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Filing Guidance Notice 2020 – A
Accident and Sickness Insurance

TO: All Carriers Offering Individual and Group Disability Policies ("Carriers")

FROM: Kevin Beagan, Deputy Commissioner

DATE: April 3, 2020

RE: Guidelines for Carriers Offering Paid Family and Medical Leave Coverage in Massachusetts to Submit Policies for Division of Insurance Review for Consistency with Department of Family and Medical Leave Standards

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The purpose of this Notice is for the Division of Insurance ("DOI" or "the Division") to provide guidance as Carriers look to develop paid family and medical leave products. These plans are ones that Carriers may offer to employers with the intent to satisfy coverage standards established by the Department of Family and Medical Leave ("DFML") according to the coverage requirements of M.G.L. c. 175M and 458 CMR 2.00. The DOI has worked closely with the DFML to develop this guidance that will explain how to file products with the Division so that the DFML may be made aware that Carriers have satisfied DFML standards.

Policy Form Filings

The DFML will consider Carrier-issued policies as consistent with DFML standards provided that:

(1) Carriers use the policy template that is attached to this Notice; AND
(2) Carriers submit their own policies that offer benefits that are at least as beneficial as the requirements found in M.G.L. c. 175M and 458 CMR 2.00.

Please note that submitted policies may include brackets to allow variability for product design but all bracketed items should be explained as part of the filing so that the Division understands that the product will always meet the relevant standards to be considered a DFML qualified policy.

Please also note that if a Carrier wishes to offer separate Paid Family Leave Policies and Paid Medical Leave Policies, as well as Paid Family and Medical Leave Policies, each of these policies must be filed as separate products with separate form identifiers.

Form Filings

In Filing Guidance Notice 2019-I, Carriers were required to include a statement in their insurance declaration filings that they would submit "a Paid Family Medical Leave policy form filing within 60 days following the DOI's issuance of an upcoming Policy Filing Guidance defining the contents of an acceptable Paid Family Medical Leave Policy." All Carriers that have made filings in accordance with Filing Guidance Notice 2019-I shall submit their policy filings via the System for Electronic Rate and Form Filing ("SERFF"), under the H21 Health-Other Type of Insurance and the H21.000 Health-Other Sub-Type of Insurance within 60 days of the date of this Notice. The Division, therefore, requests that these filings be made via SERFF by June 3, 2020.

The Division's Policy Form Review Unit has developed an expedited review process for Carriers who wish to submit their Paid Family and Medical Leave policy forms.

The filing must be made via SERFF and include:

(1) a Filing Description field beginning with the phrase "PAID FAMILY AND/OR MEDICAL LEAVE POLICY OF INSURANCE";
(2) a completed checklist – available on the Division's compliance checklist page - that highlights where each item of the standards listed in the attached policy form template is addressed within the submitted policy form;
(3) a certification that the submitted policy form offers benefits that are at least as beneficial as the requirements found in M.G.L. c. 175M and 458 CMR 2.00; and
(4) a filing fee of $75 per policy as required for a form filing.

Acknowledgement of Policies of Insurance Filings

The DOI will review all form filings to ensure filings are consistent with the requirements of this Notice. If no revisions or amendments are necessary, the DOI will acknowledge the filing in SERFF and notify the DFML.

Employers that filed a Carrier-issued Declaration of Insurance with the DFML in order to obtain an exemption were previously notified that they would be required to submit a policy form to the DFML once it was available from their Carrier. However, the DFML is no longer requiring these employers to submit the policy form to the DFML prior to the date of renewal of the exemption. The DFML will request policy form numbers from employers at the time of exemption renewal and will update its website to describe these procedures.

Amendments to Form Filings

If there are any changes, amendments, or regulatory clarifications to the provisions of the Paid Family Medical Leave statute and regulations that require amendments to the policy after it has been acknowledged by the Division, carriers should submit such changes, amendments or clarifications in a new filing according to the above-noted SERFF filing instructions. Carriers shall indicate the affected policy forms, identified by form numbers, SERFF tracking numbers and dates on which the

policies last were acknowledged.

Contact

Any questions about this Filing Guidance Notice should be directed to Sheri Cullen, Director of Policy Form Review, at (617) 521-7359 or to Sheri.Cullen@mass.gov.

PAID FAMILY AND MEDICAL LEAVE (PFML) POLICY TEMPLATE

First Page

The first page should include the name of Insurance Carrier ("Carrier"), specific reference to whether the coverage is for Paid Family Leave Coverage, Paid Medical Leave Coverage or Paid Family and Medical Leave ("PFML") Coverage, the Policyholder's name and the term of the Policy Coverage.

The first page should also include a statement that the Policy is intended to cover paid leave benefits that comply with the Massachusetts Department of Family and Medical Leave ("DFML") standards. If any Policy provisions do not conform to the requirements of M.G.L. c. 175M and 458 CMR 2.00 (hereinafter respectively referred to as "the PFML statute and regulations"), then the Carrier is required to administer paid benefits consistent with the PFML statute and regulations. The provisions of this Policy must conform with the requirements of the PFML statute and regulations.

The first page should acknowledge that if there are any changes, amendments, or regulatory clarifications to the provisions of the PFML statute and regulations then the Policy will be considered consistent with the relevant changes, amendments, or regulatory amendments and all claims practices will be updated to be in compliance with the new requirements. The Policy should be reviewed and updated at least annually to comply with any changes, amendments or regulatory clarifications.

Term of Policy and Renewal: The first page should explain the exact period that is covered by the Policy and all renewal rights offered by the Carrier.

If the Carrier elects to terminate a Policy, it must provide at least 30 days' notice to the Employer and to the DFML prior to terminating a Policy. If a Carrier elects to non-renew a Policy, it may only do so on the calendar anniversary of the initial Policy Effective Date and must provide at least 60 days' notice to the Employer and to DFML prior to non-renewing a Policy.

The following should be on the first page of the policy or in a separate notice that is attached to the front page of the policy. The notice of non-renewal should explain that if an Employer's Policy is terminated during the term of an approved DFML exemption period or prior to January 1, 2021, and the Employer does not obtain private plan coverage from another source (either its own self-insured private plan or another Carrier's fully insured private plan), the Employer may be required to remit contributions for its entire Massachusetts PFML ("MA PFML") payroll retroactive to either October 1, 2019 or the start date of the Employer's approved exemption. The Employer may be required to repay to the Family and Employment Security Trust Fund ("Trust Fund") the cost of total amount of benefits paid to Covered Individuals who received benefits from the Trust Fund and that it may be subject to additional interest and penalties established by the DFML for not maintaining a private plan.

Premiums

This section should explain how the Carrier's policy will calculate and collect premiums from the Employer, including any grace periods in the payment of premiums.
The following should be on the first page of the policy or in a separate notice that is attached to the front page of the policy. The Policy should state that if the Employer requires contributions toward premiums from Covered Individuals, this amount cannot exceed the maximum portion of contributions for Covered Individuals as described in the PFML statute and regulations. This maximum contribution amount is

subject to an annual adjustment by the DFML Director as specified in M.G.L c. 175M, § 7(e).

Amendments to Policy

If the Carrier allows amendments, this section should explain how and when there may be amendments to a Policy. The Policyholder should be informed that if any amendments are not consistent with the PFML statute and regulations when a policy is submitted as part of an application for an exemption, the DFML may deny or may withdraw the approval of a private plan exemption. If an exemption is withdrawn, the Employer may be required to remit contributions for its entire payroll retroactive to either October 1, 2019 or the start date of the Employer's approved exemption and the Employer may be required to repay to the Family and Employment Security Trust Fund ("Trust Fund") the cost of total amount of benefits paid to Covered Individuals who received benefits from the Trust Fund and that it may be subject to additional interest and penalties established by the DFML for not maintaining a private plan.

Termination and Reinstatement of Policy

This section should explain when a Carrier can terminate a Policy and must state that the Employer will receive a notice explaining the reasons why the Policy is being terminated. This section should identify the Carrier's termination notification procedures and how the Carrier will provide notice of the final termination of the Policy.

If the Carrier allows for the reinstatement of a terminated Policy after the Employer was notified of termination, the Carrier should fully describe the applicable reinstatement provisions. The policy will further state that the Carrier will notify the DFML if it agrees to reinstate the Policy and such reinstatement shall be without any gap in coverage.

[Claims of Creditors

The Policy may include an optional section stating that except when prohibited by Massachusetts law, the insurance and other benefits under this Policy may be exempt from execution, garnishment, attachment, or other legal or equitable process, for the debts or liabilities of the Covered Individuals or their beneficiaries.]

Employer Obligations:

Job and Employee Benefits Protection

This section must indicate that the Employer has the obligation to ensure that Employees retain the job protection and non-retaliation provisions guaranteed by the PFML statute and regulations. The Policy should indicate whether similar protections apply to covered contract workers, if they are included in the Policy.

Continuation of Employer-Related Health Insurance Benefits

This section should indicate that the Employer has an obligation to continue to pay the Employer's share of health insurance premiums for the Employee during a period of leave at the level and under the same conditions of coverage that would have been provided if the Employee continued working continuously for the duration of the qualified leave period. This obligation does not apply to former employees or covered contract workers if they are included in the Policy.

Continuation of Other Employee Benefits

This section should indicate that the Employer has an obligation to ensure that upon

reinstatement from qualified leave an Employee retains the right to accrue vacation time, sick leave, bonuses, advancement, seniority, length-of-service credit or other employee benefit plans or programs at the same level Employee had prior to leave. This obligation does not apply to former employees or covered contract workers if they are included in the Policy.

Records – Information to Be Furnished

This section should explain that the Employer is required to keep a record of the essential details of the private insurance coverage that applies to Covered Individuals, which may include wage or payment history if the Covered Individual's wages are used to determine the benefit amount. This section may require that the Employer furnish the required information to the Carrier within a reasonable time period, up to 15 business days. The Policy should explain that the Employer is to keep a record of all details of the insurance coverage and the Policy for a minimum period of three years after termination of the Policy and that the Employer shall furnish these records to the DFML upon request.

[Fitness for Duty: This section should state that if the Employer requires a Covered Individual to obtain a fitness of duty certificate in order to return to work at the end of a medical leave period, the Fitness for Duty section must comply with the provisions of 458 CMR 2.11. The Carrier and Employer must comply with the requirements of the PFML statute and regulations with regard to requiring certification of Fitness for Duty.]

Eligibility for Paid Family And Medical Leave Coverage

Conditions of Eligibility
This section cannot contain any elimination periods that are not authorized under the PFML statute and regulations.
[Variable for the Carrier]

When Coverage Starts [Effective date of coverage]
[Variable Date for the Carrier]

Effective Eligibility Date of Insurance Coverage:
The policy should explain the coverage relevant to the eligibility dates as follows:

Although a Policy may begin at any time, the Policy should state that in order for the Employer to qualify for an exemption from contributions to the Trust Fund, the effective eligibility date of the insurance coverage must begin no later than the first day of the quarter of the exemption effective date, for the following paid leaves:

- Leave for Covered Individuals who are unable to work due to their own serious health condition;
- Leave for Covered Individuals to bond with a child during the first 12 months after the child's birth, adoption, orfoster care placement;
- Leave for Covered Individuals for a qualifying exigency arising out of the fact that the covered individual's family member is a current member of the Armed Forces; and
- Leave for Covered Individuals to care for a family member who is or was a member of the Armed Forces and who require medical care as a result of an illness or injury related to family members' active service.

And no later than July 1, 2021, for the following paid leave:

- Leave for Covered Individuals to care for a family member with a serious health condition

Benefit Provisions

The Policy must state that all presumptions will be made in favor of the availability of leave and the payment of leave benefits.

The Policy should describe the following items:

Payment Period: The maximum payment period under the Policy. The benefits under this policy may not be conditioned on the Covered Individual first utilizing any available accrued paid leave available from the Employer. If the Covered Individual chooses to utilize accrued leave available from the Employer this use will run concurrently with the leave period.

[Variable by Carrier, but the minimum durations of paid leave allowable for qualifying reasons are:

Qualifying Reason and Minimum Duration (Medical Leave): In a Benefit Year, at least **20** weeks of leave, including the waiting period, for Covered Individuals if they are unable to work due to a serious health condition.

Qualifying Reason and Minimum Duration (Family Leave): In a Benefit Year, at least **12** weeks of leave, including the waiting period:

- To provide care to a family member with a serious health condition;
- To bond with a child during the first 12 months after the child's birth, adoption, or foster care placement; and
- For a qualifying exigency arising out of the fact that a Covered Individual's family member is a current member of the Armed Forces

In a Benefit Year, at least **26** weeks of leave, including the waiting period, to care for a family member who is or was a Covered Service Member of the Armed Forces and who requires medical care as a result of an illness or injury related to the family member's active service.

Qualifying Reason and Minimum Duration (Total Leave): In a Benefit Year a Covered Individual may take 26 weeks of leave, including the waiting period, for any combination of periods of authorized leave.]

[Waiting Period: The Carrier may require that no family or medical leave benefits will be paid during the first seven (7) calendar days of an approved initial claim for benefits.

If included in the policy, the initial seven day waiting period that is required for paid leave benefits may count against the total available period of leave in a Benefit Year. Where the approved claim involves leave on an intermittent or reduced leave schedule, the wait period shall be seven consecutive calendar days, not the aggregate accumulation of seven days of leave.

If the Covered Individual satisfies the following requirements, the seven-day waiting period for paid family leave shall not be required:

a. When a Covered Individual takes a medical leave during pregnancy or recovery from childbirth, and supported by documentation by a health care provider that it is immediately followed by a family leave; and

b. The waiting period for a claim for the medical leave has been satisfied.]

How Payments Start: This provision must meet or exceed the minimum qualifying eligibility conditions consistent with the Massachusetts PFML statute and regulations.

When Payments End: This provision must meet or exceed the minimum qualifying eligibility conditions consistent with the Massachusetts PFML statute and regulations. It may state that this occurs when the Covered Individual is no longer eligible for family or medical leave, no longer has a Serious Health Condition, no longer has a family member with a Serious Health Condition, or the person has completed the maximum payment period under the Policy.

Intermittent Leave or Reduced Leave Schedule: The Policy must describe when a Covered Individual may take intermittent or reduced leave.

- For Family Leave to bond with a Child during the first twelve months after the Child's birth, Adoption, or Foster Care placement, leave may be taken on an intermittent or reduced leave schedule only if the Employer and the Covered Individual mutually agree. The Carrier will assume that there is such agreement upon receipt of the claim request from the employee. When needed, the Carrier will validate that agreement has been reached with the employer as a condition of paying benefits.
- For Family Leave to care for a Family Member's Serious Health Condition or to care for a Family Member who is a Covered Service Member, leave may be taken on an intermittent or reduced leave schedule. The Carrier may require that it receive from the Health Care Provider, a certification that the intermittent leave schedule is medically necessary as a condition of coverage. If the Carrier requires this Health Care Provider certification, this must be stated in the Policy.
- For Family Leave due to a Qualifying Exigency arising out of a Family Member's active duty or impending call to active duty in the Armed Forces, the Policy must provide that leave may be taken on an intermittent or reduced leave schedule if the Covered Individual elects to take intermittent leave for this purpose.
- For Medical Leave due to the Covered Individual's own Serious Health Condition, leave may be taken on an intermittent or reduced leave schedule. The Carrier may require that it receive from the Health Care Provider a certification that the intermittent leave or reduced leave schedule is medically necessary as a condition of coverage. If the Carrier requires this Health Care Provider certification, this must be stated in the Policy.

Extension of Paid Leave Benefits
The Policy must indicate that the Covered Individual may submit a request for extension of paid family or medical leave.

The Carrier may require the Covered Individual to provide notice to the Carrier requesting an extension of leave. This notice period may not be greater than 14 calendar days prior to the date of expiration of the original approved leave.

If the Carrier requires a notice period, it must state that there is a provision allowing a late filed request for an extension for good cause shown.

The Carrier may require that a request for an extension of leave include the following information:

- The reason for the extension;

- The requested duration of the extended leave;
- The date on which the Covered Individual provided notice of the request for the extension and
- A newly completed or updated health care certification for medical or family leave that does not exceed the standards provided in 458 CMR 2.08(5).

The Carrier should notify the Employer of a request for an extension not more than five business days following its receipt of a completed request. The Carrier may provide to the Employer:

- The requested duration for the extension;
- Whether the newly requested leave is continuous, a reduced leave schedule, or an intermittent leave schedule; and
- Any other information or record the Carrier deems relevant to verifying and otherwise processing the claim.

The Carrier may require that the Employer, within five business days from the date of the notice of the request for extension of leave, provide to the Carrier all relevant information or records requested by the Carrier.
This information or records may include the following:

- Whether the Covered Individual will receive any paid leave benefits from the Employer during the requested extended leave period;
- Whether the employer has approved or intends to approve the request for extension under the Family and Medical Leave Act or any other policy allowing for paid or unpaid leave; and
- Any other relevant information or records related to the request for extension, including but not limited to, evidence of a fraudulent claim.

[Employer Reimbursement
If the Policy provides for Employer reimbursement of paid leave remitted to a Covered Individual, the Policy shall state the terms and conditions for reimbursement in this section.]

Substitution of Employer Provided Paid Leave.

This section should state that the Employer may not require the Covered Individual to use any sick or other accrued paid leave or paid time off prior to initiating a claim under the Policy or during the Coverage Period.

[If the Policy's Weekly Benefit Amount is equivalent to the statutory minimum Weekly Benefit Amount as described in M.G.L. c. 175M, §3, the Policy should include the following two sections:

Calculation of Weekly Benefit Amount and Use of Wages

This section should clearly state how the Weekly Benefit Amount payable to the Covered Individual is calculated. Benefits to be paid must be at least equal to the benefits that would be paid to Covered Individuals if participating in the state plan. Although all Covered Individuals must be eligible for benefits, If the weekly benefit amount differs by class of employee (e.g. part-time employees, temporary employees, covered contract workers), the different weekly benefit amounts are to be delineated clearly in this section to ensure that the minimum requirements of the PFML statute and regulations are met for all classes of Covered Individuals.

Minimum Weekly Benefit Amount:

The Carrier must describe that the minimum weekly benefit must be calculated using the Covered Individual's total wages during the base period and this amount must include wages from other employment during the base period, if those wages would be included in the base period of a qualifying claim for PFML benefits with the DFML. A definition of wages that must be included in determining the minimum Weekly Benefit Amount is available at M.G.L. c. 151A, §1(s).

The Carrier shall explain in the Policy that the Employer will be required to submit all wage information to the Carrier, and how it will obtain this information if not readily available from the Employer.

The portion of a Covered Individual's average weekly wage that is equal to or less than 50% of the state average weekly wage shall be replaced at a rate of 80% and the portion of a Covered Individual's average weekly wage that is more than 50% of the state average weekly wage shall be replaced at a rate of 50%.

If the Policy uses the state's maximum benefit amount as described in M.G.L. c. 175M, §3(b)(2), this section must include that amount and indicate that the amount will be adjusted not later than October 1 of each year and this maximum weekly benefit amount shall take effect on January 1 of the year following such adjustment.]

[If the Policy's Weekly Benefit Amount is greater than the statutory minimum Weekly Benefit Amount as described in M.G.L. c. 175M, §3, the Policy should include the following section:

Calculation of Weekly Benefit Amount and Use of Wages

The Carrier must explain in detail how it calculates the Weekly Benefit Amount.]

Payments

This section will set forth the timing and manner of benefit payments to Covered Individuals. The Carrier agrees that it will comply with the time periods and other requirements related to processing and payment of claims that are set forth in the PFML statute and regulations. This section will state that claim payments to a Covered Individual are to be paid not more than 14 days after approving an application, unless that determination occurs more than 14 calendar days before the onset of leave or eligibility, in which case the carrier shall commence payment of leave benefits as soon as leave or eligibility begins.

If the Carrier offers lump sum payments in lieu of a Weekly Benefit Amount and/or pays benefits at the beginning of a claim or in higher amount installments at the commencement of a claim, the Carrier must describe this payment schedule in detail. The Carrier must describe in this section that lump sum payments or accelerated payments are only to be offered at the beginning of the qualified leave period and only if the Covered Individual agrees to lump sum or accelerated payments.

Offset to Policy Benefits Due to Other Income:

This section will explain the permissible offsets to the Weekly Benefit Amount under the PFML statute and regulations. Under the PFML statutes and regulations, the Weekly Benefit Amount may be reduced by the amount of wages or wage replacement that a Covered Individual on family or medical leave receives for that period from:

(a) any government program or law, including unemployment benefits under M.G.L. c. 151A, or workers' compensation under M.G.L. c. 152, other than for permanent partial disability incurred prior to the family or medical leave claim; or

(b) under other state or federal temporary or permanent disability benefits law; or

(c) a permanent disability policy or program of the Employer.

Unless the aggregate amount a Covered Individual receives would exceed the Covered Individual's average weekly wage, the weekly benefit amount for a period shall not be reduced by the amount of wage replacement that a Covered Individual on family or medical leave receives for that period from

(a) a temporary disability policy or program of the Employer; or

(b) a paid family or medical leave policy of the Employer.

Other Income Not Subject to Deduction:

If the Carrier includes a section that describes other income not subject to deduction it should list each of the items, provided that none of the items are referenced under the offset section.

Exclusions

The Policy should not have any exclusions that are not specifically listed in either the PFML statute and regulations. If there are future changes to the PFML statute and regulations, these exclusions should be consistent with those changes.

Claim Provisions

This section will inform Covered Individuals how they may initiate claims for paid leave benefits. The Carrier and the Employer may not impose requirements related to notice of the need for leave or the filing of a claim for benefits that are inconsistent with notice provisions in the PFML statute or regulations.

The Carrier should clearly explain any claim provisions for paid family and/or medical leave.

The Carrier shall explain that the individual may be required to provide consent to the Carrier to share information with the Employer and with the health care provider in order to process the claim.

The Carrier may require the Covered Individual to provide a notice of an intent to file a claim to the Carrier not greater than 30 calendar days prior to the date that the approved family leave period begins or the Serious Health Condition prevents work.

If the Carrier requires a notice period, the Carrier must allow an exception for circumstances beyond the reasonable control of a Covered Individual. In this case, the Carrier may require that the notice be given as soon as practicable. The Carrier may require that notices are sent to the Employer and may indicate that a claim may be delayed or denied if this notice is not given.

The Carrier may require that in the case of medical leave when planning medical treatment, the Covered Individual must consult the Employer to schedule treatment that will not unduly disrupt the Employer's operations. In this case, the Carrier may contact the Employer within five days of a claim to collect information relevant to the claim.

The Carrier should clearly state that decisions on a claim for paid leave benefits will be made within 14 calendar days of receipt of a complete application, unless that determination occurs more than 14 calendar days before the onset of leave or eligibility, in which case the carrier shall commence payment of leave benefits as soon as leave or eligibility begins.

Certifications and Documentation Requests

This section will describe the permissible certifications and documentation that the Carrier or the

Employer may request from Covered Individuals. The Carrier may not include certification or other proof requirements in the Policy that exceed those permitted under the PFML statute or regulations.

Neither the Employer nor Carrier may require the Covered Individual to submit additional evidence unless it is specifically authorized in the PFML statute or regulations.

Certification of Serious Health Condition

For medical leave, family leave to care for a family member with a serious health condition, and Family Leave to care for a family member who is a Covered Service Member, the Carrier may not request more than a Certification of Serious Health Condition from a health care provider as outlined in 458 CMR 2.08(5).

The Carrier may require submission of the following necessary information for the following types of paid family and medical leave. The Carrier may require that claims for benefits be supported by a certification evidencing that the leave is for a qualifying reason.

For Medical Leave for a Serious Health Condition:

The Carrier may require a certification from a health care provider that includes:

- a statement that the Covered Individual has a serious health condition;
- the date on which the serious health condition commenced;
- the probable duration of the serious health condition;
- a certification by the health care provider that the Covered Individual is incapacitated from work due to the serious health condition;
- information regarding the need for intermittent leave, including a statement that such leave or schedule is medically necessary where the claim for benefits is for leave on an intermittent or reduced leave schedule.

For Family Leave to Care for Family Member with a Serious Health Condition:
The Carrier may require a certification from a health care provider that includes:

- A statement confirming the relationship between the Covered Individual and the Family Member;
- A statement that the Family Member has a Serious Health Condition;
- The date on which the Family Member's Serious Health Condition commenced;
- The probable duration of the Family Member's Serious Health Condition;
- A statement that the Covered Individual is needed to care for the Family Member; and
- An estimate regarding the frequency and anticipated duration of time that the Covered Individual is needed to care for the Family Member.

For Family Leave for the Birth of a Child:

- The Child's birth certificate; or
- A statement from the Child's Health Care Provider stating the Child's birth date; or
- A statement from the Health Care Provider of the person who gave birth stating the Child's birth date.

For Family Leave for Placement of a Child for Adoption or Foster Care:

- The Carrier may require a certification from the child's health care provider or from an adoption or foster care agency involved in the placement or the Department of Children and Families: Certification from the Child's Health Care Provider or from an Adoption or Foster Care agency involved in the placement or the department of children and families that confirms the placement and the date of placement
- The Carrier may also require that the Covered Individual provide written notice of any change of status as an adoptive or foster parent while an application for benefits is pending or while the Covered Individual is receiving benefits. In this instance, the Covered Individual, within five business days of such change in status, may be required to provide written notice of the change to the Carrier. The Department of Children and Families may confirm in writing the Covered Individual's status as an adoptive or foster parent while an application for benefits is pending or while the Covered Individual is receiving benefits.

Family Leave for a Qualifying Exigency arising out a Family Member is on Active Military Duty or Has Been Notified of an Impending Call or Order to Active Duty in the Armed Forces:

- A copy of the Family Member's active duty orders; or
- A letter of impending activation from the Family Member's commanding officer; or
- Other documentation in circumstances where, for good cause shown, the Covered Individual is unable to produce the active duty orders or letter of impending activation; and
- A statement of the family relationship between the Covered Service Member and the Covered Individual requesting benefits.

Family Leave to Care for a Family Member who is a Covered Service Member:
The Carrier may require a certification from the Covered Service Member's health care provider that includes:

- The date on which the Covered Service Member's Serious Health Condition commenced;
- The probable duration of the Serious Health Condition;
- A statement that the Covered Individual is needed to care for the Family Member;
- An estimate of the amount of time the Covered Individual will be needed to care for the Covered Service Member;
- An attestation by the Covered Service Member's Health Care Provider and the Covered Individual that the Serious Health Condition is connected to the Covered Service Member's military service; and
- A statement of the family relationship between the Covered Service Member and the Covered Individual.

Information That May Be Requested from The Employer:

The Carrier may require that the Employer, within five business days from the date of notice or the filing of a claim for benefits, provide to the Carrier all relevant information or records requested by the Carrier.

This information or records may include the following:

- Whether the Covered Individual will receive any paid leave benefits from the Employer during the requested extended leave period
- Whether the employer has approved or intends to approve the request for extension under the Family and Medical Leave Act or any other policy allowing for paid or unpaid leave; and

- Any other relevant information or records related to the request for extension, including but not limited to, evidence of a fraudulent claim.

[Overpayments

If the Policy includes a section regarding overpayments or subrogation, the Carrier should state any provisions for recouping any overpayment of benefits.]

Appeals

The Policy must include a section notifying the Covered Individual that if a paid family or medical leave claim is denied, the Covered Individual has the right to appeal a denial of the claim to the DFML within ten calendar days of receipt of notice of the determination pursuant to 458 CMR 2.14.

If the Carrier denies a claim, it must include in the denial notice that the Covered Individual may appeal a denial to the DFML and should identify how to contact the DFML.

Definitions

The definitions in the policy must align with the PFML statute and regulations, when applicable.

Terms defined under the Federal Family Medical Leave Act of 1993, as amended, and its implementing regulations shall be treated as persuasive, supplementary authority when those definitions are not facially inconsistent with the terms adopted in M.G.L. c. 175M and 458 CMR 2.00 and may be modified with any subsequent amendments or revisions to the PFML statute and regulations.

The following terms shall be included within the Policy:

Benefit Year: the period of 52 consecutive weeks beginning on the Sunday immediately preceding the first day paid family or medical leave commences for the Covered Individual.

Continuing Treatment by a Health Care Provider: includes any one or more of the following:

(a) Incapacity and treatment. A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:

1. Treatment two or more times, within 30 calendar days of the first day of incapacity, unless extenuating circumstances exist, by a health care provider, by a nurse under direct supervision of a health care provider, or by a provider of health care services (*e.g.*, physical therapist) under orders of, or on referral by, a health care provider; or

2. Treatment by a health care provider on at least one occasion, which results in a regimen of continuing treatment under the supervision of the health care provider. Treatment includes examination to determine if there is a serious health condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations. A regimen of continuing treatment includes a course of prescription medication or therapy requiring specialized equipment to resolve or alleviate the health condition.

3. The requirement for treatment by a health care provider means an in-person visit to a health care provider. The first (or only) in-person treatment visit must take place within seven calendar days of the first day of incapacity.

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

5. The term extenuating circumstances means circumstances beyond the employee's control that prevent the follow-up visit from occurring as planned by the health care provider. Whether a given set of circumstances are extenuating depends on the facts. For example, extenuating circumstances exist if a health care provider determines that a second in-person visit is needed within the 30-day period, but the health care provider does not have any available appointments during that time period.

(b) Pregnancy or Prenatal Care. Any period of incapacity due to pregnancy, or for prenatal care.

(c) Chronic Conditions. Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one which:

(1) Requires periodic visits (defined as at least twice a year) for treatment by a health care provider, or by a nurse under direct supervision of a health care provider;
(2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
(3) May cause episodic rather than a continuing period of incapacity (*e.g.*, asthma, diabetes, epilepsy, *etc.*).

(d) Permanent or Long-term Conditions. A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The Covered Individual or the Covered Individual's family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

(e) Conditions Requiring Multiple Treatments. Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, for:

1. Restorative surgery after an accident or other injury; or
2. A condition that would likely result in a period of incapacity of more than three consecutive, full calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, *etc.*), severe arthritis (physical therapy), or kidney disease (dialysis).

(f) Absences attributable to incapacity under Continuing Treatment by a Health Care Provider (b) or (c) qualify for leave even though the employee, Covered Individual or the covered family member does not receive treatment from a health care provider during the absence, and even if the absence does not last more than three consecutive, full calendar days.

(g) Cosmetic treatments are not serious health conditions unless inpatient hospital care is required or unless complications develop.

Contributions: The payments made by an employer, a covered business entity, an employee, or a self-employed individual to the Family and Employment Security Trust Fund, as required by M.G.L. c. 175M, or contributions to a private plan while the private plan is in effect.

Covered Individual: Covered Individuals are those workers that are included under the Policy. Covered individuals must include the following individuals who meet the eligibility requirements of the PFML statute and regulations:

- All the Employer's employees providing services in Massachusetts, including full-time, part-time, permanent, temporary, on call, per diem or seasonal employees who meet the minimum eligibility requirements under the MA PFML Law;
- former employees of the employer for not more than 26 weeks after separation or until re-employed, whichever comes first; and
- Massachusetts 1099-MISC contract workers if applicable, if the Employer is a Covered Business Entity.

The Department of Family and Medical Leave (DFML): The state agency established in M.G.L. c. 175M, § 8.

Eligibility Date: This term means the earliest date the Covered Individual is eligible for coverage under this Policy, and the Covered Individual has satisfied all requirements for coverage to begin.

Employee: Shall have the same meaning as provided in M.G.L. c. 151A, § 1(h); provided, however, that notwithstanding M.G.L. c. 151A, § 1(h); or any other special or general law to the contrary, Employee shall include a family child care provider, as defined in M.G.L. c. 15D, § 17(a).

Employer: Refers to the Employer Policyholder. The term Employer shall have the same meaning as provided in M.G.L. c. 151A § 1(i), provided, however, that

(a) an individual employer shall be determined by the Federal Employer Identification Number;

(b) the Department of Early Education and Care shall be deemed the employer of family child care providers, as defined in M.G.L. c. 15D, § 17(a); provided further, that the PCA Quality Home Care Workforce Council established in M.G.L. c. 118E, § 71 shall be the employer of personal care attendants, as defined in M.G.L. c. 118E, § 70.

Employment: Shall have the same meaning as provided by M.G.L. c. 151A, § 1(k); provided, further, that employment shall not include any service not included in "employment" pursuant to M.G.L. c. 151A, § 6.

Health Care Provider: An individual licensed by the State in which the individual practices to practice medicine, surgery, dentistry, chiropractic, podiatry, midwifery or osteopathy, and including the following:

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

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

(c) Christian Science Practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts.

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

Intermittent Leave: Leave taken in separate periods of time due to a single qualifying reason, rather than for one continuous period of time. Examples of intermittent leave include leave taken on an occasional basis for medical appointments or leave taken several days at a time spread over a period of months. An employer may require that intermittent leave be taken in increments not smaller than a designated minimum time period; provided, however, that an employer's designated minimum time period may not be greater than four consecutive hours.

Qualifying Reason: Any of the following reasons for which a Covered Individual is eligible for family or medical leave benefits: to bond with a child during the first 12 months after the child's birth, adoption, or foster care placement; to care for a family member's serious health condition; to care for a family member who is a covered service member; a qualifying exigency arising out of a family member's active duty or impending call to active duty in the Armed Forces; or the Covered Individual's own serious health condition that incapacitates the individual from performing the essential functions of the individual's job.

Reduced Leave Schedule: A leave schedule that reduces the usual number of hours per workweek, or hours per workday, of a Covered Individual.

Serious Health Condition: An illness, injury, impairment or physical or mental condition that involves:
(a) inpatient care in a hospital, hospice or residential medical facility; or
(b) continuing treatment by a health care provider.

Trust Fund: The Family and Employment Security Trust Fund established in M.G.L. c. 175M, § 7.

Wages: Shall have the same meaning as provided in M.G.L. c. 151A, § 1(s).

Minimum Weekly Benefit Amount: The minimum amount of wage replacement that may be paid to a Covered Individual on a weekly basis while the Covered Individual is on family or medical leave, as provided in M.G.L. c. 175M, § 3.

Weekly Benefit Amount: The amount of wage replacement that will be paid to a Covered Individual on a weekly basis while the Covered Individual is on family or medical leave under the terms of the Policy.

The following terms shall be included within a policy that includes medical leave benefits:

Medical Leave: Leave taken by a Covered Individual due to a serious health condition.

Medical Leave Benefits: Wage replacement paid to a Covered Individual while the Covered Individual is on medical leave under the Policy.

The following terms shall be included within a policy that includes family leave benefits:

Adoption: Legally and permanently assuming the responsibility of raising a child as one's own. The source of an adopted child (*i.e.*, whether from a licensed placement agency or otherwise) is not a factor in determining eligibility for leave.

Child: A biological, adopted or foster child, a stepchild or legal ward, a child to whom the Covered Individual stands *in loco parentis*, or a person to whom the Covered Individual stood in loco parentis when the person was a minor child.

Covered Service Member: either:

(a) a member of the Armed Forces, as defined in M.G.L. c. 4, § 7, including a member of the National Guard or Reserves, who is:

1. undergoing medical treatment, recuperation or therapy;
2. otherwise in outpatient status; or
3. is otherwise on the temporary disability retired list for a serious injury or illness that was incurred by the member in the line of duty on active duty in the Armed Forces, or a serious injury or illness that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces; or

(b) a former member of the Armed Forces, including a former member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy for a serious injury or illness that was incurred by the member in line of duty on active duty in the Armed Forces, or a serious injury or illness that existed before the beginning of the member's active duty and was aggravated by service in line of duty on active duty in the Armed Forces and manifested before or after the member was discharged or released from service.

Domestic Partner: A person not less than 18 years of age who:

(a) is dependent upon the Covered Individual for support as shown by either unilateral dependence or mutual interdependence that is evidenced by a nexus of factors including, but not limited to:

1. common ownership of real or personal property;
2. common householding;
3. children in common;
4. signs of intent to marry;
5. shared budgeting; and
6. the length of the personal relationship with the Covered Individual; or

(b) has registered as the domestic partner of the Covered Individual with any registry of domestic partnerships maintained by the employer of either party, or in any state, county, city, town or village in the United States.

Family Leave: Leave taken to care for a family member with a serious health condition, for a parent to bond with the parent's child during the first 12 months after the child's birth, adoption, or foster care placement, to care for a family member who is a Covered Service Member, or because of a qualifying exigency arising out of the fact that a family member is on active duty or has been notified of an impending call or order to active duty in the Armed Forces.

Family Leave Benefits: Wage replacement paid to a Covered Individual while the Covered Individual is on family leave under the Policy.

Family Member: The spouse, domestic partner, child, parent or parent of a spouse or domestic partner of the Covered Individual; a person who stood *in loco parentis* to the Covered Individual when the Covered Individual was a minor child; or a grandchild, grandparent or sibling of the Covered Individual.

Foster Care: 24-hour care for children in substitution for and away from their parents or guardian. Such placement is made by or with the agreement of the State as a result of a voluntary agreement between the parent and guardian that the child be removed from the home, or pursuant to a judicial

determination of the necessity for foster care, and involves agreement between the State and foster family that the foster family will care for the child. Although foster care may be with relatives of the child, State action is involved in the removal of the child from parental custody.

Grandparent: A parent of the Covered Individual's parent.

Parent: The biological, adoptive, step- or foster mother or father of the Covered Individual.

Qualifying Exigency: A need arising out of a Covered Individual's family member's active duty service or notice of an impending call or order to active duty in the Armed Forces, including, but not limited to, providing for the care or other needs of the military member's child or other family member, making financial or legal arrangements for the military member, attending counseling, attending military events or ceremonies, spending time with the military member during a rest and recuperation leave or following return from deployment or making arrangements following the death of the military member.

Sibling: The biological, adoptive, step- brother or sister of a Covered Individual.

If the following terms are used within the Policy, they shall have the following meanings, unless the context clearly requires otherwise:

Average Weekly Wage: Shall have the same meaning as provided in M.G.L. c. 151A, § 1(w); provided, however, that Average Weekly Wage shall be calculated using earnings from the base period; and provided further, that in the case of a self-employed individual, Average Weekly Wage shall mean 1/26 of the total earnings of the self-employed individual from the two highest quarters of the 12 months preceding such individual's application for benefits under M.G.L. c. 175M.

Base Period: Last four completed calendar quarters immediately preceding the starting date of a qualified period of paid family or medical leave. A completed calendar quarter is one for which an employment and wage detail report has been or should have been filed for employers who have not received an exemption from contributions to the Trust Fund, pursuant to 458 CMR 2.04(1)-(2).

Covered Business Entity: A business or trade that contracts with self-employed individuals for services and is required to report the payment for services to such individuals on IRS Form 1099-MISC for more than 50% of its workforce.

Covered Contract Worker: a self-employed individual who performs services as an individual entity, resides in Massachusetts, and performs services in Massachusetts for whom an employer or covered business entity is:

(a) required to report payment for services on IRS Form 1099-MISC; and
(b) required to remit contributions to the Family and Employment Security Trust Fund pursuant to the requirements of M.G.L. c. 175M, § 6.

The 1099 MISC worker must not be an independent contractor as defined by M.G.L. c. 151A, § 2.

Director: the Director of the Department of Family and Medical Leave.

Earnings from Self-employment, or Income from Self-Employment: Shall have the same meaning as "net earnings from self-employment", as defined in the Internal Revenue Code § 1402(a) as amended and in effect for the taxable year, and the implementing regulations thereunder.

Employment Benefits: All benefits provided or made available to employees by an employer, including, but not limited to, group life insurance, health insurance, disability insurance, sick leave, annual or vacation leave, educational benefits and pensions.

Financial Eligibility Test: a demonstration that, over the 12 months preceding an individual's claim for benefits, the individual has received total wages as an employee or payments for service as a covered contract worker from a Massachusetts employer or a Massachusetts covered business entity that in the aggregate equal or exceed 30 times the individual's weekly benefit amount as determined under 458 CMR 2.12, below, and that in the aggregate are not less than the dollar amount calculated annually by the Department of Unemployment Assistance pursuant to M.G.L. c. 151A, § 24(a).

Pay Period: the shortest pay period used by a business or trade for regular payments to any group of employees of the business or trade.

Qualifying Earnings:

(a) wages paid to an employee;
(b) payments by covered business entities to covered contract workers; and
(c) earnings from self-employment on which a self-employed individual is making contributions pursuant to 458 CMR 2.06.

Self-employed individual: a sole proprietor, sole member of a limited liability company or limited liability partnership or an individual whose net profit or loss from a business is required to be reported to the Massachusetts Department of Revenue; provided, however, that such individual resides in the Commonwealth.

State Average Weekly Wage: the average weekly wage in the Commonwealth as calculated under M.G.L. c. 151A, § 29(a) and determined by the Director of the Massachusetts Department of Unemployment Assistance.