

458 CMR 2.00: FAMILY AND MEDICAL LEAVE

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2.01: Purpose, Scope, and Other General Provisions

(1) Purpose. 458 CMR 2.00 clarifies procedures, practices, and policies in the administration and enforcement of the Family and Medical Leave Law, M.G.L. c. 175M.

(2) Scope. 458 CMR 2.00 applies to Massachusetts employers and covered business entities and to Massachusetts covered individuals, including employees and self-employed individuals who elect coverage, who are eligible for family and medical leave benefits pursuant to the provisions of M.G.L. c. 175M.

Under 458 CMR 2.00, an employer or covered business entity shall be considered a Massachusetts employer or covered business entity with respect to services performed by a covered individual for the employer or covered business entity, and a covered individual shall be considered a Massachusetts covered individual with respect to all services provided within, or both within and without Massachusetts for an employer or covered business entity, if:

- (a) the service performed is localized in Massachusetts. Service shall be deemed to be localized within Massachusetts if the service is performed entirely within Massachusetts, or the service is performed both within and without Massachusetts, but the service performed without Massachusetts is incidental to the individual's service within Massachusetts; for example, the service is temporary or transitory in nature, or consists of isolated transactions.
- (b) the service is not localized in any state, but some part of the service is performed in Massachusetts; and
 - 1. the individual's base of operations is in Massachusetts or, if there is no base of operations, then the place from which such service is directed or controlled, is within Massachusetts; or
 - 2. the individual's base of operations or place from which such service is directed or controlled is not in any state in which some part of the service is performed, but the individual's residence is in Massachusetts.

(3) Interaction with State and Federal Leave Laws. Leave taken under M.G.L. c. 175M shall run concurrently with leave taken under other applicable state and federal leave laws, including the Massachusetts Parental Leave Act (M.G.L. c. 149, § 105D) and the federal Family and Medical Leave Act of 1993 (29 U.S.C. 2601), when the leave is for a qualified reason under those acts.

(4) Use of Electronic Communications. Any written communication required or permitted under M.G.L. c. 175M or under 458 CMR 2.00 shall be made and transmitted in the manner and form prescribed by the director, which may include by means of electronic communication. The director shall establish procedures allowing the use of the United States Postal Service (regular mail) for persons lacking reasonable access to, or the ability to use, electronic communication.

2.02: Definitions

For the purposes of 458 CMR 2.00, the following words shall have the following meanings, unless the context clearly requires otherwise. Terms defined under the federal Family Medical Leave Act of 1993, and its implementing regulations (28 CFR § 825) 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.

Accrued Paid Leave. Leave earned by or otherwise provided to a covered individual pursuant to a benefit plan or policy offered by an employer or covered business entity including, but not limited to, sick leave, annual leave, vacation leave, personal leave, compensatory leave or paid time off. Accrued paid leave shall not include:

- (a) disability policy or program of an employer or covered business entity; or
- (b) paid family, or medical leave policy of an employer or covered business entity.

Active Duty. For the purposes of administering paid leave under M.G.L. c. 175M, and 458 CMR 2.00, Active Duty means full-time duty in the active military service of the United States and full-time National Guard duty, and deployed to a foreign country.

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.

Application for Benefits. A request for family or medical leave benefits pursuant to 458 CMR 2.08.

Average Weekly Wage. Has 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 $\frac{1}{26}$ 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. If an individual has multiple employers, the Average Weekly Wage will be calculated for each employer or covered business entity separately.

Average Working Week. The average number of hours worked from the two highest quarters of the 12 months preceding such individual's application for benefits under M.G.L. c. 175M.

Base Period. The last four completed calendar quarters within the previous five calendar quarters immediately preceding the date an application for benefits is filed with the Department for 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, pursuant to 458 CMR 2.04(1) and (2).

Benefit Year. The period of 52 consecutive weeks beginning on the Sunday immediately preceding the first day that job-protected leave under M.G.L. c. 175M commences for the covered individual.

Calendar Year. A 12-month period starting with January 1st and ending with December 31st.

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.

Complete Application. An application for benefits that contains all of the required information from the covered individual pursuant to 458 CMR 2.08(2) and all of the information required from the employer pursuant to 458 CMR 2.08(6). The application for benefits shall be deemed complete when the Department receives the information required under 458 CMR 2.08(6) or ten business days after the Department requests the information required under 458 CMR 2.08(6) from the employer, whichever is sooner.

2.02: continued

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 or telehealth visit to a health care provider. The first (or only) in-person or telehealth 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-calendar day period shall be determined by the health care provider.

5. The term extenuating circumstances means circumstances beyond the covered individual'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-calendar 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 per calendar 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 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 458 CMR 2.02: Continuing Treatment by a Health Care Provider(b) or (c) qualify for leave even though the 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.

2.02: continued

Contributions. The payments made by an employer, a covered business entity, or a covered individual to the Family and Employment Security Trust Fund, as required by M.G.L. c. 175M.

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:

- (a) for whom an employer or covered business entity is required to report payment for services on IRS Form 1099-MISC;
- (b) for whom an employer or covered business entity is required to remit contributions to the Family and Employment Security Trust Fund pursuant to the requirements of M.G.L. c. 175M, § 6;
- (c) who performs services as an individual in Massachusetts;
- (d) who resides in Massachusetts; and
- (e) who is not classified as an independent contractor pursuant to M.G.L. c. 151A, § 2.

Covered Individual, either:

- (a) an employee who meets the financial eligibility requirements of M.G.L. c. 151A, § 24(a); provided, however, that all such employment shall have been with an employer in the Commonwealth;
- (b) a self-employed individual:
 - 1. who has elected coverage under M.G.L. c. 175M, § (2)(j);
 - 2. whose reported earnings to the Massachusetts Department of Revenue from self-employment meet the financial eligibility requirements of M.G.L. c. 151A, § 24(a) as if the individual were an employee; and
 - 3. who has made contributions as required by M.G.L. c. 175M, § 6, for at least two of the previous four calendar quarters;
- (c) a covered contract worker:
 - 1. for whom at least one employer or covered business entity is required to remit contributions to the Family and Employment Security Trust Fund pursuant to M.G.L. c. 175M, § 6; and
 - 2. whose payments from such employer or covered business entity satisfy the financial eligibility requirements of M.G.L. c. 151A, § 24(a) as if the covered contract worker were an employee; or
- (d) a former employee who has:
 - 1. met the financial eligibility requirements of M.G.L. c. 151A, § 24(a) at the time of the former employee's separation from employment; provided, however, that all such employment shall have been with an employer in the Commonwealth; and
 - 2. been separated from employment for not more than 26 weeks at the start of the former employee's family or medical leave; or
- (e) a personal care attendant, as defined in M.G.L. c. 118E, § 70, whose wages from working as a personal care attendant meet the financial eligibility requirements of M.G.L. c. 151A, § 24(a); or
- (f) a family child care provider, as defined in M.G.L. c. 15D, § 17(a), whose payments from working as a family child care provider meet the financial eligibility requirements of M.G.L. c. 151A, § 24(a).

Covered Servicemember, 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

2.02: continued

(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.

Department. The Department of Family and Medical Leave established in M.G.L. c. 175M, § 8.

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

Domestic Partner. A person 18 years of age or older 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.

NON-TEXT PAGE

2.02: continued

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 at 26 U.S.C. § 1402(a), in effect for the taxable year, and the implementing regulations at 26 CFR § 1.1402(a).

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 and solely for the purposes of M.G.L. c. 175M, § 6 and the notice provisions set forth in M.G.L. c. 175M, § 4(a) and (b), Employee shall include:

- (a) a family child care provider, as defined in M.G.L. c. 15D, § 17(a); and
- (b) a personal care attendant, as defined in M.G.L. c. 118E, § 70.

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), solely for the purposes of M.G.L. c. 175M, § 6 the notice provisions set forth in M.G.L. c. 175M, § 4(a) and (b), and § 8(d);
- (c) any employer not subject to M.G.L. c. 175M may become a covered employer under M.G.L. c. 175M by notifying the Department of Family and Medical Leave and completing the procedure established by the Department;
- (d) a municipality, district, political subdivision or its instrumentalities shall not be subject to M.G.L. c. 175M, unless it adopts M.G.L. c. 175M by majority vote of its authorized local legislative body or governing body and otherwise as provided by M.G.L. c. 175M, § 10; and
- (e) 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(a), solely for the purposes of M.G.L. c. 175M, § 6, and consumers, as defined in M.G.L. c. 118E, § 70, shall be considered the employers of personal care attendants solely for the purposes of the notice requirements set forth in M.G.L. c. 175M, § 4(a) and (b), and § 8(d);
- (f) Notwithstanding any general or special law to the contrary, for the purposes of M.G.L. c. 175M, § 6, 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, and the Department of Early Education and Care shall be the employer of family child care providers, as defined in M.G.L. c. 15D, § 17(a).

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, § 6A.

Employment Benefits. All benefits provided or made available to covered individuals by an employer or covered business entity, if any, including, but not limited to, group life insurance, health insurance, disability insurance, sick leave, annual or vacation leave, educational benefits and pensions.

Extended Illness Leave Bank. A voluntary program where covered individuals may donate accrued leave time to fund a bank for the benefit of a co-worker experiencing a qualifying reason under M.G.L. c. 175M.

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.

2.02: continued

Family Leave Benefits. Wage replacement paid pursuant to M.G.L. c. 175M, § 3 and provided in accordance with M.G.L. c. 175M, § 2, to a covered individual while the covered individual is on family leave.

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.

Financial Eligibility Test. A demonstration that, over the 12 months preceding an individual's application for benefits with the Department, the individual has received total wages as an employee or payments for service as a covered contract worker from Massachusetts employers or Massachusetts covered business entities that in the aggregate equal or exceed 30 times the individual's weekly benefit amount as determined under 458 CMR 2.12, and that in the aggregate are not less than the dollar amount calculated annually by the Massachusetts Department of Unemployment Assistance pursuant to M.G.L. c. 151A, § 24(a). Wages received from multiple employers or covered business entities within the base period can be aggregated to determine financial eligibility for leave.

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 Massachusetts or any other state, commonwealth, or territory 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 Massachusetts or any other state, commonwealth, or territory 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.

Former Member of the Armed Forces. An individual who was a member of the Armed Forces, including a member of the National Guard or Reserves, and was discharged or released at any time during the five-year period prior to the first date the covered individual completes an application for benefits to care for the former member of the Armed Forces.

Grandparent. A parent of the covered individual's parents.

Good Cause. A demonstration by a party that a failure to comply with a requirement of M.G.L. c. 175M, and 458 CMR 2.00 was due to circumstances beyond the party's control.

Health Care Provider. An individual licensed by the state, commonwealth, or territory 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 the law of that state, commonwealth, or territory;
- (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 the law of that state, commonwealth or territory;
- (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.

Incapacity. An inability to perform the functions of one's position, or where the covered individual is a former employee, to perform the functions of one's most recent position or other suitable employment as that term is defined under M.G.L. c. 151A, § 25(c), due to the serious health condition, treatment therefor, or recovery therefrom.

2.02: continued

Inpatient Care. An overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity, or any subsequent treatment in connection with such inpatient care.

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. Intermittent leave shall be taken in increments consistent with the established policy of the employer or covered business entity uses to account for use of other forms of leave; provided, however, that the Department will not pay in increments of less than 15 minutes. A covered individual shall not be permitted to apply for payment for benefits associated with intermittent leave until they have eight hours of accumulated leave time, unless more than 30 calendar days has lapsed since the initial taking of such leave.

Job Protected Leave. The period of time described in 458 CMR 2.16(1), immediately following the first date on which an employee commences the taking of any type of leave that is associated with a qualifying reason, regardless of whether an application for benefits has been submitted to the Department in connection therewith or whether that leave is paid or unpaid. Employees who do not file an application for benefits with the Department, but use any other type of leave, including accrued paid leave or unpaid leave approved by an employer, leave under:

- (a) temporary disability policy or program of an employer;
- (b) paid family, or medical leave policy of an employer; or
- (c) an Extended Illness Leave Bank provided by an employer, and taken for a qualifying reason, will be entitled to job protected leave as of the date of commencing such leave and that leave will run concurrently with the leave period provided in M.G.L. c. 175M.

Medical Leave. Leave taken by a covered individual due to a serious health condition.

Medical Leave Benefits. Wage replacement paid pursuant to M.G.L. c. 175M, § 3, and provided in accordance with M.G.L. c. 175M, § 2, to a covered individual while the covered individual is on medical leave.

Municipality, District, Political Subdivision or its Instrumentality. Shall include municipal departments such as school departments, police departments, fire departments or public works departments.

Parent. The biological, adoptive, step- or foster-mother or father of the covered individual.

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

Private Plan Administrator. The third-party administrator of an employer's or covered business entity's private paid family and/or medical leave plan.

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.

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.

2.02: continued

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.

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 Massachusetts.

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.

Sibling. The biological, adoptive, step-brother or step-sister of a covered individual.

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

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).

Weekly Benefit Amount. The amount of wage replacement 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.

2.03: Covered Business Entities and Covered Contract Workers

A business or trade shall annually determine if it is a covered business entity by the following method:

- (1) The business or trade shall count the total number of self-employed individuals with whom the business or trade contracted for services during each pay period in the previous calendar year and was required to report the payment for such services on IRS Form 1099-MISC.
- (2) The business or trade shall then calculate its total workforce by adding the number of self-employed individuals counted in 458 CMR 2.03(1) to the total number of employees, including full time, part-time, and seasonal employees, that the business or trade employed during each pay period in the previous calendar year.
- (3) If the number calculated in 458 CMR 2.03(1) is greater than 50% of the number calculated in 458 CMR 2.03(2), then, for the following calendar year, the business or trade is a covered business entity, and the self-employed individuals who contract with the trade or business are covered contract workers.
- (4) Notwithstanding the requirements set forth in 458 CMR 2.03(1) through (3), self-employed individuals or covered contract workers properly classified in accordance with M.G.L. c. 151A, § 2 are not considered part of an employer's workforce.

2.04: Registration and Filing

(1) Registration. An employer, covered business entity, and any self-employed individual who elects coverage under 458 CMR 2.06 shall remit contributions owed under 458 CMR 2.05 through the Massachusetts Department of Revenue's MassTaxConnect system. Employers and covered business entities shall likewise file employment and wage detail reports through the MassTaxConnect system. Employers, covered business entities, and self-employed individuals who elect coverage and who do not have preexisting accounts on the MassTaxConnect system shall register and establish an account in order to make filings and remit contributions required under M.G.L. c. 175M, and 458 CMR 2.00.

(2) Quarterly Filing and Contribution Payment. Following the end of each calendar quarter, every employer and covered business entity and any self-employed individual who has elected coverage shall file an employment and wage detail report and payment for their contribution through the MassTaxConnect system on or before the quarterly filing deadline established by the Massachusetts Department of Revenue.

(a) The employment and wage detail report shall contain the following information for each employee, covered contract worker, and self-employed individual electing coverage:

1. name;
2. Social Security Number or individual taxpayer identification number; and
3. wages paid or other earnings.

(b) The report shall contain:

1. for each employer or covered business entity the federal employer identification number that such employer or covered business entity is required to include on a withholding tax return filed pursuant to M.G.L. c. 62B; and
2. for each self-employed individual who has elected coverage, the Social Security Number or Individual Taxpayer Identification Number of the self-employed individual.

(3) Covered Contract Workers. If an employer or covered business entity made payments to individuals for services during the calendar quarter that are required to be reported on IRS Form 1099-MISC, the employer must also report the names and Social Security numbers or Individual Taxpayer Identification numbers of those individuals, and the amounts of such payments made.

(4) Veracity/False Statements. Without limitation, any employer, covered business entity, or self-employed person electing coverage who makes a false statement or representation or willfully withholds a material fact with regard to any of the information required by 458 CMR 2.04, 458 CMR 2.00 generally, or M.G.L. c. 175M may be subject to penalties, including those under M.G.L. c. 62C, § 73.

2.05: Contributions

(1) Generally.

(a) Contributions are the payments made to the Family and Employment Security Trust Fund established in M.G.L. c. 175M, § 7 by an employer, a covered business entity, an employee, a covered contract worker, or a self-employed individual electing coverage.

(b) Beginning on October 1, 2019, the initial contribution rate shall be 0.75% of all wages or other qualifying earnings or payments, as limited by 258 CMR 2.05(1)(c) and (d). Annually, not later than October 1st, the Director shall set the contribution rate for the upcoming calendar year, as required by M.G.L. c. 175M, § 7(e).

(c) Contributions shall not be required for covered individuals' wages or other qualifying earnings or payments above the contribution and base limit established annually by the federal Social Security Administration for purposes of the Federal Old-age, Survivors, and Disability Insurance program limits pursuant to 42 U.S.C. 430.

(d) An employer or covered business entity with an average total workforce in Massachusetts of fewer than 25 persons, including employees and covered contract workers, as determined by the method specified in 458 CMR 2.05(2), shall not be required to pay the employer portion of premiums for family and medical leave, as defined in 458 CMR 2.05(5).

2.05: continued

(2) Average Total Workforce Count. An employer or covered business entity shall annually determine its workforce count based on the previous calendar year by counting the number of employees, including full time, part-time, and seasonal employees on the payroll during each pay period and dividing by the number of pay periods. If an employer or covered business entity contracted with individuals for services during any pay period and is required to report the payment to such individuals on IRS Form 1099-MISC, those covered contract workers must be included in the count for the pay period.

An employer or a covered business entity with an average total workforce that consists of more than 50% self-employed individuals for whom the employer is required to report payment for services on Internal Revenue Service form 1099-MISC shall count those self-employed individuals as covered contract workers for the purposes of determining the size of the employer's or covered business entity's average total workforce pursuant to 458 CMR 2.05(2).

(3) Required Remittance of Contributions. An employer or covered business entity shall be required to remit contributions for all employees and covered contract workers. Notwithstanding the foregoing, the Department may refund contributions paid by or on behalf of an employee, covered contract worker, or self-employed individual who has elected coverage, where the contribution remitted was greater than required under M.G.L. c. 175M, or 458 CMR 2.00, or both.

(4) Allocation of Contribution Rate between Family Leave and Medical Leave. The total contribution rate shall be allocated between the family leave contribution rate and the medical leave contribution rate. The rate allocation will be based on the Department's estimate of the anticipated costs of benefits and administration of the program. When the Department deems it necessary to do so, but no more than once a year, it may adjust the allocation of rates.

(5) Allocation of Contributions between Employers and Employees and Covered Contract Workers. In accordance with applicable laws and regulations, including the required notice under M.G.L. c. 175M, § 4(a), an employer or a covered business entity may deduct up to certain defined percentages of the required medical leave and family leave contributions directly from wages or other qualifying payments made to an employee or covered contract worker.

The employer's or covered business entity's portion of the contribution is that part of the full contribution amount not deducted from wages paid or other qualifying payments made to the employee or covered contract worker. The employer or covered business entity in all instances shall be responsible for paying and remitting the remainder of any required contribution not lawfully deducted from the employee or covered contract worker.

(a) Medical Leave Contribution. An employer or covered business entity may deduct from an employee's wages or from qualifying payments made to a covered contract worker up to 40% of the medical leave contribution required for that employee or covered contract worker.

(b) Family Leave Contribution. An employer or covered business entity may deduct from an employee's wages or from qualifying payments made to covered contract worker up to 100% of the family leave contribution required for that employee or covered contract worker.

(c) An employer or covered business entity shall not deduct a greater percentage of the medical leave and family leave contributions than the maximum authorized by M.G.L. c. 175M, § 6(e)(1) and (2). An employer or covered business entity that opts to deduct a lower percentage of medical or family leave contributions than the maximum allowable deductions specified in 458 CMR 2.05(5)(a) and (b) shall still be required to remit the full amount of contribution amount owed pursuant to 458 CMR 2.05(6).

(d) An employer or covered business entity may choose to deduct differing percentages from the wages or qualifying payments of different groups of covered individuals, but it shall not deduct more than the maximum percentages authorized by M.G.L. c. 175M, § 6(e)(1) and (2) from any employee or covered contract worker.

(6) Remitting Contributions. Based on the quarterly Employment and Wage Detail Report filed by an employer, covered business entity, or self-employed individual electing coverage, the Department will calculate the total quarterly contribution amount owed. Contributions owed must be remitted to the Department through the Massachusetts Department of Revenue's MassTaxConnect system on or before the quarterly filing deadlines established by the Massachusetts Department of Revenue.

2.05: continued

(7) Penalty. An employer or covered business entity who fails or refuses to make contributions as required in 458 CMR 2.05(6) shall be assessed an amount equal to its total annual payroll for employees and covered contract workers for each year or fraction thereof that it failed to comply multiplied by the then-current annual contribution rate required under M.G.L. c. 175M, § 6(a), in addition to the total amounts of benefits paid to covered individuals for whom it failed to make contributions. The Department may waive or modify any penalty or assessment imposed or due hereunder upon a showing of good cause.

An employer or covered business entity that failed to properly assess the allowable deduction from an employee or covered contract worker or is assessed a charge against payroll for failure to remit required contributions or that is required to repay the Trust Fund the cost of benefits paid to covered individuals for whom it failed to make contributions shall not recoup any assessment or cost of repayment through charges against employees or covered individual.

2.06: Optional Coverage for Self-employed Individuals or Employers Not Subject to M.G.L. c. 175M

(1) A self-employed individual may elect coverage under M.G.L. c. 175M and become a covered individual for an initial period of not less than three years.

(2) To elect coverage a self-employed individual shall, during a period designated by the Department, file a Self-employed Notice of Election with the Department through the Massachusetts Department of Revenue's MassTaxConnect system and thereafter register, file, and make contributions to the Family and Employment Security Trust Fund pursuant to 458 CMR 2.03, 2.04 and 2.06.

(3) The election shall be effective on the date the Self-employed Notice of Election is accepted by the Department, but a self-employed individual who elects coverage shall not be eligible to receive paid leave benefits until the individual has remitted the required contributions for at least two out of four completed calendar quarters.

(4) A self-employed individual who elects coverage shall be responsible for the full contribution amount, based on that individual's income from self-employment. If a self-employed individual elects coverage and thereafter fails to remit contributions owed for the required minimum period of three years, coverage shall be terminated. At the discretion of the Director, the self-employed individual may be disqualified from electing coverage thereafter as a self-employed individual, but shall not be precluded from obtaining coverage as an employee or covered contract worker. A self-employed individual who elects coverage and thereafter fails to remit contributions for at least three years shall not be disqualified from future coverage if the individual was not required to remit such contributions because the self-employment ended, or the individual moved away from Massachusetts.

(5) A self-employed individual who is required to be treated as a covered contract worker by a covered business entity to whom the self-employed individual provides services and whose payment for those services is subject to contributions pursuant to 458 CMR 2.05(3), may elect coverage and remit contributions on additional income from self-employment that is unrelated to services provided to a covered business entity.

(6) An employer may become a covered employer under M.G.L. c. 175M by submitting an Employer Notice of Election through an officer, director or principal of the employer in accordance with the filing requirements set forth in 458 CMR 2.04 and:

- (a) Electing coverage and remaining a covered employer for a minimum term of one year;
- (b) Complying with all audits or requests for information from the Department; and
- (c) Certifying that the employer shall provide the Department with not less than 60 calendar days notice before withdrawing its Notice of Election to be a covered employer.

The election shall be effective on the date the Covered Employer Notice of Election is submitted through the Massachusetts Department of Revenue's MassTaxConnect system and is accepted by the Department, but a covered employer that elects coverage shall not be eligible to receive paid leave benefits until the covered employer has remitted the required contributions for at least two out of four completed calendar quarters.

2.06: continued

A covered employer that has elected coverage pursuant to 458 CMR 2.06(6) and that has failed to remit contributions for more than two out of four completed calendar quarters shall be disqualified from coverage.

(7) For purposes of 458 CMR 2.00, reporting of the adoption of M.G.L. c. 175M, § 10 is completed by filing through the Federal Employer Identification Number(s) of the municipality, district, political subdivision or authority.

(8) Housing authorities, regional school districts and regional planning commissions which are not part of a municipality, district, political subdivision or its instrumentalities, may adopt the provisions of M.G.L. c. 175M § 10 through a vote of their governing bodies. Horace Mann Charter Schools' employees are considered municipal employees for the purposes of collective bargaining. Therefore, Horace Mann Charter Schools are subject to the decision of the municipal legislative body as to the adoption of M.G.L. c. 175M.

The Department will individually evaluate a request by any municipality, district, political subdivision or authority that does not fall within this definition.

2.07: Application for Exemption Due to Approved Private Plan

(1) Application. An employer or covered business entity may apply to the Department for an exemption from certain obligations under M.G.L. c. 175M by demonstrating that it offers paid family and/or medical leave benefits to covered individuals in its workforce through a private plan. An employer or covered business entity seeking an exemption must submit a Request for Exemption through the Massachusetts Department of Revenue's MassTaxConnect system. Employers and covered business entities seeking an exemption that do not have preexisting accounts on the MassTaxConnect system shall register and establish an account in order to request an exemption.

(a) Partial Exemptions.

1. An employer or covered business entity may apply for exemption from the requirement to make contributions for medical leave coverage, family leave coverage, or both.
2. An employer or covered business entity may not apply for an exemption on behalf of only a portion of its covered workforce. All employees and covered contract workers and former employees under M.G.L. c. 175M must be included in the employer's or covered business entity's private plan in order to be approved for an exemption.

(b) Exemption from Contributions and Filing Requirements.

1. If approved, the employer or covered business entity shall be exempt from the requirement to make contributions to the Trust Fund pursuant to M.G.L. c. 175M, § 6, and 458 CMR 2.05 for the approved leave type (family, medical, or both). An employer or covered business entity approved for one leave type only (either family or medical) must remit contributions owed under 458 CMR 2.05 for the leave type for which it has not been approved.
2. If approved, the employer or covered business entity shall be exempt from the filing requirements of 458 CMR 2.04 for the approved leave type (family, medical, or both.) An employer or covered business entity approved for one leave type only (either family or medical) must file a return under 458 CMR 2.04 for the leave type for which it has not been approved.

(c) Application Timing and Effective Date of Coverage.

1. Coverage under a private plan shall begin for all employees and covered contract workers no later than the first day of the first quarter immediately following the date of approval of the private plan exemption or on the date of hire of the employee or covered contract worker for private plans already approved. Employers or covered business entities that have been approved for a private plan exemption may require an employee or covered contract worker to provide verification of wages earned with an employer or covered business entity in the Commonwealth for purposes of determining whether that employee or covered contract worker meets the financial eligibility requirements of M.G.L. c. 175M, § 1.

2.07: continued

2. Applications for such exemptions will be accepted and reviewed by the Department on a rolling basis and will be effective no earlier than the quarter immediately following the date of approval. Exemptions from contributions will be effective for up to one year and may be renewed annually. The Department may establish a shorter or greater term of approval of the private plan when the Department deems it necessary. If the term of an approval of a private plan is reduced by the Department, the Department shall provide the employer with 60 calendar days notice prior to doing so. An employer or covered business entity offering paid family and medical leave benefits to its workforce through a private plan may submit an application for approval to the Department no more frequently than once per quarter.

(2) Requirements for Exemption. To be approved for an exemption from the requirement to remit contributions, an employer's or covered business entity's private plan must:

- (a) confer all the same or better benefits as those provided to employees and covered contract workers under M.G.L. c. 175M including, but not limited to, all of the requirements specified in M.G.L. c. 175M, § 11;
- (b) not cost employees and covered contract workers more than they would be charged to be eligible to receive paid leave benefits from the Trust Fund administered by the Department pursuant to M.G.L. c. 175M. Additionally, the employer's or covered business entity's policies concerning family or medical leave must provide equivalent or better rights and protections as those provided in M.G.L. c. 175M, including, for employers, the job- and benefit-protection provisions of M.G.L. c. 175M, § 2 and the non-retaliation provisions of M.G.L. c. 175M, § 9. The employer or covered business entity must certify to the Department that its private plan meets these requirements;
- (c) provide for an appeals process with the private plan administrator before a covered individual can exercise its right of appeal with the Department pursuant to 458 CMR 2.07(6)(a) and 458 CMR 2.14. This private plan appeals process shall not require the covered individual to submit an appeal less than ten calendar days from the receipt of notice of the determination. The private plan appeals process must extend the ten calendar-day filing period where an individual establishes to the satisfaction of the Department that circumstances beyond the individual's control prevented the filing of a request for an appeal within the prescribed ten-day filing period;
- (d) provide notice to the covered individual as part of any adverse determination under the private plan as to their rights under the private plan as well as the rights afforded the employee or covered contract worker pursuant to M.G.L. c. 175M, and 458 CMR 2.00; and
- (e) for purposes of determining the benefit amount and leave allotment under a private plan, the weekly benefit amount and leave allotment shall be based on the covered individual's average working week in addition to the wages or qualified earnings earned with the employer or covered business entity at the time of an application for benefits.

(3) If an employer's or covered business entity's plan is a paid family and/or medical leave plan issued by an insurance carrier, the forms of the policy must be issued by a Massachusetts licensed insurance company. The insurance carrier providing Massachusetts paid family or medical leave coverage must first submit its policy forms to the Massachusetts Division of Insurance. The Massachusetts Division of Insurance will review and acknowledge the policy form to have met the Department's requirements for the grant of a private plan exemption.

(4) If an employer's or covered business entity's plan is in the form of self-insurance, the employer or covered business entity must furnish to the Department a surety bond with the Commonwealth of Massachusetts as Obligee in such form as may be approved by the Department and in such amount as may be required by the Department. The surety company issuing the bond must be authorized to transact business in Massachusetts.

(5) Review. An employer or covered business entity that is denied an exemption from the requirement to remit contributions and that believes in good faith that its private plan meets or exceeds the requirements for exemption may request supplementary review by the Department. A request for review of a denied exemption is a form of discretionary relief and the determination of the Department is not subject to further administrative appeal.

- (a) Method. An employer or covered business entity must submit the review request electronically using the Massachusetts Department of Revenue's MassTaxConnect system.

2.07: continued

(b) Timing. An employer covered business entity must submit the review request on or before the last day of the quarter prior to the effective date of the request for an exemption.

(6) Retained Rights for Covered Individuals under Private Plans.

(a) A covered individual who is denied family or medical leave benefits by a private plan shall have a right to appeal the denial before the Department and in the district court as provided by 458 CMR 2.14(5), and M.G.L. c. 175M, § 8(d).

(b) An employee covered by a private plan approved under 458 CMR 2.07 shall retain all applicable rights under M.G.L. c. 175M, §§ 2(e) and (f) and under M.G.L. c. 175M, § 9.

(c) The private plan administrator and employer or covered business entity shall be required to furnish the Department all application for benefits documentation that is retained by the private plan administrator or employer within ten business days of the request by the Department in connection with an appeal of a denial of family or medical leave benefits by the employee or covered contract worker.

(d) Any determination by the Department in connection with the appeal of the denial of family or medical leave under the private plan shall be binding on the private plan administrator and employer or covered business entity.

(e) In the case of a covered individual covered solely under a private plan, the covered individual shall not be entitled to file an application for benefits with the Department.

(7) Audits, Withdrawal of Approval, and Penalties for Private Plans.

(a) The Department may audit any approved private plan maintained by an employer or covered business entity and may require periodic reporting to ensure that a private plan complies with the requirements of M.G.L. c. 175M, 458 CMR 2.00, or other state or federal law.

(b) Employers and covered business entities with approved private plans must retain all reports, information, and records related to the approved plan, including those related to all applications for benefits made under the plan, for three years, and must furnish same to the Department upon request.

(c) The Department may withdraw approval for a private plan when terms or conditions of the plan have been changed or violated. Causes for termination of plan approval shall include, but not be limited to the following:

1. failure to pay benefits;
2. failure to pay benefits timely and in a manner consistent with the public plan;
3. failure to maintain adequate bond coverage;
4. misuse of private plan trust funds;
5. adverse changes to the financial condition or licensure status of the employer or covered business entity, private plan insurer, or surety company responsible for a bond;
6. failure or refusal to respond to requests for information or to submit reports, records, or other information that may be required by the Department; or
7. failure to comply with M.G.L. c. 175M, 458 CMR 2.00, or other state or federal law applicable to the private plan.

(d) An employer or covered business entity, or private plan administrator must notify the Department in writing at least 30 calendar days before any proposed changes to the terms or conditions of an approved private plan.

(e) An employer or covered business entity that fails to maintain a private plan as approved by the Department or has its approval withdrawn by the Department pursuant 458 CMR 2.07(7)(c) may be subject to the following penalties:

1. Assessment of a penalty of up to an amount equal to its total annual payroll for employees and covered contract workers each year or fraction thereof that it failed to maintain said plan multiplied by the then-current annual contribution rate required under M.G.L. c. 175M, § 6(a). This amount may be subject to penalties under M.G.L. c. 62C and interest from the due date of the PFML return to the date the PFML contributions are paid at a rate prescribed by M.G.L. c. 62C, § 32.
2. The employer or covered business entity may be required to repay to the Trust Fund the total amount of benefits paid to covered individuals who received benefits from the Trust Fund.

2.07: continued

(f) The penalty prescribed in 458 CMR 2.07(7)(e)1. shall also apply to an employer or covered business entity that fails to maintain or renew a private plan approved by the Department for the future payment of leave benefits scheduled to begin on January 1, 2021, pursuant to 458 CMR 2.08(8). An employer or covered business entity who fails to maintain or renew a private plan exemption approved prior to January 1, 2021 shall be responsible for retroactive contributions to the Trust Fund.

(8) Private Plan Termination or Non-renewal and Intersection of State and Private Plans.

(a) Benefits and benefit eligibility under an approved private plan must be maintained for all covered individuals until the effective date of termination or nonrenewal of the approved private plan. An employer or covered business entity that does not intend to renew its approved private plan at the effective date of termination must notify covered individuals and the Department no later than 30 calendar days prior to the effective date of termination. The effective date of the termination of a private plan shall be on the first day of the first quarter immediately following the date of the termination or nonrenewal.

(b) An employer or covered business entity that does not renew an approved private plan must continue to provide paid leave benefits to covered individuals under the same terms and conditions of the private plan for the entire duration of the leave for requests for leave filed with the private plan administrator with a start date commencing prior to the effective date of termination or nonrenewal. In the case of intermittent leave, the private plan shall maintain coverage until the end of the employee or covered contract worker's benefit year. The Department shall continue to provide paid leave benefits to covered individuals for the entire leave duration for leave filed with the Department prior to the effective date of an employer transferring from the Trust Fund to a private plan exemption. Employers or covered business entities shall continue to provide paid leave benefits to covered individuals for the entire leave duration for leave filed under a private plan prior to the effective date of an employer transferring from a private plan exemption to the Trust Fund. Employers or covered business entities that renew a private plan with a new or different insurance carrier shall ensure that there are no gaps in coverage for covered individuals.

(c) Those covered individuals of an employer or covered business entity that does not renew an approved private plan shall be eligible to submit an application for benefits to the Department pursuant to 458 CMR 2.08 on the first day of the first quarter immediately following the date of termination or nonrenewal, subject to the conditions of 458 CMR 2.07(8)(b). The employer or covered business entity that terminates or nonrenews its private plan exemption will be required to report prior wages and qualified earnings to Massachusetts Department of Revenue pursuant to 458 CMR 2.04 and 2.05 for the four quarters immediately preceding the termination date of the exemption.

(d) An employer or covered business entity that dissolves or undergoes an acquisition or merger after the approval of an exemption and before the renewal period, shall notify the Department within 60 calendar days of the dissolution or acquisition or merger, or as soon as reasonably practicable, with sufficient documentation to allow the Department to determine, among other things, the effective date of the termination of the private plan, the listing of employees and covered contract workers that are affected, and the name and Federal Employer Identification Number of any acquiring or affiliate organization that will be assuming the employees and covered contract workers affected by the dissolution, acquisition or merger.

(e) For purposes of private plan exemptions, the following shall apply to applications for benefits submitted by former employees.

1. Covered individuals that have been separated from an employer or covered business entity for less than 26 weeks shall file applications for benefits as follows:

a. If the covered individual remains unemployed on the date that an application for benefits is filed, the covered individual shall submit an application for benefits with their former employer or covered business entity.

b. If the covered individual has become employed by a different employer or contracted with a covered business entity at the time that an application for benefits is filed, the covered individual shall submit an application for benefits with their current employer or covered business entity.

2.07: continued

If the new employer or covered business entity has a private plan exemption, the covered individual shall submit the application for benefits to the private plan in accordance with the requirements established by their employer or covered business entity. Employers or covered business entities that have been approved for a private plan exemption may require a covered individual to provide verification of wages earned with an employer or covered business entity in the Commonwealth for purposes of determining whether that covered individual meets the financial eligibility requirements of M.G.L. c. 175M, § 1.

c. If an individual submitting an application for benefits identifies themselves as a former employee, the Department or, if applicable, the employer or covered business entity that has been approved for an exemption, may inquire as to whether the individual is currently employed.

2.08: Application for Benefits Filed with the Department

(1) Process for Filing. A covered individual must file an application for benefits for family leave or medical leave benefits using forms prescribed by the Department. The individual may file an application for benefits with the Department no more than 60 calendar days before the anticipated start date of family or medical leave.

(2) Required Notice.

(a) An employee or covered contract worker shall give not less than 30 calendar days notice to their employer or covered business entity of the anticipated start date of family leave or medical leave pursuant to M.G.L. c. 175M, § 2. Notice shall be provided as soon as practicable if a delay is beyond the employee or covered contract worker's control.

(b) The Department will require an employee or covered contract worker to comply with the employer's or covered business entity's usual and customary notice and procedural requirements for leave, absent unusual circumstances. An employee or covered contract worker also may be required by an employer's or covered business entity's policy to contact a specific individual to report this information.

(c) Notice of an employee's or covered contract worker's need for family and medical leave must be made to the employer or covered business entity prior to an application to the Department for family or medical leave benefits. The Department will not accept an application for benefits, unless notice to the employer or covered business entity was made in accordance with 458 CMR 2.08(2)(a).

(d) Where an employee or covered contract worker does not comply with the notice requirement in 458 CMR 2.08(2)(a) or follow the employer's or covered business entity's usual notice and procedural requirements, and no unusual circumstances justify the failure to comply, protected leave and application for benefits may be delayed or denied by the Department.

(e) When planning medical treatment, the employee or covered contract worker must consult with the employer or covered business entity in advance of an application to the Department and make a reasonable effort to schedule the treatment so as not to disrupt unduly the employer's or covered business entity's operations, subject to the approval of the health care provider.

(f) If, for reasons beyond the covered individual's reasonable control, the individual cannot provide the Department with at least 30 calendar days notice then the individual shall provide notice as soon as is practicable. The Department shall notify a covered individual's employer or covered business entity, if applicable, not more than five business days after an application for benefits under M.G.L. c. 175M is filed, and shall facilitate the disclosure and exchange of relevant information or records regarding the application for benefits. The Department's notice to an employer or covered business entity shall contain:

1. the covered individual's full name and other identifying information;
2. the type of leave at issue;
3. the expected duration of the leave;
4. whether the request is for continuous or intermittent leave;
5. a certification as outlined in 458 CMR 2.08(5), supporting the need for a leave under M.G.L. c. 175M; and
6. any other information relevant to the application for benefits.

2.08: continued

(3) Consent. A covered individual filing an application for benefits must provide the Department with consent to share information regarding the application for benefits and other information necessary for the Department to process the individual's application for benefits, including consent to share information with the individual's employer or covered business entity (if any) and health care provider. Consent shall be acknowledged by the individual in a form provided by the Department. An application for benefits will not be processed, unless a consent is provided by the covered individual.

(4) Application for Benefits. When filed, an application for benefits will not be processed by the Department, unless the application for benefits includes all information necessary for the Department's review and processing including, but not limited to:

- (a) Identifying information, such as Social Security Number or Individual Taxpayer Identification Number;
- (b) The nature of the leave, whether family leave or medical leave;
- (c) The starting date and expected duration of the leave;
- (d) Whether the leave will be continuous or intermittent;
- (e) For employees and covered contract workers:
 - 1. Employer or covered business entity name and identification number (which is included on the notice the employer or covered business entity is required to provide to employees and covered contract workers);
 - 2. Evidence that notice was provided to the employer or covered business entity in advance of the application for benefits, including the date notice was provided to the employer or covered business entity; and
 - 3. Any denied, granted, or pending requests for leave for a qualifying reason from the employer during the last 12 months;
- (f) An attestation regarding the family relationship in the form specified by the Department if the leave involves an application for benefits for family leave benefits or an application for benefits relating to active duty military service by a family member;
- (g) Completed certification as required in 458 CMR 2.08(5);

Additional specific information requested by the Department where reasonably necessary to review and process an individual's application for benefits including, but not limited to, whether the covered individual will be receiving any other wage replacement as set forth in 458 CMR 2.12(6);

(h) If an application for benefits is filed with the Department or is filed but does not include all required information and more than 90 calendar days have passed since the start of the individual's period of leave, the covered individual may receive reduced benefits in the discretion of the Director.

(5) Certifications. All applications for benefits shall be supported by a certification evidencing that the leave is for a qualifying reason.

(a) Medical Leave Benefits. The certification must be from a health care provider and must include:

- 1. a statement that the covered individual has a serious health condition;
- 2. the date on which the serious health condition commenced;
- 3. the probable duration of the serious health condition;
- 4. other information required by the Department, including a certification by the health care provider that the individual is incapacitated from work due to the serious health condition; and
- 5. where the application for benefits is for leave on an intermittent or reduced leave schedule, information regarding the need for intermittent leave, including a statement that such leave or schedule is medically necessary.

In the event that a serious health condition of the covered individual prevents the covered individual from providing the required certification within 90 calendar days of the start of the leave, the Department will allow for a good cause exemption to permit delayed benefits under 458 CMR 2.08(4)(i).

(b) Family Leave Benefits to Care for a Family Member with a Serious Health Condition. The certification must contain a statement in a form prescribed by the Department confirming the relationship between the covered individual and the family member and must include the following from the covered individual or the family member's health care provider:

- 1. the name and address of the family member and the relationship to the covered individual;

2.08: continued

2. a statement that the family member has a serious health condition;
3. the date on which the family member's serious health condition commenced;
4. the probable duration of the family member's serious health condition;
5. a statement that the covered individual is needed to care for the family member;
6. an estimate regarding the frequency and the anticipated duration of time that the covered individual is needed to care for the family member; and
7. information from the covered individual that proves to the satisfaction of the Department the identity of the family member.

(c) Family Leave Benefits for the Birth of a Child. The certification must include:

1. the child's birth certificate;
2. a statement from the child's health care provider stating the child's birth date; or
3. a statement from the health care provider of the person who gave birth stating the child's birth date.

The leave period for which benefits are requested may only include dates within 12 months of the child's birth date. In the case of multiple births, no more than 12 weeks of leave benefits total are available in a benefit year for this purpose.

(d) Family Leave for the Placement of Child for Adoption or Foster Care. The certificate must be from the child's health care provider or from an adoption or foster care agency involved in the placement or the Massachusetts Department of Children and Families and must confirm both the placement and the date of the placement. The leave period for which benefits are requested must be for dates within 12 months of the placement date.

To the extent that the status of a covered individual as an adoptive or foster parent changes while an application for benefits is pending or while the covered individual is receiving benefits, the covered individual shall provide written notice to the Department within five business days of such change in status. The Massachusetts Department of Children and Families may confirm in writing the status of the covered individual as an adoptive or foster parent while an application for benefits is pending or while a covered individual is receiving benefits.

(e) Family Leave Benefits for a qualifying exigency arising out of the fact that 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. The certification must include:

1. a copy of the family member's active duty orders; or
2. a letter of Impending Activation from the family member's Commanding Officer; or
3. other documentation reasonably acceptable to the Department in circumstances where, for good cause shown, the applicant is unable to produce the documentation specified in 458 CMR 2.08(5)(e)1. or 2.;
4. a statement of the family relationship between the service member and the family member requesting benefits in a form prescribed by the Department;
5. information from the covered individual that proves to the satisfaction of the Department the identity of the family member;
6. the name and address of the family member being cared for;
7. the dates or period of time for which leave is requested; and
8. the underlying reason for the exigency leave.

(f) Family Leave Benefits to Care for a Family Member Who Is a Covered Service Member. The certification from the covered individual or the service member's health care provider must include:

1. the date on which the covered service member's serious health condition commenced;
2. the probable duration of the condition;
3. a statement that the covered individual is needed to care for the family member;
4. an estimate of the amount of time the covered individual will be needed to care for the family member;
5. an attestation by the service member's health care provider and the covered individual that the health condition is connected to the service member's military service;
6. a statement of the family relationship between the service member and the family member requesting benefits in a form prescribed by the Department; and
7. information from the covered individual that proves to the satisfaction of the Department the identity of the family member;
8. The name and address of the family member being cared for; and
9. other information or documentation that may be required by the Department.

2.08: continued

(g) Where it determines that a certification lacks required information, or is not accurate or authentic, or is otherwise insufficient, the Department may contact the health care provider and require that it verify, supplement, or otherwise amend the information in the certification.

(6) Information from Employer or Covered Business Entity. Following notice given under 458 CMR 2.08(2), the Department will request from the employer or covered business entity information supporting whether the employee's or covered contract worker's request for medical or family leave has been approved, denied or is pending upon the receipt of additional information.

Upon request, an employer or covered business entity shall within ten business days provide to the Department information or records relevant to an application for benefits made by a covered individual, including with respect to the covered individual the following:

- (a) Wage and/or earnings information for the past 12 months;
- (b) A description of the employee's or covered contract worker's position;
- (c) Whether the employee or covered contract worker currently works a full- or part-time schedule;
- (d) Weekly hours worked;
- (e) Prior requests/approvals for a qualifying reason;
- (f) Amount of paid leave already taken for a qualifying reason during the current benefit year;
- (g) A description of the employer's or covered business entity's own paid leave policies and whether the employee or covered contract worker has received paid or unpaid leave during the last 12 months under any plan or practice of the employer or covered business entity, and whether the employee or covered contract worker will receive any paid leave benefits from the employer or covered business entity during the requested leave period at issue;
- (h) Whether the covered individual has applied for concurrent FMLA or other leave and whether the employer or covered business entity has approved the application;
- (i) Whether the covered individual will be receiving any other wage replacement benefits as set forth in 458 CMR 2.12(6); and
- (j) Any other relevant information or records related to the claim, including any evidence of a potentially fraudulent claim.

(7) Processing of Applications. The time standards for the Department's processing of a complete application for paid leave benefits are as follows:

- (a) Within 14 calendar days of receiving an application under M.G.L. c. 175M, the Department shall notify applicants for benefits of its approval or denial of applications for paid leave benefits, or of the need for additional information from the covered individual or the employer or covered business entity. A request from the Department for additional information necessary to process an application for paid leave benefits shall satisfy the Department's obligation to timely notify applicants under M.G.L. c. 175M, § 8(b), if such request is made within 14 calendar days of its receipt of the complete application for benefits.
- (b) The Department shall commence payment of leave benefits not less than 14 calendar days after approving a complete application, unless that determination occurs more than 14 calendar days before the onset of eligibility, in which case the Department shall commence payment of leave benefits as soon as eligibility begins.

(8) Leave Allotments.

- (a) Beginning January 1, 2021, covered individuals shall be eligible for up to 26 total weeks, in the aggregate, of family and medical leave under M.G.L. c. 175M in a benefit year.
- (b) Beginning January 1, 2021, covered individuals shall be eligible for up to 12 weeks of family leave in a benefit year:
 - 1. for the birth, adoption, or foster care placement of a child; or
 - 2. due to a qualifying exigency arising out of the fact that a family member is on active duty or has been notified of an impending call to active duty in the Armed Forces.
- (c) Beginning January 1, 2021, covered individuals shall be eligible for up to 26 weeks of family leave in a benefit year in order to care for a family member who is a covered servicemember.
- (d) Beginning January 1, 2021, covered individuals shall be eligible for up to 20 weeks of medical leave in a benefit year if they have a serious health condition that incapacitates them from work.

2.08: continued

(e) Beginning July 1, 2021, covered individuals shall be eligible for up to 12 weeks of family leave to care for a family member with a serious health condition.

(f) Leave allotments are based on the number or hours or days a covered individual works. When a covered individual works a part-time schedule or variable hours, the amount of leave that a covered individual uses is determined on a *pro rata* or proportional basis. If a covered individual's schedule varies from week to week to such an extent that an employer or covered business entity is unable to determine with certainty how many hours the covered individual would otherwise have worked (but for taking leave as authorized by M.G.L. c. 175M), a weekly average of the hours scheduled over the 12 months prior to the beginning of the leave period will be used for calculating the leave entitlement.

(9) Consistent with the notice requirements set forth in 458 CMR 2.08(2)(b), the Department may allow an employer, covered business entity, or its designee to submit an application for benefits on behalf of a covered individual. In order to do so, employers, covered business entities, or leave administrators must be approved by the Department and agree to adhere to all of the requirements prescribed in 458 CMR 2.08, including the timelines set forth in 458 CMR 2.08(7).

(10) Leave for Substance Use Disorder.

(a) A Substance Use Disorder may be a serious health condition. Family or medical leave may only be taken for treatment for substance use disorder by a health care provider, by a provider of health care services on referral by a health care provider or by a program licensed or approved by the Massachusetts Department of Public Health. An absence because of the employee's use of the substance, rather than for treatment, does not qualify for leave.

(b) Treatment for substance use disorder does not prevent an employer from taking employment action against an employee. The employer may not take action against the employee because the employee has exercised his or her right to take leave for treatment. However, if the employer has an established policy, applied in nondiscriminatory manner that has been communicated to all employees, that provides under certain circumstances an employee may be terminated for substance use, pursuant to that policy, the employee may be terminated whether or not they are presently taking leave. An employee may also take leave to care for a covered family member who is receiving treatment for substance use disorder. The employer may not take action against an employee who is providing care for a covered family member receiving treatment for substance use disorder because the employee has exercised his or her right to take leave.

2.09: Determinations by the Department

(1) Except as limited by 458 CMR 2.12, the Department may approve a paid leave benefit for a qualifying reason for a period of family or medical leave stated in 458 CMR 2.08(8)(a) through (f).

(2) Application for Benefits Determination. The Department shall consider the following when making a determination on an application for benefits:

- (a) confirmation that the covered individual provided the required notice pursuant to 458 CMR 2.08(2)(a);
- (b) the financial eligibility test described in 458 CMR 2.02;
- (c) certification, as required by M.G.L. c. 175M, § 5, including a certification by a health care provider, supporting the necessity for leave;
- (d) whether the covered individual's request for family or medical leave associated with the application for benefits was approved or denied by the employer or covered business entity and the reason(s) for the approval or denial;
- (e) whether the covered individual has actually taken or plans to take the leave associated with the application for benefits; and
- (f) any other relevant information deemed necessary by the Director.

(3) The Department shall provide contemporaneous notice to the covered individual and to the employer or covered business entity, if any.

2.09: continued

- (4) The approval for payment of benefits notice shall include:
 - (a) The reason for the approved leave benefits;
 - (b) The duration of the approved leave benefits;
 - (c) For intermittent leaves, the frequency and duration of the leave benefits;
 - (d) The expiration of the approved leave benefits; and
 - (e) The weekly benefit amount.
- (5) A denial of payment of benefits notice shall include:
 - (a) The reason for the denial of leave benefits; and
 - (b) A description of the individual's appeal rights under 458 CMR 2.14.
- (6) Where the Department finds that a covered individual has failed to provide the Department with notice of a relevant change in circumstances which would have reduced the amount of benefits paid, the covered individual shall be responsible to reimburse the Department the amount overpaid within 30 calendar days of a request made by the Department.

2.10: Application for Benefits Verification, Amendment or Extension of Leave Period and Paid Leave Benefits

- (1) Application for Benefits Verification. For each request for payment associated with intermittent leave, the covered individual must verify with the Department the hours of leave taken each week in order to receive benefit payments.
- (2) Amendment of Benefits. Following an approval of an application for benefits, if there is a change in relevant circumstances that would justify an extension, reduction, or other modification of the period of leave or the amount of benefits, the covered individual and the employer or covered business entity, if any, shall have an affirmative obligation to notify the Department within seven calendar days of said change using the forms prescribed by the Department.
- (3) The Department shall provide contemporaneous notice to the individual and to the employer of any report of a change in relevant circumstance including, but not limited to, the date on which the change occurred.
- (4) Extension of Benefits. If a covered individual seeks an extension of benefits, the covered individual must file an application to request an extension using forms prescribed by the Department.
 - (a) A request for an extension must be filed 14 calendar days prior to the expiration of the original approved leave; provided, however, that the Director may allow a late filed request for extension for good cause shown.
 - (b) A request for an extension must include all information required by the Department, including the following:
 - 1. the reason for the extension;
 - 2. the requested duration of the extended leave;
 - 3. the date on which the covered individual provided notice for the request for extension to the employer (if applicable); and
 - 4. a newly completed or updated health care certification for individual or family leave that otherwise satisfies the requirements of 458 CMR 2.08(5).
 - (c) The Department shall notify an employer or covered business entity of a request for an extension not more than five business days following its receipt of a completed request form. The Department shall provide to the employer or covered business entity:
 - 1. the requested duration for the extension;
 - 2. whether the newly requested leave is continuous or intermittent;
 - 3. any additional certification from a health care provider; and
 - 4. any other information or record the Department deems relevant to verifying and otherwise processing the application for benefits.
 - (d) The covered business entity or employer shall, within ten business days from the date of the notice, provide to the Department all relevant information or records requested by the Department, which may include the following:

2.10: continued

1. Whether the covered individual will receive any paid leave benefits from the employer or covered business entity during the requested extended leave period at issue;
 2. Whether the employer or covered business entity has approved or intends to approve the request for extension under the Family and Medical Leave Act of 1993 (29 U.S.C. 2601), or any other policy of the employer or covered business entity allowing for paid or unpaid leave; and
 3. Any other relevant information or records related to the request for extension including, but not limited to, evidence of a fraudulent application for benefits.
- (e) The initial seven-calendar day waiting period for benefits, referenced in 458 CMR 2.12(7), shall not apply to an approved extension of benefits.
- (f) Any extension of an application for benefits shall be limited to any period of paid family or medical leave the employee remains eligible for in the benefit year pursuant to 458 CMR 2.10.
- (g) Applications for requests for extensions shall be deemed complete at the time the information required under 458 CMR 2.10(4)(b) has been received by the Department or the expiration of ten business days after the Department requests the information under 458 CMR 2.10(4)(c) from the employer or covered business entity, whichever is sooner, and is subject to the application for benefits approval process in 458 CMR 2.09.
- (h) The Department shall provide contemporaneous notice to the covered individual and to the employer or covered business entity, if any, of the Department's approval or denial of the extension request.
- (i) A covered individual must apply for and be eligible for benefits in any subsequent benefit year.
- (j) An employer or covered business entity may seek a medical recertification of the employee or covered contract worker's serious health condition following the expiration of the initial period of incapacity cited in the healthcare certification or where an intermittent leave has extended for a period of more than six months from the approval by the Department, whichever occurs first.

2.11: Fitness for Duty at Close of Medical Leave Period

- (1) As a condition of restoring an employee or covered contract worker whose leave was occasioned by their own serious health condition, an employer or covered business entity may have a uniformly-applied policy or practice that requires all similarly-situated employees or covered contract workers who take leave for such conditions to obtain and present certification from their health care provider that the employee or covered contract worker is able to resume work.
- (2) An employer or covered business entity may seek a fitness-for-duty certification only with regard to the particular health condition that caused the employee or covered contract worker's need for leave. The certification from the health care provider must certify that the employee or covered contract worker is able to resume work. Additionally, an employer may require that the certification specifically address the employee or covered contract worker's ability to perform the essential functions of their job. In order to require such a certification, an employer or covered business entity must provide an employee or covered contract worker with a list of the essential functions of their job within ten business days of the notice to the employer or covered business entity of the approval of leave by the Department and must indicate that the certification must address the employee or covered contract worker's ability to perform those essential functions. If the employer or covered business entity satisfies these requirements, the employee or covered contract worker's health care provider must certify that the employee or covered contract worker can perform the identified essential functions of their job.
- (3) An employer or covered business entity may delay restoration to employment until an employee or covered contract worker submits a required fitness-for-duty certification, unless the employer or covered business entity has failed to provide the notice required 458 CMR 2.11(2). If an employer or covered business entity provides the notice required, an employee or covered contract worker who does not provide a fitness-for-duty certification following the approved leave period by the Department is no longer entitled to reinstatement. In furtherance of the foregoing, an employee or covered contract worker who does not provide a fitness-for-duty certification following the approved leave period by the Department shall not be entitled to an extension of benefits, unless said extension would comply with the requirements of 458 CMR 2.10(2).

2.11: continued

(4) An employer or covered business entity is not entitled to a certification of fitness to return to duty for each absence taken on an intermittent or reduced leave schedule. An employer or covered business entity is entitled to a certification of fitness to return to duty for such absences up to once every 30 calendar days if reasonable safety concerns exist regarding the employee or covered contract worker's ability to perform their duties, based on the serious health condition for which they took leave.

2.12: Weekly Benefit Amount from the Department

(1) The weekly benefit amount for covered individuals on family or medical leave is calculated on the individual's average weekly wage at the time of the filing of a request for leave in 458 CMR 2.08, which is determined by the individual's earnings in the base period as reported to the Massachusetts Department of Revenue pursuant to 458 CMR 2.04 and 2.05. The weekly benefit amount shall not change during the term of the approved leave period subject to a pro-rated or reduced benefit amount as described in 458 CMR 2.12(5) and (6).

(2) Calculation. Subject to the limitations described in 458 CMR 2.12(2) through (6), a covered individual's weekly benefit amount shall be calculated for a family or medical leave from an individual employer or covered business entity as follows:

- (a) The portion of an 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
- (b) The portion of an individual's average weekly wage that is more than 50% of the state average weekly wage shall be replaced at a rate of 50%.

(3) Eligible Wages or Income. For purposes of calculating the weekly benefit amount, a covered individual's average weekly wage shall include only those wages or qualifying earnings subject to the contribution requirements of 458 CMR 2.05, and M.G.L. c. 175M, § 6.

(4) Maximum. The maximum weekly benefit amount approved by the Department for any individual covered under the Trust Fund shall be 64% of the state average weekly wage. A covered individual with multiple employers or covered business entities is not required to take paid family or medical leave from each employer or covered business entity during a single period of paid family or medical leave. Annually, not later than October 1st of each year, the Department shall establish a maximum weekly benefit amount at a level that is 64% of the then-applicable state average weekly wage. The adjusted maximum weekly benefit amount shall take effect on January 1st of the year following such calculation.

(5) Prorated Benefit. For a covered individual who takes leave on an intermittent or reduced leave schedule, the weekly benefit amount calculated pursuant to 458 CMR 2.12, shall be reduced in direct proportion to the intermittent or reduced leave schedule.

(6) Reductions. The weekly benefit amount for a period shall be reduced by the amount of wages, wage replacement, or leave 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 application for benefits;
- (b) under other state or federal temporary or permanent disability benefits law;
- (c) a permanent disability policy or program of an employer or covered business entity; or
- (d) 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:
 - 1. a temporary disability policy or program of the employer or covered business entity;
 - 2. a paid family or medical leave policy of the employer or covered business entity; or
 - 3. any wages received from another employer or covered business entity or through self-employment.

2.12: continued

(e) a covered individual's family or medical leave allotment under 458 CMR 2.08(8) shall be proportionately reduced by the amount of family or medical leave taken by the covered individual for any qualifying reason during the benefit year.

(f) the weekly benefit amount shall be reduced by any paid family or medical leave that a covered individual on family or medical leave receives from any source for any qualifying reason in the 12-month period prior to filing an application for benefits. However, any leave taken by the covered individual for the same qualifying reason prior to January 1, 2021, shall not count against the covered individual's weekly benefit amount and/or leave allotment.

(7) Initial Seven-day Wait Period. No family or medical leave benefits are payable during the first seven calendar days after the date on which job protected leave begins. The initial seven-day wait period for paid leave benefits will count against the total available period of leave in a benefit year. Where the approved application for benefits involves leave on an intermittent or reduced leave schedule, the wait period shall be seven consecutive calendar days from the date of the first instance of leave from the employer, not the aggregate accumulation of seven days of leave. There shall be an initial seven-day wait period for each application for benefits, with the exception of medical leave during pregnancy or recovery from childbirth if supported by documentation by a health care provider that this medical leave is immediately followed by family leave, in which case the seven-day wait period for family leave shall not be required.

(8) Substitution of Employer-provided Paid Leave.

(a) Covered individuals who use accrued paid leave or leave through an extended illness leave bank program provided by their employer or covered business entity rather than receive a paid benefit under M.G.L. c. 175M shall not receive any paid leave benefits pursuant to M.G.L. c. 175M for a period of time for which they received accrued paid time or leave through an extended illness leave program from their employer or covered business entity and the accrued paid leave or leave from an extended illness leave program provided by an employer or covered business entity shall run concurrently with any available leave under M.G.L. c. 175M.

(b) Covered individuals who choose to use accrued leave paid by the employer or covered business entity are required to follow the employer's or covered business entity's notice and certification processes related to the use of this leave.

(c) Employers and covered business entities are required to inform employees or covered contract workers who choose to use accrued leave paid or leave from an extended illness leave program provided by the employer or covered business entity that the use of these leave accruals or leave from an extended illness leave program will run concurrently with the leave period provided in M.G.L. c. 175M.

(d) Upon request from the Department, employers and covered business entities, if any, shall report the use of accrued leave by covered individuals for this purpose.

(9) Employer Reimbursement. An employer or covered business entity that makes payments to a covered individual during a period of family or medical leave that are equal to or greater than the amount required under 458 CMR 2.12(2) through (6) shall be reimbursed out of any benefits due to the covered individual or to become due from the Trust Fund by the Department. Reimbursement shall not be permitted for an employer or covered business entity that has received an approved exemption pursuant to 458 CMR 2.07.

To qualify for reimbursement from the Department an employer or covered business entity must make payments from:

- (a) temporary disability policy or program of an employer or covered business entity;
- (b) paid family, or medical leave policy of an employer or covered business entity; or
- (c) extended illness leave bank.

The policy or program or extended illness leave bank must be granted to a covered individual for a qualifying reason under M.G.L. c. 175M, that is separate from and in addition to any accrued paid leave that is made available to the covered individual. Employers and covered business entities will not be eligible for reimbursement from the Department for payments to a covered individual where the covered individual has elected to utilize accrued paid leave whether it is in *lieu* of applying for benefits to the Department or supplementary to a temporary disability policy or program of an employer or covered business entity; or paid family, or medical leave policy of an employer or covered business entity. In order to be eligible for any reimbursement under 458 CMR 2.12(9), employers and covered business entities will be required to produce evidence that payments to covered individuals for a qualifying reason were consistent with the requirements set forth in 458 CMR 2.00, and M.G.L. c. 175M.

2.12: continued

In no event shall the Department reimburse an employer or covered business entity where the covered individual has received a benefit from the Trust Fund for the same period of time.

2.13: Intermittent Leave and Reduced Leave Schedules

(1) Generally. A covered individual may take family or medical leave on an intermittent or reduced leave schedule, as follows:

(a) For family leave to bond with a child during the first 12 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 or covered business entity and employee or covered contract worker mutually agree.

(b) For family leave to care for a family member's serious health condition, to care for a family member who is a covered service member, leave may be taken on an intermittent or reduced leave schedule if the health care provider determines it is medically necessary.

(c) 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, leave may be taken on an intermittent or reduced leave schedule.

(d) For medical leave due to a covered individual's own serious health condition, intermittent leave may be taken if medically necessary. An employee or covered contract worker shall advise the employer or covered business entity, upon request, of the reasons why the intermittent/reduced leave schedule is necessary and of the schedule for treatment, if applicable. The employee or covered contract worker and employer or covered business entity shall attempt to work out a schedule for such leave that meets the individual's needs without unduly disrupting the employer or covered business entity's operations, subject to the approval of the health care provider.

(e) Self-employed individuals who have elected coverage and former employees may take leave intermittently or on a reduced leave schedule.

(2) Agreed-to Intermittent or Reduced Leave Schedules. An employee or covered contract worker who is approved for and takes leave on an intermittent or reduced leave schedule and who fails to work during the times or on the schedule agreed to with the employer may be subject to employer discipline. An employer shall notify the Department when an employee approved for intermittent leave fails to adhere to the agreed-upon intermittent or reduced leave schedule. In the event that an employee's utilization of intermittent leave is inconsistent with the Department's approval, it shall not be considered retaliation under 458 CMR 2.16(2) for an employer to request additional information related to the use of leave.

An employer or covered business entity shall furnish the Department with wages or qualified earnings paid to a covered individual on a monthly basis or at other intervals deemed necessary in the discretion of the Department. The Department may seek a refund from the covered individual or offset any future benefit payments where the Department has determined that the covered individual has received wages or qualifying payments from both the employer or covered business entity and benefits from the Trust Fund for the same period.

(3) Impact on Leave Allotments. Taking leave intermittently or on a reduced leave schedule pursuant to 458 CMR 2.13, and M.G.L. c. 175M, §§ 2(c)(2)(A) and (B) shall result in a proportionate reduction in the covered individual's available allotment of leave.

For example, if an employee who would otherwise work 40 hours per week takes eight hours of intermittent leave in a week, that leave would count as $\frac{1}{5}$ of a week of leave. If an employee who would otherwise work 30 hours per week only works 20 hours on a reduced leave schedule, the ten hours of leave would constitute $\frac{1}{3}$ of a week of leave to be counted against the available allotment of leave.

(4) In the event that a covered individual's work schedule varies from week to week, the maximum weekly benefit amount shall be calculated based on the average number of hours worked from the two highest quarters of the 12 months preceding such individual's application for benefits under M.G.L. c. 175M. A covered individual shall not be eligible for benefits in excess of the number of hours so determined by the Department. For purposes of intermittent leave, benefits may be prorated on an hourly basis utilizing the average number of hours worked during the 12 months preceding such individual's application for benefits under M.G.L. c. 175M.

2.13: continued

(5) Weekly Benefit Adjustment. As described in 458 CMR 2.12(5), a covered individual who takes leave on an intermittent or reduced schedule shall receive a weekly benefit amount that is reduced in direct proportion to the intermittent or reduced leave schedule.

(6) The benefit year for a covered individual who received benefits for an intermittent leave will commence, following an approval by the Department for continued benefits, on the Sunday immediately preceding the first absence following the exhaustion of the prior benefit year.

2.14: Application for Benefits Denials and Appeals

(1) The Department will provide contemporaneous notice to the individual and the employers or covered business entities (where applicable) of the approval or denial of an application for benefits.

(2) A covered individual may appeal a denial of family or medical leave benefits to the Department. A covered individual who is denied family or medical leave benefits by a private plan maintained by an employer or covered business entity pursuant to 458 CMR 2.07(6)(a), shall be subject to appeal pursuant to 458 CMR 2.14, and M.G.L. c. 175M, § 8(d).

(3) Filing Deadline and Late Appeals. A covered individual's request for an appeal shall be filed within ten calendar days of receipt of notice of the determination. The Department may extend the ten-day filing period where an individual establishes to the satisfaction of the Department that circumstances beyond the individual's control prevented the filing of a request for an appeal within the prescribed ten-day filing period. When the appeal is requested by a covered individual subject to an approved private plan, the covered individual requesting the appeal shall also provide a complete copy of the request to the employer or covered business entity that maintains the approved private plan.

(4) When requesting an appeal, a covered individual may request a hearing. A covered individual may agree to a disposition of the matter on the record without a hearing or may submit documents or evidence without appearing at a hearing. The conduct of a hearing regarding an appeal of a denial of benefits shall be in accordance with the procedures prescribed by M.G.L. c. 30A, and 801 CMR 1.02: *Informal/Fair Hearing Rules*. The Department will issue a final decision affirming, modifying, or revoking the initial determination within 30 calendar days of the hearing.

(5) Following the Department's issuance of a final decision on the appeal, an individual aggrieved by the Department's decision may take a further appeal by filing a complaint in the district court for the county in Massachusetts where the individual resides or was last employed. Such court action must be commenced within 30 calendar days of the date the Department's final decision is received by the individual.

(6) When a notice of a determination or a decision by the Department is transmitted by means of an electronic communication, it shall be presumed received on the date it is sent, except that any notice transmitted after 5:00 P.M. or on a state or federal holiday, Saturday, or Sunday, shall be presumed received on the next business day. When notice of a determination or a decision is sent by regular mail, it shall be presumed received three calendar days after it is mailed, except that if the third day falls on a state or federal holiday, Saturday, or Sunday, the notice shall be presumed received on the next business day. However the notice is transmitted, the presumption may be rebutted by substantial and credible evidence satisfactory to the Department that the notice was actually received on an earlier or later date. A request for an appeal shall be deemed filed on the postmark date if sent by regular mail and otherwise when actually received by the Department. A request received after 5:00 P.M. shall be deemed filed on the next business day.

2.15: Attestations and False Statements

Individuals applying for benefits or seeking to amend or extend an approved application for benefits shall attest to the truthfulness of all statements and submissions made to the Department. An individual shall not be eligible to receive family or medical leave benefits if the Department finds by a preponderance of the evidence that the individual willfully made a false statement or representation or willfully withheld a material fact in order to obtain benefits.

In determining whether an individual willfully made false statements, the Department will consider the nature and cause of the false statement and the capacity of the particular individual to recognize the error resulting in the false statement. Factors considered shall include the individual's age and intelligence as well as any physical, mental, educational, or linguistic limitation, including lack of facility with the English language. A good faith mistake of fact by the individual in the filing of an application for benefits does not constitute willfulness. A false statement shall be considered willful if the individual:

- (1) furnishes information that the individual knew, or reasonably should have known, to be incorrect;
- (2) fails to furnish information that the individual knew or reasonably should have known to be material; or
- (3) accepts a payment that the individual knew, or reasonably should have known that the individual was not entitled to receive.

If the Department finds that an individual received benefits on the basis of a false statement, it may require the individual to repay to the Trust Fund any benefits received. Employees who have been determined to have received benefits on the basis of a false statement shall not receive the protections and benefits of 458 CMR 2.16(1) through (3).

2.16: Employee Job Protection, Prohibition on Retaliation, Maintenance of Health Insurance

(1) Job Protection. An employee who has taken family or medical leave under M.G.L. c. 175M shall on returning to employment at the close of a period of approved family or medical leave be restored to the employee's previous position or to an equivalent position with the same status, pay, employment benefits, length-of-service credit and seniority as of the date of leave. An employer shall not be required to restore an employee who has taken family or medical leave under M.G.L. c. 175M to the previous or to an equivalent position if other employees of equal length of service credit and status in the same or equivalent positions have been laid off due to economic conditions or other changes in operating conditions affecting employment during the period of leave; provided, however, that the employee who has taken leave shall retain any preferential consideration for another position to which the employee was entitled as of the date of leave. Nor shall an employer be required to restore an employee who was hired for a specific term or only to perform work on a discrete project, if the employment term or project is over and the employer would not otherwise have continued to employ the employee.

Upon reinstatement, taking family or medical leave under M.G.L. c. 175M shall not affect an employee's previously held right to accrue vacation time, sick leave, bonuses, advancement, seniority, length-of-service credit or other employment benefits, plans or programs. Leave periods under M.G.L. c. 175M need not be treated as credited service for purposes of benefit accrual, vesting and eligibility to participate.

(2) Maintenance of Health Insurance. During the duration of an employee's family or medical leave, the employer shall continue to provide for, contribute to, or otherwise maintain the employee's employment-related health insurance benefits, if any, at the level and under the conditions that coverage would have been provided if the employee had continued working continuously for the duration of such leave. The provision "otherwise maintain" shall be interpreted broadly to encompass any method of benefit maintenance or approximation of benefits that permits an employee taking family or medical leave to maintain access to health coverage for the duration of the leave on the same or equivalent terms, including the employee's costs for such coverage, such as premium contributions, co-pays, and deductibles. Employers may "otherwise maintain" coverage in a variety of ways to comply with this provision including, but not limited to, the following examples:

2.16: continued

(a) The employer continues to pay its portion of the group-insurance-plan health-insurance premium for that employee for the duration of the family or medical leave from the employer, and the employee portion of the employee's employment-related health insurance benefits is remitted by the employee in accordance with the employer's uniformly-applied policies or practices.

(b) The employer reimburses the employee out of its general assets for both the monetary equivalent of the non-employee portion of the health insurance premium and any additional amount required to be paid under the federal COBRA law (29 U.S.C. § 1161 *et seq.*) or the Massachusetts Mini COBRA law (M.G.L. c. 176J, § 9) that is in excess of the non-employee portion of the health insurance premium, so that the amount the employee pays toward health insurance remains unchanged, until the employee can resume regular employer-sponsored coverage. This example would be applicable only if an employee is eligible for such coverage. In a multi-employer plan, the reimbursement out of general assets would be made by the employer employing an employee at the start of the employee's family or medical leave.

(c) An employer who participates in a plan, such as a multi-employer health plan to which more than one employer is required to contribute and which is maintained pursuant to one or more collective bargaining agreements between employee organization(s) and the employers, that establishes eligibility for coverage for a period of time based on hours worked or contributions made during an earlier qualifying period, allows employees who have established eligibility for coverage prior to beginning a family or medical leave to continue coverage while they are taking leave and while they remain eligible for coverage based on the earlier qualifying period, or allows them to use banked hours.

(d) An employer participates in a multi-employer plan that contains a provision for maintaining coverage such as through pooled contributions by all employers party to the plan.

Employers shall not be required to provide for, contribute to, or otherwise maintain employment-related health insurance benefits to an employee who does not receive or is not eligible to receive such employment-related health insurance benefits when the employee's family or medical leave begins. Nor are employers required to provide for, contribute to, or otherwise maintain health insurance benefits to covered individuals who resign during a leave or are former employees when the covered individual's family or medical leave commences.

(3) Retaliation. It shall be unlawful for any employer to threaten to retaliate or to retaliate by discharging, firing, suspending, expelling, disciplining, through the application of attendance policies or otherwise, threatening or in any other manner discriminating against an employee for exercising any right to which such employee is entitled under M.G.L. c. 175M or with the purpose of interfering with the exercise of any right to which such employee is entitled under M.G.L. c. 175M.

It shall be unlawful for any employer to threaten to retaliate or to retaliate by discharging, firing, suspending, expelling, disciplining, through the application of attendance policies or otherwise, threatening or in any other manner discriminating against an employee who has filed a complaint or instituted or caused to be instituted a proceeding under or related to this anti-retaliation provision, has testified or is about to testify in an inquiry or proceeding or has given or is about to give information connected to any inquiry or proceeding relating to this provision. Nothing in M.G.L. c. 175M or 458 CMR 2.00, however, shall limit an employer's ability to reasonably communicate with an employee who is approved for leave benefits.

Additionally, an employer may require an employee who has been approved for leave benefits to comply with reasonable attendance and call in procedures established by the employer. An employee who is approved for intermittent leave benefits must work with the employer to make an effort to take leave so as not to unduly disrupt the employer's operation. Furthermore, an employee who takes leave on an intermittent or reduced leave schedule and who fails to work during the times agreed to between the employer and the employee may be subject to employer discipline. An employee who fails to return to work or to the employee's regular work schedule following the expiration of the leave period may be subject to employer discipline.

2.16: continued

(4) Presumption. Any negative change in the seniority, status, employment benefits, pay or other terms or conditions of employment of:

(a) an employee which occurs any time during a leave taken by an employee under M.G.L. c. 175M, or during the six-month period following an employee's leave or restoration to a position pursuant to 458 CMR 2.16(3); or

(b) an employee who has participated in proceedings or inquiries pursuant to 458 CMR 2.16 within six months of the termination of proceedings shall be presumed to be retaliation under 458 CMR 2.16(3).

A negative change shall not include trivial, or subjectively perceived inconveniences that affect *de minimis* aspects of an employee's work. Such presumption shall be rebutted only by clear and convincing evidence that such employer's action was not retaliation against the employee and that the employer had sufficient independent justification for taking such action and would have in fact taken such action in the same manner and at the same time the action was taken, regardless of the employee's use of leave, restoration to a position or participation in proceedings or inquiries as described in 458 CMR 2.16. An employer found to have threatened, coerced or taken reprisal against any employee pursuant to 458 CMR 2.16 shall rescind any adverse alteration in the terms of employment for such employee and shall offer reinstatement to any terminated employee and shall also be liable in an action brought pursuant to 458 CMR 2.16(5).

A notification to the Department by an employer, under a *bona fide* belief that the employee has committed fraud in connection with the employee's application for benefits, shall not give rise to an action of retaliation or presumed retaliation under 458 CMR 2.16.

For the avoidance of doubt, leave taken by an employee under 458 CMR 2.16(3), shall begin on the first day that an employee takes leave.

The provisions of 458 CMR 2.16 shall apply to all leave associated with a qualifying reason allowable under 458 CMR 2.00, regardless of whether the employee has actually filed an application for benefits with the Department.

An employer's application of a preexisting employment rule or policy shall be deemed to be clear and convincing evidence.

(5) Civil Actions. An employee or former employee aggrieved by a violation of 458 CMR 2.16 or M.G.L. c. 175M, § 2(e) and (f) may, not more than three years after the violation occurs, institute a civil action in the superior court.

2.17: Severability

If any provision of 458 CMR 2.00 or the application of any provision of 458 CMR 2.00 to any person or circumstance is finally held invalid by a court of competent jurisdiction, the validity of the remainder of 458 CMR 2.00 shall not be affected.

REGULATORY AUTHORITY

458 CMR 2.00: M.G.L. c. 175M.

NON-TEXT PAGE