequence whose claim is barred by virtue of the expiration of the former civil statute of limitations, shall be permitted to file such claim in the Superior Court of this State. If the health-care provider committing the act of sexual abuse against a child patient was employed by an institution, agency, firm, business, corporation, or other public or private legal entity licensed by the State to provide health-care services that owed a duty of care to the child patient, or the health-care provider was engaged in some activity over which such legal entity had control, damages against such legal entity shall be awarded under this paragraph only if there is a finding of gross negligence on the part of the legal entity.

c. A person against whom a suit is filed may recover attorneys' fees where the Court determines that a false accusation was made with no basis in fact and with malicious intent. A verdict in favor of the accused shall not be the sole basis for a determination that an accusation was false. The Court must make an independent finding of an improper motive to award attorneys' fees under this section.

d. Nothing contained in this section shall apply to conduct by a health-care provider which is consistent with the recognized standard of care or the subject of a written consent.

(4) A plaintiff may toll the above statutes of limitations for a period of time up to 90 days from the applicable limitations contained in this section by sending a Notice of Intent to investigate to each potential defendant or defendants by certified mail, return receipt requested, at the defendant's or defendants' regular place of business. The notice shall state the name of the potential defendant or defendants, the potential plaintiff and give a brief description of the issue being investigated by plaintiff's counsel. The 90 days shall run from the last day of the applicable statute of limitations contained in this section. The notice shall not be filed with the court. If suit is filed after the applicable statute of limitations in this section, but before the 90-day period in this section expires, a copy of the notice shall be attached to the complaint to prove compliance with the statute of limitations.

(60 Del. Laws, c. 373, § 1; 71 Del. Laws, c. 373, § 3; 74 Del. Laws, c. 148, § 2; 74 Del. Laws, c. 391, §§ 2, 3; 77 Del. Laws, c. 384, § 1.)

§ 6857. Savings clause.

This chapter applies to actions, cases and proceedings brought after April 26, 1976, and also applies to any further conduct of actions, cases and proceedings then pending, except to the extent that application of this chapter would not be feasible, or would work injustice, in which event former procedures apply.

(60 Del. Laws, c. 373, § 1.)

§ 6858. Tail coverage for Veterans Administration hospital surgeons.

No insurance policy sold or delivered in this State providing insurance for acts of medical negligence or malpractice shall revoke the tail coverage of a retired physician as a consequence of that physician ending that physician's retirement for the specific and sole purpose of practicing medicine at a Veterans Administration facility in the State. Any contract language inconsistent with this section is void under Delaware law.

(76 Del. Laws, c. 417, § 2; 70 Del. Laws, c. 186, § 1.)

Subchapter VII

Compensation for Health Care Injuries

§ 6861. Advance payment; evidence thereof.

(a) Any advance payment made by a defendant health care provider or the provider's insurer to or for a plaintiff or any other person shall not be construed as an admission of liability for injuries or damages suffered by the plaintiff or anyone else in an action brought for health care medical negligence.

(b) Evidence of an advance payment shall not be admissible unless there is a final judgment in favor of the plaintiff, in which event the Court shall reduce the judgment to the plaintiff to the extent of the advance payment. The advance payment shall inure to the exclusive credit of the defendant or the defendant's insurer making the payment. In the event the advance payment exceeds the liability of the defendant or the insurer making it, the Court shall order any adjustment necessary to equalize the amount which each defendant is obligated to pay, exclusive of costs. In no case shall an advance payment in excess of an award be repayable by the person receiving it.

(60 Del. Laws, c. 373, § 1; 71 Del. Laws, c. 373, § 3.)

§ 6862. Collateral source.

In any medical negligence action for damages because of property damage or bodily injury, including death resulting therefrom, there may be introduced, and if introduced, the trier of facts shall consider evidence of: (1) Any and all facts available as to any public collateral source of compensation or benefits payable to the person seeking such damages (including all sums which will probably be paid payable to such person in the future) on account of such property damage or bodily injury; and (2) any and all changes, including prospective changes, in the marital, financial or other status of any persons seeking or benefiting from such damages known to the parties at the time of trial; provided, however, this section shall not be applicable to life insurance or private collateral sources of compensation or benefits.

(60 Del. Laws, c. 373, § 1; 71 Del. Laws, c. 373, § 3.)

§ 6863. Nonassignability of claims.

A claim for compensation under this chapter is not assignable; provided, however, that rights of subrogation shall not be deemed to constitute assignment.

(60 Del. Laws, c. 373, § 1.)

§ 6864. Periodic payments; reduction of awards in event of certain contingencies.

(a) Where a person recovers a judgment against a health-care provider, the Court may, after making a determination as to the amount of such judgment which was awarded as compensation for future pain and suffering, if any, the amount of such judgment awarded for future expenses of care of the injured party made necessary by reason of the injury involved, if any, and the amount of such judgment awarded as compensation for any other future damages, if any, direct that:

(1) There shall be deducted from the award, and paid to the plaintiff, an amount sufficient to cover the plaintiff's attorney's fees, expenses related to the litigation, expenses incurred for past health-care and pain and suffering incurred as of the date of said payment;

(2) The remainder of the award shall be paid to the plaintiff in equal or unequal monthly installments to be fixed by the Court for a period of time to be fixed by the Court; provided, however, that in addition thereto, medical expenses incurred and paid by plaintiff not otherwise reimbursed shall also be paid to plaintiff from the undistributed portion of the award;

(3) Each monthly installment shall, in addition, include a payment of interest on the then unpaid balance at a rate to be fixed by the Court.

(b) If a plaintiff receiving installment payments of a judgment shall die before the expiration of a 20-year period from the date of the award, and prior to the receipt by the plaintiff or on the plaintiff's behalf of all such installment payments, the Court shall deduct from the total of the installment payments then remaining unpaid the amount thereof representing compensation for future pain and suffering and future expenses of care made necessary by the injury involved, shall cause the balance of all such installments after such deduction to be paid to the estate of the plaintiff so dying and shall cause such judgment to be marked satisfied.

(c) If the plaintiff receiving installment payments shall die after the expiration of a 20-year period from the date of the award, then the payment shall automatically terminate as of the date of the plaintiff's death.

(60 Del. Laws, c. 373, § 1.)

§ 6865. Limitation on attorneys' fees.

(a) The amount of the claimant's attorneys' fees may not exceed the amounts in the following schedule:

(1) 35% of the first $100,000 of damages;

(2) 25% of the next $100,000 of damages;

(3) 10% of the balance of any awarded damages.

(b) Notwithstanding subsection (a) of this section, a claimant has the right to elect to pay for the attorneys' services on a mutually satisfactory per diem basis. The election, however, must be exercised in written form at the time of employment.

(60 Del. Laws, c. 373, § 1.)

Subchapter VIII

Study Commission

§§ 6870, 6871. Study Commission; submission of reports and proposed legislation.

Repealed by 67 Del. Laws, c. 105, § 1, effective July 12, 1989.

Part I
Insurance
Chapter 69
Captive Insurance Companies
Subchapter I
General Provisions

§ 6901. Finding; purpose.

(a) It is determined and declared as a matter of legislative finding that captive insurance companies can serve a valuable risk management function, and that their responsible utilization and the growth of the captive insurance industry in the State of Delaware are in the best interests of this State.

(b) It is further determined and declared that the purpose and policy of this chapter shall be:

(1) To provide for the regulation of captive insurance companies consistent with their nature and purpose;

(2) To provide flexibility and opportunity to captive insurance companies and to persons utilizing them; and

(3) To foster economic development in this State through the growth of the captive insurance industry.

(75 Del. Laws, c. 150, § 1.)

§ 6902. Definitions.

As used in this chapter, unless the context requires otherwise:

(1) "Affiliated company" means any person (other than a natural person in that person's individual capacity) in the same corporate system as a parent, an industrial insured, or an association member by virtue of common ownership, control, operation, or management.

(2) "Agency captive insurance company" shall mean an insurance company described in paragraphs (2)a. and b. of this section:

a. An insurance company that is owned or controlled by an insurance agency, brokerage or reinsurance intermediary, or an affiliate thereof, or under common ownership or control with such agency, brokerage or reinsurance intermediary, and that only insures the risks of insurance or annuity contracts placed by or through such agency, brokerage or reinsurance intermediary; or

b. An insurance company that is owned or controlled by a marketer or producer of service contracts and/or warranties, and that only insures or reinsures the contractual liability arising out of such service contracts or warranties sold through such marketer or producer.

c. For the purposes of this paragraph (2), "common ownership or control" shall mean ownership of 10 percent or more of the voting securities of a person or such other form of ownership or control as the Commissioner may approve.

(3) "Alien" means formed under the laws of any country or jurisdiction other than the United States of America or any of its states, districts, commonwealths and possessions.

(4) "Alien captive insurance company" means any captive insurance company formed to write insurance business of a nature that the Commissioner determines is otherwise permissible under this chapter and is licensed pursuant to the laws of an alien jurisdiction which imposes statutory or regulatory standards in a form acceptable to the Commissioner on companies transacting the business of insurance in such jurisdiction.

(5) "Association" means any legal association of persons that has been in continuous existence for at least 1 year or such lesser period of time approved by the Commissioner, the association members of which, or which does itself, whether or not in conjunction with some or all of the association members:

a. Directly or indirectly, own, control or hold with power to vote all of the outstanding voting securities or other voting interests of, or have complete voting control over, an association captive insurance company; or

b. Constitute all of the subscribers of an association captive insurance company organized as a reciprocal insurer.

(6) "Association captive insurance company" means any captive insurance company that insures risks of the association members of the association and any of their affiliated companies.

(7) "Association member" means any person that belongs to an association.

(8) "Branch business" means any insurance business transacted by a branch captive insurance company in this State.

(9) "Branch captive insurance company" means any foreign captive insurance company or alien captive insurance company that has been issued a certificate of authority by the Commissioner to transact the business of insurance in this State through a business unit with a principal place of business in this State, and has not otherwise been issued a certificate of authority by the Commissioner to transact insurance under this chapter.

(10) "Branch operations" means any business operations of a branch captive insurance company in this State.

(11) "Capital and surplus" means the amount by which the value of all of the assets of the captive insurance company exceeds all of the liabilities of the captive insurance company, as determined under the method of accounting utilized by the captive insurance company in accordance with the applicable provisions of this chapter.

(12) “Captive insurance company” means any pure captive insurance company, association captive insurance company, agency captive insurance company, sponsored captive insurance company, industrial insured captive insurance company, special purpose captive insurance company, special purpose financial captive insurance company, series captive insurance company, or risk retention group, whether domestic, foreign or alien, or branch captive insurance company, licensed under the provisions of this chapter.

(13) “Commissioner” means the Insurance Commissioner of this State.

(14) “Controlled unaffiliated business” means any person (other than a natural person in that natural person’s individual capacity):

a. That is not in the corporate system of a parent and its affiliated companies;

b. That has an existing contractual relationship with such parent or any such affiliated company; and

c. Whose risks are managed by a pure captive insurance company in accordance with § 6919 of this title.

(15) “Department” has the meaning given such term in § 102 of this title.

(16) “Domestic” means formed under the laws of this State.

(17) “Dormant captive insurance company” means a captive insurance company which meets all of the following criteria for a continuous 12-month period:

a. The company did not do all of the following:

1. Contract for, or collect, any direct premium.

2. Contract for, or assume, any reinsurance premium.

b. The company was not obligated as an insurance company of any type under any contract of insurance or reinsurance issued or entered into during any year in which it is a dormant captive insurance company.

c. The company has provided written notice to the Commissioner of its intention to be treated as a dormant captive insurance company and certifies to the matters set forth in paragraphs (17)a. and b. of this section.

(18) “Excess workers’ compensation insurance” means, in the case of an employer that has insured its workers’ compensation risks in accordance with applicable law, insurance in excess of a specified per-incident or aggregate limit established by the Commissioner. Notwithstanding the foregoing, the per-incident and aggregate limit to be utilized by the Commissioner in establishing the excess workers compensation threshold for employers that are authorized under applicable law to self insure their workers compensation risks shall be $0.00.

(19) “Foreign” means formed under the laws of any state.

(20) “Industrial insured” means an insured:

a. Who procures the insurance of any risk or risks by use of the services of a full-time employee acting as an insurance manager or buyer;

b. Whose aggregate annual premiums for insurance on all risks total at least $25,000; and

c. Who has at least 25 full-time employees.

(21) “Industrial insured captive insurance company” means any captive insurance company that insures risks of the industrial insureds that comprise the industrial insured group and any of their affiliated companies.

(22) “Industrial insured group” means any group of industrial insureds that collectively:

a. Directly or indirectly, own, control, or hold with power to vote all of the outstanding voting securities or other voting interests of, or have complete voting control over, an industrial insured captive insurance company; or

b. Constitute all of the subscribers of an industrial insured captive insurance company organized as a reciprocal insurer.

(23) “Insurance” has the meaning given such term in § 102 of this title.

(24) “Insurer” has the meaning given such term in § 102 of this title.

(25) “Mutual insurer” has the meaning given such term in § 502 of this title. A captive insurance company incorporated as a nonstock corporation, in which the policyholders are the members, is a mutual insurer.

(26) “Parent” means a person that directly or indirectly owns, controls, or holds with power to vote more than 50 percent of the outstanding voting securities or other voting interests of a pure captive insurance company.

(27) “Person” means a natural person, partnership (whether general or limited), trust, estate, association, corporation, limited liability company, statutory trust, business trust, custodian, nominee or any other individual or entity in its own or any representative capacity, in each case whether domestic, foreign, or alien.

(28) “Protected cell” has the meaning given such term in § 6932(3) of this title.

(29) “Pure captive insurance company” means a captive insurance company that insures risks of 1 or more of the following:

a. Its parent.

b. Its parent’s affiliated companies.

c. A controlled unaffiliated business.

(30) “Reciprocal insurer” has the meaning given such term in § 503 of this title.

(31) “Risk retention group” means a risk retention group formed pursuant to the Liability Risk Retention Act of 1986, 15 U.S.C. § 3901 et seq., as amended.

(32) "Series" means a series established under § 17-218(b), § 18-215(b), or § 18-218 of Title 6, § 3804(a) of Title 12, or corresponding law of another state.

(33) "Series captive insurance company" means a series which has received a certificate of authority pursuant to this chapter.

(34) "Special purpose captive insurance company" means any person that is licensed under this chapter and designated as a special purpose captive insurance company by the Commissioner.

(35) "Special purpose financial captive insurance company" means a captive insurance company that is granted a certificate of authority under subchapter III of this chapter of this title.

(36) "Sponsored captive insurance company" has the meaning given such term in § 6932(5) of this title.

(37) "State" means the State of Delaware, and "state" means any other state, district, commonwealth or possession of the United States of America.

(38) "Transacting insurance" has the meaning given such term in § 103 of this title.

(64 Del. Laws, c. 454, § 1; 70 Del. Laws, c. 186, § 1; 75 Del. Laws, c. 150, § 1; 76 Del. Laws, c. 161, § 1; 77 Del. Laws, c. 252, §§ 1-4; 80 Del. Laws, c. 46, § 3; 81 Del. Laws, c. 148, § 1; 83 Del. Laws, c. 50, § 1.)

§ 6903. License application; certificate of authority.

(a) Any person complying with § 6906 of this title may apply to the Commissioner for a certificate of authority to do any and all insurance business comprised in §§ 902-905, 906(a)(1),(2), (4)-(15) and (b), 907 and 908 of this title and to issue annuities as defined in § 2902 of this title; provided, however, that:

(1) No pure captive insurance company may directly insure any risks other than those of any 1 or more of the following:

a. Its parent.

b. Its parent's affiliated companies.

c. A controlled unaffiliated business.

(2) No association captive insurance company:

a. Organized as a reciprocal insurer may insure any risks that a reciprocal insurer is not permitted to insure under Chapter 57 of this title; and

b. May insure any risks other than those of the association members of its association and their affiliated companies, provided that an association captive insurance company may insure risks of any other person if the insurance for such other persons satisfies each of the following requirements:

1. The insurance lines for such other persons must be the same as are authorized by the Commissioner to be written by the association captive insurance company for its association members;

2. Such other persons conduct the same or a related or similar business as that of the association members of the association captive insurance company; and

3. The maximum amount of premiums received in any year from all such other persons cannot without the express written consent of the Commissioner exceed 50% of the gross direct premiums received by the association captive insurance company from its association members in its preceding financial year;

(3) No industrial insured captive insurance company:

a. Organized as a reciprocal insurer may insure any risks that a reciprocal insurer is not permitted to insure under Chapter 57 of this title; and

b. May insure any risks other than those of the industrial insureds of its industrial insured group and their affiliated companies, provided that an industrial insured captive insurance company may insure risks of any other person (other than a natural person in his or her individual capacity) if the insurance for such other persons satisfies each of the following requirements:

1. The insurance lines for such other persons must be the same as are authorized by the Commissioner to be written by the industrial insured captive insurance company for its industrial insureds;

2. Such other persons conduct the same or a related or similar business as that of the industrial insureds of the industrial insured captive insurance company; and

3. The maximum amount of premiums received in any year from all such other persons cannot without the express written consent of the Commissioner exceed 50% of the gross direct premiums received by the industrial insured captive insurance company from its industrial insureds in its preceding financial year;

(4) No risk retention group may insure any risks other than risks that may be insured by a risk retention group under Chapter 80 of this title;

(5) A special purpose captive insurance company may, in addition to the authority set forth in this section for captive insurance companies, provide insurance or reinsurance, or both, for such other risks as approved by the Commissioner;

(6) No captive insurance company may provide personal motor vehicle or homeowner's insurance coverage or any component thereof;

(7) No captive insurance company may accept or cede reinsurance except as provided in § 6911 of this title;

(8) Any captive insurance company may provide excess workers' compensation insurance to its parent and affiliated companies, unless prohibited by federal law or laws of this State or any other state having jurisdiction over the transaction, and any captive insurance company, unless prohibited by federal law, may reinsure workers' compensation of a qualified self-insured plan of its parent and affiliated companies; and

(9) A series may elect to apply for a certificate of authority as a pure, agency, association, industrial insured, or special purpose captive insurance company; or a series may elect to be licensed as a series captive insurance company.

(b) No captive insurance company shall do any insurance business in this State unless:

(1) It is authorized by the Commissioner to do insurance business in this State under 1 of the following:

a. A certificate of authority under subsection (f) of this section; or

b. A conditional certificate of authority under subsection (g) of this section;

(2) Its board of directors, members, partners, managers, committee of managers or other governing body, or in the case of a reciprocal insurer, its subscribers' advisory committee, holds at least 1 meeting each year in this State, provided that this requirement shall not apply to:

a. A branch captive insurance company; or

b. A captive insurance company that has 5 or more full-time employees each of whom has that employee's principal place of employment in this State;

(3) It maintains its principal place of business in this State or, in the case of a branch captive insurance company, it maintains in this State a principal place of business in accordance with the provisions of § 6972(c) of this title; and

(4) It identifies in its application for a certificate of authority its registered office in this State and its registered agent located at such office to accept service of process on its behalf and to otherwise act as its registered agent in this State, provided that whenever such registered agent cannot with reasonable diligence be found at the registered office of the captive insurance company, the Commissioner shall be an agent of such captive insurance company upon whom any process, notice or demand may be served.

(c) (1) Before receiving a certificate of authority, an applicant captive insurance company shall file with the Commissioner a certified copy of its organizational documents, a statement under oath of its president or other authorized person showing its financial condition, and any other statements or documents required by the Commissioner.

(2) Each applicant captive insurance company shall also file with the Commissioner evidence of the following:

a. The amount and liquidity of its assets relative to the risks to be assumed;

b. The adequacy of the expertise, experience, and character of the person or persons who will manage it;

c. The overall soundness of its plan of operation;

d. The adequacy of the loss prevention programs of its insureds; and

e. Such other factors deemed relevant by the Commissioner in ascertaining whether the proposed captive insurance company will be able to meet its policy obligations.

(d) (1) Each applicant captive insurance company shall pay to the Commissioner a nonrefundable application fee of $300 for reviewing its application to determine its completeness, and a nonrefundable processing fee of $3,200 for examining, investigating, and processing its application for a certificate of authority.

(2) The Commissioner may retain legal, financial and examination services, and other expert services from outside the Department and may charge the applicant the reasonable cost of these services.

(3) The provisions of § 330 of this title apply to reviews, examinations, investigations, and processing conducted under this section.

(4) In addition to any other fee imposed or cost assessed under this section, each captive insurance company shall pay a nonrefundable license fee for the year of registration and a nonrefundable renewal fee for each year thereafter of $400.

(5) A captive insurance company that files an application for a conditional certificate of authority under subsection (g) of this section must pay the Commissioner a fee of $100.

(e) For conducting regulatory reviews, investigations, or processing, the Commissioner is authorized to retain legal, financial and examination services and other expert services from outside the Department, the reasonable cost of which may be charged against the applicant or captive insurance company.

(f) If the Commissioner is satisfied that the documents and statements that such captive insurance company has filed comply with the provisions of this chapter, the Commissioner may grant a certificate of authority authorizing it to do insurance business in this State until April 1 thereafter, which certificate of authority may be renewed.

(g) (1) Before the completion of the Commissioner's review of a captive insurance company's application materials, the Commissioner may issue a conditional certificate of authority upon the Commissioner's receipt of all of the following:

a. Satisfactory evidence of the captive insurance company's possession of the minimum required capital and surplus set forth in § 6905 of this title; and

b. The application materials required by this chapter; and

c. A statement of compliance signed by the owner of the captive insurance company stating that to the best of the owner's belief the business plan and other documents filed with the application for a conditional certificate of authority comply with all of the following:

1. All licensing requirements mandated by this chapter; and

2. Any additional requirements the Commissioner establishes by regulation or rule.

(2) The Commissioner may summarily revoke a conditional certificate of authority without legal recourse by the captive insurance company if 1 of the following applies:

a. The Commissioner is unable to verify within 6 months of the issuance of the conditional certificate of authority that the captive insurance company possesses the minimum required capital and surplus indicated on the form submitted to the Department for issuance of the conditional certificate of authority; or

b. The Commissioner determines that the business plan or other documents filed with the application for a certificate of authority do not comply with all of the following:

1. All licensing requirements mandated by this chapter; and

2. Any additional requirements the Commissioner establishes by regulation or rule.

(3) Upon the issuance of a conditional certificate of authority under this subsection, the captive insurance company shall comply with and be subject to this chapter.

(64 Del. Laws, c. 454, § 1; 70 Del. Laws, c. 107, § 1; 70 Del. Laws, c. 186, § 1; 75 Del. Laws, c. 150, § 1; 76 Del. Laws, c. 161, §§ 2, 3; 77 Del. Laws, c. 252, § 5; 80 Del. Laws, c. 46, §§ 4-6; 81 Del. Laws, c. 453, § 1; 83 Del. Laws, c. 50, § 2.)

§ 6904. Company name.

No captive insurance company shall adopt a name that is the same as, deceptively similar to, or likely to be confused with or mistaken for, any other existing business name registered in this State.

(64 Del. Laws, c. 454, § 1; 75 Del. Laws, c. 150, § 1.)

§ 6905. Minimum capital and surplus; letter of credit.

(a) No captive insurance company shall be issued a certificate of authority unless it shall possess and thereafter maintain capital and surplus of:

(1) In the case of a pure captive insurance company, not less than $250,000;

(2) In the case of an association captive insurance company, not less than $750,000;

(3) In the case of an industrial insured captive insurance company, not less than $500,000;

(4) In the case of an agency captive insurance company, not less than $250,000;

(5) In the case of a risk retention group, not less than $1,000,000;

(6) In the case of a sponsored captive insurance company, not less than $500,000;

(7) In the case of a special purpose captive insurance company, not less than $250,000 or such other amount determined by the Commissioner;

(8) In the case of a branch captive insurance company, not less than $250,000 or such other amount determined by the Commissioner;

(9) In the case of a special purpose financial captive insurance company that is also a sponsored captive insurance company, not less than $500,000, and in the case of a special purpose financial captive insurance company that is not also a sponsored captive insurance company, not less than $250,000; and

(10) In the case of a series captive insurance company, the minimum capital and surplus shall be an amount as specified by the Commissioner.

(b) In connection with the issuance of a certificate of authority, the Commissioner may prescribe additional minimum capital and surplus based upon the type, volume, and nature of insurance business transacted.

(c) (1) Minimum capital and surplus described in this section shall be maintained in the form of cash, an irrevocable letter of credit issued by a financial institution chartered by or licensed or otherwise authorized to do banking business in this State, or by any other financial institution approved by the Commissioner, or such other assets as may be approved by the Commissioner.

(2) Minimum capital and surplus described in this section held in the form of cash or other assets approved by the Commissioner shall be maintained in a financial institution approved by the Commissioner and in compliance with any condition imposed by the Commissioner.

(d) Notwithstanding the foregoing, the minimum capital and surplus funds may be proceeds received by the captive insurance company resulting from the issuance by the captive insurance company of a surplus note as approved by the Commissioner.

(64 Del. Laws, c. 454, § 1; 75 Del. Laws, c. 150, § 1; 76 Del. Laws, c. 161, §§ 4, 5; 77 Del. Laws, c. 252, §§ 6, 7; 80 Del. Laws, c. 46, § 7; 84 Del. Laws, c. 392, § 1.)

§ 6906. Formation of captive insurance companies.

(a) A pure captive insurance company may be any of the following:

(1) Incorporated as a stock corporation or as a nonstock corporation.

(2) Formed as a limited liability company, partnership, limited partnership, series, or statutory trust, including a limited liability company, limited partnership, or statutory trust having 1 or more series.

(b) An association captive insurance company or an industrial insured captive insurance company may be any of the following:

(1) Incorporated as a stock corporation or as a nonstock corporation.

(2) Formed as a limited liability company, partnership, limited partnership, statutory trust, or series.

(3) Organized as a reciprocal insurer.

(c) A special purpose captive insurance company, special purpose financial captive insurance company, agency captive insurance company, or branch captive insurance company may be any of the following:

(1) Incorporated as a stock corporation or as a nonstock corporation.

(2) Formed as a limited liability company, partnership, limited partnership, or statutory trust, including a limited liability company, limited partnership, or statutory trust having 1 or more series.

(3) Such other person, other than a natural person in that natural person's individual capacity, approved by the Commissioner.

(d) A sponsored captive insurance company, including a sponsored captive insurance company that is also a special purpose financial captive insurance company, may be any of the following:

(1) Incorporated as a stock corporation or as a nonstock corporation.

(2) Formed as a limited liability company, partnership, limited partnership, or statutory trust, including a limited liability company, limited partnership, or statutory trust having 1 or more series.

(e) A risk retention group may take any form permitted under the Liability Risk Retention Act of 1986, 15 U.S.C. § 3901 et seq., as amended.

(f) In the case of a captive insurance company other than a branch captive insurance company:

(1) Formed as a corporation, at least 1 of the members of the board of directors or other governing body shall be a resident of, or have that member's principal place of business in, this State;

(2) Formed as a reciprocal insurer, at least 1 of the members of the subscribers' advisory committee shall be a resident of, or have its principal place of business in, this State;

(3) Formed as a limited liability company, at least 1 member, manager or person in whom management of the limited liability company is vested or to whom rights and powers to manage and control the business and affairs of the limited liability company have been delegated shall be a resident of, or have its principal place of business in, this State;

(4) Formed as a partnership, at least 1 partner or person in whom management of the partnership is vested or to whom rights and powers to manage and control the business and affairs of the partnership have been delegated shall be a resident of, or have its principal place of business in, this State;

(5) Formed as a limited partnership, at least 1 general partner or person in whom management of the limited partnership is vested or to whom rights and powers to manage and control the business and affairs of the limited partnership have been delegated shall be a resident of, or have its principal place of business in, this State; and

(6) Formed as a statutory trust, at least 1 trustee or person in whom management of the statutory trust is vested or to whom rights and powers to manage and control the business and affairs of the statutory trust have been delegated shall be a resident of, or have its principal place of business in, this State.

(g) A captive insurance company incorporated, formed or organized under the laws of this State or under the laws of another jurisdiction that is licensed under the provisions of this chapter shall have the privileges and be subject to the provisions of the laws of this State or the laws of such other jurisdiction, as applicable, under which such captive insurance company is incorporated, formed or organized as well as the applicable provisions contained in this chapter. In the event of conflict between the provisions of the laws of this State or the laws of such other jurisdiction, as applicable, under which such captive insurance company is incorporated, formed or organized, and the provisions of this chapter, the latter shall control.

(64 Del. Laws, c. 454, § 1; 66 Del. Laws, c. 223, § 1; 70 Del. Laws, c. 186, § 1; 75 Del. Laws, c. 150, § 1; 76 Del. Laws, c. 161, § 6; 77 Del. Laws, c. 252, §§ 8, 9; 80 Del. Laws, c. 46, § 8; 83 Del. Laws, c. 50, § 3; 83 Del. Laws, c. 283, § 30.)

§ 6907. Annual reports.

(a) Captive insurance companies shall not be required to make any annual report to the Commissioner except as provided in this chapter.

(b) Prior to April 15 of each year, each captive insurance company other than a branch captive insurance company for which the Commissioner has waived any of the requirements of this section pursuant to § 6974 of this title, shall submit to the Commissioner a report of its financial condition, verified by oath of 2 of its executive officers or authorized persons. Each captive insurance company shall report using generally accepted accounting principles, unless the Commissioner approves the use of statutory accounting principles or international accounting standards, with any appropriate or necessary modifications or adaptations thereof required or approved or accepted by the Commissioner for the type of insurance and kinds of insurers to be reported upon, and as supplemented by additional information required by the Commissioner. Any captive insurance company whose use of statutory accounting principles is approved by the Commissioner may make such modifications and adaptations thereof as are necessary:

(1) To record, as "admitted," the full value of all investments by such captive insurance company permitted under this chapter; and

(2) Subject to the Commissioner's approval, to make its reports under this section consistent with the purposes of this chapter.

The Commissioner shall by rule propose the forms in which captive insurance companies shall report.

(c) Any captive insurance company may make written application to the Commissioner for filing the required report on a fiscal year-end. If an alternative reporting date is granted by the Commissioner:

(1) The annual report is due 60 days after the fiscal year-end; and

(2) In order to provide sufficient detail to support the premium tax return, the captive insurance company shall file prior to April 15 of each year for each calendar year-end such form or information as the Commissioner shall by rule prescribe, verified by oath of 2 of its executive officers or other authorized persons.

(64 Del. Laws, c. 454, § 1; 75 Del. Laws, c. 150, § 1; 77 Del. Laws, c. 252, § 10; 81 Del. Laws, c. 251, § 1.)

§ 6908. Examinations and investigations.

At least once in 3 years, and whenever the Commissioner determines it to be prudent, the Commissioner or the Commissioner's examiner shall personally visit each captive insurance company and thoroughly inspect and examine its affairs to ascertain its financial condition, its ability to fulfill its obligations and its compliance with the provisions of this chapter. The Commissioner may enlarge the aforesaid 3-year period to 5 years, provided said captive insurance company is subject to a comprehensive annual audit during such period of a scope satisfactory to the Commissioner by independent auditors approved by the Commissioner. The expenses and charges of the examination shall be paid to this State by the company or companies examined.

(64 Del. Laws, c. 454, § 1; 70 Del. Laws, c. 186, § 1; 75 Del. Laws, c. 150, § 1; 80 Del. Laws, c. 46, § 9.)

§ 6909. Suspension or revocation of certificate of authority.

(a) A captive insurance company's certificate of authority to do an insurance business in this State may be suspended or revoked by the Commissioner for any of the following reasons:

(1) Insolvency;

(2) Failure to meet the requirements of § 6905 of this title;

(3) Refusal or failure to submit an annual report, as required by § 6907 of this title, or any other report or statement required by law or by lawful order of the Commissioner;

(4) Failure to comply with the provisions of its own organizational documents;

(5) Failure to pay any tax or fee, or to submit to or pay the cost of examination or any legal obligation relative thereto, as required by this chapter;

(6) Use of methods that, although not otherwise specifically prohibited by law, nevertheless render its operation detrimental or its condition unsound with respect to the public or its policyholders; or

(7) Failure otherwise to comply with the laws of this State.

(b) If the Commissioner finds, upon examination, hearing or other evidence, that any captive insurance company has committed any of the acts specified in subsection (a) of this section, the Commissioner may suspend or revoke such company's certificate of authority if the Commissioner deems it in the best interest of the public and the policyholders of such captive insurance company, notwithstanding any other provision of this title.

(c) Although issued and delivered to the captive insurance company, the certificate of authority at all times shall be the property of this State. Upon any expiration, suspension or termination thereof, the captive insurance company shall promptly deliver the certificate of authority to the Commissioner.

(d) Suspension of a captive insurance company's certificate of authority shall be for such period as the Commissioner specifies in the order of suspension. During the suspension period the Commissioner may rescind or shorten the suspension by further order.

(e) During the suspension period the captive insurance company may not solicit or write any new business but must file annual statements, pay fees and taxes as required under this chapter, and, unless otherwise provided in the order of suspension, may service its business already in force as if the certificate of authority had continued in full force.

(f) If the certificate of authority has not terminated within the suspension period, then upon expiration of the suspension period, the captive insurance company's certificate of authority shall automatically be reinstated, unless the Commissioner finds that 1 or more causes of the suspension are continuing or that the captive insurance company is otherwise not in compliance with the requirements of this chapter, of which finding the Commissioner shall give the captive insurance company notice not less than 30 days in advance of expiration of the suspension period. If not automatically reinstated, and if not already terminated, the certificate of authority terminates at the end of the suspension period.

(64 Del. Laws, c. 454, § 1; 70 Del. Laws, c. 186, § 1; 75 Del. Laws, c. 150, § 1; 76 Del. Laws, c. 161, § 7.)

§ 6910. Legal investments; management of assets.

(a) Association captive insurance companies, special purpose captive insurance companies, series captive insurance companies, and risk retention groups shall comply with:

(1) The investment requirements contained in Chapter 13 of this title, as applicable; or

(2) Such investment requirements as may be approved by the Commissioner upon application by any such captive insurance company.

(b) No pure captive insurance company, industrial insured captive insurance company, agency captive insurance company, special purpose financial captive insurance company or branch captive insurance company shall be subject to any restrictions on allowable investments whatsoever, including those limitations contained in this title; provided, however, that the Commissioner may prohibit or limit any investment that threatens the solvency or liquidity of any such captive insurance company.

(c) Loans of minimum capital and surplus funds required by § 6905 of this title are prohibited. Notwithstanding the foregoing, the minimum capital and surplus funds may be received by the issuance by the captive insurance company of a surplus note as approved by the Commissioner.

(d) Subject to subsections (a) and (b) of this section and § 6937 of this title, as applicable, a captive insurance company may own securities of or other interests in another captive insurance company, whether voting or nonvoting.

(64 Del. Laws, c. 454, § 1; 75 Del. Laws, c. 150, § 1; 76 Del. Laws, c. 161, § 8; 77 Del. Laws, c. 252, § 11; 80 Del. Laws, c. 46, § 10.)

§ 6911. Reinsurance.

(a) Any captive insurance company may provide reinsurance, on risks ceded by any other insurer, in accordance with § 910 of this title.

(b) With the exception of a risk retention group, any captive insurance company may take credit or a reduction from liability for the reinsurance of risks or portions of risks ceded to reinsurers in accordance with subchapter III of Chapter 9 of this title, or as otherwise approved by the Commissioner.

(c) A risk retention group may take credit or a reduction from liability for the reinsurance of risks or portions of risks ceded to reinsurers only in accordance with subchapter III of Chapter 9 of this title.

(64 Del. Laws, c. 454, § 1; 75 Del. Laws, c. 150, § 1; 78 Del. Laws, c. 321, § 1.)

§ 6912. Rating organization membership.

No captive insurance company shall be required to join a rating organization.

(64 Del. Laws, c. 454, § 1; 75 Del. Laws, c. 150, § 1.)

§ 6913. Prohibited associations.

No captive insurance company shall be permitted to join or contribute financially to any plan, pool, association, or guaranty or insolvency fund in this State, nor shall any such captive insurance company, or any insured or affiliate thereof, receive any benefit from any such plan, pool, association or guaranty or insolvency fund for claims arising out of the operations of such captive insurance company.

(64 Del. Laws, c. 454, § 1; 75 Del. Laws, c. 150, § 1.)

§ 6914. Tax on premiums collected.

(a) Each captive insurance company, other than a sponsored captive insurance company (including a sponsored captive insurance company that is also a special purpose financial captive insurance company), and each protected cell of a sponsored captive insurance company shall pay to the Commissioner no later than April 15 of each year a tax at the rate of $^{2}/_{10}$ of 1% on each dollar of direct premiums collected or contracted for, during the year ending December 31 next preceding, on policies or contracts of insurance written by the captive insurance company, after deducting from the direct premiums subject to the tax the amounts paid to policyholders as return premiums with respect to such preceding year only, which amounts shall include only dividends or distributions of unabsorbed premiums or premium deposits returned or credited to policyholders, up to a maximum tax for such year of $200,000; provided however, that no tax shall be due or payable as to consideration received for annuity contracts.

(b) Each captive insurance company, other than a sponsored captive insurance company (including a sponsored captive insurance company that is also a special purpose financial captive insurance company), and each protected cell of a sponsored captive insurance company shall pay to the Commissioner no later than April 15 of each year a tax at the rate of $^{1}/_{10}$ of 1% on each dollar of assumed reinsurance premiums collected or contracted for, during the year ending December 31 next preceding, on policies or contracts of insurance written by the captive insurance company, up to a maximum tax for such year of $110,000; provided, however, that no such tax applies to premiums for risks or portions of risks which are subject to taxation on a direct basis pursuant to subsection (a) of this section, and no such tax shall be payable in connection with the receipt of assets in exchange for the assumption of loss reserves and other liabilities of another insurer under common ownership and control if such transaction is part of a plan to discontinue the operations of such other insurer and if the intent of the parties to such transaction is to renew or maintain such business with the captive insurance company.

(c) (1) Except for a series captive insurance company, the annual minimum aggregate tax to be paid by a captive insurance company or a protected cell of a sponsored captive insurance company under subsections (a) and (b) of this section shall be $5,000 and the annual maximum aggregate tax to be paid by a captive insurance company or a protected cell of a sponsored captive insurance company under subsections (a) and (b) of this section shall be $200,000, provided, that the tax to be paid by a captive insurance company under subsections (a) and (b) of this section and this subsection is subject to subsections (d), (e) and (f) of this section. Each series captive insurance company

shall pay an annual minimum aggregate tax of $3,500. The aggregation of the tax paid by more than 1 series captive insurance company formed within a limited liability company or statutory trust established under § 17-218(b), § 18-215(b) of Title 6, § 3804(a) of Title 12, or corresponding law of another state shall not be restricted by the annual maximum premium tax limitations under subsections (a) and (b) of this section.

(2) Any series captive insurance company that assumes reinsurance premiums from a captive insurance company or protected cell subject to taxation under subsection (a) or (b) of this section may elect to assume the liability for the payment of the tax otherwise payable by such ceding captive insurance company or protected cell on such premium pursuant to subsection (a) or (b) of this section at the rate otherwise applicable to such premium if it had remained in such captive insurance company or protected cell, and such ceding captive insurance company or protected cell shall have no liability under subsections (a) or (b) of this section to the extent of such assumption. Nothing in this paragraph (c)(2) shall affect the application of the minimum tax imposed on the ceding captive insurance company or the series captive insurance company assuming such reinsurance premium and tax liability pursuant to paragraph (c)(1) of this section.

(3) A special purpose captive insurance company formed as a limited liability company or statutory trust established under § 17-218(b), § 18-215(b) of Title 6, § 3804(a) of Title 12, or corresponding law of another state that has established 1 or more series licensed as captive insurance companies shall not be subject to the tax imposed under subsection (a) or (b) of this section only if, during the entire calendar year for which the tax shall be imposed, the special purpose captive insurance company:

a. Did not contract for nor collect any direct premium;

b. Did not contract for nor assume any reinsurance premium; and

c. Was not obligated as an insurance company of any type under any contract of insurance or reinsurance.

(d) The tax provided for in this section shall constitute all taxes collectible under the laws of this State from any captive insurance company, and no other occupation tax or other taxes shall be levied on or collected from any captive insurance company by this State or any county, city or municipality within this State, except ad valorem taxes on real and personal property used in the production of income.

(e) The tax provided for in this section shall be calculated on an annual basis, notwithstanding that policies or contracts of insurance or contracts of reinsurance are issued on a multiyear basis. In the case of multiyear policies or contracts, the premium shall be prorated for purposes of determining the tax under this section.

(f) A captive insurance company that has 25 or more separate qualified individuals throughout a given tax year and that otherwise would be liable under this section for tax for such year in an amount exceeding $50,000 shall pay to the Commissioner under this section a tax for such year in the amount of $50,000. For purposes of this subsection, “qualified individual” means a natural person employed in this State on a regular basis of 35 or more hours per week either by such captive insurance company, or by a wholly-owned subsidiary of such captive insurance company that provides captive insurance company management, operating, investment or related services exclusively to such captive insurance company. For purposes of this subsection only, if at least 1 of 2 or more captive insurance companies under common ownership and control has 25 qualified individuals, then all captive insurance companies under common ownership and control shall be taxed as though they were a single captive insurance company. For purposes of this subsection only, “common ownership and control” means the direct or indirect ownership of 80% or more of the outstanding voting securities or other voting interests of 2 or more captive insurance companies by the same person or persons.

(64 Del. Laws, c. 454, § 1; 67 Del. Laws, c. 155, § 1; 75 Del. Laws, c. 150, § 1; 76 Del. Laws, c. 161, § 9; 80 Del. Laws, c. 46, § 11; 81 Del. Laws, c. 147, § 1; 82 Del. Laws, c. 56, § 1.)

§ 6915. Rules and regulations; in general.

The Commissioner may establish and from time to time amend such rules and regulations relating to captive insurance companies as are necessary to enable the Commissioner to carry out the provisions of this chapter.

(64 Del. Laws, c. 454, § 1; 70 Del. Laws, c. 186, § 1; 75 Del. Laws, c. 150, § 1.)

§ 6915A. Exemption from rules and regulations; special purpose captive insurance companies.

The Commissioner, on a case by case basis, may by order exempt a special purpose captive insurance company from the provisions of this chapter and any rule or regulation established by the Commissioner pursuant to § 6915 of this title that, as reasonably determined by the Commissioner based on such factors deemed relevant by the Commissioner consistent with the purposes of this chapter, are inappropriate to apply to such special purpose captive insurance company.

(75 Del. Laws, c. 150, § 1.)

§ 6916. Applicable laws.

(a) Only the following provisions of this title apply to a captive insurance company:

(1) Chapter 3 of this title, except for § § 331, 332, and 333 of this title.

(2) Sections 2702, 2703, 2706, and 2716 of this title.

(3) This chapter.

(4) Provisions of this title specifically referenced in this chapter.

(b) Subchapter V of Chapter 11, Chapters 16, 16A, 18, 50, 58 and § 909 of this title shall apply to risk retention groups.

(64 Del. Laws, c. 454, § 1; 75 Del. Laws, c. 150, § 1; 78 Del. Laws, c. 321, § 2; 79 Del. Laws, c. 90, § 1; 80 Del. Laws, c. 46, § 12; 83 Del. Laws, c. 50, § 4.)

§ 6917. Captive insurance regulatory and supervision fund.

(a) There is hereby created a fund to be known as the captive insurance regulatory and supervision fund for the purpose of providing the financial means for the Commissioner to administer this chapter. All of the tax under § 6914 of this title and all other amounts received by the Department pursuant to this chapter shall be credited to this fund.

(b) At the end of each fiscal year, the balance in the captive insurance regulatory and supervision fund, in excess of such amount reasonably necessary to finance the Commissioner's administration of this chapter during the upcoming fiscal year, shall be transferred to the General Fund.

(c) Within 30 days after the end of each fiscal year, the Commissioner shall submit to the Secretary of Finance of this State a written report stating:

(1) The total amount of taxes and other amounts paid to the Department pursuant to this chapter during such fiscal year, and the total amount of the Commissioner's costs and expenses to administer this chapter during such fiscal year; and

(2) The Commissioner's estimate of the total amount of the Commissioner's costs and expenses to administer this chapter during the current fiscal year.

(75 Del. Laws, c. 150, § 1.)

§ 6918. Delinquency.

To the extent not inconsistent with this chapter, the provisions of Chapter 59 of this title shall apply to captive insurance companies licensed under this chapter (including for this purpose individual protected cells of sponsored captive insurance companies as set forth in § 6938 of this title).

(75 Del. Laws, c. 150, § 1.)

§ 6919. Rules for controlled unaffiliated business.

The Commissioner may adopt rules establishing standards to ensure that a pure captive insurance company's parent or any of its affiliated companies is able to exercise control of the risk management function of any controlled unaffiliated business to be insured by the pure captive insurance company; provided, however, that, until such time as rules under this section are adopted, the Commissioner may approve the coverage of such risks by a pure captive insurance company, on a case by case basis.

(75 Del. Laws, c. 150, § 1.)

§ 6920. Confidentiality.

All portions of license applications reasonably designated confidential by or on behalf of an applicant captive insurance company, all information and documents, and any copies of the foregoing, produced or obtained by or submitted or disclosed to the Commissioner pursuant to subchapter III of this chapter of this title that are reasonably designated confidential by or on behalf of a special purpose financial captive insurance company, and all examination reports, preliminary examination reports, working papers, recorded information, other documents, and any copies of any of the foregoing, produced or obtained by or submitted or disclosed to the Commissioner that are related to an examination pursuant to this chapter must, unless the prior written consent (which may be given on a case-by-case basis) of the captive insurance company to which it pertains has been obtained, be given confidential treatment, are not subject to subpoena, may not be made public by the Commissioner, and may not be provided or disclosed to any other person at any time except:

(1) To the insurance department of any state or of any country or jurisdiction other than the United States of America; or

(2) To a law-enforcement official or agency of this State, any other state or the United States of America so long as such official or agency agrees in writing to hold it confidential and in a manner consistent with this section.

(75 Del. Laws, c. 150, § 1; 76 Del. Laws, c. 161, § 10.)

§ 6921. Material changes in information; continued licensure.

In the event of any material change in the financial condition or management of a captive insurance company, the captive insurance company shall notify the Commissioner in writing promptly of any such change and in any event within 10 business days thereof.

(75 Del. Laws, c. 150, § 1.)

§ 6922. Material transactions; prior notice.

No captive insurance company shall voluntarily take any of the following actions without providing the Commissioner at least 30 days prior written notice or receiving the Commissioner's approval of any such action within such 30 day period:

(1) The dissolution of the captive insurance company;

(2) Any sale, exchange, lease, mortgage, assignment, pledge or other transfer of or granting of a security interest in, all or substantially all of the assets of the captive insurance company;

(3) Any incurrence of material indebtedness by the captive insurance company;

(4) Any making of a material loan or other material extension of credit by the captive insurance company;

(5) Any material payment out of capital and surplus;

(6) Any merger or consolidation to which the captive insurance company is a constituent party;

(7) Any conversion of the captive insurance company to another business form;

(8) Any transfer to or domestication in any jurisdiction by the captive insurance company; or

(9) Any material amendment of the organizational documents of the captive insurance company.

(75 Del. Laws, c. 150, § 1.)

§ 6923. Books and records.

(a) Unless otherwise approved by the Commissioner, a captive insurance company shall maintain its books, records, documents, accounts, vouchers and agreements in this State. A captive insurance company shall make its books, records, documents, accounts, vouchers and agreements available for inspection by the Commissioner at any time. A captive insurance company shall keep its books, records, documents, accounts, vouchers and agreements in such manner that its financial condition, affairs and operations can be readily ascertained and in such manner that the Commissioner may readily verify its financial statements and determine its compliance with this chapter.

(b) Unless otherwise approved by the Commissioner, all original books, records, documents, accounts, vouchers and agreements of a captive insurance company must be preserved and kept available in this State for the purpose of examination and inspection until the Commissioner approves the destruction or other disposition of the books, records, documents, accounts, vouchers and agreements. If the Commissioner approves the preservation and keeping of the foregoing outside this State, the captive insurance company shall maintain a complete and true copy of each such original in the State. Books, records, documents, accounts, vouchers and agreements may be photographed, reproduced on film or stored and reproduced electronically.

(76 Del. Laws, c. 161, § 11.)

§ 6924. Dormant captive insurance companies.

(a) A dormant captive insurance company shall possess and maintain unimpaired capital and surplus in an amount of $25,000 or such other amount as determined by the Commissioner.

(b) A dormant captive insurance company shall not be subject to or liable for the payment of any premium tax under § 6914 of this title.

(c) A dormant captive insurance company shall not be required to do any of the following:

(1) File annual statements with the Commissioner.

(2) Prepare audited financial statements.

(3) Obtain statements of actuarial opinion.

(d) A dormant captive insurance company shall be subject to examination under § 6908 of this title for any year when it did not qualify as a dormant captive insurance company under § 6902 of this title. At the Commissioner’s discretion, it shall be subject to examination for any year in which it does qualify as a dormant captive insurance company under § 6902 of this title.

(e) The Commissioner may, upon application, declare a captive insurance company to be dormant for purposes of this section even if such captive insurance company retains liabilities associated with policies written or assumed by the company; provided that the captive insurance company has otherwise ceased the transacting of insurance business.

(f) A dormant captive insurance company shall not resume transacting the business of insurance until such time as the dormant captive insurance company has provided written notice to the Commissioner of its intention to resume assuming risk through the issuance of insurance policies, reinsurance contracts, or both, and accepting premium, whether direct, assumed via reinsurance, or both, at which time such captive insurance company shall no longer be considered a dormant captive insurance company and shall thereafter comply with all provisions of this chapter and regulations issued pursuant to this chapter applicable to such captive insurance company.

(g) If, after a period of 5 years from the date of the written notice being sent to the Commissioner, a dormant captive insurance company has not resumed transacting the business of insurance by assuming risk through the issuance of insurance policies, reinsurance contracts, or both, and accepting premium, whether direct, assumed via reinsurance, or both, the nonrefundable license renewal fee payable under § 6903(d) of this title shall be increased to $25,000 for the sixth year of dormancy and $5,000 for every year of dormancy thereafter.

(h) At the Commissioner’s discretion, a dormant captive insurance company may continue as a dormant captive insurance company for a period in excess of 5 years without incurring the additional fees set forth in subsection (g) of this section upon good reason shown and acceptable to the Commissioner.

(i) A dormant captive insurance company may continue to adjudicate and settle insurance claims brought under any contract of insurance or reinsurance issued during any year in which it was not a dormant captive insurance company. The effective date of such a contract of insurance or reinsurance must be before the dormant captive insurance became a dormant captive insurance company.

(81 Del. Laws, c. 148, § 2.)

Subchapter II
Sponsored Captive Insurance Companies

§ 6931. General.

In addition to the provisions of subchapter I of this chapter, the provisions of this subchapter shall apply to sponsored captive insurance companies, and § 6922 of this title shall apply to each protected cell of a sponsored captive insurance company.

(75 Del. Laws, c. 150, § 1.)

§ 6932. Definitions.

As used in this subchapter, unless the context requires otherwise:

(1) "Participant" means any person, including any counterparty as defined in § 6952(1) of this title, that is insured by a sponsored captive insurance company, where the losses of the participant are limited through a participant contract to the participant's pro rata share of the assets of 1 or more protected cells identified in the participant contract.

(2) "Participant contract" means a contract by which a sponsored captive insurance company insures the risks of 1 or more participants, and limits the losses of each participant to its pro rata share of the assets of 1 or more protected cells identified in the participant contract, including an SPFC contract as defined in § 6952 of this title.

(3) "Protected cell" means a separate and distinct account established and maintained by or on behalf of a sponsored captive insurance company in which assets, including assets invested pursuant to § 6937 of this title, are accounted for and recorded for 1 or more participants in accordance with the terms of 1 or more participant contracts to fund the liability of the sponsored captive insurance company assumed on behalf of the participants as set forth in the participant contracts.

(4) "Sponsor" means a person qualifying as a sponsor under § 6935 of this title.

(5) "Sponsored captive insurance company" means a captive insurance company, including a special purpose financial captive insurance company as defined in § 6952 of this title:

a. Of which the minimum capital and surplus required by this chapter is provided by 1 or more sponsors;

b. That is licensed under the provisions of this chapter;

c. That insures the risks of its participants only, through separate participant contracts; and

d. That funds its liability to each participant through 1 or more protected cells and segregates the assets of each protected cell from the assets of other protected cells and from the assets of the sponsored captive insurance company's general account.

(75 Del. Laws, c. 150, § 1; 76 Del. Laws, c. 161, § 12.)

§ 6933. Supplemental license application materials.

In addition to the information required by § 6903(c) of this title, each applicant sponsored captive insurance company shall file with the Commissioner the following:

(1) Materials demonstrating to the satisfaction of the Commissioner how the applicant will report to the Commissioner on, and account for, the loss and expense experience of each protected cell;

(2) A statement acknowledging that all financial records of the sponsored captive insurance company, including records pertaining to any protected cells, shall be made available for inspection or examination by the Commissioner or the Commissioner's designated agent;

(3) All contracts or sample contracts between the sponsored captive insurance company and any participants; and

(4) Evidence that expenses shall be allocated to each protected cell in a fair and equitable manner.

(75 Del. Laws, c. 150, § 1.)

§ 6934. Protected cells.

A sponsored captive insurance company may establish and maintain 1 or more protected cells to insure risks of 1 or more participants, subject to the following conditions:

(1) The owners of a sponsored captive insurance company shall be limited to its participants and sponsors, provided that a sponsored captive insurance company may issue nonvoting securities or interests to other persons on terms approved by the Commissioner;

(2) The assets of each protected cell shall be held and accounted for separately on the books and records of the sponsored captive insurance company to reflect the financial condition and results of operations of such protected cell, net income or loss of such protected cell, dividends or other distributions to participants of such protected cell, and such other factors regarding such protected cell as may be provided in the applicable participant contract or required by the Commissioner;

(3) The assets of a protected cell shall not be chargeable with liabilities of any other protected cell or, unless otherwise agreed in the applicable participant contract, of the sponsored captive insurance company generally;

(4) No sale, exchange, or transfer of assets, or dividend or other distribution, may be made with respect to a protected cell by such sponsored captive insurance company without the consent of the participants of each affected protected cell;

(5) No sale, exchange, or transfer of assets, or dividend or other distribution (other than a payment to a sponsor in accordance with the applicable participant contract), may be made with respect to a protected cell to a sponsor or a participant without the Commissioner's approval;

(6) Each sponsored captive insurance company shall annually file with the Commissioner such financial reports as the Commissioner shall require, which shall include, without limitation, accounting statements detailing the financial experience of each protected cell;

(7) Each sponsored captive insurance company shall notify the Commissioner in writing promptly and in any event within 10 business days of any protected cell that is insolvent or otherwise unable to meet its claim or expense obligations;

(8) No participant contract shall take effect without the Commissioner's prior written approval, and the addition of each new protected cell and withdrawal of any participant or termination of any existing protected cell shall constitute a change in the plan of operation of the sponsored captive insurance company requiring the Commissioner's prior written approval; and

(9) The business written by a sponsored captive insurance company, with respect to each protected cell, shall be:

a. Fronted by an insurance company licensed under the laws of this State or any other state;

b. Reinsured by a reinsurer authorized or approved by this State; or

c. Secured by a trust fund in this State for the benefit of policyholders and claimants or funded by an irrevocable letter of credit or other arrangement that is acceptable to the Commissioner. The amount of security provided shall be no less than the reserves associated with those liabilities which are neither fronted nor reinsured, including reserves for losses, allocated loss adjustment expenses, incurred but not reported losses and unearned premiums for business written through such protected cell. The Commissioner may require the sponsored captive insurance company to increase the funding of any security arrangement established under this paragraph (9). If the form of security is a letter of credit, the letter of credit must be established, issued or confirmed by a financial institution chartered by or licensed or otherwise authorized to do banking business in this State, or by any other financial institution approved by the Commissioner. A trust maintained pursuant to this paragraph (9) shall be established in a form and upon such terms approved by the Commissioner.

(75 Del. Laws, c. 150, § 1.)

§ 6935. Qualification of sponsors.

A sponsor of a sponsored captive insurance company shall be an insurer (including a reinsurer) licensed under the laws of this State or any other state, a captive insurance company licensed under this chapter, or any other person approved by the Commissioner. A risk retention group shall not be a sponsor of a sponsored captive insurance company, and a risk retention group may be a participant of a sponsored captive insurance company only to the extent that it is the sole participant of 1 or more protected cells.

(75 Del. Laws, c. 150, § 1.)

§ 6936. Participants in sponsored captive insurance companies.

(a) Any person may be a participant in any sponsored captive insurance company.

(b) A sponsor may be a participant in a sponsored captive insurance company.

(c) A participant need not be an owner of the sponsored captive insurance company or any affiliate thereof.

(d) Except as otherwise approved by the Commissioner, a participant may insure through a sponsored captive insurance company only its own risks and the risks of its affiliates who are participants.

(75 Del. Laws, c. 150, § 1.)

§ 6937. Investments by sponsored captive insurance companies.

(a) Notwithstanding the provisions of § 6934 of this title, a sponsored captive insurance company may combine the assets of 2 or more protected cells for purposes of investing those assets. Such a combination of assets may not be construed as defeating the segregation of assets for purposes of §§ 6934 and 6938 of this title, or for accounting or other purposes. Sponsored captive insurance companies must comply with:

(1) The investment requirements contained in Chapter 13 of this title, as applicable; or

(2) Investment requirements as may be approved by the Commissioner upon application by a sponsored captive insurance company; or

(3) In the case of a sponsored captive insurance company that is also a special purpose financial captive insurance company, the investment requirements contained in § 6910(b) of this title.

(b) Compliance with the investment requirements set forth in paragraphs (a)(1) and (a)(2) of this section must be waived for sponsored captive insurance companies to the extent that credit for reinsurance ceded to reinsurers is allowed pursuant to § 6911 of this title or to the extent otherwise considered reasonable and appropriate by the Commissioner.

(75 Del. Laws, c. 150, § 1; 76 Del. Laws, c. 161, § 13.)

§ 6938. Delinquency of sponsored captive insurance companies.

The provisions of § 6918 of this title shall apply to a sponsored captive insurance company and to each protected cell of the sponsored captive insurance company, provided:

(1) The assets of a protected cell may not be used to pay any expenses or claims other than those attributable to such protected cell; and

(2) The minimum capital and surplus of the sponsored captive insurance company shall at all times be available to pay any expenses of or claims against the sponsored captive insurance company.

(75 Del. Laws, c. 150, § 1; 77 Del. Laws, c. 252, § 12.)

Subchapter III

Special Purpose Financial Captive Insurance Companies

§ 6951. Purpose.

This subchapter provides for the authorization of special purpose financial captive insurance companies empowered to issue securities and otherwise access financial markets and alternative sources of capital through securitizations and other transactions. The intent of this subchapter is to provide for an authorization process for special purpose financial captive insurance companies that is both thorough and swift, and for the ongoing regulation of such companies that recognizes and accommodates the special purpose nature of such entities.

(76 Del. Laws, c. 161, § 15.)

§ 6952. Definitions.

As used in this subchapter, unless the context requires otherwise:

(1) "Counterparty" means a person, other than a natural person, which may but need not be the parent or an affiliate of the special purpose financial captive insurance company, that enters into an SPFC contract with a special purpose financial captive insurance company.

(2) "Insolvency" or "insolvent" means:

a. A person's inability to pay its obligations when they are due, unless those obligations are the subject of a bona fide dispute; or

b. The liabilities of a person exceed the value of all of the assets of the person. In the case of a special purpose financial captive insurance company, liabilities and assets are determined under the method of accounting used by the special purpose financial captive insurance company in accordance with § 6962 of this title.

(3) "Organizational document" means the certificate of incorporation, articles of organization, bylaws, limited liability company agreement or other documents pursuant to which a special purpose financial captive insurance company or a special purpose financial captive insurance company applicant, as the case may be, is formed.

(4) "Permitted investments" means those investments that meet the qualifications set forth in § 6910(b) of this title.

(5) "Securities" has the same meaning as defined in § 73-103(a)(23) of Title 6, and also includes any form of debt obligation, equity, surplus certificate, surplus note, funding agreement, derivative or other financial instrument that the Commissioner designates, by rule or order, as "securities" for purposes of this subchapter.

(6) "Special purpose financial captive insurance company" means a captive insurance company that is granted a certificate of authority under this subchapter.

(7) a. "Special purpose financing transaction" means:

1. A transaction or a group of related transactions, which may include but are not limited to capital market offerings and securitizations, by which:

A. Proceeds are obtained by a special purpose financial captive insurance company through the issuance of securities by the special purpose financial captive insurance company or by any other person, and all or any part of such proceeds are used to fund the special purpose financial captive insurance company's obligations under 1 or more SPFC contracts; or

B. A person provides 1 or more letters of credit or other assets to or for the benefit of the special purpose financial captive insurance company, which the Commissioner authorizes the special purpose financial captive insurance company to treat as admitted assets for purposes of the special purpose financial captive insurance company's annual report, and all or any part of those letters of credit or other assets, as applicable, are used to fund the special purpose financial captive insurance company's obligations under 1 or more SPFC contracts; or

2. Other financing arrangements as the Commissioner may approve.

b. "Special purpose financing transaction" does not include the issuance of a letter of credit to satisfy all or part of the special purpose financial captive's minimum capital and surplus requirements under § 6905 of this title.

(8) "SPFC contract" means a contract or group of related contracts between a special purpose financial captive insurance company and a counterparty or counterparties pursuant to which insurance risk is transferred by the counterparty or counterparties to the special purpose financial captive insurance company. An SPFC contract may include 1 or more other parties.

(9) "Surplus note" means an unsecured subordinated debt obligation treated as surplus and not debt in accordance with § 6956 of this title.

(76 Del. Laws, c. 161, § 15; 78 Del. Laws, c. 175, §§ 4, 87; 81 Del. Laws, c. 387, § 2.)

§ 6953. Application of subchapter.

(a) Except as otherwise provided, subchapters I, II, and IV of this chapter apply under this subchapter to special purpose financial captive insurance companies.

(b) The Commissioner, by rule or order, at the Commissioner's discretion and on a case-by-case basis, may exempt a special purpose financial captive insurance company, or 1 or more protected cells of a special purpose financial captive insurance company that is also a sponsored captive insurance company, from 1 or more of the provisions of this chapter.

(c) This subchapter is not intended to limit the transactions in which a captive insurance company other than a special purpose financial captive insurance company may engage, and this subchapter does not apply to any such other captive insurance company.

(76 Del. Laws, c. 161, § 15.)

§ 6954. Application requirements.

In addition to the items required under § 6903 of this title and, as applicable, under § 6933 of this title, a special purpose financial captive insurance company's plan of operation must include the following:

(1) A description of the contemplated special purpose financing transaction and the SPFC contract;

(2) Copies, or, at the discretion of the Commissioner, a written summary, of all material agreements, instruments or documents, including, without limitation, opinions of Delaware legal counsel regarding compliance of the SPFC contract and the special purpose financing transaction with the requirements of this chapter, that are to be entered into or required to effectuate the SPFC contract and the special purpose financing transaction, which must include:

a. The name of the counterparty;

b. The nature of the risks being assumed;

c. The proposed use of protected cells, if any; and

d. The amounts, purpose, nature and interrelationships of the various transactions required to effectuate the SPFC contract and the special purpose financing transaction;

(3) The proposed investment policy of the special purpose financial captive insurance company and a description of its proposed investment strategy;

(4) A description of the underwriting, reporting, and claims payment methods by which losses covered by the SPFC contract are to be reported, accounted for, and settled; and

(5) Pro forma balance sheets, income statements, and other financial projections demonstrating the performance of the special purpose financial captive insurance company pursuant to the SPFC contract under such stress case scenarios as may be required by the Commissioner.

(76 Del. Laws, c. 161, § 15.)

§ 6955. Certificate of authority and order.

(a) Upon a determination by the Commissioner that the requirements in § 6954 of this title have been met, the Commissioner may grant a certificate of authority and, at the discretion of the Commissioner, an order imposing the conditions, limitations or other terms that the Commissioner considers appropriate.

(b) As soon as reasonably practicable after the closing of each SPFC contract or special purpose financing transaction, and, in any event, within 30 days after such closing, the special purpose financial captive insurance company shall provide to the Commissioner a final executed copy of all material agreements, instruments or documents, including, without limitation, opinions of Delaware legal counsel regarding compliance of the SPFC contract and the special purpose financing transaction with the requirements of this chapter, that have been entered into or that have been required to effectuate the SPFC contract or the special purpose financing transaction.

(c) Any material change of the special purpose financial captive insurance company's plan of operation requires prior approval of the Commissioner. The following are not considered material changes:

(1) If approved in the plan of operation, securities subsequently issued or entered into to continue the activities of the special purpose financial captive insurance company either before or after expiration, redemption or satisfaction of part or all of the securities issued or entered into pursuant to the initial special purpose financing transaction; and

(2) If a swap transaction has been approved in the plan of operation, a change or substitution of a swap counterparty, if, at the time of the change or substitution, the replacement swap counterparty carries the same or a higher rating than its predecessor from 2 or more nationally recognized rating agencies.

(d) Upon termination or cancellation of all of the SPFC contracts and all related special purpose financing transactions set forth in a plan of operation, unless otherwise approved by the Commissioner, the certificate of authority granted by the Commissioner terminates, and the special purpose financial captive insurance company may not enter into any further or additional SPFC contracts or special purpose financing transactions.

(e) In the case of a special purpose financial captive insurance company organized as a sponsored captive insurance company, upon termination or cancellation of all of the SPFC contracts and all related special purpose financing transactions set forth in the plan of

operation with respect to a protected cell, unless otherwise approved by the Commissioner, the authority granted by the Commissioner with respect to that particular cell terminates, and the protected cell may not enter into any further or additional SPFC contracts or special purpose financing transactions.

(f) A special purpose financial captive insurance company that is organized as a sponsored captive insurance company may add or eliminate 1 or more protected cells under a single certificate of authority upon approval by the Commissioner of a plan of operation specific to the protected cells.

(g) At the request of a special purpose financial captive insurance company, a certificate of authority or an order granted under this section, or both, may be amended by the Commissioner.

(76 Del. Laws, c. 161, § 15.)

§ 6956. Securities of special purpose financial captive insurance companies.

(a) A special purpose financial captive insurance company may:

(1) Subject to the approval of the Commissioner, account for the proceeds of surplus notes issued by the special purpose financial captive insurance company as surplus and not as debt for purposes of statutory accounting; and

(2) Submit to the Commissioner periodic written requests for the advance approval by the Commissioner of the special purpose financial captive insurance company's making payments of interest on and repayments of principal of surplus notes.

(b) The Commissioner may approve, in advance, ongoing interest payments or principal repayments, or both, by the special purpose financial captive insurance company, provided that the interest payments or principal repayments, or both, are made in accordance with the plan of operation and formulas contained in the plan of operation.

(c) Notwithstanding the provisions of subsection (b) of this section, payment of interest or repayment of principal may not be made without the approval of the Commissioner if the operation or financial condition of the special purpose financial captive insurance company deviates from the formula approved by the Commissioner pursuant to subsection (b) of this section or if the payment of interest or repayment of principal threatens the solvency or liquidity of the special purpose financial captive insurance company.

(d) A security issued by a special purpose financial captive insurance company is not subject to regulation as an insurance contract. An investor in these securities or a holder of these securities is not considered to be transacting the business of insurance in this State solely by reason of having an interest in these securities. The underwriter's placement or selling agents and their partners, commissioners, officers, members, managers, employees, agents, representatives, and advisors involved in a special purpose financing transaction by a special purpose financial captive insurance company are not considered to be insurance producers or to be conducting business as an insurance company or as an insurance agency, brokerage, intermediary, advisory, or consulting business solely by virtue of their underwriting activities in connection with the special purpose financing transaction.

(76 Del. Laws, c. 161, § 15.)

§ 6957. Authorized contracts and activities.

(a) A special purpose financial captive insurance company may insure only the risks of a counterparty. A special purpose financial captive insurance company may cede risks assumed through an SPFC contract to third-party reinsurers through the purchase of reinsurance or retrocession protection as set forth in the plan of operation.

(b) A special purpose financial captive insurance company may enter into agreements with affiliated companies and third parties and conduct other commercial activities related or incidental to, or necessary to fulfill, the purposes of an SPFC contract and special purpose financing transaction contemplated by the plan of operation approved by the Commissioner. The agreements may include management and administrative services agreements and other allocation, including tax allocation, and cost-sharing agreements.

(c) A special purpose financial captive insurance company may enter into asset management agreements as provided for in a plan of operation. These agreements may include, but are not limited to, swap agreements, hedge agreements, guarantee agreements, guaranteed investment contracts, or other investment contracts.

(d) An SPFC contract must:

(1) Obligate the special purpose financial captive insurance company to indemnify the counterparty for losses or otherwise to make payments to the counterparty with respect to the insurance risk transferred thereunder; and

(2) Make provision satisfactory to the Commissioner for payment of obligations of the special purpose financial captive insurance company under the SPFC contract.

(e) Without limiting the means by which the requirements of paragraph (d)(2) of this section may be satisfied, an SPFC contract is considered to satisfy those requirements if it:

(1) Requires the special purpose financial captive insurance company to:

a. To enter into a trust agreement that meets the criteria set forth in this section and in any regulations issued by the Commissioner applicable to this subsection and that specifies the recoverables or reserves, or both, to be covered; and

b. To establish a trust account for the benefit of the counterparty;

(2) Stipulates that assets deposited in the trust account are valued according to their current fair value and consist only of permitted investments;

(3) Requires the special purpose financial captive insurance company, before depositing assets with the trustee, to execute assignments or endorsements in blank, or both, or to transfer legal title to the trustee of all shares, obligations, or any other assets requiring assignments, in order that the counterparty, or the trustee upon the direction of the counterparty, may transfer the assets whenever necessary without consent or signature from the special purpose financial captive insurance company or another entity;

(4) Requires that all settlements of account between the counterparty and the special purpose financial captive insurance company, unless otherwise approved by the Commissioner, be made in cash or its equivalent; and

(5) Stipulates that the special purpose financial captive insurance company and the counterparty agree that the assets in the trust account, established pursuant to the provisions of the SPFC contract:

a. May be withdrawn by the counterparty at any time, notwithstanding any other provisions in the SPFC contract; and

b. Must be used and applied by the counterparty or any successor by operation of law of the counterparty, including any liquidator, rehabilitator, receiver, or conservator of the counterparty, without diminution because of insolvency on the part of the counterparty or the special purpose financial captive insurance company, only for the following purposes:

1. To transfer all of the assets into 1 or more trust accounts for the benefit of the counterparty pursuant to and in accordance with the terms of the SPFC contract and in compliance with the provisions of this title; and

2. To pay any other incurred and paid amounts that the counterparty claims are due pursuant to and under the terms of the SPFC contract and in compliance with this title.

(f) An SPFC contract may allow the special purpose financial captive insurance company to seek approval from the counterparty to withdraw all or part of the assets supporting payment of obligations of the special purpose financial captive insurance company under the SPFC contract, or income from them, and to transfer the assets to the special purpose financial captive insurance company; provided, that,

(1) At the time of the withdrawal, the special purpose financial captive insurance company replaces the withdrawn assets, excluding any income withdrawn, with other permitted investments having a fair value equal to the fair value of the assets withdrawn;

(2) After giving effect to the withdrawal and replacement, the fair value of the assets supporting payment of obligations of the special purpose financial captive insurance company under the SPFC contract satisfies the requirements of paragraph (d)(2) of this section; and

(3) The approval of the counterparty is received, which approval may not be unreasonably or arbitrarily withheld.

(g) The assets of a special purpose financial captive insurance company must be preserved and administered by or on behalf of the special purpose financial captive insurance company to satisfy the liabilities and obligations of the special purpose financial captive insurance company incident to the SPFC contract and the special purpose financing transaction.

(h) Unless otherwise permitted by this subchapter or approved by the Commissioner, a special purpose financial captive insurance company may not:

(1) Issue or administer primary insurance policies;

(2) Enter into an SPFC contract with a counterparty that is an insurer if the insurer is required to be, but is not, licensed or otherwise authorized to transact the business of insurance or reinsurance in at least its state or country of domicile;

(3) Assume or retain exposure to insurance or reinsurance losses for its own account that is not funded or to be funded, in whole or in part, by proceeds from a special purpose financing transaction that complies with the provisions of this subchapter;

(4) Have any direct obligation to policyholders or reinsureds of a counterparty; or

(5) Lend to, receive a capital contribution from, invest or place in custody, trust, or under management any of its assets with, or receive a loan or advance from, other than by issuance of the securities pursuant to a special purpose financing transaction, anyone convicted of a felony, or anyone convicted of a criminal offense or found civilly liable for an offense involving the conversion or misappropriation of fiduciary funds or insurance accounts, theft, deceit, fraud, misrepresentation, or corruption.

(76 Del. Laws, c. 161, § 15.)

§ 6958. Dividends and distributions.

(a) A special purpose financial captive insurance company may declare and pay dividends or other distributions to equity holders if the dividends or other distributions do not violate the provisions of this chapter, or jeopardize the fulfillment of the obligations of the special purpose financial captive insurance company pursuant to the special purpose financing transaction or the SPFC contract, or threaten the solvency or liquidity of the special purpose financial captive insurance company.

(b) A special purpose financial captive insurance company may not declare or pay any dividend or other distribution to equity holders if the dividend or distribution violates the terms of the special purpose financing transaction, and may not declare or pay any dividend or other distribution to equity holders which decreases the capital and surplus of the special purpose financial captive insurance company below the minimum amount required under § 6905 of this title.

(c) The Commissioner may approve, in advance, a special purpose financial captive insurance company's declaring and paying, on an ongoing basis, dividends or other distributions, or both, to equity holders, provided that each dividend or other distribution is made in accordance with the plan of operation and formulas contained in the plan.

(76 Del. Laws, c. 161, § 15.)

§ 6959. Delinquency.

(a) Sections 6918 and 6938 of this title apply to any special purpose financial captive insurance company except as otherwise provided in this section.

(b) Any delinquency proceeding pursuant to Chapter 59 of this title, or any temporary restraining order or injunction issued pursuant thereto with respect to a counterparty, may not prohibit the transaction of business by a special purpose financial captive insurance company, including its performance of its obligations under a special purpose financing transaction, or any action or proceeding against a special purpose financial captive insurance company or its assets.

(c) The commencement of a summary proceeding with respect to a special purpose financial captive insurance company, and any order issued by the court in such a summary proceeding, may not prohibit payments by the special purpose financial captive insurance company or any action required to make the payment, provided that the payments:

(1) Are made pursuant to a special purpose financing transaction or an SPFC contract: and

(2) Are consistent with the special purpose financial captive insurance company's plan of operation, its certificate of authority, and any order issued in connection therewith, as they may be amended from time to time.

(d) Notwithstanding any other provisions of this title or other laws of this State:

(1) A receiver of a counterparty may not take action seeking to void, and has no authority to void, a nonfraudulent transfer by a counterparty to a special purpose financial captive insurance company of money or other property made pursuant to an SPFC contract; and

(2) A receiver of a special purpose financial captive insurance company may not take action seeking to void, and has no authority to void, a nonfraudulent transfer by the special purpose financial captive insurance company of money or other property made to a counterparty pursuant to an SPFC contract or made pursuant to a special purpose financing transaction.

(e) Notwithstanding any other provision of this title or other laws of this State, the assets of a special purpose financial captive insurance company, including assets held in trust for the benefit of the counterparty, may not be consolidated with or included in the estate of a counterparty in any bankruptcy, insolvency, delinquency, or similar proceeding against the counterparty.

(76 Del. Laws, c. 161, § 15.)

§ 6960. Discount on reserves; report on reserves.

(a) A special purpose financial captive insurance company shall file annually with the Commissioner an actuarial opinion on reserves provided by an approved independent actuary.

(b) A special purpose financial captive insurance company may discount its reserves in accordance with the actuarial opinion filed under this section, subject to review by the Commissioner.

(76 Del. Laws, c. 161, § 15.)

§ 6961. Certain actions by the Commissioner.

Other than under § 6959 of this title, the Commissioner shall notify a special purpose financial captive insurance company not less than 30 days before suspending, revoking, amending, or modifying its certificate of authority or any order issued in connection therewith. The notice must state the basis for the suspension, revocation, amendment, or modification. The special purpose financial captive insurance company must be afforded the opportunity for a hearing and all rights provided pursuant to the provisions of the Administrative Procedures Act, Chapter 101 of Title 29.

(76 Del. Laws, c. 161, § 15.)

§ 6962. Books and records.

Notwithstanding § 6907 of this title, a special purpose financial captive insurance company shall calculate reserves and otherwise report using statutory accounting principles, unless the Commissioner requires, approves, or accepts the use of generally accepted accounting principles or international accounting standards, in either case with any appropriate or necessary modifications or adaptations thereof required or approved or accepted by the Commissioner, and as supplemented by additional information required by the Commissioner.

(76 Del. Laws, c. 161, § 15.)

Subchapter IV

Branch Captive Insurance Companies

§ 6971. Establishment of a branch captive.

A branch captive may be established in this State in accordance with the provisions of this chapter to write any line of business for which captive insurance companies are authorized under § 6903(a) of this title. In addition to the general provisions of this chapter, the provisions of this subchapter shall apply to branch captive insurance companies.

(77 Del. Laws, c. 252, § 13.)

§ 6972. Definitions.

As used in this subchapter, unless the context require otherwise:

(1) “Alien captive insurance company” means any insurance company formed to write insurance business of a nature that the Commissioner determines is otherwise permissible under this chapter and is licensed pursuant to the laws of an alien jurisdiction which imposes statutory or regulatory standards in a form acceptable to the Commissioner on companies transacting the business of insurance in such jurisdiction.

(2) “Branch business” means any insurance business transacted by a branch captive insurance company in this State.

(3) “Branch captive insurance company” means any alien captive insurance company that has been issued a certificate of authority by the Commissioner to transact the business of insurance in this State through a business unit with a principal place of business in this State, and has not otherwise been issued a certificate of authority by the Commissioner to transact insurance under this chapter.

(4) “Branch operations” means any business operations of a branch captive insurance company in this State.

(77 Del. Laws, c. 252, § 13.)

§ 6973. Security required.

(a) No branch captive insurance company shall be issued a license unless it shall possess and thereafter maintain, as security for the payment of liabilities attributable to the branch operations:

(1) Minimum capital and surplus as set forth in § 6905 of this title; and

(2) Reserves on such insurance policies or such reinsurance contracts as may be issued or assumed by the branch captive insurance company through its branch operations, including reserves for losses, allocated loss adjustment expenses, incurred but not reported losses, and unearned premiums with regard to business written through the branch operations; provided, however, the Commissioner may permit a branch captive insurance company to credit against any such reserve requirement either of the following:

a. Assets belonging to the branch captive insurance company that are in trust for, or otherwise segregated and controlled by, a ceding company, that secure the reinsurance obligations of the branch captive insurance company to such ceding company; or

b. Assets belonging to a reinsurer if held in trust for, or otherwise under the control of the branch captive insurance company and that secure the obligations of such reinsurer to the branch captive insurance company.

(b) Subject to the prior approval of the Commissioner, the amounts required in paragraphs (a)(1) and (2) of this section may be held in the form of:

(1) A trust formed under a trust agreement and funded by assets acceptable to the Commissioner;

(2) An irrevocable letter of credit issued or confirmed by a bank approved by the Commissioner; or

(3) Any combination thereof.

(c) The Commissioner may, on a case by case basis, exempt a branch captive insurance company from any or all of the requirements of this section, provided the Commissioner finds satisfactory evidence of the branch captive insurer’s financial stability.

(77 Del. Laws, c. 252, § 13.)

§ 6974. Annual reports.

(a) Notwithstanding § 6907 of this title, a branch captive insurance company shall file with the Commissioner a copy of all reports and statements required to be filed under the laws of the jurisdiction in which the foreign captive insurance company or alien captive insurance company is formed, verified by oath of 2 of its executive officers. Such reports and statements shall be filed with the Commissioner on the same day that such reports and statements are due in the domiciliary jurisdiction of the foreign captive insurance company or alien captive insurance company.

(b) If the Commissioner is satisfied that the annual report filed in accordance with subsection (a) of this section provides adequate information concerning the financial condition of the branch captive insurance company, the Commissioner may waive the requirement for completion of the annual report required under § 6907 of this title. If the Commissioner is not satisfied with the reports and statements filed pursuant to subsection (a) of this section, a report that meets the requirements of § 6907 of this title shall be filed with the Commissioner at such date as the Commissioner shall establish.

(c) If the foreign captive insurance company or alien captive insurance company is not required to file reports or statements in its domiciliary jurisdiction, the requirements of § 6907 of this title shall apply.

(77 Del. Laws, c. 252, § 13; 80 Del. Laws, c. 46, § 13.)

§ 6975. Examination of branch captives.

(a) The examination of a branch captive insurance company pursuant to § 6908 of this title shall be of branch business and branch operations only, so long as the branch captive insurance company provides annually to the Commissioner a certificate of compliance, or its equivalent, issued by or filed with the licensing authority of the domiciliary jurisdiction of the foreign captive insurance company or alien captive insurance company, and demonstrates to the Commissioner’s satisfaction that it is operating in sound financial condition in accordance with all applicable laws and regulations of such jurisdiction.

(b) Notwithstanding subsection (a) of this section, if the Commissioner elects to waive any of the requirements of § 6973 of this title pursuant to § 6973(c) of this title, the Commissioner shall examine so much of the financial condition and affairs of the foreign captive insurance company or alien captive insurance company as the Commissioner deems appropriate.

(c) As a condition of the issuance of a certificate of authority under this chapter, the foreign captive insurance company or alien captive insurance company shall grant authority to the Commissioner for examination of the affairs of such foreign captive insurance company or alien captive insurance company in the jurisdictions in which the foreign captive insurance company or alien captive insurance company is formed, operates or maintains books and records.

(77 Del. Laws, c. 252, § 13; 80 Del. Laws, c. 46, § 14.)

§ 6976. Taxation of branch captives.

In the case of a branch captive insurance company, the tax provided for in § 6914 of this title shall apply only to the branch business of such company.

(77 Del. Laws, c. 252, § 13.)

Subchapter V

Miscellaneous

§ 6980. Federal Home Loan Bank membership.

A captive insurance company may apply for and become a member of a Federal Home Loan Bank, as defined in 12 U.S.C. § 1422(1)(A). The Commissioner may issue such reasonable rules, regulations and orders as the Commissioner may deem necessary or desirable to effectuate the purposes of this section, including setting standards for captive insurance companies qualifying for, entering into, and reporting advance agreements with Federal Home Loan Banks.

(80 Del. Laws, c. 46, § 15.)

§ 6981. Repeals; effective date; applicability.

(a) Except as provided in subsection (b) of this section, this chapter shall apply to all captive insurance companies.

(b) Chapter 69 of this title as in effect prior to July 11, 2005, chapter is hereby repealed, except as set forth in the next sentence. Chapter 69 of this title as in effect on July 11, 2005, shall apply to any captive insurance company licensed under such chapter as of such date that has not submitted a written notice to the Commissioner under subsection (c) of this section.

(c) Any captive insurance company licensed in this State as of July 11, 2005, that otherwise would be subject to the application of Chapter 69 of this title as in effect on such date may elect to become subject to the application of this chapter instead by submitting to the Commissioner a written notice to that effect.

(75 Del. Laws, c. 150, § 1; 76 Del. Laws, c. 161, § 14; 77 Del. Laws, c. 252, § 13.)

§ 6982. Reserved power of this State to alter or repeal chapter.

All provisions of this chapter may be altered from time to time or repealed.

(75 Del. Laws, c. 150, § 1; 76 Del. Laws, c. 161, § 14; 77 Del. Laws, c. 252, § 13.)

§ 6983. Short title.

This chapter may be cited as the “Delaware Revised Captive Insurance Company Act.”

(75 Del. Laws, c. 150, § 1; 76 Del. Laws, c. 161, § 14; 77 Del. Laws, c. 252, § 13.)

Part I
Insurance

Chapter 70
Sealed Container Defense in Product Liability [Transferred to Chapter 25I of Title 6]

§ 7001. Sealed container defense in product liability [Transferred to § 2501I of Title 6].

(66 Del. Laws, c. 45, § 1; 70 Del. Laws, c. 186, § 1.)

Part I
Insurance
Chapter 71
Long-Term Care Insurance

§ 7101. Statement of purpose.

The purpose of this chapter is to promote the public interest; to promote the availability of long-term care insurance policies; to protect applicants for long-term care insurance, as defined in this chapter, from unfair or deceptive sales or enrollment practices; to establish standards for long-term care insurance; to facilitate public understanding and comparison of long-term care insurance policies; and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

(67 Del. Laws, c. 102, § 1.)

§ 7102. Scope.

The requirements of this chapter shall apply to policies delivered or issued for delivery in this State on or after January 1, 1990. This chapter is not intended to supersede the obligations of entities subject to this chapter to comply with the substance of other applicable insurance laws insofar as such laws do not conflict with this chapter; provided, however, that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not be applied to long-term care insurance. A policy which is not advertised, marketed or offered as long-term care insurance or nursing home insurance need not meet the requirements of this chapter.

(67 Del. Laws, c. 102, § 1.)

§ 7103. Definitions.

The following words, terms and phrases, when used in this chapter, shall have the meanings ascribed to them in this section, except where the context clearly indicates a different meaning:

(1) "Applicant" shall mean:

a. In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and

b. In the case of a group long-term care insurance policy, the proposed certificate holder.

(2) "Certificate" shall mean, for the purposes of this chapter, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this State.

(3) "Commissioner" shall mean the Insurance Commissioner of this State.

(4) "Group long-term care insurance" shall mean a long-term care insurance policy which is delivered or issued for delivery in this State and issued to:

a. One or more employers or labor organizations, or to a trust or to the trustees of a fund established by 1 or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof, or for members or former members or a combination thereof, of the labor organization; or

b. Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and such association has been maintained in good faith for purposes other than obtaining insurance; or

c. An association or a trust or the trustee or trustees of a fund established, created or maintained for the benefit of members of 1 or more associations. Prior to advertising, marketing or offering such policy within this State, each such association or the insurer of such association, shall file evidence with the Commissioner that the association has at the outset a minimum of 100 persons; has been organized and maintained in good faith for purposes other than that of obtaining insurance; has been in active existence for at least 1 year; and has a constitution and bylaws which provide that:

1. The association holds regular meetings not less than annually to further purposes of the members;

2. Except for credit unions, the association collects dues or solicits contributions from members; and

3. The members of the association have voting privileges and representation on the governing board and committees.

Thirty days after such filing the association shall be deemed to satisfy such organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements; or

d. A group other than as described in paragraphs (4)a.-c. of this section, subject to a finding by the Commissioner that:

1. The issuance of the group policy is not contrary to the best interest of the public;

2. The issuance of the group policy would result in economies of acquisition or administration; and

3. The benefits are reasonable in relation to the premiums charged.

(5) "Long-term care insurance" shall mean any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis, for 1 or more

necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Such term includes group and individual policies or riders whether issued by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. The words "long-term care" shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for 1 or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision contained herein, any product advertised, marketed, or offered as long-term care insurance shall be subject to this chapter.

(6) "Policy" shall mean, for the purposes of this chapter, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this State by an insurer; fraternal benefit society; nonprofit health, hospital or medical service corporation; prepaid health plan; health maintenance organization or any similar organization.

(67 Del. Laws, c. 102, § 1; 68 Del. Laws, c. 160, §§ 1, 2.)

§ 7104. Extraterritorial jurisdiction; group long-term care insurance.

No group long-term care insurance coverage may be offered to a resident of this State under a group policy issued in another state to a group described in § 7103(4) of this title, unless this State or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this State has made a determination that such requirements have been met.

(67 Del. Laws, c. 102, § 1; 68 Del. Laws, c. 160, § 3.)

§ 7105. Disclosure and performance standards for long-term care insurance.

(a) The Commissioner may adopt regulations that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, rescission of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms.

(b) No long-term care insurance policy may:

(1) Be cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder; or

(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3) Provide coverage for skilled nursing care only, or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care; or

(4) Condition eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.

(c) *Preexisting conditions.* — (1) No long-term care insurance policy or certificate, other than a policy or certificate thereunder issued to a group as defined in § 7103(4)a. of this title, shall use a definition of "preexisting condition" which is more restrictive than the following: "Preexisting condition" shall mean a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within 6 months preceding the effective date of coverage of an insured person.

(2) No long-term care insurance policy or certificate, other than a policy or certificate thereunder issued to a group as defined in § 7103(4)a. of this title, shall exclude coverage for a loss or confinement which is the result of a preexisting condition, unless such loss or confinement begins within 6 months following the effective date of coverage of an insured person.

(3) The Commissioner may extend the limitation periods set forth in paragraphs (c)(1) and (2) of this section as to specific age group categories in specific policy forms, upon findings that the extension is in the best interest of the public.

(4) The definition of "preexisting condition" shall not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant; and, on the basis of the answers on that application, from underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether or not it is disclosed on the application, need not be covered until the waiting period described in paragraph (c)(2) of this section expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph (c)(2) of this section.

(d) *Prior hospitalization and/or institutionalization.* — (1) No long-term care insurance policy may be delivered or issued for delivery in this State if such policy conditions eligibility for any benefits on a prior hospitalization requirement; or if such policy conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care.

(2) A long-term care insurance policy containing post-confinement, post-acute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.

(3) A long-term care insurance policy or rider which conditions eligibility for noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than 30 days.

(4) No long-term care insurance policy which provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge from the institution.

(e) The Commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.

(f) *Right to return; free look.* — Long-term care applicants shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in § 7103(4)d. of this title, the applicant is not satisfied for any reason.

(g) *Outline of coverage.* — (1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of the initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

a. The Commissioner shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

b. In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form.

c. In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

(2) The outline of coverage shall include:

a. A description of the principal benefits and coverage provided in the policy;

b. A statement of the principal exclusions, reductions and limitations contained in the policy;

c. A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion of group coverage shall be specifically described;

d. A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

e. A description of the terms under which the policy or certificate may be returned and premium refunded; and

f. A brief description of the relationship of cost of care and benefits.

(h) A certificate issued pursuant to a group long-term care insurance policy which policy is delivered or issued for delivery in this State shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions and limitations contained in the policy; and

(3) A statement that the group master policy determines governing contractual provisions.

(i) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

(1) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(2) An illustration of the amount of benefits, the length of benefit and the guaranteed lifetime benefits, if any, for each covered person;

(3) Any exclusions, reductions and limitations on benefits of long-term care; and

(4) If applicable to the policy type, the summary shall include a disclosure of the effects of exercising other rights under the policy, a disclosure of guarantee related to long-term care costs of insurance charges and current and projected maximum lifetime benefits.

(j) Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. Such report shall include:

(1) Any long-term care benefits paid out during the month;

(2) An explanation of any changes in the policy, e.g., death benefits or cash values, due to long-term care benefits being paid out; and

(3) The amount of long-term care benefits existing or remaining.

(k) Any policy or rider advertised, marketed or offered as long-term care or nursing home insurance shall comply with this chapter.

(67 Del. Laws, c. 102, § 1; 68 Del. Laws, c. 160, §§ 4-7; 77 Del. Laws, c. 471, § 2.)

§ 7106. Nonforfeiture benefit requirement.

(a) No insurer may issue or deliver a long-term care insurance policy in this State unless the insurer offers to the applicant the option to purchase a policy that provides for nonforfeiture benefits.

(b) The Insurance Commissioner shall promulgate rules and regulations which specify the types of nonforfeiture benefits to be included in the policies and certificates, the standards for the benefits and the date nonforfeiture benefits must commence.

(70 Del. Laws, c. 351, § 1.)

§ 7107. Administrative procedures.

The Commissioner shall issue reasonable regulations to establish minimum standards for marketing practices, agent compensation, agent testing, penalties and reporting practices for long-term care insurance, and any other rules and regulations necessary for or as an aid to the administration or effectuation of this chapter. Regulations adopted pursuant to this chapter shall be in accordance with the provisions of Chapter 101 of Title 29.

(67 Del. Laws, c. 102, § 1; 68 Del. Laws, c. 160, § 8; 70 Del. Laws, c. 351, § 1.)

§ 7108. Title.

This chapter shall be known and may be cited as the “Long-Term Care Insurance Act.”

(67 Del. Laws, c. 102, § 1; 70 Del. Laws, c. 351, § 1.)

§ 7109. Penalties.

In addition to any other penalties provided by the laws of this State, any insurer or agent found to have violated any requirement of this State relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to 3 times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

(68 Del. Laws, c. 160, § 9; 70 Del. Laws, c. 351, § 1.)

Part I
Insurance
Chapter 72
Small Employer Health Insurance

§ 7201. Purpose.

The purpose and intent of this chapter are to promote the availability of health insurance coverage to small employers regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to establish limitations on the use of preexisting condition exclusions, to provide for development of "basic" and "standard" health benefit plans to be offered to all small employers, to provide for establishment of a reinsurance program, and to improve the overall fairness and efficiency of the small group health insurance market.

This chapter is not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance.

(68 Del. Laws, c. 175, § 1; 68 Del. Laws, c. 340, § 1.)

§ 7202. Definitions [For application of this section, see 79 Del. Laws, c. 99, § 19].

As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries, or other individual acceptable to the Commissioner, that a small employer carrier is in compliance with the provisions of § 7205 of this title, based upon an examination and including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through 1 or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Affiliation period" means a period of time not to exceed 2 months (3 months for late enrollees) during which a health maintenance organization does not collect premiums and coverage issued is not effective.

(4) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(5) "Basic health benefit plan" means a lower cost health benefit plan developed pursuant to § 7211 of this title.

(6) "Board" means the board of directors of the program established pursuant to § 7210 of this title [repealed].

(7) "Bona fide association" means, with respect to health insurance coverage offered in Delaware, an association which:

a. Has been actively in existence for at least 5 years;

b. Has been formed and maintained in good faith for purposes other than obtaining insurance and does not condition membership on the purchase of association-sponsored insurance;

c. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee) and clearly so states in all membership and application materials;

d. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member) and clearly so states in all marketing and application materials;

e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association and clearly so states in all marketing and application materials; and

f. Provides and annually updates information necessary for the Commissioner to determine whether or not an association meets the definition of a bona fide association before qualifying as a bona fide association for the purposes of this chapter.

(8) "Carrier" means any entity that provides health insurance in this State. For the purposes of this chapter, carrier includes an insurance company, health service corporation, health maintenance organization and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(9) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claim experience, health status and duration of coverage shall not be case characteristics for the purposes of this chapter. The small employer carrier shall not use case characteristics other than age, industry (subject to § 7205(6) of this title), geographic area, family composition, unhealthy lifestyle choices and group size without prior approval of the Commissioner.

(10) "Class of business" means all of a carrier's business unless more than 1 class is established pursuant to § 7204 of this title.

(11) "Commissioner" means the Insurance Commissioner of this State.

(12) "Committee" means the Health Benefit Plan Committee created pursuant to § 7211 of this title.

(13) "Control" shall be defined in the same manner as in § 5002 of this title.

(14) “Creditable coverage” means, with respect to an individual, health benefits or coverage provided under any of the following:

a. A group health benefit plan;

b. An individual health benefit plan or individual insurance coverage;

c. Part A or Part B of Title XVIII of the Social Security Act [42 U.S.C. § 1395 et seq. or 42 U.S.C. § 1395j et seq.];

d. Title XIX of the Social Security Act [42 U.S.C. § 1396 et seq.], other than coverage consisting solely of benefits under § 1928 [42 U.S.C. § 1396s];

e. Chapter 55 of Title 10, United States Code [10 U.S.C. § 1071 et seq.];

f. A medical care program of the Indian Health Service or of a tribal organization;

g. A state health benefits risk pool;

h. A health plan offered under Chapter 89 of Title 5, United States Code;

i. A public health plan as defined in federal regulations;

j. A health benefit plan under § 5(e) of the Peace Corps Act [22 U.S.C. § 2504(e)].

(15) “Dependent” means a spouse, a child under the age of 26 years, and an unmarried child of any age who is medically certified as totally disabled and dependent upon the parent.

(16) “Eligible employee” means an employee who works on a full-time basis and has a normal work week of 30 or more hours. The term includes a sole proprietor, a partner of a partnership and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary or substitute basis. With respect to any health benefit plan of a small employer that is purchased through the state health insurance exchange program or Small Business Health Options Program (SHOP) established pursuant to the Patient Protection and Affordable Care Act [P.L. 111-148], the term “eligible employee” shall not include a sole proprietor, a partner of a partnership, independent contractor, a member of a limited liability company taxed as a partnership, shareholder owning more than 2% of an S corporation, or any owner of more than 5% of other businesses, or any family member of such owners or partners, or an employee who works on a part-time, temporary or substitute basis.

(17) “Established geographic service area” means a geographic area, as approved by the Commissioner and based on the carrier’s certificate of authority to transact insurance in this State, within which the carrier is authorized to provide coverage.

(18) “Health benefit plan” means any hospital or medical expense policy or certificate, hospital or medical service corporation contract, health maintenance organization or health service corporation subscriber contract or any other similar health contract, including a high deductible medical expense policy used in conjunction with a medical savings account, subject to the jurisdiction of the Commissioner available for use, offered or sold to an individual in the State of Delaware. This term includes a bona fide association plan if such plan provides coverage to 1 or more eligible employees of a small employer in Delaware.

“Health benefit plan” does not include: accident only; credit; dental; vision; Medicare supplement; benefits for long-term care, home health care, community-based care or any combination thereof; disability income insurance; liability insurance including general liability insurance and automobile liability insurance; coverage for on-site medical clinics; coverage issued as a supplement to liability insurance, worker’s compensation or similar insurance; or automobile medical payment insurance. The term also excludes specified disease, hospital confinement indemnity or limited benefit health insurance if such types of coverage do not provide coordination of benefits and are provided under separate policies or certificates; provided, that the carrier offering such policies or certificates complies with the following:

a. The carrier files on or before March 1 of each year a certification with the Commissioner that contains the statement and information described in paragraph (18)b. of this section.

b. The certification shall contain the following:

1. A statement from the carrier certifying that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance.

2. A summary description of each policy or certificate described in this paragraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age or other factors) charged for these policies and certificates in this State.

c. In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this State on or after July 1, 1997, the carrier files with the Commissioner the information and statement required in paragraph (18)b. of this section at least 30 days prior to the date the policy or certificate is issued or delivered in this State.

(19) “Health status-related factor” means any of the following factors:

a. Health status;

b. Medical condition, including both physical and mental illnesses;

c. Claims experience;

d. Receipt of health care;

e. Medical history;

f. Genetic information, as defined in § 2317 of this title;

g. Evidence of insurability, including conditions arising out of acts of domestic violence;

h. Disability.

(20) "Index rate" means, for each class of business as to a rating period for small employers, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(21) "Late enrollee" means an eligible employee or dependent who requests enrollment in a group health benefit plan following the initial enrollment period during which such individual is entitled to enroll under the terms of the health benefit plan, if such initial enrollment period is a period of at least 30 days. An eligible employee or dependent shall not be considered a late enrollee if:

a. The individual:

1. Was covered under other creditable coverage at the time of the initial enrollment period and, if required by the employer, policyholder, carrier or issuer, the employee stated at the time of initial enrollment that this was the reason for declining enrollment;

2. Lost coverage under the other creditable coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the creditable coverage, death of a spouse, legal separation or divorce or employer contributions towards such coverage was terminated; and

3. Requests enrollment within 30 days after termination of the other creditable coverage;

b. The individual is employed by an employer that offers multiple health benefit plans and elects a different plan during an open enrollment period;

c. A court has ordered that coverage be provided for a dependent under a covered employee's health benefit plan and the request for enrollment is made within 30 days after issuance of such court order; or

d. A person becomes a dependent of a covered person through marriage, birth, adoption or placement for adoption and requests enrollment no later than 30 days after becoming such a dependent. In such case, coverage shall commence on the date the person becomes a dependent if a request for enrollment is received in a timely fashion before such date.

(22) "Medical care" means amounts paid for:

a. The diagnosis, cure, mitigation, treatment or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

b. Transportation primarily for and essential to medical care referred to in paragraph (22)a. of this section; and

c. Insurance covering medical care referred to in paragraphs (22)a. and b. of this section.

(23) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered or which could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(24) "Plan of operation" means the plan of operation of the program established pursuant to § 7210 of this title [repealed].

(25) "Premium" means all moneys paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(26) "Producer" means agent and/or broker.

(27) "Program" means the Delaware Small Employer Reinsurance Program created by § 7210 of this title [repealed].

(28) "Qualifying previous coverage" and "qualifying existing coverage" shall have the same meaning as the term "creditable coverage;" provided however, that for purposes of determining a participation requirement, "qualifying previous coverage" and "qualifying existing coverage" means benefits or coverage provided under:

a. Medicare or Medicaid;

b. An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or

c. An individual health insurance policy (including coverage issued by a health maintenance organization, health service organization and fraternal benefit society) that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan; provided, that such policy has been in effect for 1 year.

(29) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(30) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to § 7210 of this title [repealed].

(31) "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health-care providers that have entered into a contractual arrangement with the carrier pursuant to Chapter 64 of this title or otherwise to provide health-care services to covered individuals.

(32) "Risk-assuming carrier" means a small employer carrier whose application is approved by the Commissioner pursuant to § 7209 of this title.

(33) “Small employer” means any person, firm, corporation, partnership or association that is actively engaged in business that, on at least 50% of its working days during the preceding calendar quarter, employed no more than 50 eligible employees, the majority of whom were employed within this State. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered 1 employer. With respect to any health benefit plan of a small employer that is purchased through the state health insurance exchange program or SHOP established pursuant to the Patient Protection and Affordable Care Act [P.L. 111-148], the term “small employer” shall not include a sole proprietorship, partnership, independent contractor, limited liability company taxed as a partnership, S corporation or any other business that employs only such owners or partners or family members thereof.

(34) “Small employer carrier” means a carrier that offers health benefit plans covering eligible employees of 1 or more small employers in this State.

a. Except as provided in paragraph (34)b. of this section, for the purposes of this chapter, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as 1 carrier and any restrictions or limitations imposed by this chapter shall apply as if all health benefit plans delivered or issued for delivery to small employers in this State by such affiliated carriers were issued by 1 carrier.

b. An affiliated carrier that is a health maintenance organization having a certificate of authority under Chapter 64 of this title may be considered to be a separate carrier for the purposes of this chapter.

c. Unless otherwise authorized by the Commissioner, a small employer carrier shall not enter into 1 or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this State if such arrangements would result in less than 50% of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier. The provisions of §§ 910 and 4944 of this title shall apply if a small employer carrier cedes or assumes all of the insurance obligation or risk with respect to 1 or more health benefit plans delivered or issued for delivery to small employers in this State.

In the case of an employer that was not in existence throughout the preceding calendar quarter, the determination of whether such employer is a small or large employer shall be based on the average number of employees that is reasonably expected such employer will employ on business days in the current calendar year.

(35) “Standard health benefit plan” means a health benefit plan developed pursuant to § 7211 of this title.

(36) “Unhealthy lifestyle choices” means smoking or maintaining excessive weight, blood pressure or cholesterol, other than due to organic causes that are being treated by a physician, as those conditions or actions may be more fully defined by regulation by the Commissioner.

(37) “Waiting period” means, with respect to a group health plan and an individual who is a potential participant in or beneficiary of the plan, the period that must pass with respect to the individual before the individual is eligible for benefits under the terms of the plan. For purposes of calculating periods of creditable coverage, a waiting period shall not be considered a gap in coverage.

(68 Del. Laws, c. 175, § 1; 68 Del. Laws, c. 340, § 1; 69 Del. Laws, c. 323, § 1; 69 Del. Laws, c. 403, §§ 1, 2; 71 Del. Laws, c. 143, §§ 4, 5; 72 Del. Laws, c. 383, § 5; 79 Del. Laws, c. 99, § 14.)

§ 7203. Applicability and scope.

This chapter shall apply to any health benefit plan provided by a small employer which provides coverage to the employees of such small employer in this State.

(68 Del. Laws, c. 175, §§ 1, 3; 68 Del. Laws, c. 340, § 1.)

§ 7204. Establishment of classes of business.

(a) A small employer carrier may establish more than 1 class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

(1) The small employer carrier uses more than 1 type of system for the marketing and sale of health benefit plans to small employers;

(2) The small employer carrier has acquired a class of business from another small employer carrier; or

(3) The small employer carrier provides coverage to 1 or more association groups that meet the requirements of § 3506 of this title.

(b) A small employer carrier may establish no more than 9 classes of business under subsection (a) of this section, except as provided for in subsection (d) of this section.

(c) The Commissioner may establish regulations to provide for periods of transition in order for a small employer carrier to come into compliance with subsections (a) and (b) of this section in the instance of acquisition of a block of business from another small employer carrier.

(d) The Commissioner may approve the establishment of more than 9 classes of business upon a finding that such action would enhance the efficiency and fairness of the small employer marketplace.

(e) A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.

(68 Del. Laws, c. 340, § 1.)

§ 7205. Restrictions relating to premium rates.

Premium rates for health benefit plans subject to this chapter shall be subject to the following provisions:

(1) The index rate for any class of business shall not exceed the index rate for similar coverage for any other class of business by more than 20 percent in any rating period.

(2) The premium rates for similar health benefit plans within a class of business shall not vary from the index rate by more than 35 percent, with:

a. An additional combined variation of no more than 10 percent for gender and geography; and

b. The actuarially justified adjustment for age and family composition,

provided, that the small employer carrier shall file a document as prescribed by the Commissioner setting out the age classes and family composition classes used pursuant to this paragraph, including actuarial certification of these classes.

(3) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

a. The percentage change in the new business premium rate calculated using premium rates on the first day of the prior rating period and the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

b. Any adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less than 1 year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and

c. Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

(4) Adjustments in rates for claim experience, health status and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer. This prohibition shall not be construed to prevent a carrier from establishing premium discounts or rebates or modifying otherwise applicable co-payments or deductibles in return for adherence to programs of health promotion and disease prevention, if otherwise allowed by law.

(5) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers pursuant to § 7210 of this title [repealed].

(6) A small employer carrier may utilize industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification shall not exceed the lowest rate factor associated with any industry classification by more than 15 percent.

(7) In the case of health benefit plans delivered or issued for delivery prior to January 4, 1993, a premium rate for a rating period may exceed the ranges set forth in paragraphs (1) and (2) of this section for a period of 1 year following January 4, 1993. In such case, the percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

a. The percentage change in the new business premium rate calculated using premium rates on the first day of the prior rating period and the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

b. Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

(8) a. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

b. A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(9) For purposes of this subsection, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted provider network results in substantial differences in claims costs.

(68 Del. Laws, c. 175, § 1; 68 Del. Laws, c. 340, § 1; 71 Del. Laws, c. 143, § 6.)

§ 7206. Renewability of coverage.

(a) A health benefit plan subject to this chapter shall be renewable with respect to all eligible employees or dependents, at the option of the small employer, except in any of the following cases:

(1) Nonpayment of the required premiums;

(2) Fraud or misrepresentation of the small employer or, with respect to coverage of individual insureds, the insureds or their representatives;

(3) Noncompliance with the carrier's minimum participation requirements;

(4) Noncompliance with the carrier's employer contribution requirements;

(5) Repeated misuse of a provider network provision;

(6) The small employer carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to small employers in this State. In such a case the carrier shall:

a. Provide advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed; and

b. Provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected insured individual is known to reside at least 180 days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the commissioner under this subparagraph shall be provided at least 3 working days prior to the notice to the affected small employers;

(7) The Commissioner finds that the continuation of the coverage would:

a. Not be in the best interests of the policyholders or certificate holders;

b. Impair the carrier's ability to meet its contractual obligations.

In such instance the Commissioner shall assist affected small employers in finding replacement coverage;

(8) With respect to a carrier that offers a health benefit plan through a managed care plan, there is no longer any enrollee in connection with such plan that lives, resides or works in the service area of the carrier;

(9) An employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan; or

(10) With respect to coverage that is made available only through 1 or more bona fide associations, the membership of an employer ceases.

(b) A small employer carrier that elects not to renew a health benefit plan under paragraph (a)(6) of this section shall be prohibited from writing new business in the small employer market in this State for a period of 5 years from the date of notice to the Commissioner.

(c) In the case of a small employer carrier doing business in 1 established geographic service area of the State, the rules set forth in this chapter shall apply only to the carrier's operations in that service area.

(68 Del. Laws, c. 175, § 1; 68 Del. Laws, c. 340, § 1; 71 Del. Laws, c. 143, § 7.)

§ 7207. Availability of coverage; preexisting conditions; minimum participation [For application of this section, see 79 Del. Laws, c. 99, § 19].

(a) (1) Subject to paragraph (a)(4) of this section, every small employer carrier shall, as a condition of transacting business in this State with small employers, actively offer to small employers at least 2 health benefit plans. One health benefit plan offered by each small employer carrier shall be a basic health benefit plan and 1 plan shall be a standard health benefit plan.

(2) a. A small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to any small employer meeting the requirements of paragraph (a)(3) of this section that applies to either such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this chapter.

b. In the case of a small employer carrier that establishes more than 1 class of business pursuant to § 7204 of this title, the small employer carrier shall maintain and issue to such small employers at least 1 basic health benefit plan and at least 1 standard health benefit plan in each class of business so established. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

1. The criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health benefit plan;

2. The criteria are not related to the health status or claim experience of the small employer;

3. The criteria are applied consistently to all small employers applying for coverage in the class of business; and

4. The small employer carrier provides for the acceptance of all eligible small employers into 1 or more classes of business.

The provisions of this subparagraph shall not apply to a class of business into which the small employer carrier is no longer enrolling new small businesses.

(3) A small employer is eligible under paragraph (a)(2) of this section if it employed at least 1 or more eligible employees within this State on at least 50 percent of its working days during the preceding calendar quarter.

(4) The provisions of this section shall be effective 180 days after the Commissioner's and Delaware Health Care Commission's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to § 7211 of this title; provided, that if the Small Employer Health Reinsurance Program created pursuant to § 7210 of this title [repealed] is not yet operative on that date, the provisions of this paragraph shall be effective on the date that program begins operation.

(b) (1) A small employer carrier shall file with the Commissioner, in a format and manner prescribed by the Commissioner, the basic health benefit plans and the standard health benefit plans to be used by the carrier within 90 days after the Commissioner establishes the guidelines thereof. A health benefit plan filed pursuant to this paragraph may be used by a small employer carrier beginning 30 days after it is filed unless the Commissioner disapproves its use.

(2) The Commissioner at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this chapter.

(c) Health benefit plans covering small employers shall comply with the following provisions:

(1) A health benefit plan shall not deny, exclude or limit benefits for a covered individual for losses due to a preexisting condition.

(2) A health maintenance organization may impose an affiliation period. An affiliation period shall run concurrently with any waiting period imposed. Such a health maintenance organization may, in lieu of an affiliation period, use an alternative method to address adverse selection with the prior approval of the Insurance Commissioner.

(3) A health benefit plan shall waive any affiliation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services provided, that the qualifying previous coverage was continuous to a date not more than 63 days prior to the effective date of the new coverage, excluding any waiting period applicable to the new plan. This paragraph does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(4) A health benefit plan may not exclude coverage for late enrollees for a preexisting condition.

(5) a. Except as provided in subsection (d) of this section, requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

b. A small employer carrier may vary the application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

c. An employee who does not participate in the health benefit plan and who presents satisfactory evidence that the employee has coverage through a spouse or other qualifying existing coverage shall not be counted by a small employer carrier with respect to number or percent participation requirements.

d. A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has contracted for coverage.

(6) a. If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in paragraph (c)(4) of this section.

b. A small employer carrier shall not modify a basic or standard health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(d) (1) A small employer carrier shall not be required to offer coverage or accept applications pursuant to subsection (a) of this section in the case of the following:

a. To a small employer, where the small employer is not physically located in the carrier's established geographic service area;

b. To an employee, when the employee does not work or reside within the carrier's established geographic service area; or

c. Within an area where the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the Commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group policyholders and enrollees.

(2) A small employer carrier that cannot offer coverage pursuant to paragraph (d)(1)c. of this section may not offer coverage in the applicable area to new cases of employer groups with more than 50 eligible employees or to any small employer groups until the later of 180 days following each such refusal or the date on which the carrier notifies the Commissioner that it has regained capacity to deliver services to small employer groups.

(e) A small employer carrier shall not be required to provide coverage to its employers pursuant to subsection (a) of this section for any period of time for which the Commissioner determines that requiring the acceptance of small employers in accordance with the provisions of subsection (a) of this section would place the small employer carrier in a financially impaired condition.

(f) Effective July 1, 1997, every small employer carrier shall also offer to small employers a choice of all the other small group plans the carrier markets in Delaware; except that this requirement shall not apply to:

(1) A health benefit plan offered by a carrier if such plan is made available in the small group market only through 1 or more bona fide association plans; or

(2) A business group of 1 where the business group of 1 does not meet the carrier's actuarially-based underwriting criteria.

(g) A health benefit plan shall not establish rules for eligibility for any individual to enroll under the plan based on any health status-related factors in relation to the individual or a dependent of the individual.

(68 Del. Laws, c. 340, § 1; 69 Del. Laws, c. 403, §§ 3-5; 70 Del. Laws, c. 186, § 1; 71 Del. Laws, c. 143, §§ 8-12; 72 Del. Laws, c. 383, §§ 1, 2; 79 Del. Laws, c. 99, § 15.)

§ 7208. Notice of intent to operate as a risk-assuming carrier.

(a) (1) Each small employer carrier desiring to operate as a risk-assuming carrier shall make application to the Commissioner within 30 days of January 4, 1993 to operate as a risk-assuming carrier, pursuant to § 7209 of this title.

(2) The Commissioner may permit a carrier to modify its status at any time for good cause shown.

(3) The Commissioner shall establish an application process for small employer carriers seeking to change their status under this subsection.

(b) A reinsuring carrier that applies and is approved to operate as a risk-assuming carrier shall not be permitted to continue to reinsure any health benefit plan with the Program. Such a carrier shall pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

(68 Del. Laws, c. 340, § 1.)

§ 7209. Application to become a risk-assuming carrier.

(a) A small employer carrier may apply to become a risk-assuming carrier by filing an application with the Commissioner in a form and manner prescribed by the Commissioner.

(b) The Commissioner shall consider the following factors in evaluating an application filed under subsection (a) of this section:

(1) The carrier's financial condition;

(2) The carrier's history of rating and underwriting small employer groups;

(3) The carrier's commitment to market fairly to all small employers in the State or its established geographic service area, as applicable;

(4) The carrier's experience with managing the risk of small employer groups; and

(5) The effect of approval and disapproval on the small employer insurance market and the Delaware Small Employer Health Reinsurance Program pursuant to § 7210 of this title [repealed].

(c) The Commissioner may rescind the approval granted to a risk-assuming carrier under this section if the Commissioner finds that:

(1) The carrier's financial condition will no longer support the assumption of risk from issuing coverage to small employers in compliance with § 7207 of this title without the protection afforded by the Program;

(2) The carrier has failed to market fairly to all small employers in the State or its established geographic service area, as applicable; or

(3) The carrier has failed to provide coverage to eligible small employers as required in § 7207 of this title.

(d) A small employer carrier electing to be a risk-assuming carrier shall not be subject to the provisions of § 7210 of this title [repealed].

(68 Del. Laws, c. 340, § 1; 69 Del. Laws, c. 403, § 6.)

§ 7210. Small Employer Health Reinsurance Program [Repealed].

Repealed by 77 Del. Laws, c. 106, § 3, effective July 6, 2009.

§ 7211. Health benefit plan committee.

(a) The Commissioner shall appoint a Health Benefit Plan Committee. The Committee shall be composed of representatives of carriers, small employers and employees, health-care providers and producers.

(b) The Committee shall recommend the form and level of coverages to be made available by small employer carriers pursuant to § 7207 of this title.

(c) The Committee shall recommend benefit levels, cost sharing levels, exclusions and limitations for the basic health benefit plan and the standard health benefit plan. The Committee shall also design a basic health benefit plan and a standard health benefit plan which contain benefit and cost sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law.

(1) The plans recommended by the Committee may include cost containment features such as:

a. Utilization review of health-care services, including review of medical necessity of hospital and physician services;

b. Case management;

c. Selective contracting with hospitals, physicians and other health-care providers;

d. Reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and

e. Other managed care provisions.

(2) The Committee shall submit the health benefit plans described in paragraph (c)(1) of this section to the Commissioner and the Delaware Health Care Commission for approval within 180 days after the appointment of the Committee.

(68 Del. Laws, c. 340, § 1.)

§ 7212. Periodic market evaluation.

The board, in consultation with the Committee, shall study and report at least every 3 years to the Commissioner on the effectiveness of this chapter. The report shall analyze the effectiveness of the chapter in promoting rate stability, product availability and coverage

affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency and fairness of the small employer group health insurance marketplace. The report shall address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of the chapter. The report may contain recommendations for market conduct or other regulatory standards or action.

(68 Del. Laws, c. 340, § 1.)

§ 7213. Waiver of certain state laws.

No law requiring the coverage of a health-care service or benefit, or requiring the reimbursement, utilization or inclusion of a specific category of licensed health-care practitioner, shall apply to a basic health benefit plan delivered or issued for delivery to small employers in this State pursuant to this chapter.

(68 Del. Laws, c. 340, § 1.)

§ 7214. Administrative procedures.

The Commissioner shall issue regulations in accordance with § 314 of this title and Chapter 101 of Title 29, for the implementation and administration of this chapter.

(68 Del. Laws, c. 340, § 1.)

§ 7215. Standards to assure fair marketing.

(a) Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the State. If a small employer carrier denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan and a standard health benefit plan.

(b) (1) Except as provided in paragraph (b)(2) of this section, no small employer carrier or producer shall, directly or indirectly, engage in the following activities:

a. Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

b. Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(2) The provision of paragraph (b)(1) of this section shall not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(c) Except as provided in this section, no small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic area of the small employer.

(d) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the Program, to a producer, if any, for the sale of a basic or standard health benefit plan.

(e) No small employer carrier may terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation or geographic location of the small employers placed by the producer with the small employer carrier.

(f) No small employer carrier or producer may induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(g) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

(h) The Commissioner may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this State.

(i) (1) A violation of this section by a small employer carrier or a producer shall be an unfair trade practice under §§ 2303 and 2304 of this title.

(2) If a small employer carrier enters into a contract, agreement or other arrangement with a thirrd-party administrator to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this State, the third-party administrator shall be subject to this section as if it were a small employer carrier.

(68 Del. Laws, c. 340, § 1.)

§ 7216. Regulations; exceptions.

(a) The Commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of this chapter, including regulations that:

(1) Assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design (not including differences due to the nature of the groups assumed to select particular health benefit plans); and

(2) Prescribe the manner in which case characteristics may be used by small employer carriers.

(b) The Commissioner may suspend for a specified period the application of paragraph (a)(1) of this section as to the premium rates applicable to 1 or more small employers included within a class of business of a small employer carrier for 1 or more rating periods upon a filing by the small employer carrier and a finding by the Commissioner either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

(68 Del. Laws, c. 175, § 1; 68 Del. Laws, c. 340, § 1.)

§ 7217. Disclosure of rating practices; certification of compliance.

(a) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(1) The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

(2) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and the factors, other than claim experience that affect changes in premium rates;

(3) The provisions relating to renewability of policies and contracts;

(4) The provisions relating to any preexisting condition provision; and

(5) The benefits available under all health benefit plans for which the employer is qualified.

(b) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(c) Each small employer carrier shall file with the Commissioner annually on or before March 15, an actuarial certification certifying that the carrier is in compliance with this chapter and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the Commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

(d) A small employer carrier shall make information and documentation described in subsection (b) of this section available to the Commissioner upon request. Except in cases of violations of this chapter, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the Commissioner to persons outside of the Department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

(68 Del. Laws, c. 175, § 1; 68 Del. Laws, c. 340, § 1; 71 Del. Laws, c. 143, § 13.)

§ 7218. Factors for premium rates; premium rate variations; premium rate adjustments; "stop-loss" policies prohibited.

(a) The only factors, other than plan design and family composition, that may be considered by a small employer carrier in setting premium rates for small employer health insurance are age, health status, and size of the group. "Health status" as used in this section means medical condition, including physical and mental illnesses; claims experience; receipt of health care; evidence of insurability; medical history; and unhealthy lifestyle choices as defined in § 7202 of this title.

(b) The maximum premium rate variation between high and low small employer health insurance risk groups of 2 to 50 employees is a ratio of 5 for the high risk groups to 1 for the low risk groups. The ratio of premium rate variation between high and low risk small employee groups of 2 to 50 employees must decrease by a factor of .5 for high risk groups annually on July 1, until the premium rate variation ratio is 3 for the high risk groups to 1 for the low risk groups.

(c) The maximum premium rate variation between high and low small employer health insurance risk groups of a single employee, known as "groups of one," is a ratio of 6 for the high risk groups to 1 for the low risk groups. The ratio of premium rate variation between high and low risk small employer groups of 1 must decrease by a factor of .5 for high risk groups of 1 annually on July 1, until the premium rate variation ratio is 4 for the high risk groups to 1 for the low risk groups. Nothing in this provision may be construed to create separate risk pools for groups of one and groups of 2 to 50.

(d) A group may not receive a premium rate adjustment for a change in the health status of the members of the group that exceeds 15%, whether higher or lower, from the prior year.

(e) A small employer health insurance carrier may make available, issue, or renew a "stop loss" policy to a small employer if that small employer employs more than 5 eligible employees, the majority of whom are employed within this State, on at least 50% of its working days during the preceding calendar quarter.

(f) Nothing herein shall apply to any company licensed under Chapter 69 of this title.

(77 Del. Laws, c. 388, § 1, 2; 78 Del. Laws, c. 25, § 1; 81 Del. Laws, c. 420, § 1.)

Part I
Insurance

Chapter 73
Pharmacy Access Act

§ 7301. Title.

This chapter shall be known as the “Pharmacy Access Act.”

(69 Del. Laws, c. 227, § 1.)

§ 7302. Purpose and applicability.

(a) The General Assembly finds that pharmaceutical services and prescription drugs are an essential service to the people of this State and that the broadest possible access to such services should be mandated and therefore finds that this chapter shall apply to all health benefit plans providing pharmaceutical service benefits, including prescription drugs, to any resident of Delaware. This chapter shall also apply to insurance companies and health maintenance organizations that provide or administer coverage and benefits for prescription drugs.

(b) This chapter shall not apply to any entity that has its own facility, employs or contracts with physicians, pharmacists, nurses and other health-care personnel, and that dispenses prescription drugs from its own pharmacy to its employees and to enrollees of its health benefit plan; provided, however, this chapter shall apply to an entity otherwise excluded that contracts with an outside pharmacy or group of pharmacies to provide prescription drugs and services. This chapter shall not apply to any federal program, clinical trial program, hospital or other health-care facility when dispensing prescription drugs to its patients.

(69 Del. Laws, c. 227, § 1.)

§ 7303. Access and prohibitions.

(a) Any person in the State may select the pharmacy of the person’s choice as long as the pharmacy has agreed to participate in the plan according to the terms offered by the insurer.

(b) Any pharmacy or pharmacist has the right to participate as a contract provider under a plan or policy if the pharmacy or pharmacist agrees to accept the terms and reimbursement set forth by the insurer.

(c) No insurer shall impose on a beneficiary any co-payment or condition that is not equally imposed with all contracting pharmacy providers the beneficiary may utilize.

(d) No insurer shall require a beneficiary, as a condition of payment or reimbursement, to purchase pharmacy services, including prescription drugs, exclusively through a mail-order pharmacy.

(e) A pharmacist or pharmacy shall not interfere with the control of over-utilization of a plan’s covered services and may not waive, discount, rebate or distort in any way the designated co-payment of any insurer plan or patient’s co-insurance portion of a prescription drug coverage plan.

(f) At least 60 days prior to the effective date of any health benefit plan or renewal of any pharmacy contract network which provides for coverage of pharmacy services, including prescription drug coverage, to Delaware residents, and restricts pharmacy participation, the entity providing the health benefit plan shall provide notice to all pharmacies within the State and shall offer to the pharmacies the opportunity to participate in the health benefit plan. Such notice and offer shall be considered given upon delivery of written notice to the Delaware Pharmaceutical Society, Inc. or its successor, and upon publication of such notice in a newspaper of general circulation throughout the State. All pharmacies within the State shall be eligible to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs. The health benefit insurer shall inform the plan beneficiaries of the names and locations of pharmacies that are participating in the plan as providers of pharmacy services.

(g) Any provision in a health benefit plan which is executed, delivered or renewed, or otherwise contracted for in this State that is contrary to any provision of this section shall, to the extent of the conflict, be void.

(h) It shall be a violation of this section for any insurer of any person to provide any health benefit plan that provides for pharmaceutical services to residents of this State that does not conform to the provisions of this section.

(69 Del. Laws, c. 227, § 1; 70 Del. Laws, c. 186, § 1.)

Part I
Insurance
Chapter 74
The HIV Testing for Insurance Act

§ 7401. Title.

This chapter may be cited as the "HIV Testing For Insurance Act."

(70 Del. Laws, c. 176, § 1.)

§ 7402. Definitions.

For the purpose of this chapter, the following definitions apply:

(1) "Applicant" means the individual proposed for insurance coverage.

(2) "HIV" means the human immunodeficiency virus or any other identified causative agent of acquired immune deficiency syndrome (AIDS).

(3) "HIV test" means an enzyme-linked immunosorbent assay (ELISA) to determine the presence of antibodies to the human immunodeficiency virus (HIV) or such other test as may be approved by the Department of Health and Social Services; in the event of a positive or indeterminate result, the Western Blot Assay or an equivalent or more reliable confirmatory test shall also be administered prior to notification of the test result.

(4) "Informed consent" means a voluntary agreement of consent of HIV testing executed by the subject of the test or the subject's legal guardian. Information provided prior to consent shall be provided in such a manner as to be understood by the subject of the test, and shall fully describe:

(a) The test procedures generally;

(b) The implications of the test results;

(c) How the test results will be used;

(d) With whom the test results shall be shared;

(e) The methods of transmission and methods of prevention of HIV infection;

(f) The medically accepted degree of reliability of the testing procedures;

(g) The opportunity of medical treatment for HIV infection and any related infections if diagnosed;

(h) The presumption that a person who is infected with HIV is infected for life; and

(i) The responsibility of an infected person not to knowingly infect others.

(5) "Insurer" means any individual, corporation, association, partnership, fraternal benefit society or any other entity engaged in the insurance underwriting business, except insurance agents and brokers. This term shall also include medical service plans and hospital plans and health maintenance organizations and health service corporations which shall be designated as engaged in the business of insurance for the purpose of this chapter.

(70 Del. Laws, c. 176, § 1.)

§ 7403. Insurer requirements; informed consent; use of results; information.

(a) No insurer shall request or require that an applicant submit to an HIV test unless the insurer first:

(1) Obtains the applicant's prior written informed consent;

(2) Reveals to the applicant the use to which the HIV test results may be put and entities to whom test results may be disclosed pursuant to §§ 7404 and 7405 of this title; and

(3) Provides the applicant with written information approved by the Department of Health and Social Services, such as the brochure "HIV and AIDS" published by the American Red Cross, or its successor, or a similar brochure.

(b) An applicant may ask the person conducting the medical examination and testing on behalf of the insurer any questions the applicant may have regarding the HIV test and the informed consent. Such person shall either answer the questions to the extent of the person's knowledge or inform the applicant that prior to undergoing medical examination and testing, the applicant may wish to consult a physician or other knowledgeable health care professional, at the applicant's expense, if any.

(c) No positive ELISA test result may be used for any purpose unless it has been confirmed by a Western Blot Assay or an equivalent or more accurate confirmatory test.

(70 Del. Laws, c. 176, § 1.)

§ 7404. Disclosure limitations.

(a) In addition to the disclosure provided for in § 7405 of this title, or Subsection (b) of this section, on the basis of the applicant's written informed consent as specified in § 7403 of this title, an insurer may also disclose an applicant's HIV test result to its reinsurers or to

those contractually retained medical personnel and insurance affiliates, excluding agents and brokers, which are involved in underwriting or claims decisions regarding the individual's application, provided disclosure is necessary to make underwriting or claims decisions regarding such application.

(b) An insurer may report a confirmed positive HIV test result to a medical information exchange agency, such as the Medical Information Bureau, provided that:

(1) The informed consent form clearly explains that such disclosure may be made; and

(2) a. The results are reported in a manner that only identifies that the applicant has had an abnormal blood test result; or

b. The results are reported in a manner that utilizes a neutral identifier to keep the identity of the individual confidential and anonymous to such agency.

(c) Insurers shall maintain strict confidentiality regarding HIV test results. Information regarding HIV test results may not be disclosed outside the insurer except as provided for in this section and in § 7405 of this title.

(70 Del. Laws, c. 176, § 1.)

§ 7405. Notification.

An insurer who fails to issue a policy an applicant due to the results of HIV testing shall notify the applicant in writing of an adverse underwriting decision based upon the results of such applicant's medical examination and testing but shall not disclose the specific results of such medical examination and testing to the applicant. The insurer shall also inform the applicant that the results of the medical examination and testing will be sent to the physician designated by the applicant at the time of application and that such physician should be contacted for information regarding the applicant's medical examination and testing. If a physician was not designated at the time of application, the insurer shall request that the applicant name a physician to whom a copy of the results of the medical examination and testing may be sent. In the event that an applicant fails to identify a physician despite the efforts of the insurer to have the applicant do so, the insurer shall convey to the Department of Health and Social Services information in the insurer's possession which may be necessary to locate and inform the applicant of the applicant's positive HIV test result. If a physician is named by the applicant, the insurer shall, at the time notification is made to the physician, inform the physician that if the applicant fails to contact the physician within 30 days of the notice, the physician shall convey to the Department of Health and Social Services information in the physician's possession which may be necessary to locate and inform the applicant of the applicant's positive HIV test result. The physician shall make such notification to the Department of Health and Social Services if the applicant fails to contact the physician within 30 days of the insurer's notice. All reports made pursuant to this chapter are confidential and protected from release and shall be used for the sole purpose of locating and informing the applicant of the applicant's positive HIV test result.

(70 Del. Laws, c. 176, § 1.)

Part I
Insurance
Chapter 75
Delaware Viatical Settlements Act

§ 7501. Short title.

This chapter may be cited as the “Delaware Viatical Settlements Act.”

(72 Del. Laws, c. 132, § 1; 81 Del. Laws, c. 172, § 1.)

§ 7502. Definitions.

As used in this chapter:

(1) “Advertising” means any written, electronic or printed communication, or any communication by means of recorded telephone messages or transmitted on radio, television, the Internet, or similar communications media, including film strips, motion pictures, and videos, which are published, disseminated, circulated, or placed directly before the public in this State for the purpose of creating an interest in or inducing a person to purchase, sell, assign, devise, bequest, or transfer the death benefit or ownership of a life insurance policy pursuant to a viatical settlement contract.

(2) “Business of viatical settlements” means an activity involved in, but not limited to, the offering, soliciting, negotiating, procuring, effectuating, purchasing, investing, financing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, hypothecating or in any other manner, acquiring an interest in a life insurance policy by means of a viatical settlement contract. The term does not include a “viatical settlement investment” as defined in the Delaware Securities Act, § 73-103(a) of Title 6.

(3) “Chronically ill” means any of the following:

a. Being chronically unable to perform at least 2 activities of daily living (i.e., eating, toileting, transferring, bathing, dressing or continence).

b. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

c. Having a level of disability similar to that described in paragraph (3)a. of this section as determined by the Secretary of Health and Human Services.

(4) “Commissioner” means the Insurance Commissioner of this State.

(5) “Financing entity” means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, or any person that has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract and all of the following:

a. The person’s principal activity related to the transaction is providing funds to effect the viatical settlement or purchase of 1 or more viaticated policies.

b. The person has an agreement in writing with 1 or more licensed viatical settlement providers to finance the acquisition of viatical settlement contracts.

The term does not include a nonaccredited investor or a viatical settlement purchaser.

(6) “Fraudulent viatical settlement act” includes:

a. Acts or omissions committed by any person who knowingly or with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, commits or permits its employees or its agents to engage in acts including:

1. Presenting, causing to be presented or preparing with knowledge or belief that it will be presented to or by a viatical settlement provider, viatical settlement broker, viatical settlement purchaser, financing entity, insurer, insurance producer or any other person, false material information or concealing material information, as part of, in support of or concerning a fact material to 1 or more of the following:

A. An application for the issuance of a viatical settlement contract or insurance policy.

B. The underwriting of a viatical settlement contract or insurance policy.

C. A claim for payment or benefit pursuant to a viatical settlement contract or insurance policy.

D. Premiums paid on an insurance policy.

E. Payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract or insurance policy.

F. The reinstatement or conversion of an insurance policy.

G. The solicitation, offer, effectuation, or sale of a viatical settlement contract or insurance policy.

H. The issuance of written evidence of viatical settlement contract or insurance.

I. A financing transaction.

2. Employing any plan, financial structure, device, scheme, or artifice to defraud related to viaticated policies.

b. In the furtherance of a fraud or to prevent the detection of a fraud any person commits or permits its employees or its agents to do any of the following:

1. Remove, conceal, alter, destroy or sequester the assets or records of a licensee or other person engaged in the business of viatical settlements.

2. Misrepresent or conceal the financial condition of a licensee, financing entity, insurer, or other person.

3. Transact the business of viatical settlements in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of viatical settlements.

4. File with the Commissioner or the equivalent chief insurance regulatory official of another jurisdiction a document containing false information or otherwise conceals information about a material fact from the Commissioner.

c. Embezzlement, theft, misappropriation or conversion of monies, funds, premiums, credits, or other property of a viatical settlement provider, insurer, insured, viator, insurance policy owner or any other person engaged in the business of viatical settlements or insurance.

d. Recklessly entering into, negotiating, brokering, otherwise dealing in a viatical settlement contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, where the person intended to defraud the policy's issuer, the viatical settlement provider, or the viator. "Recklessly" means engaging in the conduct in conscious and clearly unjustifiable disregard of a substantial likelihood of the existence of the relevant facts or risks, such disregard involving a gross deviation from acceptable standards of conduct.

e. Facilitating the change of state of ownership of a policy or certificate or the state of residency of a viator to a state or jurisdiction that does not have a law similar to this Act for the express purposes of evading or avoiding the provisions of this Act.

f. Attempting to commit, assisting, aiding or abetting in the commission of, or attempting or conspiring to commit, the acts or omissions specified in this paragraph (6).

(7) "Life insurance producer" means any person licensed in this State as a resident or nonresident insurance producer who has received qualification or authority for life insurance coverage or a life line of coverage pursuant to Chapter 17 of this title.

(8) "Person" means a legal entity, including an individual, partnership, limited liability company, association, trust, corporation, or other legal entity.

(9) "Policy" or "insurance policy" means an individual or group policy, group certificate, contract, or arrangement of life insurance owned by a resident of this State, regardless of whether delivered or issued for delivery in this State.

(10) "Related provider trust" means a titling trust or other trust established by a licensed viatical settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction.

(11) "Special purpose entity" means a corporation, partnership, trust, limited liability company or other similar entity formed solely to provide either directly or indirectly access to institutional capital markets:

a. For a financing entity or licensed viatical settlement provider; or

b. 1. In connection with a transaction in which the securities in the special purpose entity are acquired by the viator or by "qualified institutional buyers" as defined in Rule 144A [17 C.F.R. 230.144A] promulgated under the Securities Act of 1933 [15 U.S.C. § 77a et seq.], as amended; or

2. The securities pay a fixed rate of return commensurate with established asset-backed institutional capital markets.

(12) "Terminally ill" means having an illness or sickness that can reasonably be expected to result in death in 24 months or fewer.

(13) "Viatical settlement broker" means a person, including a life insurance producer as provided for in § 7503 of this title, who working exclusively on behalf of a viator and for a fee, commission or other valuable consideration offers or attempts to negotiate viatical settlement contracts between a viator and 1 or more viatical settlement providers or 1 or more viatical settlement brokers. Irrespective of the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent only the viator, and not the insurer or the viatical settlement provider, and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator. The term does not include an attorney, licensed CPA, or financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider or purchaser.

(14) a. "Viatical settlement contract" means a written agreement entered into between a viator and a viatical settlement provider or any affiliate of the viatical settlement provider establishing the terms under which compensation or anything of value is or will be paid, which compensation or value is less than the expected death benefits of the insurance policy or certificate, in return for the viator's present or future assignment, transfer, sale, devise, or bequest of the death benefit or ownership of all or any portion of the insurance policy or certificate of insurance.

b. "Viatical settlement contract" includes a premium finance loan made for a life insurance policy by a lender to viator on, before, or after the date of issuance of the policy where any of the following are met:

1. The viator or the insured receives on the date of the premium finance loan a guarantee of a future viatical settlement value of the policy.

2. The viator or the insured agrees on the date of the premium finance loan to sell the policy or any portion of its death benefit on any date following the issuance of the policy.

c. "Viatical settlement contract" does not include any of the following:

1. A policy loan or accelerated death benefit made by the insurer pursuant to the policy's terms.

2. Loan proceeds that are used solely to pay any of the following:

A. Premiums for the policy.

B. The costs of the loan, including interest, arrangement fees, utilization fees and similar fees, closing costs, legal fees and expenses, trustee fees and expenses, and third-party collateral provider fees and expenses, including fees payable to letter of credit issuers.

3. A loan made by a bank or other licensed financial institution in which the lender takes an interest in a life insurance policy solely to secure repayment of a loan or, if there is a default on the loan and the policy is transferred, the transfer of such a policy by the lender, if the default itself is not pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this Act.

4. A loan made by a lender that does not violate Chapter 48 of this title, if the premium finance loan is not described in paragraph (14)b. of this section.

5. An agreement where all the parties have an insurable interest in the insured as defined in § 2704 or § 2705 of this title.

6. Any designation, consent or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life insurance on the life of the employee, where the employer or the trustee has an insurable interest as defined in § 2704(c)(3) of this title.

7. A bona fide business succession planning arrangement between any of the following:

A. One or more shareholders in a corporation or between a corporation and 1 or more of its shareholders or 1 or more trust established by its shareholders.

B. One or more partners in a partnership or between a partnership and 1 or more of its partners or 1 or more trust established by its partners.

C. One or more members in a limited liability company or between a limited liability company and 1 or more of its members or 1 or more trust established by its members.

8. An agreement entered into by a service recipient, or a trust established by the service recipient, and a service provider, or a trust established by the service provider, who performs significant services for the service recipient's trade or business.

9. Any other contract, transaction or arrangement exempted from the definition of viatical settlement contract by the Commissioner based on a determination that the contract, transaction, or arrangement is not of the type intended to be regulated by this Act.

(15) "Viatical settlement provider" means a person, other than a viator, that enters into or effectuates a viatical settlement contract with a viator resident in this State.

The term does not include any of the following:

a. A bank, savings bank, savings and loan association, credit union, or other licensed lending institution that takes an assignment of a life insurance policy solely as collateral for a loan.

b. A premium finance company making premium finance loans and exempted by the Commissioner from the licensing requirement under the premium finance laws that takes an assignment of a life insurance policy solely as collateral for a loan.

c. The issuer of the life insurance policy.

d. An authorized or eligible insurer that provides stop loss coverage or financial guaranty insurance to a viatical settlement provider, purchaser, financing entity, special purpose entity or related provider trust.

e. A natural person who enters into or effectuates no more than 1 agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit.

f. A financing entity.

g. A special purpose entity.

h. A related provider trust.

i. A viatical settlement purchaser.

j. Any other person that the Commissioner determines is not the type of person intended to be covered by the definition of viatical settlement provider.

(16) "Viatical settlement purchaser" means a person who provides a sum of money as consideration for a life insurance policy or an interest in the death benefits of a life insurance policy, or a person who owns or acquires or is entitled to a beneficial interest in a trust

that owns a viatical settlement contract or is the beneficiary of a life insurance policy that has been or will be the subject of a viatical settlement contract, for the purpose of deriving an economic benefit.

The term does not include any of the following:

a. A licensee under this Act.

b. An accredited investor or qualified institutional buyer as defined, respectively, in Rule 501(a) [17 C.F.R. § 230.501(a)] or Rule 144A [17 C.F.R. § 230.144A] promulgated under the Federal Securities Act of 1933 [15 U.S.C. § 77a et seq.], as amended.

c. A financing entity.

d. A special purpose entity.

e. A related provider trust.

(17) "Viaticated policy" means a life insurance policy or certificate that has been acquired by a viatical settlement provider pursuant to a viatical settlement contract.

(18) "Viator" means the owner of a life insurance policy or a certificate holder under a group policy who resides in this State and enters or seeks to enter into a viatical settlement contract. For the purposes of this Act, a viator is not limited to an owner of a life insurance policy or a certificate holder under a group policy insuring the life of an individual with a terminal or chronic illness or condition except where specifically addressed. If there is more than 1 viator on a single policy and the viators are residents of different states, the transaction is governed by the law of the state in which the viator having the largest percentage ownership resides or, if the viators hold equal ownership, the state of residence of 1 viator agreed upon in writing by all the viators. The term does not include any of the following:

a. A licensee under this Act, including a life insurance producer acting as a viatical settlement broker pursuant to this Act.

b. A person who is a qualified institutional buyer as defined, respectively, in Rule 144A [17 C.F.R. § 230.144A] promulgated under the Federal Securities Act of 1933 [15 U.S.C. § 77a et seq.], as amended.

c. A financing entity.

d. A special purpose entity.

e. A related provider trust.

(72 Del. Laws, c. 132, § 1; 72 Del. Laws, c. 420, § 1; 81 Del. Laws, c. 172, § 1; 81 Del. Laws, c. 387, § 2.)

§ 7503. License and bond requirements.

(a) A person may not operate as a viatical settlement provider or viatical settlement broker without first obtaining a license from the Commissioner of the state of residence of the viator.

(b) A life insurance producer who has been duly licensed as a resident insurance producer with a life line of authority in this State or the producer's home state for at least 1 year and who is licensed as a nonresident producer in this State meets the licensing requirements of this section and is permitted to operate as a viatical settlement broker.

(1) Not later than 30 days from the first day of operating as a viatical settlement broker, the life insurance producer shall notify the Commissioner that the producer is acting as a viatical settlement broker on a form prescribed by the Commissioner and shall pay any applicable fee to be determined by the Commissioner. Notification includes an acknowledgement that the life insurance producer will operate as a viatical settlement broker in accordance with this Act.

(2) The insurer that issued the policy being viaticated is not responsible for any act or omission of a viatical settlement broker or viatical settlement provider arising out of or in connection with the viatical settlement transaction, unless the insurer receives compensation for the placement of a viatical settlement contract from the viatical settlement provider or viatical settlement broker in connection with the viatical settlement contract.

(c) A person licensed as an attorney, certified public accountant, or financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the viator, whose compensation is not paid directly or indirectly by the viatical settlement provider, may negotiate viatical settlement contracts on behalf of the viator without having to obtain a license as a viatical settlement broker.

(d) An application for a viatical settlement provider or viatical settlement broker license must be made to the Commissioner by the applicant on a form prescribed by the Commissioner and must be accompanied by the fees specified in § 701(30) of this title.

(e) Licenses may be renewed from year to year on the anniversary date upon payment of the annual renewal fees specified in § 701(30) of this title. Failure to pay the fees by the renewal date results in expiration of the license.

(f) The applicant shall provide information on forms required by the Commissioner. The Commissioner has the authority, at any time, to require the applicant to fully disclose the identity of all stockholders, partners, officers, members and employees, and the Commissioner may, in the exercise of the Commissioner's discretion, refuse to issue a license in the name of a legal entity if the Commissioner is not satisfied that any officer, employee, stockholder, partner or member thereof who may materially influence the applicant's conduct meets the standards for licensure under this Act.

(g) A license issued to a legal entity authorizes all partners, officers, members, and designated employees to act as viatical settlement providers or viatical settlement brokers, as applicable, under the license, and all those persons must be named in the application and any supplements to the application.

(h) Upon the filing of an application and the payment of the license fee, the Commissioner shall make an investigation of each applicant and issue a license if the Commissioner finds that the applicant:

(1) If a viatical settlement provider, has provided a detailed plan of operation.

(2) Is competent and trustworthy and intends to act in good faith in the capacity involved by the license applied for.

(3) Has a good business reputation and has had experience, training, or education so as to be qualified in the business for which the license is applied for.

(4) a. If a viatical settlement provider, has demonstrated evidence of financial responsibility in a format prescribed by the Commissioner through either a surety bond executed and issued by an insurer authorized to issue surety bonds in this State or a deposit of cash, certificates of deposit or securities or any combination thereof in the amount of $250,000.

b. [Repealed.]

c. The Commissioner may ask for evidence of financial responsibility at any time the Commissioner deems necessary.

d. Any surety bond issued pursuant to paragraph (h)(4) of this section must be in the favor of this State and must specifically authorize recovery by the Commissioner on behalf of any person in this State who sustained damages as the result of erroneous acts, failure to act, conviction of fraud, or conviction of unfair practices by the viatical settlement provider.

e. Notwithstanding any provision of this section to the contrary, the Commissioner shall accept, as evidence of financial responsibility, proof that financial instruments in accordance with the requirements in this paragraph have been filed with 1 state where the applicant is licensed as a viatical settlement provider.

(5) If a legal entity, provides a certificate of good standing from the state of its domicile.

(6) If a viatical settlement provider or viatical settlement broker, has provided an anti-fraud plan that meets the requirements of § 7514(g) of this title.

(i) The Commissioner may not issue a license to a nonresident applicant, unless a written designation of an agent for service of process is filed and maintained with the Commissioner or the applicant has filed with the Commissioner the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the Commissioner.

(j) A viatical settlement provider or viatical settlement broker shall provide to the Commissioner new or revised information about officers, 10% or more stockholders, partners, directors, members or designated employees within 30 days of the change.

(k) An individual licensed as a viatical settlement broker shall complete, on a biennial basis, 15 hours of training related to viatical settlements and viatical settlement transactions, as required by the Commissioner, but a life insurance producer who is operating as a viatical settlement broker pursuant to subsection (b) of this section is not subject to the requirements of this subsection. Any person failing to meet the requirements of this subsection is subject to the penalties imposed by the Commissioner.

(72 Del. Laws, c. 132, § 1; 70 Del. Laws, c. 186, § 1.; 81 Del. Laws, c. 172, § 1; 81 Del. Laws, c. 344, §§ 1, 2; 83 Del. Laws, c. 20, § 1.)

§ 7504. License revocation and denial.

(a) The Commissioner may refuse to issue, suspend, revoke or refuse to renew the license of a viatical settlement provider or viatical settlement broker if the Commissioner finds any of the following:

(1) There was a material misrepresentation in the application for the license.

(2) The licensee or any officer, partner, member or key management personnel has been convicted of fraudulent or dishonest practices, is subject to a final administrative action, or is otherwise shown to be untrustworthy or incompetent.

(3) The viatical settlement provider demonstrates a pattern of unreasonable payments to viators.

(4) The licensee or any officer, partner, member or key management personnel has been found guilty of, or has pleaded guilty or nolo contendere to, any felony, or to a misdemeanor involving fraud or moral turpitude, regardless of whether a judgment of conviction has been entered by the court.

(5) The viatical settlement provider has entered into any viatical settlement contract that has not been approved pursuant to this Act.

(6) The viatical settlement provider has failed to honor contractual obligations set out in a viatical settlement contract or a viatical settlement purchase agreement.

(7) The licensee no longer meets the requirements for initial licensure.

(8) The viatical settlement provider has assigned, transferred or pledged a viaticated policy to a person other than a viatical settlement provider licensed in this State, a viatical settlement purchaser, an accredited investor or qualified institutional buyer as defined respectively in Rule 501(a) [17 C.F.R. § 230.501(a)] or Rule 144A [17 C.F.R.§ 230.144A] promulgated under the Federal Securities Act of 1933 [15 U.S.C. § 77a et seq.], as amended, financing entity, special purpose entity, or related provider trust.

(9) The licensee or any officer, partner, member or key management personnel has violated any provision of this Act.

(b) The Commissioner may suspend, revoke, or refuse to renew the license of a viatical settlement broker or a life insurance producer operating as a viatical settlement broker pursuant to this Act if the Commissioner finds that the viatical settlement broker or life insurance producer has violated the provisions of this Act or has otherwise engaged in bad faith conduct with 1 or more viators.

(c) If the Commissioner denies a license application or suspends, revokes, or refuses to renew the license of a viatical settlement provider or viatical settlement broker, or suspends, revokes, or refuses to renew a license of a life insurance producer operating as a viatical settlement broker pursuant to this Act, the Commissioner shall conduct a hearing in accordance with §§ 323-327 of this title and Chapter 101 of title 29.

(81 Del. Laws, c. 172, § 1.)

§ 7505. Approval of viatical settlement contracts and disclosure statements.

A person may not use a viatical settlement contract form or provide to a viator a disclosure statement form in this State unless it is first filed with and approved by the Commissioner. The Commissioner shall disapprove a viatical settlement contract form or disclosure statement form if, in the Commissioner's opinion, the contract or provisions contained therein fail to meet the requirements of §§ 7508, 7510, 7513, and 7514(b) of this title or are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the viator. At the Commissioner's discretion, the Commissioner may require the submission of advertising material.

(72 Del. Laws, c. 132, § 1; 81 Del. Laws, c. 172, § 1.)

§ 7506. Reporting requirements and privacy.

(a) Each viatical settlement provider shall file with the Commissioner on or before March 1 of each year an annual statement containing such information as the Commissioner may prescribe by regulation. Such information is limited to only those transactions where the viator is a resident of this State. Individual transaction data regarding the business of viatical settlements or data that could compromise the privacy of personal, financial, and health information of the viator or insured must be filed with the Commissioner on a confidential basis.

(b) Except as otherwise allowed or required by law, a viatical settlement provider, viatical settlement broker, insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured’s identity, may not disclose that identity as an insured, or the insured’s financial or medical information to any other person unless the disclosure is any of the following:

(1) Necessary to effect a viatical settlement between the viator and a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure.

(2) Necessary to effect a viatical settlement purchase agreement between the viatical settlement purchaser and a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure.

(3) Provided in response to an investigation or examination by the Commissioner or any other governmental officer or agency or pursuant to the requirements of § 7514(c) of this title.

(4) A term of or condition to the transfer of a policy by 1 viatical settlement provider to another viatical settlement provider.

(5) Necessary to permit a financing entity, related provider trust, or special purpose entity to finance the purchase of policies by a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure.

(6) Necessary to allow the viatical settlement provider or viatical settlement broker or their authorized representatives to make contacts for the purpose of determining health status.

(7) Required to purchase stop loss coverage or financial guaranty insurance.

(72 Del. Laws, c. 132, § 1; 81 Del. Laws, c. 172, § 1.)

§ 7507. Examination or investigations.

(a) *Authority, scope and scheduling of examinations. —*

(1) The Commissioner may conduct an examination under this Act of a licensee as often as the Commissioner, in the Commissioner’s discretion, deems appropriate after considering the factors set forth in this subsection.

(2) In scheduling and determining the nature, scope, and frequency of the examinations, the Commissioner shall consider such matters as consumer complaints, results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, report of independent certified public accountants, and other relevant criteria as determined by the Commissioner.

(3) For purposes of completing an examination of a licensee under this Act, the Commissioner may examine or investigate any person, or the business of any person, if the examination or investigation is, in the sole discretion of the Commissioner, necessary or material to the examination of the licensee.

(4) In lieu of an examination under this Act of any foreign or alien licensee licensed in this State, the Commissioner may, at the Commissioner’s discretion, accept an examination report on the licensee as prepared by the commissioner for the licensee’s state of domicile or port-of-entry state.

(5) As far as practical, the examination of a foreign or alien licensee must be made in cooperation with the insurance supervisory officials of other states in which the licensee transacts business.

(b) *Record retention requirements. —*

(1) A person required to be licensed by this Act must retain copies of all of the following for 5 years:

a. Proposed, offered or executed contracts, purchase agreements, underwriting documents, policy forms, and applications from the date of the proposal, offer or execution of the contract or purchase agreement, whichever is later.

b. All checks, drafts, or other evidence and documentation related to the payment, transfer, deposit or release of funds from the date the transaction.

c. All other records and documents related to the requirements of this Act.

(2) This section does not relieve a person of the obligation to produce these documents to the Commissioner after the retention period has expired if the person has retained the documents.

(3) Records required to be retained by this section must be legible and complete and may be retained in paper, photograph, microprocess, magnetic, mechanical, or electronic media, or by any process that accurately reproduces or forms a durable medium for the reproduction of a record.

(c) *Conduct of examinations. —*

(1) Upon determining that an examination should be conducted, the Commissioner shall issue an examination warrant appointing 1 or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the Examiners Handbook adopted by the National Association of Insurance Commissioners (NAIC). The Commissioner may also employ such other guidelines or procedures as the Commissioner may deem appropriate.

(2) Every licensee or person from whom information is sought, its officers, directors and agents shall provide to the examiners timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, assets and computer or other recordings relating to the property, assets, business and affairs of the licensee being examined. The officers, directors, employees and agents of the licensee or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of a licensee, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the Commissioner is grounds for suspension, revocation or refusal of, or nonrenewal of any license or authority held by the licensee to engage in the viatical settlement business or other business subject to the Commissioner's jurisdiction. Any proceedings for suspension, revocation or refusal of any license or authority must be conducted pursuant to §§ 323-327 of this title and Chapter 101 of Title 29.

(3) The Commissioner has the power to issue subpoenas, administer oaths, and examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the Commissioner may petition the Superior Court, in any county in which is pending the proceeding at which such individual is so required to appear, or the Superior Court in the county in which such individual resides, and upon proper showing, the Court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order is punishable as contempt of court.

(4) When making an examination under this Act, the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as examiners, the reasonable cost of which must be borne by the licensee that is the subject of the examination.

(5) Nothing contained in this Act limits the Commissioner's authority to terminate or suspend an examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this State. Findings of fact and conclusions made pursuant to any examination are prima facie evidence in any legal or regulatory action.

(6) Nothing contained in this Act limits the Commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or licensee workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action brought as part of the Commissioner's official duties which the Commissioner may, in the Commissioner's sole discretion, deem appropriate.

(d) *Examination reports. —*

(1) Examination reports may only be comprised of facts appearing upon the books, records or other documents of the licensee, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

(2) No later than 60 days following completion of the examination, the examiner in charge shall file with the Commissioner a verified written report of examination under oath. Upon receipt of the verified report, the Commissioner shall transmit the report to the licensee examined, together with a notice that affords the licensee examined a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report.

(3) In the event the Commissioner determines that regulatory action is appropriate as a result of an examination, the Commissioner may initiate any proceedings or actions provided by law.

(e) *Confidentiality of examination information. —*

(1) Names and individual identification data for all viators is private and confidential information and may not be disclosed by the Commissioner, unless required by law.

(2) Except as otherwise provided in this Act, all examination reports, working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the Commissioner or any other person in the course of an examination made under

this Act, or in the course of analysis or investigation by the Commissioner of the financial condition or market conduct of a licensee are confidential and privileged, are not a "public record" under the Freedom of Information Act, Chapter 100 of Title 29, are not subject to subpoena, and are not subject to discovery or admissible in evidence in any private civil action. The Commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties.

(3) Documents, materials, or other information, including all working papers and copies thereof in the possession or control of the NAIC and its affiliates and subsidiaries are confidential and privileged, are not subject to subpoena, and are not subject to discovery or admissible in evidence in any private civil action if they are any of the following:

a. Created, produced or obtained by or disclosed to the NAIC and its affiliates and subsidiaries in the course of assisting an examination made under this Act, or assisting a commissioner in the analysis or investigation of the financial condition or market conduct of a licensee.

b. Disclosed to the NAIC and its affiliates and subsidiaries under paragraph (e)(4) of this section by a commissioner.

c. For the purposes of paragraph (e)(2) of this section, "Act" includes the law of another state or jurisdiction that is substantially similar to this Act.

(4) The Commissioner or any person that receives the documents, material, or other information while acting under the authority of the Commissioner, including the NAIC and its affiliates and subsidiaries, may not testify in any private civil action concerning any confidential documents, materials, or information subject to paragraph (e)(1) of this section.

(5) In order to assist in the performance of the Commissioner's duties, the Commissioner may do all of the following:

a. Share documents, materials or other information, including the confidential and privileged documents, materials or information subject to paragraph (e)(1) of this section, with other state, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal and international law-enforcement authorities, if that recipient agrees to maintain the confidentiality and privileged status of the document, material, communication, or other information.

b. Receive documents, materials, communications or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law-enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

c. Enter into agreements governing sharing and use of information consistent with this subsection.

(6) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information occurs as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in paragraph (e)(5) of this section.

(7) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection is available and enforceable in any proceeding in, and in any court of, this State.

(8) Nothing contained in this Act prevents or prohibits the Commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the commissioner of any other state or country, or to law-enforcement officials of this or any other state or agency of the federal government at any time or to the NAIC, if such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this Act.

(f) *Conflict of interest. —*

(1) An examiner may not be appointed by the Commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this Act. This section does not automatically preclude an examiner from being any of the following:

a. A viator.

b. An insured in a viaticated insurance policy.

c. A beneficiary in an insurance policy that is proposed to be viaticated.

(2) Notwithstanding paragraph (f)(1) of this section, the Commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though these persons may from time to time be similarly employed or retained by persons subject to examination under this Act.

(g) *Immunity from liability. —*

(1) No cause of action may exist and no liability may be imposed against the Commissioner, the Commissioner's authorized representatives, or any examiner appointed by the Commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this Act.

(2) No cause of action may exist and no liability may be imposed against any person for the act of communicating or delivering information or data to the Commissioner or the Commissioner's authorized representative or examiner pursuant to an examination made under this Act, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive. This paragraph does not abrogate or modify any common law or statutory privilege or immunity heretofore enjoyed by any person identified in paragraph (g)(1) of this section.

(3) A person identified in paragraph (g)(1) or (g)(2) of this section is entitled to an award of attorneys' fees and costs if the person is the prevailing party in a civil lawsuit for libel, slander, or any other relevant tort arising out of activities related to carrying out the provisions of this Act and the party bringing the lawsuit did not have a reasonable basis in law or fact to bring the lawsuit at the time the lawsuit was initiated.

(h) *Investigative authority of the Commissioner. —*

The Commissioner may investigate suspected fraudulent viatical settlement acts and persons engaged in the business of viatical settlements.

(72 Del. Laws, c. 132, § 1; 81 Del. Laws, c. 172, § 1.)

§ 7508. Disclosure to viator.

(a) With each application for a viatical settlement, a viatical settlement provider or viatical settlement broker shall provide the viator with at least the following disclosures no later than the time the application for the viatical settlement contract is signed by all parties. The disclosures must be provided in a separate document that is signed by the viator and the viatical settlement provider or viatical settlement broker, and must provide the following information:

(1) There are possible alternatives to viatical settlement contracts, including any accelerated death benefits or policy loans offered under the viator's life insurance policy.

(2) That a viatical settlement broker represents exclusively the viator, and not the insurer or the viatical settlement provider, and owes a fiduciary duty to the viator, including a duty to act according to the viator's instructions and in the best interest of the viator.

(3) Some or all of the proceeds of the viatical settlement may be taxable under federal income tax and state franchise and income taxes, and that assistance should be sought from a professional tax advisor.

(4) Proceeds of the viatical settlement could be subject to the claims of creditors.

(5) Receipt of the proceeds of a viatical settlement may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements, and that advice should be obtained from the appropriate government agencies.

(6) The viator has the right to rescind a viatical settlement contract before the earlier of 60 calendar days after the date upon which the viatical settlement contract is executed by all parties or 30 calendar days after the viatical settlement proceeds have been paid to the viator, as provided in § 7510 of this title. Rescission, if exercised by the viator, is effective only if both notice of the rescission is given, and the viator repays all proceeds and any premiums, loans and loan interest paid on account of the viatical settlement within the rescission period. If the insured dies during the rescission period, the viatical settlement contract is deemed to have been rescinded, subject to repayment by the viator or the viator's estate of all viatical settlement proceeds and any premiums, loans and loan interest the viatical settlement within 60 days of the insured's death.

(7) Funds will be sent to the viator within 3 business days after the viatical settlement provider has received the insurer or group administrator's written acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.

(8) Entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the viator, and that assistance should be sought from a financial adviser.

(9) Disclosure to a viator must include distribution of a brochure describing the process of viatical settlements. The NAIC's form for the brochure must be used unless another form is developed or approved by the Commissioner.

(10) The disclosure document must contain the following language:

"All medical, financial or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years."

(11) Following execution of a viatical settlement contract, the insured may be contacted for the purpose of determining the insured's health status and to confirm the insured's residential or business street address and telephone number, or as otherwise provided in this Act. This contact must be limited to once every 3 months if the insured has a life expectancy of more than 1 year, and no more than once per month if the insured has a life expectancy of 1 year or less. All such contracts may only be made by a viatical settlement provider licensed in the state in which the viator resided at the time of the viatical settlement, or by the authorized representative of a duly licensed viatical settlement provider.

(b) A viatical settlement provider shall provide the viator with at least the following disclosures no later than the date the viatical settlement contract is signed by all parties. The disclosures must be conspicuously displayed in the viatical settlement contract or in a separate document signed by the viator and provide the following information:

(1) The affiliation, if any, between the viatical settlement provider and the issuer of an insurance policy to be viaticated.

(2) The document must include the name, business address, and telephone number of the viatical settlement provider.

(3) Any affiliations or contractual arrangements between the viatical settlement provider and the viatical settlement purchaser.

(4) If an insurance policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured under the policy to be viaticated, the viator must be informed of the possible loss of coverage on the other lives under the policy and must be advised to consult with his or her insurance producer or the company issuing the policy for advice on the proposed viatical settlement.

(5) State the dollar amount of the current death benefit payable to the viatical settlement provider under the policy or certificate. If known, the viatical settlement provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy or certificate, and the extent to which the viator's interest in those benefits will be transferred as a result of the viatical settlement contract.

(6) State whether the funds will be escrowed with an independent third party during the transfer process, and if so, provide the name, business address, and telephone number of the independent third party escrow agent, and the fact that the viator or owner may inspect or receive copies of the relevant escrow or trust agreements or documents.

(c) A viatical settlement broker shall provide the viator with at least the following disclosures no later than the date the viatical settlement contract is signed by all parties. The disclosures must be conspicuously displayed in the viatical settlement contract or in a separate document signed by the viator and provide the following information:

(1) The name, business address, and telephone number of the viatical settlement broker.

(2) A full, complete, and accurate description of all offers, counter-offers, acceptances and rejections relating to the proposed viatical settlement contract.

(3) A written disclosure of any affiliations or contractual arrangements between the viatical settlement broker and any person making an offer in connection with the proposed viatical settlement contracts.

(4) The amount and method of calculating the broker's compensation. The term "compensation" includes anything of value paid or given to a viatical settlement broker for the placement of a policy.

(5) Where any portion of the viatical settlement broker's compensation, as defined in paragraph (c)(4) of this section, is taken from a proposed viatical settlement offer, the broker shall disclose the total amount of the viatical settlement offer and the percentage of the viatical settlement offer comprised by the viatical settlement broker's compensation.

(d) If the viatical settlement provider transfers ownership or changes the beneficiary of the insurance policy, the provider shall communicate in writing the change in ownership or beneficiary to the insured within 20 days after the change.

(72 Del. Laws, c. 132, § 1; 70 Del. Laws, c. 186, § 1.; 81 Del. Laws, c. 172, § 1.)

§ 7509. Disclosure to insurer.

Prior to the initiation of a plan, transaction, or series of transactions, a viatical settlement broker or viatical settlement provider shall fully disclose to an insurer a plan, transaction, or series of transactions, to which the viatical settlement broker or viatical settlement provider is a party, to originate, renew, continue, or finance a life insurance policy with the insurer for the purpose of engaging in the business of viatical settlements at any time prior to, or during the first 5 years after, issuance of the policy.

(81 Del. Laws, c. 172, § 1.)

§ 7510. General rules.

(a) A viatical settlement provider entering into a viatical settlement contract shall first obtain the following:

(1) If the viator is the insured, a written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence to enter into a viatical settlement contract.

(2) A document in which the insured consents to the release of the insured's medical records to a licensed viatical settlement provider, viatical settlement broker, and the insurance company that issued the life insurance policy covering the life of the insured.

(3) Within 20 days after a viator executes documents necessary to transfer any rights under an insurance policy or within 20 days of entering any agreement, option, promise, or any other form of understanding, expressed or implied, to viaticate the policy, the viatical settlement provider shall give written notice to the insurer that issued that insurance policy that the policy has or will become a viaticated policy. The notice must be accompanied by the documents required by this subsection.

(4) The viatical settlement provider shall deliver a copy of the medical release required under paragraph (a)(2) of this section, a copy of the viator's application for the viatical settlement contract, the notice required under § 7509 of this title, and a request for verification of coverage to the insurer that issued the life policy that is the subject of the viatical transaction. The NAIC's form for verification of coverage must be used unless another form is developed and approved by the Commissioner.

(5) The insurer shall respond to a request for verification of coverage submitted on an approved form by a viatical settlement provider or viatical settlement broker within 30 calendar days of the date the request is received and indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the insurance contract or possible fraud. The insurer shall accept a request for verification of coverage made on an NAIC form or any other form

approved by the Commissioner. The insurer shall accept an original, facsimile, or electronic copy of such request and any accompanying authorization signed by the viator. Failure by the insurer to meet its obligations under this subsection is a violation of §§ 7511(c) and 7516 of this title.

(6) Prior to or at the time of execution of the viatical settlement contract, the viatical settlement provider shall obtain a witnessed document in which the viator consents to the viatical settlement contract, represents that the viator has a full and complete understanding of the viatical settlement contract, that the viator has a full and complete understanding of the benefits of the life insurance policy, acknowledges that the viator is entering into the viatical settlement contract freely and voluntarily and, for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness or condition that was diagnosed after the life insurance policy was issued.

(7) If a viatical settlement broker performs any of these activities required of the viatical settlement provider, the provider is deemed to have fulfilled the requirements of this subsection.

(b) All medical information solicited or obtained by any licensee is subject to the applicable provisions of state law relating to confidentiality of medical information.

(c) All viatical settlement contracts entered into in this State must provide the viator with an absolute right to rescind the contract before the earlier of 60 calendar days after the date upon which the viatical settlement contract is executed by all parties or 30 calendar days after the viatical settlement proceeds have been sent to the viator as provided in this section. Rescission by the viator may be conditioned upon the viator both giving notice and repaying to the viatical settlement provider within the rescission period all proceeds of the settlement and any premiums, loans and loan interest paid by or on behalf of the viatical settlement provider in connection with or as a consequence of the viatical settlement. If the insured dies during the rescission period, the viatical settlement contract is deemed to have been rescinded, subject to repayment to the viatical settlement provider or purchaser of all viatical settlement proceeds, and any premiums, loans and loan interest that have been paid by the viatical settlement provider or purchaser, which must be paid within 60 calendar days of the death of the insured. In the event of any rescission, if the viatical settlement provider has paid commissions or other compensation to a viatical settlement broker in connection with the rescinded transaction, the viatical settlement broker shall refund all such commissions and compensation to the viatical settlement provider within 5 business days following receipt of written demand from the viatical settlement provider, which demand must be accompanied by either the viator's notice of rescission if rescinded at the election of the viator, or notice of the death of the insured if rescinded by reason of the death of the insured within the applicable rescission period.

(d) The viatical settlement provider shall instruct the viator to send the executed documents required to effect the change in ownership, assignment or change in beneficiary directly to the independent escrow agent. Within 3 business days after the date the escrow agent receives the document (or from the date the viatical settlement provider receives the documents, if the viator erroneously provides the documents directly to the provider), the provider must pay or transfer the proceeds of the viatical settlement into an escrow or trust account maintained in a state or federally-chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). Upon payment of the settlement proceeds into the escrow account, the escrow agent shall deliver the original change in ownership, assignment or change in beneficiary forms to the viatical settlement provider or related provider trust or other designated representative of the viatical settlement provider. Upon the escrow agent's receipt of the acknowledgment of the properly completed transfer of ownership, assignment or designation of beneficiary from the insurance company, the escrow agent shall pay the settlement proceeds to the viator.

(e) Failure to tender consideration to the viator for the viatical settlement contract within the time set forth in the disclosure pursuant to § 7508(a)(7) of this title renders the viatical settlement contract voidable by the viator for lack of consideration until the time consideration is tendered to and accepted by the viator. Funds are deemed sent by a viatical settlement provider to a viator as of the date that the escrow agent either releases funds for wire transfer to the viator or places a check for delivery to the viator via United States Postal Service or other nationally recognized delivery service.

(f) Contacts with the insured for the purpose of determining the health status of the insured by the viatical settlement provider or viatical settlement broker after the viatical settlement has occurred may only be made by the viatical settlement provider or broker licensed in this State or its authorized representative and are limited to once every 3 months for insureds with a life expectancy of more than 1 year, and to no more than 1 per month for insureds with a life expectancy of 1 year or less. The provider or broker shall explain the procedure for these contacts at the time the viatical settlement contract is entered into. The limitations set forth in this subsection do not apply to any contacts with an insured under a viaticated policy for reasons other than determining the insured's health status. Viatical settlement providers and viatical settlement brokers are responsible for the actions of their authorized representatives.

(g) A related provider trust must have a written agreement with the licensed viatical settlement provider under which the licensed viatical settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files related to viatical settlement transactions available to the Commissioner as if those records and files were maintained directly by the licensed viatical settlement provider.

(72 Del. Laws, c. 132, § 1; 70 Del. Laws, c. 186, § 1; 81 Del. Laws, c. 172, § 1.)

§ 7511. Prohibited practices.

(a) It is a violation of this Act for any person to enter into a viatical settlement contract at any time prior to the application or issuance of a policy which is the subject of viatical settlement contract or within a 5-year period commencing with the date of issuance of the

insurance policy or certificate unless the viator certifies to the viatical settlement provider that 1 or more of the following conditions have been met within the 5-year period:

(1) The policy was issued upon the viator's exercise of conversion rights arising out of a group or individual policy, if the total of the time covered under the conversion policy plus the time covered under the prior policy is at least 60 months. The time covered under a group policy must be calculated without regard to any change in insurance carriers, if the coverage has been continuous and under the same group sponsorship.

(2) The viator submits independent evidence to the viatical settlement provider that 1 or more of the following conditions have been met within the 5-year period:

a. The viator or insured is terminally or chronically ill.

b. The viator's spouse dies.

c. The viator divorces his or her spouse.

d. The viator retires from full-time employment.

e. The viator becomes physically or mentally disabled and a physician determines that the disability prevents the viator from maintaining full-time employment.

f. A final order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor of the viator, adjudicating the viator bankrupt or insolvent, or approving a petition seeking reorganization of the viator or appointing a receiver, trustee, or liquidator to all or a substantial part of the viator's assets.

(3) The viator enters into a viatical settlement contract more than 2 years after the date of issuance of a policy and, with respect to the policy, at all times prior to the date that is 2 years after policy issuance, the following conditions are met:

a. Policy premiums have been funded exclusively with unencumbered assets, including an interest in the life insurance policy being financed only to the extent of its net cash surrender value, provided by, or fully recourse liability incurred by, the insured or a person described in § 7502(14)c.5. of this title.

b. There is no agreement or understanding with any other person to guarantee any such liability or to purchase, or stand ready to purchase, the policy, including through an assumption or forgiveness of the loan.

c. Neither the insured nor the policy has been evaluated for settlement.

(b) Copies of the independent evidence described in paragraph (a)(2) of this section and documents required by § 7510(a) of this title must be submitted to the insurer when the viatical settlement provider or other party entering into a viatical settlement contract with a viator submits a request to the insurer for verification of coverage. The copies must be accompanied by a letter of attestation from the viatical settlement provider that the copies are true and correct copies of the documents received by the viatical settlement provider.

(c) If the viatical settlement provider submits to the insurer a copy of the owner or insured's certification described in § 7511(a) of this title and the independent evidence required by paragraph (a)(2) of this section when the provider submits a request to the insurer to effect the transfer of the policy or certificate to the viatical settlement provider, the copy conclusively establishes that the viatical settlement contract satisfies the requirements of this subsection and the insurer shall timely respond to the request.

(d) No insurer may, as a condition of responding to a request for verification of coverage or effecting the transfer of a policy pursuant to a viatical settlement contract, require that the viator, insured, viatical settlement provider, or viatical settlement broker sign any form, disclosure, consent, or waiver form that has not been expressly approved by the Commissioner for use in connection with viatical settlement contracts in this State.

(e) Upon receipt of a properly completed request for change of ownership or beneficiary of a policy, the insurer shall respond in writing within 30 calendar days with written acknowledgement confirming that the change has been effected or specifying the reasons why the requested change cannot be processed. The insurer may not unreasonably delay effecting change of ownership or beneficiary and may not otherwise seek to interfere with any viatical settlement contract lawfully entered into in this State.

(81 Del. Laws, c. 172, § 1; 70 Del. Laws, c. 186, § 1.)

§ 7512. Prohibited practices and conflicts of interest.

(a) With respect to any viatical settlement contract or insurance policy, a viatical settlement broker may not knowingly solicit an offer from, effectuate a viatical settlement with, or make a sale to any viatical settlement provider, viatical settlement purchaser, financing entity or related provider trust that is controlling, controlled by, or under common control with such viatical settlement broker.

(b) With respect to any viatical settlement contract or insurance policy, no viatical settlement provider knowingly may enter into a viatical settlement contract with a viator, if, in connection with such viatical settlement contract, anything of value will be paid to a viatical settlement broker that is controlling, controlled by, or under common control with such viatical settlement provider or the viatical settlement purchaser, financing entity or related provider trust that is involved in such viatical settlement contract.

(c) A violation of subsection (a) or (b) of this section is a fraudulent viatical settlement act.

(d) A viatical settlement provider may not enter into a viatical settlement contract unless the viatical settlement promotional, advertising and marketing materials, as may be prescribed by regulation, have been filed with the Commissioner. Marketing materials may not

expressly reference that the insurance is “free” for any period of time. The inclusion of any reference in the marketing materials that would cause a viator to reasonably believe that the insurance is free for any period of time is a violation of this Act.

(e) A life insurance producer, insurance company, viatical settlement broker, or viatical settlement provider may not make any statement or representation to the applicant or policyholder in connection with the sale or financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time unless provided in the policy.

(81 Del. Laws, c. 172, § 1.)

§ 7513. Advertising for viatical settlements.

(a) The purpose of this section is to provide prospective viators with clear and unambiguous statements in the advertisement of viatical settlements and to assure the clear, truthful, and adequate disclosure of the benefits, risks, limitations, and exclusions of any viatical settlement contract bought or sold. This purpose is intended to be accomplished by the establishment of guidelines and standards of permissible and impermissible conduct in the advertising of viatical settlements to assure that product descriptions are presented in a manner that prevents unfair, deceptive, or misleading advertising and is conducive to accurate presentation and description of viatical settlements through the advertising media and material used by viatical settlement licensees.

(b) This section applies to any advertising of viatical settlement contracts or related products or services intended for dissemination in this State, including internet advertising viewed by persons located in this State. Where disclosure requirements are established pursuant to federal regulation, this section must be interpreted so as to minimize or eliminate conflict with federal regulation wherever possible.

(c) Every viatical settlement licensee shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its contracts, products, and services. All advertisements, regardless of by whom written, created, designed, or presented, are the responsibility of the viatical settlement licensees, as well as the individual who created or presented the advertisement. A system of control must include regular routine notification, at least once a year, to agents and others authorized by the viatical settlement licensee who disseminate advertisements of the requirements and procedures for approval prior to the use of any advertisements not furnished by the viatical settlement licensee.

(d) Advertisements must be truthful and not misleading in fact or by implication. The form and content of an advertisement of a viatical settlement contract or product or service must be sufficiently complete and clear so as to avoid deception. The advertisement must not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive must be determined by the Commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

(e) Certain viatical settlement advertisements are deemed false and misleading on their face and are prohibited. Those advertisements include the following representations:

(1) “Guaranteed,” “fully secured,” “100 percent secured,” “fully insured,” “secure,” “safe,” “backed by rated insurance companies,” “backed by federal law,” “backed by state law,” or “state guaranty funds,” or similar representations.

(2) “No risk,” “minimal risk,” “low risk,” “no speculation,” “no fluctuation,” or similar representations.

(3) “Qualified or approved for individual retirement accounts (IRAs), Roth IRAs, 401(k) plans, simplified employee pensions (SEP), 403(b), Keogh plans, TSA, other retirement account rollovers,” “tax deferred,” or similar representations.

(4) Utilization of the word “guaranteed” to describe the fixed return, annual return, principal, earnings, profits, investment, or similar representations.

(5) “No sales charges or fees” or similar representations.

(6) “High yield,” “superior return,” “excellent return,” “high return,” “quick profit,” or similar representations.

(7) Purported favorable representations or testimonials about the benefits of viatical settlement contracts as an investment, taken out of context from newspapers, trade papers, journals, radio and television programs, and all other forms of print and electronic media.

(f) The information required to be disclosed under this section may not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.

(1) An advertisement may not omit material information or use words, phrases, statements, references, or illustrations if the omission or use has the capacity, tendency, or effect of misleading or deceiving viators as to the nature or extent of any benefit, loss covered, premium payable, or state or federal tax consequence. The fact that the viatical settlement contract offered is made available for inspection prior to consummation of the sale, or an offer is made to refund the payment if the viator is not satisfied or that the viatical settlement contract includes a “free look” period that satisfies or exceeds legal requirements, does not remedy misleading statements.

(2) An advertisement may not use the name or title of a life insurance company or a life insurance policy unless the advertisement has been approved by the insurer.

(3) An advertisement may not represent that premium payments will not be required to be paid on the life insurance policy that is the subject of a viatical settlement contract in order to maintain that policy, unless that is the fact.

(4) An advertisement may not state or imply that interest charged on an accelerated death benefit or a policy loan is unfair, inequitable, or in any manner an incorrect or improper practice.

(5) The words “free,” “no cost,” “without cost,” “no additional cost,” “at no extra cost,” or words of similar import may not be used with respect to any benefit or service unless true. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the payment or use other appropriate language.

(6) Testimonials, appraisals, or analyses used in advertisements must be genuine; represent the current opinion of the author; be applicable to the viatical settlement contract, product or service advertised, if any; and be accurately reproduced with sufficient completeness to avoid misleading or deceiving prospective viators as to the nature or scope of the testimonials, appraisal, analysis, or endorsement. In using testimonials, appraisals, or analysis, a licensee under this Act makes as its own all the statements contained therein, and the statements are subject to all the provisions of this section.

a. If the individual making a testimonial, appraisal, analysis or an endorsement has a financial interest in the party making use of the testimonial, appraisal, analysis, or endorsement, either directly or through a related entity as a stockholder, director, officer, employee or otherwise, or receives any benefit directly or indirectly other than required union scale wages, that fact must be prominently disclosed in the advertisement.

b. An advertisement may not state or imply that a viatical settlement contract, benefit, or service has been approved or endorsed by a group of individuals, society, association, or other organization unless that is the fact and unless any relationship between an organization and the viatical settlement licensee is disclosed. If the entity making the endorsement or testimonial is owned, controlled, or managed by the viatical settlement licensee, or receives any payment or other consideration from the viatical settlement licensee for making an endorsement or testimonial, that fact must be disclosed in the advertisement.

c. When an endorsement refers to benefits received under a viatical settlement contract, all pertinent information must be retained for a period of 5 years after its use.

(g) An advertisement may not contain statistical information unless it accurately reflects recent and relevant facts. The source of all statistics used in an advertisement must be identified.

(h) An advertisement may not disparage insurers, viatical settlement providers, viatical settlement brokers, insurance producers, policies, services, or methods of marketing.

(i) The name of the viatical settlement licensee must be clearly identified in all advertisements about the licensee or its viatical settlement contract, products or services, and if any specific viatical settlement contract is advertised, the viatical settlement contract must be identified either by form number or some other appropriate description. If an application is part of the advertisement, the name of the viatical settlement provider must be shown on the application.

(j) An advertisement may not use a trade name, group designation, name of the parent company of a viatical settlement licensee, name of a particular division of the viatical settlement licensee, service mark, slogan, symbol, or other device or reference without disclosing the name of the viatical settlement licensee, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the viatical settlement licensee, or to create the impression that a company other than the viatical settlement licensee would have any responsibility for the financial obligation under a viatical settlement contract.

(k) An advertisement may not use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color, or other characteristics are so similar to a combination of words, symbols, or physical materials used by a government program or agency or otherwise appear to be of such a nature that they tend to mislead prospective viators into believing that the solicitation is in some manner connected with a government program or agency.

(*l*) An advertisement may state that a viatical settlement licensee is licensed in the state where the advertisement appears, if it does not exaggerate that fact or suggest or imply that competing viatical settlement licensee may not be so licensed. The advertisement may ask the audience to consult the licensee’s web site or contact the Department of Insurance to find out if the state requires licensing and, if so, whether the viatical settlement provider, viatical settlement broker is licensed.

(m) An advertisement may not create the impression that the viatical settlement provider, its financial condition or status, the payment of its claims or the merits, desirability, or advisability of its viatical settlement contracts forms are recommended or endorsed by any government entity.

(n) The name of the actual licensee must be stated in all of its advertisements. An advertisement may not use a trade name, any group designation, name of any affiliate or controlling entity of the licensee, service mark, slogan, symbol, or other device in a manner that would have the capacity or tendency to mislead or deceive as to the true identity of the actual licensee or create the false impression that an affiliate or controlling entity would have any responsibility for the financial obligation of the licensee.

(o) An advertisement may not directly or indirectly create the impression that any division or agency of the State or of the United States government endorses, approves, or favors any of the following:

(1) Any viatical settlement licensee or its business practices or methods of operation.

(2) The merits, desirability or advisability of any viatical settlement contract.

(3) Any viatical settlement contract.

(4) Any life insurance policy or life insurance company.

(p) If the advertiser emphasizes the speed with which the viatication will occur, the advertising must disclose the average time frame from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the viator.

(q) If the advertising emphasizes the dollar amounts available to viators, the advertising must disclose the average purchase price as a percent of face value obtained by viators contracting with the licensee during the past 6 months.

(81 Del. Laws, c. 172, § 1.)

§ 7514. Fraud prevention and control.

(a) *Fraudulent viatical settlement acts, interference, and participation of convicted felons prohibited. —*

(1) A person may not commit a fraudulent viatical settlement act.

(2) A person may not knowingly or intentionally interfere with the enforcement of the provisions of this Act or investigations of suspected or actual violations of this Act.

(3) A person in the business of viatical settlements may not knowingly or intentionally permit any person convicted of a felony or of any other crime involving dishonesty or breach of trust to participate in the business of viatical settlements.

(b) *Fraud warning required. —*

(1) Viatical settlements contract forms and applications for viatical settlements, regardless of the form of transmission, must contain the following statement or a substantially similar statement:

"Any person who knowingly presents false information in an application for insurance or viatical settlement contract is guilty of a crime and may be subject to fines and confinement in prison."

(2) The lack of a statement as required in paragraph (b)(1) of this section does not constitute a defense in any prosecution for a fraudulent viatical settlement act.

(c) *Mandatory reporting of fraudulent viatical settlement acts. —*

(1) Any person engaged in the business of viatical settlements having knowledge or a reasonable suspicion that a fraudulent viatical settlement act is being, will be, or has been committed shall provide to the Commissioner such information as required by, and in a manner prescribed by, the Commissioner.

(2) Any other person having knowledge or a reasonable belief that a fraudulent viatical settlement act is being, will be, or has been committed may provide to the Commissioner the information required by, and in a manner prescribed by, the Commissioner.

(d) *Immunity from liability. —*

(1) No cause of action may exist and no civil liability may be imposed on a person for furnishing information concerning suspected, anticipated, or completed fraudulent viatical settlement acts or suspected or completed fraudulent insurance acts, if the information is provided to or received from any of the following:

a. The Commissioner or the Commissioner's employees, agents, or representatives.

b. Federal, state or local law–enforcement or regulatory officials or their employees, agents, or representatives.

c. A person involved in the prevention and detection of fraudulent viatical settlement acts or that person's agents, employees, or representatives.

d. The National Association of Insurance Commissioners (NAIC), National Association of Securities Dealers (NASD), the North American Securities Administrators Association (NASAA), or their employees, agents or representatives, or other regulatory body overseeing life insurance, viatical settlements, securities, or investment fraud.

e. The life insurer that issued the life insurance policy covering the life of the insured.

(2) Paragraph (d)(1) of this section does not apply to statements made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent viatical settlement act, the party bringing the action must plead specifically any allegation that paragraph (d)(1) of this section does not apply because the person filing the report or furnishing the information did so with actual malice.

(3) A person furnishing information as identified in paragraph (d)(1) of this section is entitled to an award of attorneys' fees and costs if the person is the prevailing party in a civil lawsuit for libel, slander, or any other relevant tort arising out of activities related to carrying out the provisions of this Act and the party bringing the lawsuit did not have a reasonable basis in law or fact to bring the lawsuit at the time that it was initiated. However, such an award does not apply to any person furnishing information concerning that person's own fraudulent viatical settlement acts.

(4) This section does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in paragraph (d)(1) of this section.

(e) *Confidentiality. —*

(1) The documents and evidence provided pursuant to subsection (d) of this section or obtained by the Commissioner in an investigation of suspected or actual fraudulent viatical settlement acts are privileged and confidential. The documents and evidence are not public records and are not subject to discovery or subpoena in a civil action.

(2) Paragraph (e)(1) of this section does not prohibit release by the Commissioner of documents and evidence obtained in an investigation of suspected or actual fraudulent viatical settlement acts:

a. In administrative or judicial proceedings to enforce laws administered by the Commissioner.

b. To federal, state or local law-enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraudulent viatical settlement acts, or to the NAIC.

c. At the discretion of the Commissioner, to a person in the business of viatical settlements that is aggrieved by a fraudulent viatical settlement act.

(3) Release of documents and evidence under paragraph (e)(2) of this section does not abrogate or modify the privilege granted in paragraph (e)(1) of this section.

(f) *Other law-enforcement or regulatory authority. —*

This Act does not:

(1) Preempt the authority or relieve the duty of the Attorney General or any other law-enforcement or regulatory agencies to investigate, examine and prosecute suspected violations of law.

(2) Prevent or prohibit a person from disclosing voluntarily information concerning viatical settlement fraud to a law-enforcement or regulatory agency other than the Insurance Department.

(3) Limit the powers granted elsewhere by the laws of this State to the Commissioner or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

(g) *Viatical settlement antifraud initiatives. —*

(1) Viatical settlement providers and viatical settlement brokers shall have in place antifraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent viatical settlement acts. At the discretion of the Commissioner, the Commissioner may order, or a licensee may request and the Commissioner may grant, such modifications of the following required initiatives as necessary to ensure an effective antifraud program. The modifications may be more or less restrictive than the required initiatives so long as the modifications may reasonably be expected to accomplish the purpose of this section.

(2) Antifraud initiatives must include:

a. Fraud investigators, who may be viatical settlement provider or viatical settlement broker employees or independent contractors.

b. An antifraud plan, which must be submitted to the Commissioner. The antifraud plan must include:

1. A description of the procedures for detecting and investigating possible fraudulent viatical settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

2. A description of the procedures for reporting possible fraudulent viatical settlement acts to the Commissioner.

3. A description of the plan for antifraud education and training of underwriters and other personnel.

4. A description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent viatical settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

c. Antifraud plans submitted to the Commissioner are privileged and confidential. The plans are not public records and are not subject to discovery or subpoena in a civil action.

(81 Del. Laws, c. 172, § 1.)

§ 7515. Injunctions; civil remedies; cease and desist.

(a) In addition to the penalties and other enforcement provisions of this Act, if any person violates this Act or any regulation implementing this Act, the Commissioner, through the Attorney General, may seek an injunction in a court of competent jurisdiction and may apply for temporary and permanent orders that the Commissioner determines are necessary to restrain the person from committing the violation.

(b) Any person damaged by the acts of a person in violation of this Act may bring a civil action against the person committing the violation in a court of competent jurisdiction.

(c) The Commissioner may issue, in accordance with § 312 of this title, a cease and desist order upon a person that violates any provision of this Act, any regulation or order adopted by the Commissioner, or any written agreement entered into with the Commissioner.

(d) When the Commissioner finds that an activity in violation of this Act presents an immediate danger to the public that requires an immediate final order, the Commissioner may issue an emergency cease and desist order reciting with particularity the facts underlying the findings. The emergency cease and desist order is effective immediately upon service of a copy of the order on the respondent and remains effective for 90 days. If the Commissioner begins nonemergency cease and desist proceedings, the emergency cease and desist order remains effective during the pendency of such proceedings, absent an order by a court of competent jurisdiction to the contrary.

(e) In addition to the penalties and other enforcement provisions of this Act, any person who violates this Act is subject to civil penalties of up to $50,000 per violation. Civil penalties may only be imposed pursuant to an order of the Commissioner issued in accordance with § 312 of this title and § 10128 of Title 29. The Commissioner's order may require a person found to be in violation of this Act to make restitution to persons aggrieved by violations of this Act.

(f) If the Commissioner has reason to believe that any person has committed a fraudulent viatical settlement act, or any other law applicable to viatical settlements for which criminal prosecution is provided, the Commissioner shall give the information relative thereto

to the Attorney General. The Attorney General shall promptly review any information provided and may take any legal action deemed necessary or appropriate under the circumstances.

(g) (1) Except where a victim is 62 years of age or older, or an "adult who is impaired" as defined in § 3902 of Title 31, or a "person with a disability" as defined in § 3901(a)(2) of Title 12, a fraudulent viatical settlement act is a class A misdemeanor unless (i) the value of property, services, or other benefit wrongfully obtained or attempted to obtain, or (ii) the aggregate economic loss suffered by any person as a result of the violation, whichever is greater, is $1,500 or more, in which case it is a class G felony.

(2) Where a victim is 62 years of age or older, or an "adult who is impaired" as defined in § 3902 of Title 31, or a "person with a disability" as defined in § 3901(a)(2) of Title 12, a fraudulent viatical settlement act is a class G felony unless (i) the value of property, services, or other benefit wrongfully obtained or attempted to be obtained, or (ii) the aggregate economic loss suffered by any person as a result of the violation, whichever is greater, is $1,500 or more, in which case it is a class F felony.

(3) Notwithstanding paragraphs (g)(1) and (2) of this section:

a. Where (i) the value of property, services, or other benefit wrongfully obtained or attempted to be obtained, or (ii) the aggregate economic loss suffered by any person as a result of the violation, whichever is greater, is more than $50,000 but less than $100,000, a fraudulent viatical settlement act is a class D felony.

b. Where (i) the value of property, services, or other benefit wrongfully obtained or attempted to obtain, or (ii) the aggregate economic loss suffered by any person as a result of the violation, whichever is greater, is $100,000 or more, a fraudulent viatical settlement act is a class B felony.

(h) A person convicted of a fraudulent viatical settlement act must pay restitution to persons aggrieved by the violation of this Act. Restitution must be ordered in addition to a fine or imprisonment, but not in lieu of a fine or imprisonment.

(i) Except for a fraudulent viatical settlement act committed by a viator, the enforcement provisions and penalties of this section may not apply to a viator.

(j) In any prosecution under subsections (f) and (g) of this section, the value of the viatical settlement contracts within any 6-month period may be aggregated and the defendant charged accordingly in applying the provisions of this section but when 2 or more offenses are committed by the same person in 2 or more counties, the accused may be prosecuted in any county in which 1 of the offenses was committed for all of the offenses aggregated under this section. The applicable statute of limitations may not begin to run until the insurance company or law-enforcement agency is aware of the fraud, but in no event may the prosecution be commenced later than 7 years after the act has occurred.

(81 Del. Laws, c. 172, § 1.)

§ 7516. Authority to promulgate regulations.

The Commissioner has the authority to:

(1) Promulgate regulations implementing this chapter.

(2) Establish standards for evaluating reasonableness of payments under viatical settlement contracts for persons who are terminally or chronically ill. This authority includes regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a life insurance policy insuring the life of a person that is chronically or terminally ill.

(3) Establish appropriate licensing requirements, fees, and standards for continued licensure for viatical settlement providers and viatical settlement brokers.

(4) Require a bond or other mechanism for financial accountability for viatical settlement providers.

(5) Adopt rules governing the relationship and responsibilities of both insurers and viatical settlement providers and viatical settlement brokers during the viatication of a life insurance policy or certificate.

(72 Del. Laws, c. 132, § 1; 81 Del. Laws, c. 172, § 1; 83 Del. Laws, c. 20, § 2.)

§ 7517. Unfair trade practices.

A violation of this Act, including the commission of a fraudulent viatical settlement act, is an unfair or deceptive act or practice in the business of insurance under § 2304 of this title, subject to the penalties contained in Chapter 23 of this title.

(72 Del. Laws, c. 132, § 1; 81 Del. Laws, c. 172, § 1.)

§ 7518. Nonpreemption of requirements under the Delaware Securities Act.

Nothing in this chapter preempts any provision set forth in Chapter 73 of Title 6, as amended, including the regulation of securities transactions in viatical settlement investments and the licensing of any person or entity engaged in the sale of securities.

(81 Del. Laws, c. 172, § 1.)

§ 7519. Severability.

If any portion of this Act or any amendments thereto, or its applicability to any person or circumstance is held invalid by a court, the remainder of this Act or its applicability to other persons or circumstances are not affected.

(81 Del. Laws, c. 172, § 1.)

§ 7520. Effective date.

A viatical settlement provider or viatical settlement broker transacting business in this State may continue to do so pending approval or disapproval of the provider or broker's application for a license as long as the application is filed with the Commissioner by January 1, 2018.

(81 Del. Laws, c. 172, § 1.)

Part I
Insurance
Chapter 76
Discount Medical Plans

§ 7601. Definitions.

For purposes of this chapter:

(1) The terms "affiliate," "control," and "subsidiary" shall have the meanings ascribed to them in § 5001 of this title.

(2) "Ancillary services" includes, but is not limited to, audiology, dental, vision, mental health, substance abuse, chiropractic and podiatry services. "Ancillary services" do not include services which are unrelated to medical care, and do not include the sale of eyeglasses or hearing aids if such sale does not involve, respectively, a vision or hearing examination or other medical treatment.

(3) "Commissioner" means the Insurance Commissioner of this State.

(4) a. "Discount medical plan" means a business arrangement or contract in which a person, in exchange for consideration paid by members, offers access for its members to providers of medical or ancillary services and the right to receive discounts on medical or ancillary services provided under the discount medical plan from those providers.

b. "Discount medical plan" does not include:

1. A plan that does not charge consideration from a member to use the plan's discount medical card; or

2. Any product already expressly authorized as insurance by the Commissioner pursuant to this title; or

3. Any physician or group of physicians or contracts regulated by the Board of Medical Licensure and Discipline.

(5) "Discount medical plan organization" means an entity that, in exchange for consideration, provides access for discount medical plan members to providers of medical or ancillary services and the right to receive medical or ancillary services from those providers at a discount. It is the organization that contracts with providers, provider networks or other discount medical plan organizations to offer access to medical or ancillary services at a discount and determines the charge to discount medical plan members.

(6) a. "Facility" means an institution providing medical or ancillary services in a health-care setting.

b. "Facility" includes, but is not limited to:

1. A hospital or other licensed inpatient center;

2. An ambulatory surgical or treatment center;

3. A skilled nursing center;

4. A residential treatment center;

5. A rehabilitation center; and

6. A diagnostic laboratory or imaging center.

(7) "Health-care professional" means a physician, pharmacist or other health-care practitioner who is licensed, accredited or certified to perform specified medical or ancillary services within the scope of that practitioner's license, accreditation, certification or other appropriate authority and consistent with state law.

(8) "Health carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health-care services, including but not limited to an insurance company, health service corporation, health maintenance organization and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Health carrier" also includes any third-party administrator or other entity that adjusts, administers or settles claims in connection with health benefit plans.

(9) "Marketer" means a person or entity that markets, promotes, sells or distributes a discount medical plan, including a private label entity that places its name on and markets or distributes a discount medical plan pursuant to a marketing agreement with a discount medical plan organization.

(10) a. "Medical services" means any maintenance care of, or preventive care for, the human body or care, service or treatment of an illness or dysfunction of, or injury to, the human body.

b. "Medical services" includes, but is not limited to, physician care, inpatient care, hospital surgical services, emergency services, ambulance services, laboratory services and medical equipment and supplies.

c. "Medical services" does not include pharmacy services, and does not include the sale of eyeglasses or hearing aids if such sale does not involve, respectively, a vision or hearing examination or other medical treatment.

(11) "Member" means any individual who pays consideration for the right to receive the benefits of a discount medical plan.

(12) "Provider" means any health-care professional or facility that has contracted, directly or indirectly, with a discount medical plan organization to provide medical or ancillary services to members.

(13) "Provider network" means an entity that negotiates directly or indirectly with a discount medical plan organization on behalf of more than 1 provider to provide medical or ancillary services to members.

(77 Del. Laws, c. 470, § 1; 70 Del. Laws, c. 186, § 1; 77 Del. Laws, c. 319, § 1.)

§ 7602. Applicability and scope.

(a) This chapter applies to all discount medical plan organizations doing business in Delaware.

(b) A discount medical plan organization that is a health carrier licensed pursuant to Chapter 5 of this title, a health service corporation subject to Chapter 63 of this title, or managed care organization subject to Chapter 64 of this title:

(1) Is not required to obtain a license under § 7603 of this title, except that any of its affiliates that operate as a discount medical plan organization in this State shall obtain a license under § 7603 and comply with all other provisions of this chapter; but

(2) Is required to comply with §§ 7606, 7607, 7608, 7609, and 7610 of this title and report any of the information described in § 7612 of this title in the form and manner as the Commissioner may require.

(77 Del. Laws, c. 470, § 1.)

§ 7603. Licensing requirements.

(a) Before doing business in this State as a discount medical plan organization, a person shall obtain a license from the Commissioner to operate as a discount medical plan organization.

(b) Each application for a license to operate as a discount medical plan organization:

(1) Shall be in a form prescribed by the Commissioner and verified by an officer or authorized representative of the applicant; and

(2) Shall demonstrate, set forth or be accompanied by the following, if applicable:

a. The applicable fees required under Chapter 7 of this title;

b. A copy of the organization documents of the applicant, such as the articles of incorporation, including all amendments;

c. A copy of the applicant's bylaws or other enabling documents that establish organizational structure;

d. The applicant's federal identification number, business address and mailing address;

e. 1. A list of names, addresses, official positions and biographical information of the individuals who are responsible for conducting the applicant's affairs, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, the officers, contracted management company personnel and any person or entity owning or having the right to acquire 10% or more of the voting securities of the applicant; and

2. A disclosure of the extent and nature of any contracts or arrangements between any individual who is responsible for conducting the applicant's affairs and the discount medical plan organization, including any possible conflicts of interest;

f. A complete biographical statement, on forms prescribed by the Commissioner, with respect to each individual identified under paragraph (b)(2)e. of this section;

g. A statement generally describing the applicant, its facilities and personnel and the medical or ancillary services for which a discount will be made available under the discount medical plan;

h. A copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of medical or ancillary services to members;

i. A copy of the form of any contract made or arrangement to be made between the applicant and any individual listed in paragraph (b)(2)e. of this section;

j. A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership or other entity for the performance on the applicant's behalf of any function, including marketing, administration, enrollment, investment management and subcontracting for the provision of medical or ancillary services to members;

k. A description of the proposed methods of marketing, including, but not limited to, describing the use of marketers, use of the Internet, sales by telephone, and use of salespersons to market the discount medical plan benefits;

l. A description of the member complaint procedures to be established and maintained by the applicant;

m. The name and address of the applicant's Delaware statutory agent for service of process, notice or demand, or if not domiciled in this State, a power of attorney duly executed by the applicant, appointing the Commissioner and duly authorized deputies, as the true and lawful attorney of the applicant in and for this State upon whom all process in any legal action or proceeding against the discount medical plan organization on a cause of action arising in this State may be served; and

n. Any other information the Commissioner may reasonably require.

(c) Within 90 days after the date of receipt of a completed application, the Commissioner shall:

(1) Issue a license if the Commissioner is satisfied that the applicant has met the following:

a. The requirements of subsection (b) of this section have been met;

b. The ownership, control and management of the applicant are competent and trustworthy and possess managerial experience that would make the proposed operation of the discount medical plan organization beneficial to discount medical plan members; or

(2) Disapprove the application and state the grounds for disapproval.

(d) Prior to licensure by the Commissioner, each discount medical plan organization shall establish an Internet website in order to conform to the requirements of § 7608(e) of this title.

(e) (1) A license is effective for 1 year, unless prior to its expiration the license is renewed in accordance with this subsection or suspended or revoked in accordance with subsection (f) of this section.

(2) At least 90 days before a license expires, the discount medical plan organization shall submit:

a. A renewal application form; and

b. The renewal fee.

(3) The Commissioner shall renew the license of each holder that meets the requirements of this chapter and pays the appropriate renewal fee required by Chapter 7 of this title.

(f) (1) The Commissioner may suspend the authority of a discount medical plan organization to enroll new members or refuse to renew or revoke a discount medical plan organization's license if the Commissioner finds that any of the following conditions exist:

a. The discount medical plan organization is not operating in compliance with this chapter;

b. The discount medical plan organization has advertised, merchandised or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading or unfair practices with respect to advertising or merchandising;

c. The discount medical plan organization is not fulfilling its obligations as a discount medical plan organization; or

d. The continued operation of the discount medical plan organization would be harmful to its members or contrary to their interests.

(2) If the Commissioner has cause to believe that grounds for the nonrenewal, suspension or revocation of a license exists, the Commissioner shall notify the discount medical plan organization in writing specifically stating the grounds for the refusal to renew or suspension or revocation and may pursue a hearing on the matter in accordance with the provisions of Chapter 101 of Title 29.

(3) When the license of a discount medical plan organization is non-renewed, surrendered or revoked, the discount medical plan organization shall proceed, immediately following the effective date of the order of revocation or, in the case of a nonrenewal, the date of expiration of the license, to wind up its affairs transacted under the license. The discount medical plan organization shall not engage in any further advertising, solicitation, collecting of fees or renewal of contracts.

(4) a. The Commissioner shall, in the Commissioner's order suspending the authority of the discount medical plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, that must be met by the discount medical plan organization prior to reinstatement of its license to enroll members.

b. The Commissioner may rescind or modify the order of suspension prior to the expiration of the suspension period.

c. The license of a discount medical plan organization shall not be reinstated unless requested by the discount medical plan organization. The Commissioner shall not grant the request for reinstatement if the Commissioner finds that the circumstances for which the suspension occurred still exist or are likely to recur.

(g) In lieu of suspending or revoking a discount medical plan organization's license under subsection (f) of this section, whenever the discount medical plan organization has been found to have violated any provision of this chapter, the Commissioner may:

(1) Issue and cause to be served upon the organization charged with the violation a copy of the findings and an order requiring the organization to cease and desist from engaging in the act or practice that constitutes the violation; and

(2) Impose any penalties consistent with § 7613 of this title.

(h) Each licensed discount medical plan organization shall notify the Commissioner immediately whenever the discount medical plan organization's license, or other form of authority, to operate as a discount medical plan organization in another state is suspended, revoked or non-renewed in that state.

(i) A provider who provides discounts to that provider's own patients without any cost or fee of any kind to the patient is not required to obtain and maintain a license under this chapter as a discount medical plan organization.

(77 Del. Laws, c. 470, § 1; 70 Del. Laws, c. 186, § 1.)

§ 7604. Surety bond or deposit requirements.

(a) Each licensed discount medical plan organization shall maintain in force a surety bond in its own name in an amount not less than $50,000 to be used in the discretion of the Commissioner to protect the financial interest of members. The amount and form of the surety bond shall be determined by and subject to the approval of the Commissioner. The bond shall be issued by an insurance company licensed to do business in this State.

(b) In lieu of the bond specified in subsection (a) of this section, a licensed discount medical plan organization may deposit and maintain deposited with the Commissioner, or at the discretion of the Commissioner, with any organization or trustee acceptable to the Commissioner through which a custodial or controlled account is utilized, cash, securities or any combination of these or other measures that are acceptable to the Commissioner. The assets in the deposit, including assets such as securities which fluctuate in market value, shall be subject at all times to the review and approval of the Commission, who may require that different assets be placed on deposit.

(c) All income from a deposit made under subsection (b) of this section shall be an asset of the discount medical plan organization.

(d) Except for the Commissioner, the assets or securities held in this State as a deposit under subsection (a) or (b) of this section shall not be subject to levy by a judgment creditor or other claimant of the discount medical plan organization.

(77 Del. Laws, c. 470, § 1.)

§ 7605. Examinations and investigations.

(a) The Commissioner may examine or investigate the business and affairs of any discount medical plan organization to protect the interests of the residents of Delaware.

(b) An examination or investigation conducted as provided in subsection (a) of this section shall be performed in accordance with the provisions of Chapter 3 of this title, and the Commissioner shall have the authority with respect to examination of discount medical plan organizations as the Commissioner has with respect to insurers under Chapter 3 of this title.

(c) The discount medical plan organization or applicant that is the subject of the examination or investigation shall pay the expenses incurred in conducting the examination or investigation. Failure by the discount medical plan organization or applicant to pay the expenses is grounds for denial of a license to operate as a discount medical plan organization or revocation of a license to operate as a discount medical plan organization.

(77 Del. Laws, c. 470, § 1; 70 Del. Laws, c. 186, § 1.)

§ 7606. Fees; refund requirements; bundling of services.

(a) A discount medical plan organization may charge a periodic charge as well as a reasonable 1-time processing fee for a discount medical plan.

(b) If a member cancels his or her membership in the discount medical plan organization within the first 30 days after the date of receipt of the written document for the discount medical plan described in § 7610(d) of this title, the member shall receive a reimbursement of all periodic charges upon return of the discount medical plan card to the discount medical plan organization.

(1) Cancellation occurs when notice of cancellation is given to the discount medical plan organization.

(2) Notice of cancellation is deemed given when delivered by hand or deposited in a mailbox, properly addressed and postage prepaid to the mailing address of the discount medical plan organization or emailed to the email address of the discount medical plan organization.

(c) A discount medical plan organization shall return any periodic fee charged or collected after the member has returned the discount medical plan card or given the discount medical plan organization notice of cancellation.

(d) If the discount medical plan organization cancels a membership for any reason other than nonpayment of fees by the member, the discount medical plan organization shall make a pro rata reimbursement of all periodic charges to the member.

(e) When a marketer or discount medical plan organization sells a discount medical plan in conjunction with any other products, the fees for each discount medical plan shall be provided in writing to the member, unless the entire amount of the periodic charge for the discount medical plan and any other product will be refunded if the member cancels his or her membership in the discount medical plan organization within the first 30 days after the date of receipt of the written document for the discount medical plan as provided in subsection (b) of this section.

(f) Any discount medical plan organization that is a health carrier licensed pursuant to Chapter 5 of this title that provides a discount medical plan product that is incidental to an insured product sold to policyholders is not subject to this section.

(77 Del. Laws, c. 470, § 1; 70 Del. Laws, c. 186, § 1.)

§ 7607. Form filing requirements.

A discount medical plan organization shall file the initial written materials sent to new members, as described under § 7610(d) of this title, with the Delaware Insurance Commissioner prior to use. If a discount medical plan organization uses a form template for marketers, filing of the template form shall be acceptable.

(77 Del. Laws, c. 470, § 1.)

§ 7608. Provider agreements; provider listing requirements.

(a) A discount medical plan organization shall have a written provider agreement with all providers offering medical or ancillary services to its members. The written provider agreement may be entered into directly with the provider or indirectly with a provider network to which the provider belongs. A provider agreement between a discount medical plan organization and a provider shall provide the following:

(1) A list of the medical or ancillary services and products to be provided at a discount;

(2) The amount or amounts of the discounts or, alternatively, a fee schedule that reflects the provider's discounted rates; and

(3) That the provider will not charge members more than the discounted rates.

(b) A provider agreement between a discount medical plan organization and a provider network shall require that the provider network have written agreements with its providers that:

(1) Contain the provisions described in paragraph (a)(2) of this section;

(2) Authorize the provider network to contract with the discount medical plan organization on behalf of the provider; and

(3) Require the provider network to maintain an up-to-date list of its contracted providers and to provide the list on a monthly basis to the discount medical plan organization.

(c) A provider agreement between a discount medical plan organization and an entity that contracts with a provider network shall require that the entity, in its contract with the provider network, require the provider network to have written agreements with its providers that comply with paragraph (b)(3) of this section.

(d) The discount medical plan organization shall maintain a copy of each active provider agreement into which it has entered.

(e) Each discount medical plan organization shall maintain on an Internet website page an up-to-date list of the names and addresses of the providers with which it has contracted directly or through a provider network. The Internet website address shall be prominently displayed on all of its advertisements, marketing materials, brochures and discount medical plan cards. This subsection applies to those providers with which the discount medical plan organization has contracted with directly as well as those providers that are members of a provider network with which the discount medical plan organization has contracted.

(77 Del. Laws, c. 470, § 1.)

§ 7609. Marketing requirements.

(a) A discount medical plan organization may market directly or contract with other marketers for the distribution of its product.

(b) The discount medical plan organization shall have an executed written agreement with a marketer prior to the marketer's marketing, promoting, selling or distributing the discount medical plan. The agreement between the discount medical plan organization and the marketer shall prohibit the marketer from using advertising, marketing materials, brochures and discount medical plan cards without the discount medical plan organization's approval in writing. The discount medical plan organization shall be bound by and responsible for the activities of a marketer that are within the scope of the marketer's agency relationship with the organization. A discount medical plan organization shall approve in writing all advertisements, marketing materials, brochures and discount cards used by marketers to market, promote, sell or distribute the discount medical plan prior to their use. A discount medical plan organization shall promptly submit to the Commissioner all advertising, marketing materials and brochures regarding a discount medical plan.

(77 Del. Laws, c. 470, § 1.)

§ 7610. Marketing restrictions and disclosure requirements.

(a) All advertisements, marketing materials, brochures, discount medical plan cards and any other communications of a discount medical plan organization provided to purchasers, prospective purchasers and members shall be truthful and not misleading in fact or in implication. An advertisement, any marketing material, brochure, discount medical plan card or other communication is misleading in fact or in implication if it has a capacity or tendency to mislead or deceive based on the overall impression that it is reasonably expected to create within the segment of the public to which it is directed.

(b) A discount medical plan organization shall not:

(1) Except as otherwise required by this chapter or as a disclaimer of any relationship between discount medical plan benefits and insurance, or as a description of an insurance product connected with a discount medical plan, use in its advertisements, marketing material, brochures and discount medical plan cards the term "insurance";

(2) Except as otherwise required by state law, describe or characterize the discount medical plan as being insurance whenever a discount medical plan is bundled with an insured product and the insurance benefits are incidental to the discount medical plan benefits;

(3) Use in its advertisements, marketing material, brochures and discount medical plan cards the terms "health plan," "coverage," "copay," "copayments," "deductible," "preexisting conditions," "guaranteed issue," "premium," "PPO," "preferred provider organization," or other terms in a manner that could reasonably mislead an individual into believing that the discount medical plan is health insurance;

(4) Use language in its advertisements, marketing material, brochures and discount medical plan cards with respect to being "licensed" by the State Insurance Department in a manner that could reasonably mislead an individual into believing that the discount medical plan is insurance or has been endorsed by the State;

(5) Make misleading, deceptive or fraudulent representations regarding the discount or range of discounts offered by the discount medical plan card or the access to any range of discounts offered by the discount medical plan card;

(6) Have restrictions on access to any listed discount medical plan providers, except for waiting periods and notification periods; or

(7) Pay providers any fees for medical or ancillary services or collect or accept money from a member to pay a provider for medical or ancillary services provided under the discount medical plan.

(c) Each discount medical plan organization shall make the following general disclosures:

(1) In writing in not less than 12-point type;

(2) On the first content page of any advertisements, marketing materials or brochures made available to the public relating to a discount medical plan; and

(3) In addition to any enrollment forms given to a prospective or new member, the prospective or new members shall receive a statement which states:

a. That the plan is not insurance;

b. That the range of discounts for medical or ancillary services provided under the plan will vary depending on the type of provider and medical or ancillary service received;

c. That the plan does not make payments to providers for the medical or ancillary services received under the discount medical plan;

d. That the plan member is obligated to pay for all medical or ancillary services, but will receive a discount from those providers that have contracted with the discount medical plan organization; and

e. The toll-free telephone number and Internet website address for the licensed discount medical plan organization for prospective members and members to obtain additional information about and assistance on the discount medical plan and up-to-date lists of providers participating in the discount medical plan.

If the initial contact with a prospective member is by telephone, the disclosures required under subsection (a) of this section shall be made orally and included in the initial written materials that describe the benefits under the discount medical plan provided to the prospective or new member.

(d) In addition to the general disclosures required under subsection (c) of this section, each discount medical plan organization shall provide to:

(1) Each applicant, at the time of application, information that describes the terms and conditions of the discount medical plan, including any limitations or restrictions on the refund of any processing fees or periodic charges associated with the discount medical plan; and

(2) Each new member a written document that contains the terms and conditions of the discount medical plan.

(e) The written document required under paragraph (d)(2) of this section shall be clear and include information on:

(1) The name of the member;

(2) The benefits to be provided under the discount medical plan;

(3) Any processing fees and periodic charges associated with the discount medical plan, including any limitations or restrictions on the refund of any processing fees and periodic charges;

(4) The mode of payment of any processing fees and periodic charges, such as monthly, quarterly, etc., and procedures for changing the mode of payment;

(5) Any limitations, exclusions or exceptions regarding the receipt of discount medical plan benefits;

(6) Any waiting periods for certain medical or ancillary services under the discount medical plan;

(7) Procedures for obtaining discounts under the discount medical plan, such as requiring members to contact the discount medical plan organization to make an appointment with a provider on the member's behalf;

(8) Cancellation procedures, including information on the member's 30-day cancellation rights and refund requirements and procedures for obtaining refunds;

(9) Renewal, termination and cancellation terms and conditions;

(10) Procedures for adding new members to a family discount medical plan, if applicable;

(11) Procedures for filing complaints under the discount medical plan organization's complaint system and information that, if the member remains dissatisfied after completing the organization's complaint system, the plan member may contact that member's local state insurance department; and

(12) The name and mailing address of the licensed discount medical plan organization or other entity where the member can make inquiries about the plan, send cancellation notices and file complaints.

(77 Del. Laws, c. 470, § 1; 70 Del. Laws, c. 186, § 1.)

§ 7611. Notice of change in name or address.

Each discount medical plan organization shall provide the Commissioner at least 30 days notice of any change in the discount medical plan organization's name, address, principal business address or mailing address or Internet website address.

(77 Del. Laws, c. 470, § 1.)

§ 7612. Annual reports.

(a) If the information required in subsection (b) of this section is not provided at the time of renewal of a license under § 7603(e) of this title, a discount medical plan organization shall file an annual report with the Commissioner in the form prescribed by the Commissioner, within 3 months after the end of each calendar year.

(b) The report shall include:

(1) If different from the initial application for a license or at the time of renewal of a license or the last annual report, as appropriate, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements with these persons and the discount medical plan organization, including any possible conflicts of interest;

(2) The number of discount medical plan members in the State;

(3) The discount medical plan's most recent audited financial statement and most current unaudited financial statement; and

(4) Any other information relating to the performance of the discount medical plan organization that may be required by the Commissioner.

(c) Any discount medical plan organization that fails to file an annual report in the form and within the time required by this section shall:

(1) Forfeit:

a. Up to $500 each day for the first 10 days during which the violation continues; and

b. Up to $1,000 each day after the first 10 days during which the violation continues; and

(2) Upon notice by the Commissioner, lose its authority to enroll new members or to do business in this State while the violation continues.

(77 Del. Laws, c. 470, § 1.)

§ 7613. Penalties.

Section 329 and Chapter 24 of this title, relating to administrative penalties and fraud, shall apply to discount medical plan organizations.

(77 Del. Laws, c. 470, § 1.)

§ 7614. Injunctions.

(a) In addition to the penalties and other enforcement provisions of this chapter, the Commissioner may seek both temporary and permanent injunctive relief when:

(1) A discount medical plan is being operated by a person or entity that is not licensed pursuant to this chapter; or

(2) Any person, entity or discount medical plan organization has engaged in any activity prohibited by this chapter or any regulation adopted pursuant to this chapter.

(b) The venue for any proceeding brought pursuant to this section shall be in the Delaware Court of Chancery.

(c) The Commissioner's authority to seek injunctive relief is not conditioned on having conducted any proceeding pursuant to Chapter 101 of Title 29.

(77 Del. Laws, c. 470, § 1.)

Part II
Miscellaneous

Chapter 77
Suretyship

Subchapter I

Corporate Sureties

§ 7701. Execution and sufficiency of corporate suretyship.

(a) Whenever any bond, undertaking, recognizance or other obligation is by law or the charter, ordinances, rules or regulations of any municipality, board, body, organization or public officer required or permitted to be made, given, tendered or filed with surety or sureties, and whenever the performance of any act, duty or obligation, or the refraining from any act, is required or permitted to be guaranteed, such bond, undertaking, obligation, recognizance or guarantee may be executed by an insurer duly authorized to transact surety insurance in this State under a certificate of authority issued by the Insurance Commissioner of this State.

(b) The execution by such insurer of such bond, undertaking, obligation, recognizance or guarantee shall be in all respects a full and complete compliance with every requirement of every law, charter, ordinance, rule or regulation that such bond, undertaking, obligation, recognizance or guarantee shall be executed by 1 surety or by 1 or more sureties, or that such sureties shall be residents or freeholders, either or both, or possess any other qualification, and shall be accordingly accepted and treated.

(18 Del. C. 1953, § 7701; 56 Del. Laws, c. 460.)

§ 7702. Acceptance and approval by public officers.

(a) Any public officer or department of state, county or municipal government, whose duty it may be to approve the surety upon any bond or bonds, may accept and approve such bonds when executed by the principal therein and by any surety insurer qualified to act as surety or guarantor as provided in § 7701 of this title. The Levy Court and County Councils of the several counties of this State may accept such bonds as security for receivers of taxes and county treasurers in lieu of the security provided for by the laws of this State.

(b) Whenever any bond, undertaking, recognizance or guarantee has been duly executed in compliance with the terms of this chapter by the principal or principals therein, and by an insurer, duly authorized under the law of this State to transact the business of executing bonds of suretyship, then any officer, judge or any department of the state, or of any county or municipal government, whose duty it may be to approve of the surety upon the bond, undertaking, recognizance or guarantee may accept and approve such bond, undertaking, recognizance or guarantee.

(18 Del. C. 1953, § 7702; 56 Del. Laws, c. 460.)

§ 7703. Agreement requiring principal to deposit assets; withdrawal.

Any party of whom a bond or undertaking is required may agree with sureties for the deposit for safe keeping of any and all moneys and other depositable assets for which such sureties are or may be held responsible with a trust company, safe deposit company or bank authorized by law to transact business as such in this State, if such deposit is otherwise proper, in such manner as to prevent the withdrawal of such moneys and assets or any part thereof, except with the written consent of such sureties, or an order of the court, made on such notice to them as such court may direct.

(18 Del. C. 1953, § 7703; 56 Del. Laws, c. 460; 70 Del. Laws, c. 186, § 1.)

§ 7704. Release of liability on bond; procedure.

The surety or representatives of any surety, upon the bond of any trustees, committee, guardian, assignees, receiver, executor or administrator or other fiduciary, may apply by petition to the court wherein the bond is filed or which may have jurisdiction of such trustee, committee, guardian, assignee, receiver, executor or administrator or other fiduciary or to a judge of the court, praying to be relieved from further liability as such surety for the acts or omissions of the trustee, committee, guardian, assignee, receiver, executor or administrator or other fiduciary, which may occur after the date of the order relieving such surety, to be granted as herein provided for; and to require such trustee, committee, guardian, receiver, assignee, executor or administrator or other fiduciary to show cause why he or she should not account, and such surety to be relieved from any such further liability as aforesaid, and such principal be required to give a new bond. Thereupon, upon the filing of such petition, the court or judge thereof shall issue such order, returnable at such time and place and to be served in such manner, as such court or judge may direct, and may restrain such trustee, committee, guardian, assignee, receiver, executor or administrator or other fiduciary from acting except in such manner as it may direct to preserve the trust estate, and, upon the return of such order to show cause, if the principal in the bond account in due form of law and file a new bond duly approved, then such court or judge shall make an order releasing such surety filing the petition from liability upon the bond for any subsequent act or default of the principal; and in default of such principal thus accounting and filing such bond, such court or judge shall make an order directing such trustee, committee, guardian, assignee, receiver, executor or administrator, or other fiduciary to account in due form of law, and, if

the trust fund or estate shall be satisfactorily accounted for and delivered or properly secured, such surety shall be discharged from any and all further liability as such for the subsequent acts or omissions of the trustee, guardian, committee, assignee, receiver, executor or administrator or other fiduciary after the day of such surety being so relieved and discharged.

(18 Del. C. 1953, § 7704; 56 Del. Laws, c. 460; 70 Del. Laws, c. 186, § 1.)

§ 7705. Estoppel of surety insurer to deny corporate power.

No insurer having signed any bond, undertaking or obligation as surety, guarantor or indemnitor shall be permitted to deny its corporate power to execute such instrument or incur such liability, in any proceeding to enforce liability against it thereunder.

(18 Del. C. 1953, § 7705; 56 Del. Laws, c. 460.)

§ 7706. Premium on bond of public officer; expense of office.

The expenses incurred by any public officer for suretyship upon any bond required by law of him or her, as well as the expenses for suretyship upon any bond required of any of his or her assistants or clerks, shall, where the bond or bonds are required for the protection of the State, be paid for by the State, and where the bond or bonds are required for the protection of any of the several counties, be paid for by the Levy Court or County Council of the county, and where the bond or bonds are required for the protection of a municipality, be paid for by the municipality, and shall be charged to and considered a part of the expenses of the office held by the official. The cost of the bond shall not exceed the sum or sums determined by any applicable rate filed by the surety with the Insurance Commissioner.

(18 Del. C. 1953, § 7706; 56 Del. Laws, c. 460; 70 Del. Laws, c. 186, § 1.)

§ 7707. Premium on bond of fiduciary; expense of estate.

Any receiver, guardian, assignee, committee, trustee, executor, administrator or other fiduciary required by law or the order of any court to give a bond, undertaking or other obligation as such, who shall avail himself or herself of corporate suretyship in such bond, undertaking or obligation as authorized by the laws of this State, may present to the proper court or officer before whom he or she is required to account a statement and receipt showing the amount of charges paid for such corporate suretyship; and thereupon the court or other officer, before whom such accounting is rendered, may either order and direct such sum, either in whole or in part, to be a charge upon the estate and charged accordingly; or it may direct that no part thereof shall be a charge upon the estate. No charge for such suretyship shall in any case be allowed in excess of the sum or sums determined by any applicable rate filed by the surety with the Insurance Commissioner.

(18 Del. C. 1953, § 7707; 56 Del. Laws, c. 460; 70 Del. Laws, c. 186, § 1.)

§ 7708. Warrant of attorney.

In all instances where corporate suretyship is offered in accordance with this chapter, and where the form of bond required by law contains a warrant of attorney, the bond shall be accepted without such warrant of attorney being written therein.

(18 Del. C. 1953, § 7708; 56 Del. Laws, c. 460.)

Subchapter II

Rights of Sureties

§ 7709. Assignment of obligation.

Where any persons are bound in any bond, bill or other writing made payable to any person, his or her executors, administrators, order or assigns, and the money due thereon or any balance thereof, shall be paid or tendered by a surety therein, the obligee shall be obliged to assign such bond, bill or other writing to such surety, and such assignee shall, by virtue of such assignment, have an action in his or her own name thereon against the principal debtor or his or her representative.

(18 Del. C. 1953, § 7709; 56 Del. Laws, c. 460; 70 Del. Laws, c. 186, § 1.)

§ 7710. Joint sureties or debtors; assignment.

Where several persons are bound together in any bond, bill or other writing as joint debtors or as joint sureties, in any sum of money made payable to any person, his or her executors, administrators, order or assign and such bond, bill, or other writing shall be paid by any of such joint debtors or joint sureties, the creditor shall assign such bond, bill, or other writing, to the person paying the same; and such assignee shall, in his or her own name, as assignee, or otherwise, have such action or remedy as the creditor himself or herself might have had against the other joint debtors, or sureties, or their representatives, to recover such proportion of the money, so paid, as may be justly due from the defendants.

(18 Del. C. 1953, § 7710; 56 Del. Laws, c. 460; 70 Del. Laws, c. 186, § 1.)

§ 7711. Defense of infancy to joint sureties or debtors.

Where several persons are bound together in any bond, bill or other writing or judgment as joint debtors or as joint sureties, in any sum of money, made payable to any person or corporation, the executors, administrators, successors, order or assigns, and 1 or more of such persons was, at the time of making, signing or executing the same, or at the time of the rendition of such judgment, an infant,

such fact shall be no defense in any action, proceeding or suit for the enforcement of the liability of those bound thereunder, excepting as regards the person who was an infant at the time of making, signing or executing such bond, bill or other writing, or who was an infant at the time such judgment was rendered.

(18 Del. C. 1953, § 7711; 56 Del. Laws, c. 460; 70 Del. Laws, c. 186, § 1.)

§ 7712. Rights of surety or of joint debtor on payment of judgment.

(a) If a judgment recovered against principal and surety shall be paid by the surety, the creditor shall mark such judgment to the use of the surety so paying the same; and the transferee shall, in the name of the plaintiff, have the same remedy by execution or other process against the principal debtor as the creditor could have had, the transfer by marking to the use of the surety being first filed of record in the court where the judgment is.

(b) Where there is a judgment against several debtors or sureties and any of them shall pay the whole, the creditor shall mark such judgment to the use of the persons so paying the same; and the transferee shall, in the name of the plaintiff, be entitled to an execution or other process against the other debtors or sureties in the judgment, for a proportionable part of the debt or damages paid by such transferee; but, no defendant shall be debarred of any remedy against the plaintiff or the plaintiff's representatives or assigns by any legal or equitable course of proceeding whatever.

(18 Del. C. 1953, § 7712; 56 Del. Laws, c. 460; 70 Del. Laws, c. 186, § 1.)

§ 7713. Affidavit of sum due.

Before any transferee shall have the benefit of § 7712 of this title, the transferee shall file in the court, or before the justice of the peace where such proceedings are instituted, a statement of the sum due from the defendant with an affidavit that it is wholly unpaid.

(18 Del. C. 1953, § 7713; 56 Del. Laws, c. 460; 70 Del. Laws, c. 186, § 1.)

§ 7714. Execution and effect of transfer.

Transfers, by marking to the use of the persons paying such judgment, shall be in writing, signed by the plaintiff or by the plaintiff's attorney of record, and after the date thereof, the plaintiff may not release, or discharge any of the debts or sums so paid, but such transfer shall be without recourse to the plaintiff, and shall not make the plaintiff liable to the transferee in case the latter shall not recover the same.

(18 Del. C. 1953, § 7714; 56 Del. Laws, c. 460; 70 Del. Laws, c. 186, § 1.)

§ 7715. Application of chapter.

Every provision in this chapter giving a right or remedy to, or imposing a duty upon, or referring to the act of a debtor, obligor, assignor or transferor, or a surety, obligee, assignee or transferee, creditor, or other person shall be construed to extend to or against his or her executors, administrators or assigns, when so applicable.

(18 Del. C. 1953, § 7715; 56 Del. Laws, c. 460; 70 Del. Laws, c. 186, § 1.)

§ 7716. Remedies of codebtor or cosurety.

(a) Whenever 1 or more of several codebtors or cosureties for the payment of a debt shall pay or shall have paid to the creditor or creditors the sum due, including the costs, if any, that may have been incurred by them, the person or persons so paying, if the amount paid shall exceed their proportion of liability for the demand, shall be entitled to have a transfer of the creditor's or creditors' securities for the payment of the debt, whatever the nature of such securities may be, to enable him or her or them to obtain contribution from the others, liable with himself or herself or themselves; such transfer may be made by assignment, marking to the use, or other appropriate method.

(b) When such transfer is made, the transferee or transferees shall be entitled to and shall have in his or her or their own name or names as such, or by and in the name of such creditor or creditors, for his or her or their own use as transferee or transferees, all and singular the remedy or remedies against the other debtor or debtors, surety or sureties which the creditor or creditors could have; and no such payment shall in anywise operate to discharge, impair or otherwise affect the securities held by the creditor or creditors to the prejudice of the debtor or debtors, surety or sureties, so paying; nor shall any release of such codebtor or codebtors, cosurety or cosureties, or entry of satisfaction upon any lien against him or her or them operate in any respect as a payment or discharge of the demand itself or of any of the securities therefor as against the other parties originally bound, to the end that such codebtor or codebtors, cosurety or cosureties may recover by the use of the creditor or creditors' means or remedies the proportion of the demand which the codebtor or codebtors, cosurety or cosureties ought to pay according to law and equity.

(c) The transfer to be made by the creditor or creditors shall not enable the transferee or transferees to take any legal proceedings against the codebtor or codebtors, cosurety or cosureties, unless such transferee or transferees, or some creditable person for him or her or them, shall first file in the office of the Prothonotary or justice of the peace of the county where legal proceedings are contemplated to be taken an affidavit, setting forth the amount which he or she claims his or her or their codebtor or codebtors, cosurety or cosureties is or are bound to contribute on account of such coindebtment or cosuretyship, and such amount shall be endorsed by the Prothonotary or magistrate upon the process issued.

(18 Del. C. 1953, § 7716; 56 Del. Laws, c. 460; 70 Del. Laws, c. 186, § 1.)

§ 7717. Entry of satisfaction of judgment.

(a) Upon the payment of any judgment under and according to the provisions of this chapter, the right or power of the creditor or plaintiff therein to enter satisfaction upon the record of such judgment shall eo instanti, cease and determine, and this whether the transfer of such judgment shall have been made or not; the fact of the payment thereof shall be sufficient.

(b) If any creditor or plaintiff in such judgment, after payment of any judgment to such creditor or plaintiff shall enter or cause to be entered satisfaction of the judgment upon the record thereof, without the express consent, in writing, of the person entitled, under the provisions of this chapter, to its transfer, the court in which such judgment is recovered shall, upon application of the person so entitled and upon sufficient proof of the facts, strike from the record the entry of satisfaction, whereupon the judgment shall be and remain in full force and virtue, and as valid and binding upon the defendant therein as it was or could have been, had such entry of satisfaction never been made. The application shall be in writing, and sworn or affirmed to by the applicant, and shall contain a general statement of the facts. Nothing in this section shall be construed to divest or interfere in any way with any rights which may have been acquired by innocent third persons who, in good faith, and without notice, may have relied and acted upon the protection and security of the entry of satisfaction. No defendant shall be debarred of any remedy against the plaintiff or the plaintiff’s representatives or assigns by any legal or equitable course of proceedings whatever.

(18 Del. C. 1953, § 7717; 56 Del. Laws, c. 460; 70 Del. Laws, c. 186, § 1.)

Part II
Miscellaneous

Chapter 80
Risk Retention Act

§ 8001. Purpose.

The purpose of this chapter is to regulate the formation and/or operation of risk retention groups and purchasing groups in this State formed pursuant to the provisions of the federal Liability Risk Retention Act of 1986 ("RRA 1986") [15 U.S.C. § 3901 et seq.], to the extent permitted by such law.

(68 Del. Laws, c. 57, § 1.)

§ 8002. Definitions.

As used in this chapter:

(1) "Commissioner" means the Insurance Commissioner of Delaware or the commissioner, director or superintendent of insurance in any other state;

(2) "Completed operations liability" means liability arising out of the installation, maintenance or repair of any product at a site which is not owned or controlled by:

a. Any person who performs that work; or

b. Any person who hires an independent contractor to perform that work; but shall include liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability;

(3) "Domicile," for purposes of determining the state in which a purchasing group is domiciled, means:

a. For a corporation, the state in which the purchasing group is incorporated; and

b. For an unincorporated entity, the state of its principal place of business;

(4) "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able:

a. To meet obligations to policy holders with respect to known claims and reasonably anticipated claims; or

b. To pay other obligations in the normal course of business;

(5) "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance and any other arrangement for shifting and distributing risk which is determined to be insurance under the laws of this State;

(6) "Liability":

a. Means legal liability for damages (including costs of defense, legal costs and fees and other claims expenses) because of injuries to other persons, damage to their property or other damage or loss to such other persons resulting from or arising out of:

1. Any business (whether profit or nonprofit), trade, product, services (including professional services), premises or operations; or

2. Any activity of any state or local government, or any agency or political subdivision thereof; and

b. Does not include personal risk liability and an employer's liability with respect to its employees other than legal liability under the federal Employers' Liability Act (45 U.S.C. § 51 et seq.);

(7) "Personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from personal, familial or household responsibilities or activities, rather than from responsibilities or activities referred to in paragraph (6) of this section;

(8) "Plan of operation or a feasibility study" means an analysis which presents the expected activities and results of a risk retention group including, at a minimum:

a. Information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations;

b. For each state in which it intends to operate, the coverages, deductibles, coverage limits, rates and rating classification systems for each line of insurance the group intends to offer;

c. Historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available;

d. Pro forma financial statements and projections;

e. Appropriate opinions by a qualified, independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition;

f. Identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, investment policies and reinsurance agreements;

g. Identification of each state in which the risk retention group has obtained, or sought to obtain, a charter and license, and a description of its status in each such state; and

h. Such other matters as may be prescribed by the commissioner of the state in which the risk retention group is chartered for liability insurance companies authorized by the insurance laws of that state;

(9) "Product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage or property damage (including damages resulting from the loss of use of property) arising out of the manufacture, design, importation, distribution, packaging, labeling, lease or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of such a person when the incident giving rise to the claim occurred;

(10) "Purchasing group" means any group which:

a. Has as one of its purposes the purchase of liability insurance on a group basis;

b. Purchases such insurance only for its group members and only to cover their similar or related liability exposure, as described in paragraph (10)c. of this section;

c. Is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations; and

d. Is domiciled in any state;

(11) "Risk retention group" means any corporation or other limited liability association:

a. Whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its group members;

b. Which is organized for the primary purpose of conducting the activity described under paragraph (11)a. of this section;

c. Which:

1. Is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

2. Before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the insurance commissioner of at least 1 state that it satisfied the capitalization requirements of such state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since such date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability (as such terms were defined in the Product Liability Risk Retention Act of 1981 [15 U.S.C. § 3901 et seq.] before the date of the enactment of the Liability Risk Retention Act of 1986 [15 U.S.C. § 3901 et seq.]);

d. Which does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such a person;

e. Which:

1. Has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group; or

2. Has as its sole owner an organization which has as:

(I) Its members only persons who comprise the membership of the risk retention group; and

(II) Its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group;

f. Whose members are engaged in businesses or activities similar or related with respect to the liability of which such members are exposed by virtue of any related, similar or common business trade, product, services, premises or operations;

g. Whose activities do not include the provision of insurance other than:

1. Liability insurance for assuming and spreading all or any portion of the liability of its group members; and

2. Reinsurance with respect to the liability of any other risk retention group (or any members of such other group) which is engaged in businesses or activities so that such group or member meets the requirement described in paragraph (11)f. of this section from membership in the risk retention group which provides such reinsurance; and

h. The name of which includes the phrase "risk retention group";

(12) "State" means any state of the United States or the District of Columbia.

(68 Del. Laws, c. 57, § 1; 68 Del. Laws, c. 335, §§ 1, 2.)

§ 8003. Risk retention groups chartered in this State.

(a) A risk retention group shall, pursuant to this chapter, be chartered and licensed to write only liability insurance pursuant to this chapter and, except as provided elsewhere in this chapter, must comply with all of the laws, rules, regulations and requirements applicable to such insurers chartered and licensed in this State and with § 8004 of this title to the extent such requirements are not a limitation on laws, rules, regulations or requirements of this State.

(b) Before it may offer insurance in any state, each risk retention group shall also submit for approval to the Insurance Commissioner of this State a plan of operation or feasibility study. The risk retention group shall submit an appropriate revision in the event of any subsequent material change in any item of the plan of operation or feasibility study, within 10 days of any such change. The group shall not offer any additional kinds of liability insurance, in this State or in any other state, until a revision of such plan or study is approved by the Commissioner.

(c) At the time of filing its application for charter, the risk retention group shall provide to the Commissioner in summary form the following information: The identity of the initial members of the group, the identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group, the amount and nature of initial capitalization, the coverages to be afforded and the states in which the group intends to operate. Upon receipt of this information, the Commissioner shall forward such information to the National Association of Insurance Commissioners. Providing notification to the National Association of Insurance Commissioners is in addition to and shall not be sufficient to satisfy the requirements of § 8004 of this title or any other sections of this chapter.

(d) *Governance standards for risk retention groups. —*

By January 1, 2018, existing risk retention groups shall be in compliance with the following governance standards. New risk retention groups shall be in compliance with the standards at the time of licensure.

(1) *Board of directors. —*

As used in this section, the "board of directors" or "board" means the governing body of the risk retention group elected by the shareholders or members to establish policy, elect or appoint officers and committees, and make other governing decisions, and "director" means a natural person designated in the articles of the risk retention group, or designated, elected, or appointed by any other manner, name or title to as a director.

a. 1. *Independent directors. —*

The board of directors of the risk retention group shall have a majority of independent directors. If the risk retention group is a reciprocal, then the attorney-in-fact would be required to adhere to the same standards regarding independence of operation and governance as imposed on the risk retention group's board of directors/subscribers advisory committee under these standards; and, to the extent permissible under state law, service providers of a reciprocal risk retention group should contract with the risk retention group and not the attorney-in-fact.

2. No director qualifies as "independent" unless the board of directors affirmatively determines that the director has no "material relationship" with the risk retention group. Each risk retention group shall disclose these determinations to its domestic regulator, at least annually. For this purpose, any person that is a direct or indirect owner of or subscriber in the risk retention group (or is an officer, director or employee of such an owner and insured, unless some other position of such officers, director or employee constitutes a "material relationship"), as contemplated by § 3901(a)(4)(E)(ii) of the Liability Risk Retention Act [15 U.S.C. § 3901(a)(4)(E)(ii)], is considered to be "independent."

b. "Material relationship" of a person with the risk retention group includes any of the following:

1. The receipt in any 1 12-month period of compensation or payment of any other item of value by such person, a member of such person's immediate family or any business with which such person is affiliated from the risk retention group or a consultant or service provider to the risk retention group or a consultant or service provider to the risk retention group is greater than or equal to 5% of the risk retention group's gross written premium for such 12-month period or 2% of its surplus, whichever is greater, as measured at the end of any fiscal quarter falling in such a 12-month period. Such person or immediate family member of such person is not independent until 1 year after his or her compensation from the risk retention group falls below the threshold.

2. A relationship with an auditor as follows: a director or an immediate family member of a director who is affiliated with or employed in a professional capacity by a present or former internal or external auditor of the risk retention group is not independent until 1 year after the end of the affiliation, employment or auditing relationship.

3. A relationship with a related entity as follows: a director or immediate family member of a director who is employed as an executive officer of another company where any of the risk retention group's present executives serve on that other company's board of directors is not independent until 1 year after the end of such service or the employment relationship.

(2) *Service provider contracts. —*

The term of any material service provider contract with the risk retention group shall not exceed 5 years. Any such contract, or its renewal, shall require the approval of the majority of the risk retention group's independent directors. The risk retention group's board of directors shall have the right to terminate any service provider, audit or actuarial contracts at any time for cause after providing adequate notice as defined in the contract. The service provider contract is deemed material if the amount to be paid for such contract is greater than or equal to 5% of the risk retention group's annual gross written premium or 2% of the its surplus, whichever is greater.

a. For purposes of this subsection, "service providers" shall include: captive managers; auditors; accountants; actuaries; investment advisors; lawyers; managing general underwriters or other party responsible for underwriting, determination of rates, collection of premium, adjusting and settling claims and/or the preparation of financial statements. Any reference to "lawyers" in the prior sentence does not include defense counsel retained by the risk retention group to defend claims, unless the amount of fees paid to such lawyers is "material" as referenced in paragraph (d)(1)b. of this section.

b. No service provider contract meeting the definition of "material relationship" contained in paragraph (d)(1)b. of this section shall be entered into unless the risk retention group has notified the Commissioner in writing of its intention to enter into such transaction at least 30 days prior thereto and the Commissioner has not disapproved it within such period.

(3) *Written policy. —*

The risk retention group's board of directors shall adopt a written policy in the plan of operation as approved by the board that requires the board to:

a. Assure that all owners and insurers of the risk retention group receive evidence of ownership interest;

b. Develop a set of governance standards applicable to the risk retention group;

c. Oversee the evaluation of the risk retention group's management including but not limited to the performance of the captive manager, managing general underwriter, or other party or parties responsibility for underwriting, determination of rates, collection of premium, adjusting or settling claims or the preparation of financial statements;

d. Review and approve the amount to be paid for all material service providers; and

e. Review and approve, at least annually:

1. Risk retention group's goals and objectives relevant to the compensation of officers and service providers;

2. The officers# and service providers# performance in light of those goals and objectives; and

3. The continued engagement of the officers and material service providers.

(4) *Audit committee. —*

The risk retention group shall have an audit committee composed of at least 3 independent board members as defined in paragraph (d)(1) of this section. A nonindependent board members may participate in the activities of the audit committee, if invited by the members, but cannot be a member of such committee.

a. The audit committee shall have a written charter that defines the committee's purpose, which, at a minimum must be to:

1. Assist board oversight of:

A. The integrity of the financial statements;

B. The compliance with legal and regulatory requirements; and

C. The qualifications, independence and performance of the independent auditor and actuary;

2. Discuss the annual audited financial statements and quarterly financial statements with management;

3. Discuss the annual audited financial statements with its independent auditor and, if advisable, discuss its quarterly financial statements with its independent auditor;

4. Discuss policies with respect to risk assessment and risk management;

5. Meet separately and periodically, either directly or through a designated representative of the committee, with management and intendent auditors;

6. Review with the independent auditor any audit problems or difficulties and management's response;

7. Set clear hiring policies of the risk retention group as to the hiring of employees or former employees of the independent auditor;

8. Require the external auditor to rotate the lead, or coordinating, audit partner having primary responsibility for the risk retention group's audit as well as the audit partner responsible for reviewing that audit so that neither individual performs audit services for more than 5 consecutive fiscal years; and

9. Report regulatory to the board of directors.

b. The domestic regulator may waive the requirement to establish an audit committee composed of independent board members if the risk retention group is able to demonstrate to the domestic regulator that it is impracticable to do so and the risk retention group's board of directors itself is otherwise able to accomplish the purposes of an audit committee, as described in paragraph (d)(4)a. of this section.

(5) *Governance standards. —*

The board of directors shall adopt and disclose governance standards, where "disclose" means making such information available through electronic (e.g., posting such information on the risk retention group's website) or other means, and providing such information to members or insureds upon request, which shall include:

a. A process by which the directors are elected by the owner/insureds;

b. Director qualification standards;

c. Director responsibilities;

d. Director access to management and, as necessary and appropriate, independent advisors;

e. Director compensation;

f. Director orientation and continuing education;

g. The policies and procedures that are followed for management succession; and

h. The policies and procedures that are followed for annual performance evaluation of the board.

(6) *Business conduct and ethics. —*

The board of directors shall adopt and disclose a code of business conduct and ethic for directors, officers, and employees and promptly disclose to the board of directors any waivers of the code for directors or executive officers, which shall include all of the following topics:

a. Conflicts of interest;

b. Matters covered under the corporate opportunities doctrine under the state of domicile;

c. Confidentiality;

d. Fair dealing;

e. Protection and proper use of risk retention group assets;

f. Compliance with all applicable laws, rules and regulations;

g. Requiring the reporting of any illegal or unethical behavior which affects the operation of the risk retention group.

(7) *Reporting noncompliance. —*

The captive manager, president, or chief executive officer of the risk retention group shall promptly notify the domestic regulator in writing if that captive manager, president, or chief executive becomes aware of any material non-compliance with any of these governance standards.

(68 Del. Laws, c. 57, § 1; 70 Del. Laws, c. 186, § 1; 80 Del. Laws, c. 284, § 1.)

§ 8004. Risk retention groups not chartered in this State.

Risk retention groups chartered and licensed in states other than this State and seeking to do business as a risk retention group in this State shall comply with the laws of this State as follows:

(1) *Notice of operations and designation of Commissioner as agent. —* a. Before offering insurance in this State, a risk retention group shall submit to the Commissioner:

1. A statement identifying the state or states in which the risk retention group is chartered and licensed as a liability insurance company, charter date, its principal place of business and such other information, including formation on its membership, as the Commissioner of this State may require to verify that the risk retention group is qualified under § 8002(11) of this title;

2. A copy of its plan of operations or feasibility study and revisions of such plan or study submitted to the state in which the risk retention group is chartered and licensed; provided, however, that the provision relating to the submission of a plan of operation or feasibility study shall not apply with respect to any line or classification of liability insurance which:

(I) Was defined in the Product Liability Risk Retention Act of 1981 [15 U.S.C. § 3901 et seq.] before October 27, 1986; and

(II) Was offered before such date by any risk retention group which had been chartered and operating for not less than 3 years before such date.

b. The risk retention group shall submit a copy of any revision to its plan of operation or feasibility study required by § 8003(b) of this title at the same time that such revision is submitted to the commissioner of its chartering state.

c. The risk retention group shall submit a statement of registration, for which a filing fee shall be determined by the Commissioner, which designates the Commissioner as its agent for the purpose of receiving service of legal documents or process.

(2) *Financial condition. —* Any risk retention group doing business in this State shall submit to the Commissioner:

a. A copy of the group's financial statement submitted to the state in which the risk retention group is chartered and licensed which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist (under criteria established by the National Association of Insurance Commissioners);

b. A copy of each examination of the risk retention group as certified by the Commissioner or public official conducting the examination;

c. Upon request by the Commissioner, a copy of any information or document pertaining to any outside audit performed with respect to the risk retention group; and

d. Such information as may be required to verify its continuing qualification as a risk retention group under § 8002(11).

(3) *Taxation. —* a. Each risk retention group shall be liable for the payment of premium taxes and taxes on premiums of direct business for risks resident or located within this State, and shall report to the Commissioner the net premiums written for risks resident or located within this State. Such risk retention group shall be subject to taxation, and any applicable fines and penalties related thereto, on the same basis as a foreign admitted insurer.

b. To the extent licensed agents or brokers are utilized pursuant to § 8012 of this title, they shall report to the Commissioner the premiums for direct business for risks resident or located within this State which such licensees have placed with or on behalf of a risk retention group not chartered in this State.

c. To the extent that insurance agents or brokers are utilized pursuant to § 8012 of this title, such agent or broker shall keep a complete and separate record of all policies procured from each such risk retention group, which record shall be open to examination by the Commissioner, as otherwise provided in this title. These records shall, for each policy and each kind of insurance provided thereunder, include the following:

1. The limit of liability;
2. The time period covered;
3. The effective date;
4. The name of the risk retention group which issued the policy;
5. The gross premium charged; and
6. The amount of return premiums, if any.

(4) *Compliance with Unfair Claims Settlement Practices Act.* — Any risk retention group, its agents and representatives shall comply with the Unfair Claims Settlement Practices Act of this State, § 2301 et seq. of this title.

(5) *Deceptive, false or fraudulent practices.* — Any risk retention group shall comply with the laws of this State regarding deceptive, false or fraudulent acts or practices. However, if the Commissioner seeks an injunction regarding such conduct, the injunction must be obtained from a court of competent jurisdiction.

(6) *Examination regarding financial condition.* — Any risk retention group must submit to an examination by the Commissioner to determine its financial condition if the commissioner of the jurisdiction in which the group is chartered and licensed has not initiated an examination or does not initiate an examination within 60 days after a request by the Commissioner of this State. Any such examination shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with NAIC's Examiner Handbook.

(7) *Notice to purchasers.* — Every application form for insurance from a risk retention group, and every policy (on its front and declaration pages) issued by a risk retention group, shall contain in 10-point type the following notice:

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

(8) *Prohibited acts regarding solicitation or sale.* — The following acts by a risk retention group are hereby prohibited:

a. The solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in such group; and

b. The solicitation or sale of insurance by, or operation of, a risk retention group that is in hazardous financial condition or financially impaired.

(9) *Prohibition on ownership by an insurance company.* — No risk retention group shall be allowed to do business in this State if an insurance company is directly or indirectly a member or owner of such risk retention group, other than in the case of a risk retention group all of whose members are insurance companies.

(10) *Prohibited coverage.* — The terms of any insurance policy issued by any risk retention group shall not provide, or be construed to provide, coverage prohibited generally by statute of this State or declared unlawful by the highest court of this State whose law applies to such policy.

(11) *Delinquency proceedings.* — A risk retention group not chartered in this State and doing business in this State shall comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by a state insurance commissioner if there has been a finding of financial impairment after an examination under paragraph (6) of this section.

(12) *Penalties.* — A risk retention group that violates any provision of this chapter will be subject to fines and penalties including revocation of its right to do business in this State, applicable to licensed insurers generally.

(13) *Operation prior to June 25, 1991.* — In addition to complying with the requirements of this section, any risk retention group operating in this State prior to June 25, 1991, shall, within 30 days after June 25, 1991, comply with paragraph (1)a. of this section.

(68 Del. Laws, c. 57, § 1; 68 Del. Laws, c. 335, § 3.)

§ 8005. Compulsory associations.

(a) No risk retention group shall be required or permitted to join or contribute financially to any insurance insolvency guaranty fund, or similar mechanism, in this State, nor shall any risk retention group, or its insureds or claimants against its insureds, receive any benefit from any such fund for claims arising under the insurance policies issued by such risk retention group.

(b) When a purchasing group obtains insurance covering its members' risks from an insurer not authorized in this State or a risk retention group, no such risks, wherever resident or located, shall be covered by any insurance guaranty fund or similar mechanism in this State.

(c) When a purchasing group obtains insurance covering its members' risks from an authorized insurer, only risks resident or located in this State shall be covered by the State Guaranty Fund subject to Chapter 42 of this title.

(68 Del. Laws, c. 57, § 1; 68 Del. Laws, c. 335, § 4.)

§ 8006. Countersignatures not required.

A policy of insurance issued to a risk retention group or any member of that group shall not be required to be countersigned as otherwise provided in Chapter 17 of this title.

(68 Del. Laws, c. 57, § 1.)

§ 8007. Purchasing groups — Exemption from certain laws.

A purchasing group and its insurer or insurers shall be subject to all applicable laws of this State, except that a purchasing group and its insurer or insurers shall be exempt, in regard to liability insurance for the purchasing group, from any law that would:

(1) Prohibit the establishment of a purchasing group;

(2) Make it unlawful for an insurer to provide or offer to provide insurance on a basis providing, to a purchasing group or its members, advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages or other matters;

(3) Prohibit a purchasing group or its members from purchasing insurance on a group basis described in paragraph (2) of this section;

(4) Prohibit a purchasing group from obtaining insurance on a group basis because the group has not been in existence for a minimum period of time or because any member has not belonged to the group for a minimum period of time;

(5) Require that a purchasing group must have a minimum number of members, common ownership or affiliation, or certain legal form;

(6) Require that a certain percentage of a purchasing group must obtain insurance on a group basis;

(7) Otherwise discriminate against a purchasing group or any of its members; or

(8) Require that any insurance policy issued to a purchasing group or any of its members be countersigned by an insurance agent or broker residing in this State.

(68 Del. Laws, c. 57, § 1.)

§ 8008. Notice and registration requirements of purchasing groups.

(a) A purchasing group which intends to do business in this State shall, prior to doing business, furnish notice to the Commissioner which shall:

(1) Identify the state in which the group is domiciled;

(2) Identify all other states in which the group intends to do business;

(3) Specify the lines and classifications of liability insurance which the purchasing group intends to purchase;

(4) Identify the insurance company or companies from which the group intends to purchase its insurance and the domicile of such company;

(5) Specify the method by which, and the person or persons, if any, through whom insurance will be offered to its members whose risks are resident or located in this State;

(6) Identify the principal place of business of the group; and

(7) Provide such other information as may be required by the Commissioner to verify that the purchasing group is qualified under § 8002(10) of this title.

(b) A purchasing group shall, within 10 days, notify the Commissioner of any changes in any of the items set forth in subsection (a) of this section.

(c) The purchasing group shall register with and designate the Commissioner as its agent solely for the purpose of receiving service of legal documents or process, for which a filing fee shall be determined by the Commissioner, except that such requirements shall not apply in the case of a purchasing group which only purchases insurance that was authorized under the federal Product Liability Risk Retention Act of 1981 [15 U.S.C. § 3901 et seq.], and:

(1) Which in any state of the United States:

a. Was domiciled before April 1, 1986; and

b. Is domiciled on and after October 27, 1986;

(2) Which:

a. Before October 27, 1986, purchased insurance from an insurance carrier licensed in any state; and

b. Since October 27, 1986, purchased its insurance from an insurance carrier licensed in any state; or

(3) Which was a purchasing group under the requirements of the federal Product Liability Risk Retention Act of 1981 [15 U.S.C. § 3901 et seq.] before October 27, 1986.

(d) Each purchasing group that is required to give notice pursuant to subsection (a) of this section shall also furnish such information as may be required by the Commissioner to:

(1) Verify that the entity qualifies as a purchasing group;

(2) Determine where the purchasing group is located; and

(3) Determine appropriate tax treatment.

(e) Any purchasing group which was doing business in this State prior to June 25, 1991, shall, within 30 days after June 25, 1991, furnish notice to the Commissioner pursuant to subsection (a) of this section and furnish such information as may be required pursuant to subsections (b) and (c) of this section.

(68 Del. Laws, c. 57, § 1.)

§ 8009. Restrictions on insurance purchased by purchasing groups.

(a) A purchasing group may not purchase insurance from a risk retention group that is not chartered in a state or from an insurer not admitted in the state in which the purchasing group is located, unless the purchase is effected through a licensed agent or broker acting pursuant to the surplus lines laws and regulations of such state.

(b) A purchasing group which obtains liability insurance from an insurer not admitted in this State or a risk retention group shall inform each of the members of such group which have a risk resident or located in this State that such risk is not protected by an insurance insolvency guaranty fund in this State, and that such risk retention group or such insurer may not be subject to all insurance laws and regulations of this State.

(c) No purchasing group may purchase insurance providing for a deductible or self-insured retention applicable to the group as a whole; however, coverage may provide for a deductible or self-insured retention applicable to individual members.

(d) Purchases of insurance by purchasing groups are subject to the same standards regarding aggregate limits which are applicable to all purchases of group insurance.

(68 Del. Laws, c. 57, § 1.)

§ 8010. Purchasing group taxation.

Premium taxes and taxes on premiums paid for coverage of risks resident or located in this State by a purchasing group or any members of the purchasing groups shall be:

(1) Imposed at the same rate and subject to the same interest, fines and penalties as that applicable to premium taxes and taxes on premiums paid for similar coverage from a similar insurance source by other insureds; and

(2) Paid first by such insurance source, and if not by such source by the agent or broker for the purchasing group, and if not by such agent or broker then by the purchasing group, and if not by such purchasing group then by each of its members.

(68 Del. Laws, c. 57, § 1.)

§ 8011. Administrative and procedural authority regarding risk retention groups and purchasing groups.

The Commissioner is authorized to make use of any of the powers established under the Insurance Code of this State to enforce the laws of this State not specifically preempted by the Risk Retention Act of 1986 [15 U.S.C. § 3901 et seq.] including the Commissioner's administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders, impose penalties and seek injunctive relief. With regard to any investigation, administrative proceedings or litigation, the Commissioner can rely on the procedural laws of this State. The injunctive authority of the Commissioner, in regard to risk retention groups, is restricted by the requirement that any injunction be issued by a court of competent jurisdiction.

(68 Del. Laws, c. 57, § 1.)

§ 8012. Duty of agents or brokers to obtain license.

(a) No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating or procuring liability insurance in this State from a risk retention group unless such person, firm, association or corporation is licensed as an insurance agent or broker in accordance with Chapter 17 of this title.

(b) *Purchasing groups.* — (1) No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating or procuring liability insurance in this State for a purchasing group from an authorized insurer or a risk retention group chartered in a state unless such person, firm, association or corporation is licensed as an insurance agent or broker in accordance with Chapter 17 of this title.

(2) No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating or procuring liability insurance coverage in this State for any member of a purchasing group under a purchasing group's policy unless such person, firm, association or corporation is licensed as an insurance agent or broker in accordance with Chapter 17 of this title.

(3) No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating or procuring liability insurance from an insurer not authorized to do business in this State on behalf of a purchasing group located in this State unless such person, firm, association or corporation is licensed as a surplus lines agent or excess line broker in accordance with Chapter 17 of this title.

(c) For purposes of acting as an agent or broker for a risk retention group or purchasing group pursuant to subsections (a) and (b) of this section, the requirement of residence in this State shall not apply.

(d) Every person, firm, association or corporation licensed pursuant to Chapter 17 of this title, on business placed with risk retention groups or written through a purchasing group, shall inform each prospective insured of the provisions of the notice required by § 8004(7) of this title in the case of a risk retention group and § 8009(c) of this title in the case of a purchasing group.

(68 Del. Laws, c. 57, § 1.)

§ 8013. Binding effect of orders issued in United States District Court.

An order issued by any District Court of the United States enjoining a risk retention group from soliciting or selling insurance, or operating in any state (or in all states or in any territory or possession of the United States) upon a finding that such a group is in hazardous financial or financially impaired condition shall be enforceable in the courts of the State.

(68 Del. Laws, c. 57, § 1.)

§ 8014. Rules and regulations.

The Commissioner may establish and from time to time amend such rules relating to risk retention groups as may be necessary or desirable to carry out the provisions of this chapter.

(68 Del. Laws, c. 57, § 1.)

Part II
Miscellaneous

Chapter 83
Use of Credit Information in Insurance

(81 Del. Laws, c. 108, § 1.)

§ 8301. Purpose [For applicability of this section, see 81 Del. Laws, c. 108, § 3].

The purpose of this chapter is to regulate the use of credit information for personal insurance, so that consumers are afforded certain protections with respect to the use of such information.

(81 Del. Laws, c. 108, § 1.)

§ 8302. Scope [For applicability of this section, see 81 Del. Laws, c. 108, § 3].

This chapter applies to all policies of automobile, motorcycle, boat and personal watercraft, recreational vehicle, homeowners, mobile-homeowners, manufactured homeowners insurance, and noncommercial dwelling fire insurance issued by an insurer for personal or family protection.

(76 Del. Laws, c. 175, § 1; 81 Del. Laws, c. 108, § 1.)

§ 8303. Definitions [For applicability of this section, see 81 Del. Laws, c. 108, § 3].

As used in this chapter:

(1) "Adverse action" means a denial or cancellation of, an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of, any insurance, existing or applied for, in connection with the underwriting of personal insurance.

(2) "Affiliate" means any company that controls, is controlled by, or is under common control with another company.

(3) "Applicant" means an individual who has applied to be covered by a personal insurance policy with an insurer.

(4) "Consumer" means an insured whose credit information is used or whose insurance score is calculated in the underwriting or rating of a personal insurance policy or an applicant for such a policy.

(5) "Consumer reporting agency" means any person which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.

(6) "Credit information" means any credit-related information derived from a credit report, found on a credit report itself, or provided on an application for personal insurance. Information that is not credit-related shall not be considered "credit information," regardless of whether it is contained in a credit report or in an application, or is used to calculate an insurance score.

(7) "Credit report" means any written, oral, or other communication of information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing or credit capacity which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor to determine personal insurance premiums, eligibility for coverage, or tier placement.

(8) "Insurance score" means a number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or in part on credit information for the purposes of predicting the future insurance loss exposure of an individual applicant or insured.

(76 Del. Laws, c. 175, § 1; 81 Del. Laws, c. 108, § 1.)

§ 8304. Use of credit information [For applicability of this section, see 81 Del. Laws, c. 108, § 3].

(a) An insurer authorized to do business in Delaware that uses credit information to underwrite or rate risks, shall not do any of the following:

(1) Use an insurance score that is calculated using income, gender, sexual orientation, gender identity, education, address, zip code, race, ethnic group, religion, marital status, or nationality of the consumer as a factor.

(2) Deny, cancel or nonrenew a personal insurance policy solely on the basis of credit information, without consideration of any other applicable underwriting factor independent of credit information and not expressly prohibited by paragraph (a)(1) of this section.

(3) Base an insured's renewal rates for personal insurance solely upon credit information, without consideration of any other applicable factor independent of credit information.

(4) Take an adverse action against a consumer solely because he or she does not have a credit card account, without consideration of any other applicable factor independent of credit information.

(5) Consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating personal insurance, unless the insurer does 1 of the following:

a. Treats the consumer as otherwise approved by the Insurance Commissioner, if the insurer presents information that such an absence or inability relates to the risk for the insurer.

b. Treats the consumer as if the applicant or insured had neutral credit information, as defined by the insurer.

c. Excludes the use of credit information as a factor and uses only other underwriting criteria.

(6) Request credit information at renewal unless requested to do so by a consumer or the consumer's agent. Upon the request of the insured, the insurer shall, at the time of a policy's renewal or anniversary date, rerate the policy based upon a current credit report and give the insured the benefit of any improvement in the insured's insurance score. No adverse underwriting decision may result from a rerating conducted pursuant to this paragraph. An insurer need not recalculate the insurance score or obtain the updated credit report of an insured more frequently than once in a 12-month period. This paragraph shall not apply if the insurer's filed rating plan does not use any credit information for the purpose of rating renewals, including any residual effect from the use of credit information at initial underwriting. Regardless of the requirements of this paragraph, no insurer need obtain current credit information for an insured if 1 of the following applies:

a. The insurer is treating the consumer as otherwise approved by the Commissioner.

b. The policy is in the most favorably-priced tier of the insurer, within a group of affiliated insurers.

c. Credit was not used for underwriting or rating such insured when the policy was initially written.

(7) Use any of the following as a negative factor in any insurance scoring methodology or in reviewing credit information for the purpose of underwriting or rating a policy of personal insurance:

a. Credit inquiries not initiated by the consumer or inquiries requested by the consumer for his or her own credit information.

b. Inquiries relating to insurance coverage, if so identified on a consumer's credit report.

c. Collection accounts with a medical industry code, if so identified on the consumer's credit report.

d. Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the home mortgage industry and made within 30 days of one another, unless only 1 inquiry is considered.

e. Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the automobile lending industry and made within 30 days of one another, unless only 1 inquiry is considered.

f. Bankruptcy adjudications more than 5 years from date of the credit report.

g. Suits and judgments whose date of entry are more than 5 years from the date of the credit report or that exceed the governing statute of limitations, whichever is the longer period.

h. Accounts placed for collection or charged to profits and loss more than 7 years from the date of the credit report.

i. Records of arrest, indictment, or conviction of crime where the date of disposition, release or parole is more than 7 years from the date of the credit report.

j. Any other adverse item or information which is more than 7 years from the date of the credit report.

k. The total available line of credit; however, an insurer may consider the total amount of outstanding debt in relation to the total available line of credit.

(8) Take an adverse action on a homeowners insurance policy based solely on the credit information of a spouse who has no title or ownership interest in the property to be insured and is not an applicant.

(b) If, as the result of any acquisition or transfer of all or part of a book of business of an agent, insurer, or broker, a policy is transferred from 1 insurer to another and rerated, the rerating shall be considered a rerating of the policy currently in force upon renewal subject to the restrictions and benefits set forth in paragraph (a)(6) of this section, above, provided that an insurer may offer a policyholder to rewrite the policy using credit and may, at the policyholder's option, rewrite the policy using credit if it results in a lower premium for the policyholder.

(81 Del. Laws, c. 108, § 1; 70 Del. Laws, c. 186, § 1.)

§ 8305. Extraordinary life circumstances [For applicability of this section, see 81 Del. Laws, c. 108, § 3].

(a) Notwithstanding any other law or regulation, an insurer that uses credit information shall, on written request from an applicant for insurance coverage or an insured, provide reasonable exceptions to the insurer's rates, rating classifications, company or tier placement, or information that has been directly influenced by any of the following events:

(1) Catastrophic event, as declared by the federal or state government.

(2) Serious illness or injury, or serious illness or injury to an immediate family member.

(3) Death of a spouse, child, or parent.

(4) Divorce or involuntary interruption of legally-owed alimony or support payments.

(5) Identity theft.

(6) Temporary loss of employment for a period of 3 months or more, if it results from involuntary termination.

(7) Military deployment overseas.

(8) Other events, as determined by the insurer.

(b) If an applicant or insured submits a request for an exception as set forth in subsection (a) of this section, an insurer may, in its sole discretion, but is not mandated to do any of the following:

(1) Require the consumer to provide reasonable written and independently verifiable documentation of the event.

(2) Require the consumer to demonstrate that the event had direct and meaningful impact on the consumer's credit information.

(3) Require such request be made no more than 60 days from the date of the application for insurance or the policy renewal.

(4) Grant an exception despite the consumer not providing the initial request for an exception in writing.

(5) Grant an exception where the consumer asks for consideration of repeated events or the insurer has considered this event previously.

(c) An insurer is not out of compliance with any law or rule relating to underwriting, rating, or rate filing as a result of granting an exception under this section. Nothing in this section shall be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this section.

(d) The insurer shall provide notice to consumers that reasonable exceptions are available and information about how the consumer may inquire further.

(e) Within 30 days of the insurer's receipt of sufficient documentation of an event described in subsection (a) of this section, the insurer shall inform the consumer of the outcome of the request for a reasonable exception. Such communication shall be in writing or provided to an applicant in the same medium as the request.

(81 Del. Laws, c. 108, § 1.)

§ 8306. Dispute resolution and error correction [For applicability of this section, see 81 Del. Laws, c. 108, § 3].

If it is determined through the dispute resolution process set forth in the federal Fair Credit Reporting Act, 15 U.S.C. § 1681i(a)(5), that the credit information of a current insured was incorrect or incomplete and if the insurer receives notice of such determination from either the consumer reporting agency or from the insured, the insurer shall re-underwrite and rerate the consumer within 30 days of receiving the notice. After re-underwriting or rerating the insured, the insurer shall make any adjustments necessary, consistent with its underwriting and rating guidelines. If an insurer determines that the insured has overpaid premium, the insurer shall refund to the insured the amount of overpayment calculated back to the shorter of either the last 12 months of coverage or the actual policy period.

(81 Del. Laws, c. 108, § 1.)

§ 8307. Notification [For applicability of this section, see 81 Del. Laws, c. 108, § 3].

(a) If an insurer writing personal insurance uses credit information in underwriting or rating a consumer, the insurer or its agent shall disclose, either on the insurance application or at the time the insurance application is taken, that it may obtain credit information in connection with such application. Such disclosure shall be either written or provided to an applicant in the same medium as the application for insurance. The insurer need not provide the disclosure statement required under this section to any insured on a renewal policy, if such consumer has previously been provided a disclosure statement. The following example disclosure statement constitutes compliance with this paragraph:

"In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of your insurance score."

(b) If an insurer writing personal insurance used credit information in underwriting or rating a consumer, the insurer or its agent shall disclose either on the insurance application or at the time the application is taken, that if the application is approved and the applicant becomes a policyholder, he or she has the right to request a re-underwrite or rerate of his or her policy on an annual basis based upon current credit report. The notice shall state that the review will be conducted for the sole purpose of determining whether the use of the new credit information would lead to a reduction and will not be used for any other purpose, including an increase in premiums. The following example disclosure statement constitutes compliance with the paragraph:

"If we do use a credit based score, you will have the right on an annual basis to request that we obtain a current credit report for you and determine whether use of the new credit report would result in a decrease in your insurance premiums. If the new credit report that we receive would result in a decrease in your insurance premiums, we will make that reduction. If the new credit information would not reduce your insurance premiums, the credit report will not be used to impact your premiums in any way."

This subsection does not apply if an insurer's filed rating plan does not use any credit information for the purpose of rating renewals, including any residual effect from the use of credit at initial underwriting.

(c) On an annual basis, the insurer shall inform its policyholders of their right to have their credit information reviewed to determine whether the use of the current credit report would result in a lower premium, in accordance with the procedures set forth in this chapter.

This notification shall be in at least 18-point type and included with the renewal notice. The notification shall be accompanied by a form that the policyholder must complete and send to the insurer to request that the credit information be obtained and reviewed. The notification shall advise the policyholder that the request form must be mailed within 2 weeks of the date of mailing of the renewal notification by the insurer for a premium adjustment to be made for the upcoming policy period. The notification shall also advise the policyholder that they must comply with the renewal notice requirements regarding the payment amount and due date regardless of whether they choose to request a review of their credit report and that any decrease of premium as a result of the new credit report be effective on the upcoming renewal date provided in the renewal notice. This subsection does not apply to any renewal for which the insurer's filed rating plan does not use any credit information, including residual effect from the use of credit information at initial underwriting. An insurer that is exempt from this subsection shall advise its policyholder of the exemption and the reason for the exemption with the policyholder's renewal notice.

(81 Del. Laws, c. 108, § 1; 70 Del. Laws, c. 186, § 1.)

§ 8308. Adverse action [For applicability of this section, see 81 Del. Laws, c. 108, § 3].

If an insurer takes an adverse action based upon credit information, the insurer must meet all of the following notice requirements:

(1) Provide notification to the consumer that an adverse action has been taken, in accordance with the requirements of the federal Fair Credit Reporting Act, 15 U.S.C. § 1681m(a).

(2) Provide notification to the consumer explaining the reason for the adverse action. The reasons must be provided in sufficiently clear and specific language so that a person can identify the basis for the insurer's decision to take an adverse action. Such notification shall include a description of up to 4 factors that were the primary influences of the adverse action. The use of generalized terms such as "poor credit history," "poor credit rating," or "poor insurance score" does not meet the explanation requirements of this paragraph. Standardized credit explanations provided by consumer reporting agencies or other third-party vendors are deemed to comply with this section.

(3) If the adverse action is a denial of personal insurance, provide notification that the applicant may inquire further about the credit information on which the denial is based and obtain a free copy of the credit report, the applicant may do so by mailing a written request to the insurer, or other such party as the insurer may identify in the notice, no more than 30 days after the date the notice of refusal was mailed to the applicant.

(4) Provide a statement that the consumer reporting agency that provided the credit information upon which the denial was based did not make the denial decision and is unable to provide the applicant the specific reasons for the denial.

(5) If the adverse action is a denial of personal insurance, the notice of denial shall be retained by the insurer and a record of the insurance score, related notice and correspondence with the applicant shall be maintained by the insurer or their vendor for a minimum of 3 years from the date of the denial notification to the applicant.

(81 Del. Laws, c. 108, § 1.)

§ 8309. Filing [For applicability of this section, see 81 Del. Laws, c. 108, § 3].

(a) Insurers that use insurance scores to underwrite and rate risks must file their scoring models with the Commissioner. A third party may file scoring models on behalf of insurers. A filing that includes insurance scoring may include loss experience justifying the use of credit information.

(b) Any filing relating to credit information is considered proprietary or trade secret under § 10002(o)(2) of Title 29 or upon the request of the insurer or owner of the document and subject to the confidentiality provisions of § 321(g) of this title.

(81 Del. Laws, c. 108, § 1; 83 Del. Laws, c. 65, § 1.)

§ 8310. Indemnification; causes of action and defenses [For applicability of this section, see 81 Del. Laws, c. 108, § 3].

An insurer shall indemnify, defend, and hold agents harmless from and against all liability, fees, and costs arising out of or relating to the actions, errors, or omissions of an insurer who obtains or uses credit information and/or insurance scores from an independent source, provided the producer follows the instructions of or procedures established by the insurer and complies with any applicable law or regulation. Nothing in this chapter shall be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this section. This chapter shall not create a cause of action for any person or entity, other than the Commissioner, against an insurer or its representative based upon a violation of § 2304(15)c. of this title. In the same manner, nothing in this chapter shall establish a defense for any party to any cause of action based upon a violation of § 2304(15)c. of this title.

(76 Del. Laws, c. 175, § 1; 81 Del. Laws, c. 108, § 1.)

§ 8311. Sale of policy term information by consumer reporting agency [For applicability of this section, see 81 Del. Laws, c. 108, § 3].

(a) No consumer reporting agency shall provide or sell data or lists that include any information that in whole or in part was submitted in conjunction with an insurance inquiry about a consumer's credit information or a request for a credit report or insurance score. Such

information includes, but is not limited to, the expiration dates of an insurance policy or any other information that may identify time periods during which a consumer's insurance may expire and the terms and conditions of the consumer's insurance coverage.

(b) The restrictions provided in subsection (a) of this section do not apply to data or lists the consumer reporting agency supplies to the insurance producer from whom information was received, the insurer on whose behalf such producer acted, or such insurer's affiliates or holding companies.

(c) Nothing in this section shall be construed to restrict any insurer from being able to obtain a claims history report or a motor vehicle report.

(81 Del. Laws, c. 108, § 1.)

§ 8312. Severability [For applicability of this section, see 81 Del. Laws, c. 108, § 3].

If any section, paragraph, sentence, clause, phrase, or any part of this chapter is declared invalid due to an interpretation of or a future change in the federal Fair Credit Reporting Act [15 U.S.C. § 1681 et seq.], the remaining sections, paragraphs, sentences, clauses, phrases, or parts thereof shall be in no manner affected thereby but shall remain in full force and effect.

(81 Del. Laws, c. 108, § 1.)

Part II
Miscellaneous
Chapter 84
Risk Management and Own Risk and Solvency Assessment (ORSA)

§ 8401. Short title.

This chapter may be cited as the "Risk Management and Own Risk and Solvency Assessment (ORSA) Act."

(79 Del. Laws, c. 422, § 1.)

§ 8402. Purpose and scope.

The purpose of this chapter is to provide the requirements for maintaining a risk management framework and completing an own risk and solvency assessment (ORSA) and provide guidance and instructions for filing an ORSA summary report with the Insurance Commissioner of this State.

The requirements of this chapter shall apply to all insurers domiciled in this State unless exempt pursuant to § 8407 of this title.

The General Assembly finds and declares that the ORSA summary report will contain confidential and sensitive information related to an insurer or insurance group's identification of risks material and relevant to the insurer or insurance group filing the report. This information will include proprietary and trade secret information that has the potential for harm and competitive disadvantage to the insurer or insurance group if the information is made public. It is the intent of this General Assembly that the ORSA summary report shall be a confidential document filed with the Insurance Commissioner, that the ORSA summary report will be shared only as stated herein and to assist the Insurance Commissioner in the performance of his or her duties, and that in no event shall the ORSA summary report be subject to public disclosure.

(79 Del. Laws, c. 422, § 1; 70 Del. Laws, c. 186, § 1.)

§ 8403. Definitions.

As used in this chapter, unless the context requires otherwise:

(1) *"Insurance group."* — For the purpose of conducting an ORSA, the term "insurance group" shall mean those insurers and affiliates included within an insurance holding company system as defined in Chapter 50 of this title.

(2) *"Insurer."* — The term "insurer" shall have the same meaning as set forth in § 102 of this title, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(3) *"ORSA Guidance Manual."* — The term "ORSA Guidance Manual" shall mean the current version of the Own Risk and Solvency Assessment Guidance Manual developed and adopted by the National Association of Insurance Commissioners (NAIC) and as amended from time to time. A change in the ORSA Guidance Manual shall be effective on the January 1 following the calendar year in which the changes have been adopted by the NAIC.

(4) *"ORSA summary report."* — An "ORSA summary report" shall mean a confidential high-level summary of an insurer or insurance group's ORSA.

(5) *"Own risk and solvency assessment" or "ORSA."* — An "own risk and solvency assessment" or "ORSA" shall mean a confidential internal assessment, appropriate to the nature, scale and complexity of an insurer or insurance group, conducted by that insurer or insurance group of the material and relevant risks associated with the insurer or insurance group's current business plan, and the sufficiency of capital resources to support those risks.

(79 Del. Laws, c. 422, § 1.)

§ 8404. Risk management framework.

An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing and reporting on its material and relevant risks. This requirement may be satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer.

(79 Del. Laws, c. 422, § 1.)

§ 8405. ORSA requirement.

Subject to § 8407 of this title, an insurer, or the insurance group of which the insurer is a member, shall regularly conduct an ORSA consistent with a process comparable to the ORSA Guidance Manual. The ORSA shall be conducted no less than annually but also at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

(79 Del. Laws, c. 422, § 1.)

§ 8406. ORSA summary report.

(a) Upon the Insurance Commissioner's request, and no more than once each year, an insurer shall submit to the Insurance Commissioner an ORSA summary report or any combination of reports that together contain the information described in the ORSA Guidance Manual, applicable to the insurer and/or the insurance group of which it is a member. Notwithstanding any request from the Insurance Commissioner, if the insurer is a member of an insurance group, the insurer shall submit the report or reports required by this subsection if the Insurance Commissioner is the lead State Commissioner of the insurance group as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(b) The report or reports shall include a signature of the insurer or insurance group's chief risk officer or other executive having responsibility for the oversight of the insurer's enterprise risk management process attesting to the best of his or her belief and knowledge that the insurer applies the enterprise risk management process described in the ORSA summary report and that a copy of the report has been provided to the insurer's board of directors or the appropriate committee thereof.

(c) An insurer may comply with subsection (a) of this section by providing the most recent and substantially similar report(s) provided by the insurer or another member of an insurance group of which the insurer is a member to the insurance commissioner of another state or to a supervisor or regulator of a foreign jurisdiction, if that report provides information that is comparable to the information described in the ORSA Guidance Manual. Any such report in a language other than English must be accompanied by a translation of that report into the English language.

(79 Del. Laws, c. 422, § 1; 70 Del. Laws, c. 186, § 1.)

§ 8407. Exemption.

(a) An insurer shall be exempt from the requirements of this chapter, if:

(1) The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000; and,

(2) The insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premium including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $1,000,000,000.

(b) If an insurer qualifies for exemption pursuant to paragraph (a)(1) of this section, but the insurance group of which the insurer is a member does not qualify for exemption pursuant to paragraph (a)(2) of this section, then the ORSA summary report that may be required pursuant to § 8406 of this title shall include every insurer within the insurance group. This requirement may be satisfied by the submission of more than 1 ORSA summary report for any combination of insurers provided any combination of reports includes every insurer within the insurance group.

(c) If an insurer does not qualify for exemption pursuant to paragraph (a)(1) of this section, but the insurance group of which it is a member qualifies for exemption pursuant to paragraph (a)(2) of this section, then the only ORSA summary report that may be required pursuant to § 8406 of this title shall be the report applicable to that insurer.

(d) An insurer that does not qualify for exemption pursuant to subsection (a) of this section may apply to the Insurance Commissioner for a waiver from the requirements of this chapter based upon unique circumstances. In deciding whether to grant the insurer's request for waiver, the Insurance Commissioner may consider the type and volume of business written, ownership and organizational structure, and any other factor the Insurance Commissioner considers relevant to the insurer or insurance group of which the insurer is a member. If the insurer is part of an insurance group with insurers domiciled in more than 1 state, the Insurance Commissioner shall coordinate with the lead state insurance commissioner and with the other domiciliary insurance commissioners in considering whether to grant the insurer's request for a waiver.

(e) Notwithstanding the exemptions stated in this section:

(1) The Insurance Commissioner may require that an insurer maintain a risk management framework, conduct an ORSA and file an ORSA summary report based on unique circumstances including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests.

(2) The Insurance Commissioner may require that an insurer maintain a risk management framework, conduct an ORSA and file an ORSA summary report if the insurer has risk-based capital for company action level event as set forth in § 5803 of this title, meets 1 or more of the standards of an insurer deemed to be in hazardous financial condition as defined in 18 DE Admin. Code 304 standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition (Formerly Regulation 70), or otherwise exhibits qualities of a troubled insurer as determined by the Insurance Commissioner.

(f) If an insurer that qualifies for an exemption pursuant to subsection (a) of this section subsequently no longer qualifies for that exemption due to changes in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer shall have 1 year following the year the threshold is exceeded to comply with the requirements of this chapter.

(79 Del. Laws, c. 422, § 1.)

§ 8408. Contents of ORSA summary report.

(a) The ORSA summary report shall be prepared consistent with the ORSA Guidance Manual, subject to the requirements of subsection (b) of this section. Documentation and supporting information shall be maintained and made available upon examination or upon request of the Insurance Commissioner.

(b) The review of the ORSA summary report, and any additional requests for information, shall be made using similar procedures currently used in the analysis and examination of multi-state or global insurers and insurance groups.

(79 Del. Laws, c. 422, § 1.)

§ 8409. Confidentiality.

(a) Documents, materials or other information, including the ORSA summary report, in the possession of or control of the Department of Insurance that are obtained by, created by or disclosed to the Insurance Commissioner or any other person under this chapter, is

recognized by this State as being proprietary and to contain trade secrets. All such documents, materials or other information shall be confidential by law and privileged, shall not be subject to this State's Freedom of Information Act, § 10001 et seq. of Title 29, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Insurance Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the Insurance Commissioner's official duties. The Insurance Commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer.

(b) Neither the Insurance Commissioner nor any person who received documents, materials or other ORSA-related information, through examination or otherwise, while acting under the authority of the Insurance Commissioner or with whom such documents, materials or other information are shared pursuant to this chapter shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (a) of this section.

(c) In order to assist in the performance of the Insurance Commissioner's regulatory duties, the Insurance Commissioner:

(1) May, upon request, share documents, materials or other ORSA-related information, including the confidential and privileged documents, materials or information subject to subsection (a) of this section, including proprietary and trade secret documents and materials with other state, federal and international financial regulatory agencies, including members of any supervisory college, as described in § 5014 of this title, with the NAIC and with any third-party consultants designated by the Insurance Commissioner, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality; and

(2) May receive documents, materials or other ORSA-related information, including otherwise confidential and privileged documents, materials or information, including proprietary and trade-secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college, and from the NAIC, and shall maintain as confidential or privileged any documents, materials or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

(3) Shall enter into a written agreement with the NAIC or a third-party consultant governing sharing and use of information provided pursuant to this chapter, consistent with this subsection that shall:

a. Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant pursuant to this chapter, including procedures and protocols for sharing by the NAIC with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

b. Specify that ownership of information shared with the NAIC or a third-party consultant pursuant to this chapter remains with the Insurance Commissioner and the NAIC's or a third-party consultant's use of the information is subject to the direction of the Insurance Commissioner;

c. Prohibit the NAIC or third-party consultant from storing the information shared pursuant to this chapter in a permanent database after the underlying analysis is completed;

d. Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third-party consultant pursuant to this chapter is subject to a request or subpoena to the NAIC or a third-party consultant for disclosure or production;

e. Require the NAIC or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this chapter; and

f. In the case of an agreement involving a third-party consultant, provide for the insurer's written consent.

(d) The sharing of information and documents by the Insurance Commissioner pursuant to this chapter shall not constitute a delegation of regulatory authority or rulemaking, and the Insurance Commissioner is solely responsible for the administration, execution and enforcement of the provisions of this chapter.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials or other ORSA-related information shall occur as a result of disclosure of such ORSA-related information or documents to the Insurance Commissioner under this section or as a result of sharing as authorized in this chapter.

(f) Documents, materials or other information in the possession or control of the NAIC or a third-party consultant pursuant to this chapter shall be confidential by law and privileged, shall not be subject to this State's Freedom of Information Act, § 10001 et seq. of Title 29, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

(79 Del. Laws, c. 422, § 1.)

§ 8410. Sanctions.

Any insurer failing, without just cause, to timely file the ORSA summary report as required in this chapter shall be subject to the enforcement and penalty provisions set forth in Chapter 3 of this title.

(79 Del. Laws, c. 422, § 1.)

§ 8411. Severability clause.

If any provision of this chapter, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this chapter which can be given effect without the invalid provision or application, and to that end the provisions of this chapter are severable.

(79 Del. Laws, c. 422, § 1.)

§ 8412. Effective date.

The requirements of this chapter shall become effective on January 1, 2015. The first filing of the ORSA summary report shall be in 2015 pursuant to § 8406 of this title.

(79 Del. Laws, c. 422, § 1.)

Part II
Miscellaneous

Chapter 85
Corporate Governance Annual Disclosure Act

§ 8501. Short title.

This chapter may be cited as the "Corporate Governance Annual Disclosure Act."

(81 Del. Laws, c. 119, § 1.)

§ 8502. Purpose and scope.

(a) The purpose of this chapter is to:

(1) Provide the Commissioner a summary of an insurer or insurance group's corporate governance structure, policies and practices to permit the Commissioner to gain and maintain an understanding of the insurer's corporate governance framework.

(2) Outline the requirements for completing a corporate governance annual disclosure with the Commissioner.

(3) Provide for the confidential treatment of the corporate governance annual disclosure and related information that will contain confidential and sensitive information related to an insurer or insurance group's internal operations and proprietary and trade secret information which, if made public, could potentially cause the insurer or insurance group competitive harm or disadvantage.

(b) Nothing in this chapter shall be construed to prescribe or impose corporate governance standards and internal procedures beyond that which is required under applicable state corporate law. Notwithstanding the foregoing, nothing in this chapter shall be construed to limit the Commissioner's authority, or the rights or obligations of third parties, under § 318 through § 321 of this title.

(c) The requirements of this chapter shall apply to all insurers domiciled in this State.

(81 Del. Laws, c. 119, § 1.)

§ 8503. Definitions.

As used in this chapter, unless the context requires otherwise:

(1) *"Commissioner." —*

The term "Commissioner" shall mean the Insurance Commissioner of this State.

(2) *"Corporate governance annual disclosure" or "CGAD." —*

The term "corporate governance annual disclosure" or "CGAD" shall mean a confidential report filed by the insurer or insurance group made in accordance with the requirements of this chapter.

(3) *"Insurance group." —*

For purposes of this chapter, the term "insurance group" shall mean those insurers and affiliates included within an insurance holding company system as defined in Chapter 50 of this title.

(4) *"Insurer." —*

The term "insurer" shall have the same meaning as set forth in § 102(10) of this title, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(5) *"NAIC." —*

The term "NAIC" shall mean the National Association of Insurance Commissioners.

(81 Del. Laws, c. 119, § 1.)

§ 8504. Disclosure requirement.

(a) An insurer, or the insurance group of which the insurer is a member, shall, no later than June 1 of each calendar year, submit to the Commissioner a Corporate Governance Annual Disclosure (CGAD) that contains the information described in § 8506(b) of this title. Notwithstanding any request from the Commissioner made pursuant to subsection (c) of this section below, if the insurer is a member of an insurance group, the insurer shall submit the report required in this section to the Commissioner of the lead state for the insurance group, in accordance with the laws of the lead state, as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC.

(b) The CGAD must include a signature of the insurer or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer has implemented the corporate governance practices and that a copy of the disclosure has been provided to the insurer's board of directors or the appropriate committee thereof.

(c) An insurer not required to submit a CGAD under this section shall do so upon the Commissioner's request.

(d) For purposes of completing the CGAD, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the 3 criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

(e) The review of the CGAD and any additional requests for information shall be made through the lead state as determined by the procedures within the most recent Financial Analysis Handbook referenced in subsection (a) of this section.

(f) Insurers providing information substantially similar to the information required by this chapter in other documents provided to the Commissioner, including proxy statements filed in conjunction with Form B requirements, or other state or federal filings provided to this Department shall not be required to duplicate that information in the CGAD, but shall only be required to cross reference the document in which the information is included.

(81 Del. Laws, c. 119, § 1.)

§ 8505. Rules and regulations.

The Commissioner may, upon notice and an opportunity for all interested parties to be heard, issue such rules, regulations and orders as shall be necessary to carry out the provisions of this chapter.

(81 Del. Laws, c. 119, § 1.)

§ 8506. Contents of corporate governance annual disclosure.

(a) The insurer or insurance group shall have discretion over the responses to the CGAD inquiries, provided the CGAD shall contain the material information necessary to permit the Commissioner to gain an understanding of the insurer's or group's corporate governance structure, policies and practices. The Commissioner may request additional information that he or she deems material and necessary to provide the Commissioner with a clear understanding of the corporate governance policies, the reporting or information system or controls implementing those policies.

(b) Notwithstanding subsection (a) of this section above, the CGAD shall be prepared consistent with the Corporate Governance Annual Disclosure Model Regulation to be promulgated by the Commissioner. Documentation and supporting information shall be maintained and made available upon examination by or upon request of the Commissioner.

(81 Del. Laws, c. 119, § 1; 70 Del. Laws, c. 186, § 1.)

§ 8507. Confidentiality.

(a) Documents, materials or other information including the CGAD, in the possession or control of the Department that are obtained by, created by or disclosed to the Commissioner or any other person under this chapter, are recognized by this State as being proprietary and to contain trade secrets. All such documents, materials or other information shall be confidential by law and privileged, shall not be subject to the Freedom of Information Act, § 10001 et seq. of Title 29, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties. The Commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer. Nothing in this section shall be construed to require written consent of the insurer before the Commissioner may share or receive confidential documents, materials or other CGAD-related information pursuant to subsection (c) of this section to assist in the performance of the Commissioner's regular duties.

(b) Neither the Commissioner nor any person who received documents, materials or other CGAD-related information, through examination or otherwise, while acting under the authority of the Commissioner, or with whom such documents, materials or other information are shared pursuant to this chapter shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (a) of this section.

(c) In order to assist in the performance of the Commissioner's regulatory duties, the Commissioner:

(1) May, upon request, share documents, materials or other CGAD-related information including the confidential and privileged documents, materials or information subject to subsection (a) of this section, including proprietary and trade secret documents and materials with other state, federal and international financial agencies, including members of any supervisory college as described in § 5014 of this title, with the NAIC, and with third-party consultants pursuant to § 8508 of this title, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, material or other information and has verified in writing the legal authority to maintain confidentiality; and

(2) May receive documents, materials or other CGAD-related information, including otherwise confidential and privileged documents, materials or information, including proprietary and trade-secret information or documents, from regulatory officials of

other state, federal and international financial regulatory agencies, including members of any supervisory college as described in § 5014 of this title, and from the NAIC, and shall maintain as confidential or privileged any documents, materials or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

(d) The sharing of information and documents by the Commissioner pursuant to this chapter shall not constitute a delegation of regulatory authority or rulemaking, and the Commissioner is solely responsible for the administration, execution and enforcement of the provisions of this chapter.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials or other CGAD-related information shall occur as a result of disclosure of such CGAD-related information or documents to the Commissioner under this section or as a result of sharing as authorized in this chapter.

(81 Del. Laws, c. 119, § 1.)

§ 8508. NAIC and third-party consultants.

(a) The Commissioner may retain, at the insurer's expense, third-party consultants, including attorneys, actuaries, accountants and other experts not otherwise a part of the Commissioner's staff as may be reasonably necessary to assist the Commissioner in reviewing the CGAD and related information or the insurer's compliance with this chapter.

(b) Any persons retained under subsection (a) of this section shall be under the direction and control of the Commissioner and shall act in a purely advisory capacity.

(c) The NAIC and third-party consultants shall be subject to the same confidentiality standards and requirements as the Commissioner.

(d) As part of the retention process, a third-party consultant shall verify to the Commissioner, with notice to the insurer, that it is free of a conflict of interest and that it has internal procedures in place to monitor compliance with a conflict and to comply with the confidentiality standards and requirements of this chapter.

(e) A written agreement with the NAIC or a third-party consultant governing sharing and use of information provided pursuant to this chapter shall contain the following provisions and expressly require the written consent of the insurer prior to making public information provided under this chapter:

(1) Specific procedures and protocols for maintaining the confidentiality and security of CGAD-related information shared with the NAIC or a third-party consultant pursuant to this chapter;

(2) Procedures and protocols for sharing by the NAIC only with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

(3) A provision specifying that ownership of the CGAD-related information shared with the NAIC or a third-party consultant remains with the Department and the NAIC's or third-party consultant's use of the information is subject to the direction of the Commissioner;

(4) A provision that prohibits the NAIC or a third-party consultant from storing the information shared pursuant to this chapter in a permanent database after the underlying analysis is completed;

(5) A provision requiring the NAIC or third-party consultant to provide prompt notice to the Commissioner and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's CGAD-related information; and

(6) A requirement that the NAIC or a third-party consultant consent to intervention by an insurer in any judicial or administrative action in which the NAIC or third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or third-party consultant pursuant to this chapter.

(81 Del. Laws, c. 119, § 1.)

§ 8509. Sanctions.

Any insurer failing, without just cause, to timely file the CGAD as required in this chapter shall be required, after notice and hearing, to pay a penalty of $500 for each day's delay, to be recovered by the Commissioner and the penalty so recovered shall be paid into the General Fund. The maximum penalty under this section is $25,000. The Commissioner may reduce the penalty if the insurer demonstrates to the Commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

(81 Del. Laws, c. 119, § 1.)

§ 8510. Severability clause.

If any provision of this chapter other than § 8507 of this title, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this chapter which can be given effect without the invalid provision or application, and to that end the provisions of this chapter, with the exception of § 8507 of this title, are severable.

(81 Del. Laws, c. 119, § 1.)

§ 8511. Effective date.

The requirements of this chapter shall become effective on January 1, 2018. The first filing of the CGAD shall be in 2018.

(81 Del. Laws, c. 119, § 1.)

Part II
Miscellaneous

Chapter 86
Insurance Data Security Act

(82 Del. Laws, c. 176, § 1.)

§ 8601. Short title.

This chapter is known and may be cited as the "Insurance Data Security Act."

(82 Del. Laws, c. 176, § 1.)

§ 8602. Purpose and intent.

(a) Notwithstanding any other provision of law, this chapter establishes the exclusive state standards for data security and the investigation of, and notification to, the Commissioner and consumers when a cybersecurity event involving a licensee under this title occurs.

(b) This chapter may not be construed to create or imply a private cause of action for violation of its provisions, nor may it be construed to curtail a private cause of action which would otherwise exist in the absence of this chapter.

(82 Del. Laws, c. 176, § 1.)

§ 8603. Definitions.

As used in this chapter:

(1) "Authorized individual" means an individual to whom a licensee gave authorization to access and use nonpublic information that the licensee and the licensee's information system holds.

(2) "Commissioner" means the Insurance Commissioner of the State of Delaware.

(3) "Consumer" means an individual, including an applicant, policyholder, insured, beneficiary, claimant, and certificate holder, who is a resident of this State and whose nonpublic information is in a licensee's possession, custody, or control.

(4) "Cybersecurity event" means an event resulting in unauthorized access to, disruption of, or misuse of an information system or nonpublic information stored on an information system. "Cybersecurity event" does not include either of the following:

a. The unauthorized acquisition of encrypted nonpublic information if the encryption, process, or key is not also acquired, released, or used without authorization.

b. An event for which the licensee has determined that the nonpublic information accessed by an unauthorized person has not been used or released and has been returned or destroyed.

(5) "Department" means the Department of Insurance.

(6) "Encrypted" means the transformation of data into a form which results in a low probability of assigning meaning without the use of a protective process or key.

(7) "Information security program" means the administrative, technical, and physical safeguards that a licensee uses to access, collect, distribute, process, protect, store, use, transmit, dispose of, or otherwise handle nonpublic information.

(8) "Information system" means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination, or disposition of electronic information, and a specialized system such as an industrial or process controls system, telephone switching and private branch exchange system, or environmental control system.

(9) "Insurer" includes an insurer, health service corporation, managed care organization, or health maintenance organization licensed under this title.

(10) "Licensee" means a person who is licensed, authorized to operate, or registered, or required to be licensed, authorized, or registered, under the insurance laws of this State. "Licensee" does not mean either of the following:

a. A purchasing group or risk retention group that is chartered and licensed in a state other than this State.

b. A licensee that is acting as an assuming insurer that is domiciled in a state other than this State or another jurisdiction.

(11) "Multi-factor authentication" means authentication through verification of at least 2 of the following types of authentication factors:

a. Knowledge factors, such as a password.

b. Possession factors, such as a token or text message on a mobile phone.

c. Inherence factors, such as a biometric characteristic.

(12) "Nonpublic information" means electronic information that is not publicly-available information and is at least 1 of the following:

a. Information concerning a consumer which because of name, number, personal mark, or other identifier can be used to identify the consumer, in combination with any 1 or more of the following data elements:

1. Social Security number.

2. Driver's license number or nondriver identification card number.

3. Financial account number or credit or debit card number.

4. A security code, access code, or password that would permit access to a consumer's financial account.

5. A biometric record.

b. Information or data, except age or gender, in any form or medium created by or derived from a health-care provider or consumer that can be used to identify a consumer and relates to any of the following:

1. The past, present, or future physical, mental, or behavioral health or condition of a consumer or a member of a consumer's family.

2. The provision of health care to a consumer.

3. Payment for the provision of health care to a consumer.

(13) "Notice", for purposes of the consumer notice required under § 8606(c) of this title, means any of the following:

a. Written notice.

b. Telephonic notice.

c. Electronic notice, if the notice provided is consistent with the provisions regarding electronic signatures and records under 15 U.S.C. § 7001 or if the licensee's primary means of communication with the consumer is by electronic means.

1. Substitute notice, if any of the following apply:

A. The licensee who is required to provide notice under this chapter demonstrates that the cost of providing notice will exceed $75,000.

B. The affected number of consumers to be notified exceeds 100,000.

C. The licensee does not have sufficient contact information to provide notice.

2. "Substitute notice" means all of the following:

A. Electronic notice, if the licensee has an email address for the affected consumer.

B. Conspicuous posting of the notice on the licensee's website page, if the licensee maintains 1 or more website pages.

C. Notice to major statewide media, including newspapers, radio, and television.

D. Publication on the major social media platforms of the licensee who is providing notice.

(14) "Person" means as defined in § 102 of this title.

(15) a. "Publicly-available information" means information that a licensee has a reasonable basis to believe is lawfully made available to the general public, including any of the following:

1. A federal, state, or local government record.

2. A widely-distributed information source or media.

3. A disclosure to the general public that is required under federal, state, or local law.

b. For purposes of this definition, "reasonable basis to believe that information is lawfully made available to the general public" means a licensee has taken steps and determined all of the following:

1. That the information is of the type that is available to the general public.

2. If a consumer can direct that the information may not be made available to the general public, the consumer has not done so.

(16) "Risk assessment" means the action that a licensee is required to take under § 8604(c) of this title.

(17) "State", if capitalized, means the State of Delaware.

(18) "Third-party service provider" means a person who is not a licensee and who contracts with a licensee to maintain, process, store, or otherwise is permitted access to nonpublic information through the person's provision of services to the licensee.

(82 Del. Laws, c. 176, § 1.)

§ 8604. Information security program [For application of this section, see 82 Del. Laws, c. 176, § 2].

(a) *Implementation of an information security program. —*

(1) A licensee shall develop, implement, and maintain a comprehensive, written information security program that is based on the licensee's risk assessment and contains administrative, technical, and physical safeguards for the protection of nonpublic information and the licensee's information system.

(2) An information security program under this section must be commensurate with the size and complexity of a licensee; the nature and scope of a licensee's activities, including the licensee's use of a third-party service provider; and the sensitivity of the nonpublic information that the licensee uses or has in the licensee's possession, custody, or control.

(b) *Objectives of information security program. —*

A licensee's information security program must be designed to do all of the following:

(1) Protect the security and confidentiality of nonpublic information and the security of the information system.

(2) Protect against threats or hazards to the security or integrity of nonpublic information and the information system.

(3) Protect against unauthorized access to or use of nonpublic information, and minimize the likelihood of harm to a consumer.

(4) Define and periodically reevaluate a schedule for retention of nonpublic information and a mechanism for its destruction when retention of the nonpublic information is no longer needed.

(c) *Risk assessment. —*

A licensee shall do all of the following:

(1) Designate 1 or more employees, an affiliate, or an outside vendor designated to act on the licensee's behalf and be responsible for managing and overseeing the information security program.

(2) Identify reasonably-foreseeable internal or external threats that could result in unauthorized access, transmission, disclosure, misuse, alteration, or destruction of nonpublic information, including the security of an information system or nonpublic information that a third-party service provider has access to or holds.

(3) Assess the likelihood and potential damage of a threat identified under paragraph (c)(2) of this section, taking into consideration the sensitivity of the nonpublic information.

(4) Assess the sufficiency of policies, procedures, information systems, and other safeguards in place to manage a threat identified under paragraph (c)(2) of this section, including consideration of threats in each relevant area of the licensee's operations, including all of the following:

a. Employee training and management.

b. An information system, including network and software design and information classification, governance, processing, storage, transmission, and disposal.

c. Detecting, preventing, and responding to an attack, intrusion, or other system failure.

(5) Implement information safeguards to manage the threats identified in the licensee's ongoing assessment under paragraph (c)(2) of this section and, at least annually, assess the effectiveness of the safeguards' key controls, systems, and procedures.

(d) *Risk management. —*

Based on a licensee's risk assessment, the licensee shall do all of the following:

(1) Design an information security program to mitigate the identified risks, commensurate with all of the following:

a. The licensee's size and complexity.

b. The nature and scope of the licensee's activities, including the licensee's use of a third-party service provider.

c. The sensitivity of the nonpublic information that the licensee uses or has in the licensee's possession, custody, or control.

(2) Determine if a security measure listed in paragraphs (d)(2)a. through k. of this section is appropriate and implement each appropriate security measure.

a. Place an access control on an information system, including a control to authenticate and permit access only to an authorized individual to protect against the unauthorized acquisition of nonpublic information.

b. Identify and manage the data, personnel, devices, systems, and facilities that enable the organization to achieve business purposes in accordance with their relative importance to business objectives and the organization's risk strategy.

c. Restrict physical access to nonpublic information to authorized individuals only.

d. Protect by encryption or other appropriate means all nonpublic information while the nonpublic information is transmitted over an external network and all nonpublic information stored on a laptop computer or other portable computing or storage device or media.

e. Adopt both of the following:

1. Secure development practices for an application that a licensee uses and was developed in-house.

2. Procedures for evaluating, assessing, or testing the security of an application that a licensee uses and was developed externally.

f. Modify the information system in accordance with the licensee's information security program.

g. Utilize effective controls, which may include multi-factor authentication procedures for employees or authorized individuals accessing nonpublic information.

h. Regularly test and monitor systems and procedures to detect actual and attempted attacks on, or intrusions, into an information system.

i. Include audit controls within the information security program designed to do both of the following:

1. Detect and respond to a cybersecurity event.

2. Reconstruct material financial transactions sufficient to support the licensee's normal operations and obligations.

j. Implement measures to protect against the destruction, loss, or damage of nonpublic information due to environmental hazards, such as fire and water damage, other catastrophes, or technological failures.

k. Develop, implement, and maintain procedures for the secure disposal of nonpublic information in any format.

(3) Include cybersecurity risks in the licensee's enterprise risk management process.

(4) Stay informed regarding emerging threats or vulnerabilities and utilize reasonable security measures when sharing information relative to the character of the sharing and the type of information shared.

(5) Provide the licensee's personnel with cybersecurity awareness training that is updated as necessary to reflect risks that the licensee identified in the licensee's risk assessment under this section.

(e) *Oversight by board of directors. —*

If a licensee has a board of directors, the board or an appropriate committee of the board shall, at a minimum, do all of the following:

(1) Require the licensee's executive management or its delegates to develop, implement, and maintain the licensee's information security program.

(2) Require the licensee's executive management or its delegates to report in writing at least annually all of the following information:

a. The overall status of the information security program and the licensee's compliance with this chapter.

b. Material matters related to the information security program, including addressing issues such as the following:

1. Risk assessment, risk management, and control decisions.

2. Third-party service provider arrangements.

3. Results of testing.

4. Cybersecurity events or violations and management's responses to the events.

5. Recommendations for changes in the information security program.

(3) If executive management delegates any of its responsibilities under this section, all of the following must occur:

a. Executive management shall oversee the development, implementation, and maintenance of the licensee's information security program that the delegate prepares.

b. The delegate shall submit to executive management a report that complies with the requirements of the report to the board of directors under paragraph (e)(2) of this section.

(f) *Oversight of third-party service provider arrangements. —*

(1) A licensee shall exercise due diligence in selecting a third-party service provider.

(2) A licensee shall require a third-party service provider to implement appropriate administrative, technical, and physical measures to protect and secure the information system and nonpublic information that the third-party service provider has access to or holds. The third-party service provider is not considered to have access to or hold encrypted nonpublic information for purposes of this section if the associated protective process or key necessary to assign meaning to the nonpublic information is not within the third-party service provider's possession.

(g) *Program adjustments. —*

A licensee shall monitor, evaluate, and adjust as appropriate the information security program consistent with all of the following:

(1) Relevant changes in technology.

(2) The sensitivity of the licensee's nonpublic information.

(3) Internal or external threats to information.

(4) The licensee's own changing business arrangements, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements, and changes to information systems.

(h) *Incident response plan. —*

(1) As part of a licensee's information security program, the licensee shall establish a written incident response plan designed to promptly respond to, and recover from, a cybersecurity event that compromises the confidentiality, integrity, or availability of any of the following:

a. Nonpublic information in the licensee's possession.

b. The licensee's information system.

c. The continuing functionality of any aspect of the licensee's business or operations.

(2) An incident response plan under this section must address all of the following areas:

a. The internal process for responding to a cybersecurity event.

b. The goals of the incident response plan.

c. The definition of clear roles, responsibilities, and levels of decision-making authority.

d. External and internal communications and information sharing.

e. Identification of requirements for the remediation of any identified weaknesses in an information system and associated controls.

f. Documentation and reporting regarding cybersecurity events and related incident response activities.

g. As necessary, the evaluation and revision of the incident response plan following a cybersecurity event.

(i) *Annual certification to the Commissioner of domiciliary state. —*

An insurer domiciled in this State shall do all of the following:

(1) Submit annually to the Commissioner a written statement by February 15, certifying that the insurer is in compliance with the requirements under in this section.

(2) Maintain for the Department's examination all records, schedules, and data supporting a certificate under this subsection for a period of 5 years.

(3) To the extent an insurer has identified an area, system, or process that requires material improvement, updating, or redesign, document the identification and the remedial effort planned and underway to address the identified area, system, or process. Documentation under this paragraph (i)(3) must be available for the Commissioner's inspection.

(82 Del. Laws, c. 176, § 1.)

§ 8605. Investigation of a cybersecurity event.

(a) If a licensee learns that a cybersecurity event has or may have occurred, the licensee, or an outside vendor or service provider designated to act on behalf of the licensee, shall conduct a prompt investigation.

(b) During an investigation under this section, the licensee, or an outside vendor or service provider designated to act on behalf of the licensee, shall, at a minimum, do as much of the following as possible:

(1) Determine whether a cybersecurity event has occurred.

(2) Assess the nature and scope of the cybersecurity event.

(3) Identify the nonpublic information that may have been involved in the cybersecurity event.

(4) Perform or oversee reasonable measures to restore the security of the information system compromised in the cybersecurity event to prevent further unauthorized acquisition, release, or use of nonpublic information that is in the licensee's possession, custody, or control.

(c) If a licensee provides nonpublic information to a third-party service provider and learns that a cybersecurity event has or may have occurred in a system that the third-party service provider maintains, the licensee shall complete the steps listed in subsection (b) of this section or make reasonable efforts to confirm and document that the third-party service provider has completed the steps.

(d) A licensee shall maintain records concerning a cybersecurity event for a period of at least 5 years from the date of the cybersecurity event and shall produce those records upon the Commissioner's demand.

(82 Del. Laws, c. 176, § 1.)

§ 8606. Notification of a cybersecurity event.

(a) *Notification to the Commissioner. —*

A licensee shall notify the Commissioner as promptly as possible but in no event later than 3 business days from the licensee's determination that a cybersecurity event has occurred if either of the following criteria has been met:

(1) The licensee is an insurer who is domiciled in this State or a producer whose home state is this State, as "home state" is defined under Chapter 17 of this title, and the cybersecurity event results in any of the following:

a. A reasonable likelihood of materially harming a consumer.

b. A reasonable likelihood of materially harming any material part of the licensee's normal operation.

c. The licensee is required to provide notice of the cybersecurity event to a government body, self-regulatory agency, or other supervisory body under state or federal law.

(2) The licensee reasonably believes that the nonpublic information involved is regarding 250 or more consumers and either of the following apply:

a. The cybersecurity event impacts a licensee that is required to provide notice to a government body, self-regulatory agency, or other supervisory body under state or federal law.

b. The cybersecurity event has a reasonable likelihood of materially harming either of the following:

1. A consumer.

2. A material part of the licensee's normal operations.

(b) *Notice requirements. —*

(1) a. If notice to the Commissioner is required under subsection (a) of this section, a licensee shall provide the information in a form as directed by the Commissioner.

b. A licensee has a continuing obligation to update and supplement initial and subsequent notifications to the Commissioner regarding material changes to previously-provided information relating to a cybersecurity event.

(2) A licensee shall provide as much of the following information as possible:

a. Date of the cybersecurity event.

b. Description of how the information was exposed, lost, stolen, or breached, including the specific role and responsibility of a third-party service provider, if any.

c. How the cybersecurity event was discovered.

d. Whether any lost, stolen, or breached information has been recovered and, if so, how it was lost, stolen, or breached.

e. The identity of the source of the cybersecurity event.

f. Whether the licensee has filed a police report or notified a regulatory, government, or law-enforcement agency and, if so, when the notification was provided.

g. Description of the specific types of information acquired without authorization. For the purposes of this paragraph (b)(2)g., "specific types of information" means particular data elements, including medical information, financial information, or information allowing identification of a consumer.

h. The period during which the cybersecurity event compromised the information system.

i. The number of total consumers in this State who are affected by the cybersecurity event. The licensee shall provide the best estimate in the initial report to the Commissioner and update the estimate with each subsequent report to the Commissioner under this section.

j. The results of an internal review identifying a lapse in either automated controls or internal procedures, or confirming that the automated controls or internal procedures were followed.

k. Description of efforts being undertaken to remediate the situation which permitted the cybersecurity event to occur.

l. A copy of the licensee's privacy policy and a statement outlining the steps the licensee will take to investigate and notify a consumer affected by a cybersecurity event.

m. The name of a contact person who is both familiar with the cybersecurity event and authorized to act for the licensee.

(c) *Notification to consumers. —*

If a licensee determines that a cybersecurity event that has a reasonable likelihood of materially harming a consumer has occurred and the event is 1 for which the licensee is required under subsection (a) of this section to notify the Commissioner, the licensee shall provide notice of the event to each affected consumer and provide a copy of the notice to the Commissioner.

(1) A licensee must provide notice under this subsection (c) of this section without unreasonable delay but no later than 60 days after determining that a cybersecurity event occurred, unless any of the following apply:

a. Federal law requires a shorter time period.

b. A law-enforcement agency determines that the notice will impede a criminal investigation and the law-enforcement agency has requested that the licensee delay notice. Delayed notice must be made after the law-enforcement agency determines, and notifies the licensee, that notice will not compromise the criminal investigation.

c. If a licensee that is otherwise required by this section to provide notice could not, through reasonable diligence, identify within 60 days of a cybersecurity event that a customer's nonpublic information was included in the event, the licensee must provide the notice required under this section to the consumer as soon as practicable after the identification, unless the licensee provides or has provided substitute notice under § 8603(m)(4) of this title.

(2) If a cybersecurity event includes a Social Security number, a licensee shall offer to each consumer whose nonpublic information, including Social Security number, was breached or is reasonably believed to have been breached, credit monitoring services at no cost to the consumer for a period of 1 year.

a. The licensee shall provide all information necessary for the consumer to enroll in credit monitoring services and include information on how the consumer can place a credit freeze on the consumer's credit file.

b. Credit monitoring services are not required if, after an appropriate investigation, the licensee reasonably determines that the cybersecurity event is unlikely to result in harm to the consumer whose nonpublic information has been breached.

(3) If a cybersecurity event consists of a breach of email account login credentials that the licensee furnished to the consumer, including a username or email address and in combination with a password or security question and answer that permit access to an online account, the licensee may not provide notice under this section via the involved email address. The licensee must instead provide notice under this section through another method under § 8603(m) of this title or by clear and conspicuous notice delivered to the consumer online when the consumer is connected to the online account from an internet protocol address or online location from which the licensee knows the consumer customarily accesses the account.

(d) *Notice regarding cybersecurity events of third-party service providers. —*

(1) If a cybersecurity event occurs in a system that a third-party service provider maintains and of which a licensee has become aware, the licensee shall treat the event as it would under subsection (a) of this section unless the third-party service provider provides the notice to the Commissioner under this section.

(2) The computation of a licensee's deadline under this section begins on the first business day after the third-party service provider notifies the licensee of the cybersecurity event or the licensee otherwise has actual knowledge of the cybersecurity event, whichever is sooner.

(3) Nothing in this chapter prevents or abrogates an agreement between a licensee and another licensee, a third-party service provider, or another party to fulfill the investigation requirements under § 8605 of this title or notice requirements under this section.

(e) *Notice regarding cybersecurity events of reinsurers to insurers. —*

(1) If a cybersecurity event involves nonpublic information that is used by a licensee who is acting as an assuming insurer, or the nonpublic information is in the possession, custody, or control of a licensee who is acting as an assuming insurer and does not have a direct contractual relationship with the affected consumer, the licensee who is acting as an assuming insurer shall notify its affected ceding insurers and the Commissioner of the licensee who is acting as an assuming insurer's state of domicile within 3 business days of determining that a cybersecurity event has occurred. A ceding insurer who has a direct contractual relationship with an affected consumer shall fulfill the consumer notification requirements under subsection (c) of this section and any other notification requirement under this section relating to a cybersecurity event.

(2) If a cybersecurity event involves nonpublic information that is in the possession, custody, or control of a third-party service provider of a licensee who is acting as an assuming insurer, the licensee who is acting as an assuming insurer shall notify the affected ceding insurer and the Commissioner of the licensee who is acting as an assuming insurer's state of domicile within 3 business days of receiving notice from the licensee who is acting as an assuming insurer's third-party service provider that a cybersecurity event has occurred. A ceding insurer that has a direct contractual relationship with an affected consumer shall fulfill the consumer notification requirements under subsection (c) of this section and any other notification requirement under this section relating to a cybersecurity event.

(f) *Notice regarding cybersecurity events of insurers to producers of record. —*

If a cybersecurity event for which consumer notice is required under this section involves nonpublic information that is in the possession, custody, or control of a licensee who is an insurer, or a licensee's third-party service provider and for which a consumer accessed the insurer's services through an independent insurance producer, the licensee shall notify the producers of record of the consumer who was affected by the cybersecurity event in a reasonable manner and at a time reasonably concurrent with the time at which notice is provided to the affected consumer. The insurer is excused from this obligation for a producer who is not authorized by law or contract to sell, solicit, or negotiate on behalf of the insurer, and in an instance in which the insurer does not have the current producer of record information for the consumer.

(82 Del. Laws, c. 176, § 1.)

§ 8607. Power of Commissioner.

(a) The Commissioner may examine and investigate the affairs of a licensee to determine whether the licensee has been or is engaged in any conduct in violation of this chapter. The Commissioner's power under this section is in addition to the powers the Commissioner has under § 318 of this title. An examination or investigation must be conducted under § 320 through § 322 of this title.

(b) If the Commissioner has reason to believe that a licensee has been or is engaged in conduct in this State that violates this chapter, the Commissioner may take necessary or appropriate action to enforce the provisions of this chapter.

(82 Del. Laws, c. 176, § 1.)

§ 8608. Confidentiality.

(a) (1) Documents, materials, or other information in the Department's control or possession that a licensee or employee or agent acting on behalf of a licensee furnished under § 8604(i) or § 8606(b)(2)b., (b)(2)c., (b)(c)d., (b)(2)e., (b)(2)h., (b)(2)j., or (b)(2)k. of this title, or that the Commissioner obtained in an examination or investigation under § 8607 of this title are confidential and privileged, and are not subject to any of the following:

a. The Freedom of Information Act, Chapter 100 of Title 29.

b. Subpoena.

c. Discovery or admissible in evidence in any private civil action.

(2) Notwithstanding paragraph (a)(1) of this section, the Commissioner may use documents, materials, or other information listed in paragraph (a)(1) of this section in the furtherance of a regulatory or legal action brought as a part of the Commissioner's duties.

(b) Neither the Commissioner nor a person who received a document, materials, or other information listed in paragraph (a)(1) of this section while acting under the Commissioner's authority is permitted or required to testify in a private civil action concerning the confidential document, materials, or information.

(c) In order to assist in the performance of the Commissioner's duties under this chapter, the Commissioner may do any of the following:

(1) Share documents, materials, or other information, including a confidential and privileged documents, materials, or information subject to subsection (a) of this section, with another state, federal, or international regulatory agency; the National Association of Insurance Commissioners and its affiliates or subsidiaries; and a state, federal, and international law-enforcement authority, if the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material, or other information.

(2) May receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information from the National Association of Insurance Commissioners or its affiliates or subsidiaries and from a regulatory or law-

enforcement official of another foreign or domestic jurisdictions. The Commissioner shall maintain as confidential or privileged documents, materials, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the documents, materials, or information.

(3) Share documents, materials, or other information subject to subsection (a) of this section with a third-party consultant or vendor, if the consultant agrees in writing to maintain the confidentiality and privileged status of the documents, materials, or other information.

(4) Enter into an agreement governing the sharing and use of information consistent with this subsection.

(d) A waiver of an applicable privilege or claim of confidentiality in documents, materials, or information may not occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (c) of this section.

(e) Nothing in this chapter prohibits the Commissioner from releasing final, adjudicated actions that are open to public inspection under the Delaware Freedom of Information Act, Chapter 100 of Title 29, to a database or other clearinghouse service that the National Association of Insurance Commissioners or its affiliates or subsidiaries maintains.

(f) Documents, materials, or other information that the National Association of Insurance Commissioners or a third-party consultant or vendor possess or controls under this chapter is confidential by law and privileged, is not subject to the Delaware Freedom of Information Act, Chapter 100 of Title 29, is not subject to subpoena, and is not subject to discovery or admissible in evidence in a private civil action.

(82 Del. Laws, c. 176, § 1.)

§ 8609. Exceptions.

(a) The following exceptions apply to this chapter:

(1) A licensee with fewer than 15 employees is exempt from § 8604 of this chapter.

(2) A licensee subject to the Health Insurance Portability and Accountability Act [P.L. 104-191, as amended] that has established and maintains an information security program under the statutes, rules, regulations, procedures, or guidelines established thereunder, is considered to meet the requirements of § 8604 of this title, if the licensee is compliant with, and submits a written statement certifying its compliance, the same.

(3) A licensee’s employee, agent, representative, or designee, who is also a licensee, is exempt from § 8604 of this title and is not required to develop the employee’s, agent’s, representative’s, or designee’s own information security program to the extent that the employee, agent, representative or designee is covered by the other licensee’s information security program.

(b) Nothing in this chapter creates a duty or liability for a provider of communication services for the transmission of voice, data, or other information over its network.

(c) If a licensee ceases to qualify for an exception under this section, the licensee has 180 days to comply with this chapter.

(82 Del. Laws, c. 176, § 1.)

§ 8610. Penalties.

If a licensee violates this chapter, the licensee may be subject to penalties under § 329 of this title.

(82 Del. Laws, c. 176, § 1.)

§ 8611. Regulations.

The Commissioner may, in accordance with § 311 of this title, promulgate regulations necessary to carry out the provisions of this chapter.

(82 Del. Laws, c. 176, § 1.)

Part II
Miscellaneous

Chapter 87
The Delaware Health Insurance Individual Market Stabilization Reinsurance Program

(82 Del. Laws, c. 61, § 2.)

§ 8701. Definitions.

As used in this chapter, unless the context clearly indicates a different meaning, the following words and phrases shall have the meaning ascribed to them in this section:

(1) "Affordable Care Act" means the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq.

(2) "Assessment" means any payment required to be made under § 8703 of this title.

(3) "Carrier" means any entity that provides health insurance in this State. For the purposes of this chapter, carrier includes an insurance company, health service corporation, health maintenance organization, managed care organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(4) "Commission" and "DHCC" mean the Delaware Health Care Commission created pursuant to § 9902 of Title 16.

(5) "Commissioner" means the Insurance Commissioner of the State of Delaware.

(6) "Department" means the Delaware Department of Insurance.

(7) "Individual health benefit plan" means any policy offered in the individual market that is subject to the single risk pool requirements of § 1312(c)(1) of the Affordable Care Act [42 U.S.C. § 18032(c)(1)].

(8) "Program" means the Delaware Health Insurance Individual Market Stabilization Reinsurance Program created by § 9903(g) of Title 16.

(82 Del. Laws, c. 61, § 2; 83 Del. Laws, c. 37, § 22.)

§ 8702. Applicability and scope.

(a) This chapter shall apply to the following licensees:

(1) Any carrier, as defined under § 8701 of this title.

(2) Any other person or entity subject to regulation by the State that provides products that may be subject to an assessment by the State under this chapter.

(b) This chapter shall not apply to plans of health insurance or health benefits designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act (42 U.S.C. §§ 1395 et seq., 1396 et seq., and 1397aa et seq.), known as Medicare, Medicaid; Chapter 52 of Title 29; or any other similar coverage under state or federal governmental plans.

(c) This chapter shall not apply to stand-alone dental insurance, stand-alone vision insurance, long-term care insurance, disability income insurance and all accident-only insurance.

(82 Del. Laws, c. 61, § 2; 83 Del. Laws, c. 283, § 31.)

§ 8703. Delaware Health Insurance Individual Market Stabilization and Reinsurance Program assessment.

(a) The purpose of this section is to establish a funding mechanism for the Delaware Health Insurance Individual Market Stabilization and Reinsurance Program created by § 9903(g) of Title 16.

(b) Following successful approval of Delaware's § 1332 [42 U.S.C. § 18052] waiver application under the Affordable Care Act by the Centers for Medicare and Medicaid Services and beginning in calendar year 2020, any carrier subject to this chapter shall be assessed 2.75% annually on all amounts used to calculate the entity's premium tax liability or the amount of the entity's premium tax exemption value for the previous calendar year.

(c) Each carrier, entity, or person subject to the assessment pursuant to this section shall submit payment to the Delaware Department of Insurance on or before March 1 of each year.

(d) Upon receipt of the funds paid to the Department pursuant to subsection (c) of this section, the Commissioner shall remit the total amount to the Commission to be held on reserve for the funding and administering of the Program in accordance with § 9903(g) of Title 16.

(e) [Repealed.]

(f) In the event Delaware's § 1332 [42 U.S.C. § 18052] waiver under the Affordable Care Act is invalidated, revoked, or expires by the Centers for Medicare and Medicaid Services, Delaware may no longer collect the assessment defined under this section.

(g) The State may not hold more than 5 years of operating and administrative funds to cover the Program. In the event collections exceed that amount, the State must notify the carriers that the following year's assessment will be waived.

(h) Funding deposited into the Delaware Health Insurance Individual Market Stabilization Reinsurance Fund shall be used by the Department of Health and Social Services, in conjunction with the Department, to operate and administer the Fund, and such funding

shall also be used by the Department of Health and Social Services to secure federal matching funds available through § 1332 of the Affordable Care Act [42 U.S.C. § 18052].

(i) In the event that funding is insufficient to cover the administration and operations of the Program, the Department of Health & Social Services may suspend the program until funding is identified and secured.

(82 Del. Laws, c. 61, § 2; 83 Del. Laws, c. 283, § 32.)

Part II
Miscellaneous
Chapter 88
Pet Insurance Act

§ 8801. Short title.

This chapter is known and may be cited as the “Pet Insurance Act.”

(84 Del. Laws, c. 184, § 1.)

§ 8802. Scope and purpose.

(a) The purpose of this chapter is to promote the public welfare by creating a comprehensive legal framework within which pet insurance may be sold in Delaware.

(b) This chapter applies to all of the following:

(1) A pet insurance policy that is issued to a resident of Delaware.

(2) A pet insurance policy that is sold, solicited, negotiated, or offered in Delaware.

(3) A pet insurance policy or certificate that is delivered or issued for delivery in Delaware.

(c) An applicable provision of Delaware’s insurance law other than under this chapter applies to pet insurance, except that a provision of this chapter supersedes a general provision of law that would otherwise be applicable to pet insurance.

(84 Del. Laws, c. 184, § 1.)

§ 8803. Definitions; use of defined terms in policies.

(a) As used in this chapter:

(1) “Chronic condition” means a condition that can be treated or managed, but not cured.

(2) “Congenital anomaly or disorder” means a condition that is present from birth, whether inherited or caused by the environment, which may cause or contribute to illness or disease.

(3) “Hereditary disorder” means an abnormality that is genetically transmitted from parent to offspring and may cause illness or disease.

(4) “Orthopedic” refers to a condition affecting the bone, skeletal muscle, cartilage, tendon, ligament, or joint. “Orthopedic” includes elbow dysplasia, hip dysplasia, intervertebral disc degeneration, patellar luxation, or ruptured cranial cruciate ligament. “Orthopedic” does not include a cancer or a metabolic, hemopoietic, or autoimmune disease.

(5) “Pet insurance” means a property insurance policy that provides coverage for accidents or illnesses, or both, of a pet.

(6) “Preexisting condition” means a condition for which any of the following are true prior to the effective date of a pet insurance policy or during a waiting period:

a. A veterinarian provided medical advice.

b. The pet received previous treatment.

c. Based on information from verifiable sources, the pet had signs or symptoms directly related to the condition for which a claim is being made.

(7) “Renewal” means to issue and deliver at the end of an insurance policy period a policy which supersedes a policy previously issued and delivered by the same pet insurer or affiliated pet insurer and which provides types and limits of coverage substantially similar to those contained in the policy being superseded.

(8) “Veterinarian” means an individual who holds a valid license to practice veterinary medicine from the appropriate licensing entity in the jurisdiction in which the individual practices.

(9) “Veterinary expenses” means the costs associated with medical advice, diagnosis, care, or treatment that a veterinarian provides, including the cost of a drug a veterinarian prescribes.

(10) “Waiting period” means the period of time specified in a pet insurance policy that is required to transpire before some or all of the coverage in the policy can begin.

(11) “Wellness program” means a subscription or reimbursement-based program that is separate from an insurance policy that provides goods and services to promote the general health, safety, or wellbeing of a pet.

(b) If a pet insurer uses a term under this chapter in a policy of pet insurance, the pet insurer shall use the term’s definition under this chapter and include the term’s definition in the policy. The pet insurer shall make the definition available through a clear and conspicuous link on the main page of the pet insurer or pet insurer’s program administrator’s website.

(c) Nothing in this chapter prohibits or limits the type of exclusion a pet insurer may use in the pet insurers’ policy or requires a pet insurer to have a limitation or exclusion under this chapter.

(84 Del. Laws, c. 184, § 1.)

§ 8804. Disclosures.

(a) A pet insurer transacting pet insurance shall disclose all of the following to consumers:

(1) If the policy excludes coverage due to any of the following:

a. A preexisting condition.

b. A hereditary disorder.

c. A congenital anomaly or disorder.

d. A chronic condition.

(2) If the policy includes an exclusion other than those in paragraph (a)(1) of this section, the following statement: "Other exclusions may apply. Please refer to the exclusions section of the policy for more information."

(3) A policy provision that limits coverage through a waiting period or affiliation period, or a deductible, coinsurance, or an annual or lifetime policy limit.

(4) If the pet insurer reduces coverage or increases premiums based on the insured's claim history, the age of the covered pet, or a change in the geographic location of the insured.

(5) If the underwriting company differs from the brand name used to market and sell the product.

(b) *Right to examine and return policy.* — (1) Unless the insured has filed a claim under a pet insurance policy, a pet insurance applicant has the right to examine and return the policy, certificate, or rider to the company or an agent or insurance producer of the company within 30 days of its receipt and to have the premium refunded if, after examination of the policy, certificate, or rider, the applicant is not satisfied for any reason.

(2) A pet insurance policy, certificate, or rider must have a notice prominently printed on or attached to the first page and include specific instruction to accomplish a return. The following free look statement or language substantially similar must be included:

"You have 30 days from the day you receive this policy, certificate, or rider to review it and return it to the company if you decide not to keep it. You do not have to tell the company why you are returning it. If you decide not to keep it, simply return it to the company at its administrative office or you may return it to the agent or insurance producer that you bought it from as long as you have not filed a claim. You must return it within 30 days of the day you first received it. The company will refund the full amount of any premium paid within 30 days after it receives the returned policy, certificate, or rider. The premium refund will be sent directly to the person who paid it. The policy, certificate or rider will be void as if it had never been issued."

(c) A pet insurer shall clearly disclose a summary description of the basis or formula on which the pet insurer determines a claim payment under a pet insurance policy within the policy, prior to policy issuance and through a clear and conspicuous link on the main page of the pet insurer or pet insurer's program administrator's website.

(d) A pet insurer that uses a benefit schedule to determine claim payment under a pet insurance policy shall do all of the following:

(1) Clearly disclose the applicable benefit scheduled in the policy.

(2) Disclose each benefit schedule that the pet insurer used under its pet insurance policy through a clear and conspicuous link on the main page of the pet insurer or pet insurer's program administrator's website.

(e) A pet insurer that determines a claim payment under a pet insurance policy based on usual and customary fees, or another reimbursement limitation based on prevailing veterinary service provider charges, shall do all of the following:

(1) Include a usual and customary fee limitation provision in the policy that clearly describes the pet insurer's basis for determining usual and customary fees and how that basis is applied in calculating a claim payment.

(2) Disclose the pet insurer's basis for determining usual and customary fees through a clear and conspicuous link on the main page of the pet insurer or pet insurer's program administrator's website.

(f) If a medical examination by a licensed veterinarian is required to effectuate coverage, the pet insurer shall clearly and conspicuously disclose the required aspects of the examination prior to purchase and disclose that examination documentation may result in a preexisting condition exclusion.

(g) A waiting period, and a requirement applicable to a waiting period, must be clearly and prominently disclosed to consumers prior to the policy purchase.

(h) A pet insurer shall include a summary of each policy provision required under subsections (a) through (g) of this section, inclusive, in a separate document titled "Insurer Disclosure of Important Policy Provisions."

(i) A pet insurer shall post the "Insurer Disclosure of Important Policy Provisions" document required under subsection (h) of this section through a clear and conspicuous link on the main page of the pet insurer or pet insurer's program administrator's website.

(j) In connection with the issuance of a new pet insurance policy, the pet insurer shall provide the consumer with a copy of the "Insurer Disclosure of Important Policy Provisions" document required under subsection (h) of this section in at least 12-point type when the pet insurer delivers the policy.

(k) At the time a pet insurance policy is issued or delivered to a policyholder, the pet insurer shall include a written disclosure with all of the following information, printed in 12-point boldface type:

(1) The Department of Insurance's mailing address, toll-free telephone number, and website address.

(2) The address and customer service telephone number of the pet insurer or the agent or broker of record.

(3) If the policy was issued or delivered by an agent or broker, a statement advising the policyholder to contact the agent or broker for assistance.

(*l*) The disclosure required under this section is in addition to another disclosure requirement required by law or regulation.

(84 Del. Laws, c. 184, § 1.)

§ 8805. Policy conditions.

(a) (1) A pet insurer may issue a policy that excludes coverage on the basis of 1 or more preexisting conditions with appropriate disclosure to the consumer. The pet insurer has the burden of proving that the preexisting condition exclusion applies to the condition for which a claim is being made.

(2) A condition for which coverage is afforded on a policy may not be considered a preexisting condition on a renewal of the policy.

(b) A pet insurer may issue a policy that imposes a waiting period on effectuation of the policy that does not exceed 30 days for an illness or orthopedic condition not resulting from an accident. A waiting period for accidents is prohibited.

(1) A pet insurer utilizing a waiting period permitted under this subsection (b) shall include a provision in the contract that allows the waiting period to be waived upon completion of a medical examination. A pet insurer may require the examination to be conducted by a licensed veterinarian after the purchase of the policy.

a. The policyholder must pay for a medical examination under subsection (b) of this section, unless the policy specifies that the pet insurer must pay for the examination.

b. A pet insurer may specify an element to be included as part of the examination and require documentation thereof, but a specification may not unreasonably restrict a consumer's ability to waive a waiting period under subsection (b) of this section.

(2) A waiting period, and a requirement applicable to a waiting period, must be clearly and prominently disclosed to consumers prior to the policy purchase.

(3) A waiting period may not be applied to a renewal of existing coverage.

(c) A pet insurer may not require a veterinary examination of the covered pet for the insured to have the insured's policy renewed.

(d) If a pet insurer includes a prescriptive, wellness, or noninsurance benefit in the policy form, the benefit is made part of the policy contract and must follow applicable laws and regulations under this title.

(e) An insured's eligibility to purchase a pet insurance policy must not be based on participation, or lack of participation, in a separate wellness program.

(84 Del. Laws, c. 184, § 1.)

§ 8806. Sales practices for wellness programs.

(a) A pet insurer or insurance producer may not market a wellness program as pet insurance.

(1) If a wellness program undertakes to indemnify or pay another as to loss from a certain specified contingency or peril, or to pay or grant a specified amount or determinable benefit in connection with an ascertainable risk contingency, the wellness program is transacting in the business of insurance and is subject to the Insurance Code.

(2) The definition for "wellness program" under § 8803 of this title does not classify a contract directly between a service provider and a pet owner that involves only the 2 parties as being "the business of insurance," unless another indication of insurance also exists.

(b) If a pet insurer or insurance producer sells a wellness program, all of the following apply:

(1) The purchase of the wellness program must not be a requirement to the purchase of pet insurance.

(2) The cost of the wellness program must be separate and identifiable from a pet insurance policy that a pet insurer or insurance producer sells.

(3) The terms and conditions for the wellness program must be separate from a pet insurance policy that a pet insurer or insurance producer sells.

(4) A product or coverage available through the wellness program may not duplicate a product or coverage available through the pet insurance policy.

(5) The advertising of the wellness program must not be misleading and must meet the requirements of this subsection.

(6) A pet insurer or producer shall clearly disclose all of the following to consumers, printed in 12-point boldface type:

a. That a wellness program is not insurance.

b. The address and customer service telephone number of the pet insurer or insurance producer or broker of record.

c. The Department of Insurance's mailing address, toll-free telephone number, and website address.

(c) Coverage included in a pet insurance policy contract described as a "wellness" benefit is insurance.

(84 Del. Laws, c. 184, § 1.)

§ 8807. Insurance producer training.

(a) An insurance producer may not sell, solicit, or negotiate a pet insurance product until after the producer is appropriately licensed and has completed the required training under subsection (c) of this section.

(b) An insurer must ensure that the insurer's insurance producer is trained under subsection (c) of this section and that the insurance producer is appropriately trained on the coverage and condition of the insurer's pet insurance product.

(c) Training required under this section must include information on all of the following:

(1) A preexisting condition and waiting period.

(2) The difference between pet insurance and a noninsurance wellness program.

(3) A hereditary disorder, congenital anomaly, or disorder and chronic condition and how a pet insurance policy interacts with the disorder, anomaly, or condition.

(4) Rating, underwriting, renewal and any other related administrative topic.

(d) The satisfaction of the training requirement of another state that is substantially similar to subsection (c) of this section satisfies the training requirement under this chapter. The Commissioner shall determine whether the training of another state meets the requirements of this subsection.

(84 Del. Laws, c. 184, § 1.)

§ 8808. Regulations.

The Insurance Commissioner may promulgate rules and regulations to administer this chapter.

(84 Del. Laws, c. 184, § 1.)

§ 8809. Violations.

A violation of this chapter is subject to penalties under § 329 of this title.

(84 Del. Laws, c. 184, § 1.)