MASSACHUSETTS PAID FAMILY AND MEDICAL LEAVE BENEFITS



FOR COVERED INDIVIDUALS OF:

Bollus Lynch, LLP

CLASS(ES):

All Eligible MA Partners

REVISION EFFECTIVE DATE:

January 1, 2026

PUBLICATION DATE:

October 30, 2025

NOTICE(S)

This Policy covers paid leave benefits that comply with the Massachusetts Department of Family and Medical Leave ("DFML") standards. If the provisions of this Policy and requirements of M.G.L. c. 175M and 458 CMR 2.00 (hereinafter respectively referred to as "the PFML statute and regulations") do not agree, the PFML statute and regulations will apply. This Policy will also be modified to comply with any changes, amendments or regulatory clarifications to the provisions of the PFML statute and regulations, as required. If there is a conflict between this Policy and the PFML statute and regulations, the PFML statute and regulations shall control, unless this Policy's provisions are more beneficial to the Covered Individual, then this Policy shall control.

The PFML statute and regulations differ from the provisions of the federal Family and Medical Leave Act ("FMLA").

In accordance with the requirements of the PFML statute and regulations, all presumptions will be made in favor of the availability of leave and the payment of leave benefits.

Following at least 30 days advance written notice to the Employer and the DFML, we have the right to terminate the Policy. If we decide to non-renew the Policy, we will provide at least 60 days advance written notice to the Employer and the DFML and the non-renewal will be effective on the next Policy Anniversary. If an Employer's Policy is terminated during the term of an approved DFML exemption period or prior to January 1, 2021, and the Employer does not obtain private plan coverage from another source, we will notify the Employer that the Employer may be required to remit Contributions retroactive to either October 1, 2019 or the start date of the Employer's approved exemption. The Employer may be required to repay the Family and Employment Security Trust Fund ("Trust Fund") the cost of the total Weekly Benefit Amount paid to Covered Individuals who received benefits from the Trust Fund and that it may be subject to additional interest and penalties established by the DFML for not maintaining a private plan.

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

NOTICE(S)

If a Covered Individual has any questions about or concerns with this insurance, please have them first contact the Employer or their benefits administrator. If, after doing so, the Covered Individual still has a question or concern, they may contact us at:

United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-833-928-2179
www.mutualofomaha.com

When contacting us, the Covered Individual should have their Policy number available.

TABLE OF CONTENTS

PAGE

POLICY OF INSURANCE 1

GENERAL PROVISIONS 2
- Payment of Premiums 2
- Premium Changes 2
- Termination 2
- Reinstatement After Termination 3
- Employer Responsibilities 3
- Employer Obligations 4
- Effective Eligibility Date of Insurance Coverage 4
- Policies 4

SCHEDULE 5
- Policy Information 5
- Family Leave Benefits 5
- Medical Leave Benefits 5
- Eligibility for Family or Medical Leave Insurance 6
- Waiting Period 6
- Verification of Wages 6
- Weekly Benefit Amount Calculation 6
- Leave Allotment 6
- Other Income Sources 6
- Explanation of Other Income Sources 7
- Maximum Benefit Period 7
- Intermittent Leave or Reduced Leave Schedule 7
- When Family or Medical Leave Benefits End 8
- Benefits for Former Employees 8
- Extension of Family or Medical Leave Benefits 8
- Fitness for Duty 9
- Substitution of Employer Provided Paid Leave 9

PREMIUMS AND RATE GUARANTEE 10
- Premiums 10
- Rate Guarantee Date 10
- Premium Allocation 10

PREMIUM PAYMENTS 11
- Payment of Premium Through Payroll Deduction 11
- Grace Period 11
- Premium and Premium Changes 11

CLAIMS PROVISIONS 12
- Proof of Leave 12
- How to Obtain Plan Benefits 12
- Claim Assistance 12
- Certifications 12
- Claim Review Process 14
- Payment of Claims 14
- Mode of Payment 14
- Overpayments 14
- Authority to Interpret Policy 15

STANDARD PROVISIONS 16
- Insurance Contract 16
- Changes in the Insurance Contract 16
- Incontestability 16
- Misstatement of Age 16

Legal Actions....16
Conformity with State and Federal Law....16

DEFINITIONS....17

POLICY OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Policy.

United of Omaha Life Insurance Company certifies that Group Policy Number GUPM-BNQL (the Policy) has been issued to Bollus Lynch, LLP (the Employer).

Insurance is provided for Covered Individuals of the Employer subject to the terms and conditions of the Policy.

Please read this Policy carefully. The benefits described in this Policy are effective only if a Covered Individual is eligible for the Insurance , becomes insured and remains insured as described in this Policy and according to the terms and conditions of the Policy.

The Policy is part of a contract between United of Omaha Life Insurance Company and the Employer, and may be amended, changed or terminated without the Covered Individual's consent or notice to them.

We agree to pay benefits subject to the terms, conditions, and limitations of this Policy and in accordance with the PFML statute and regulations.

This Policy replaces any Massachusetts Paid Family and Medical Leave policy previously issued by us.

The Policy is nonparticipating, therefore it will pay no dividends.

UNITED OF OMAHA LIFE INSURANCE COMPANY

James T. Blackledge
Chief Executive Officer

Terrance S. DeWald
Corporate Secretary

GENERAL PROVISIONS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Policy.

PAYMENT OF PREMIUMS

The premium for this Policy equals the sum of the individual premiums for each Covered Individual as described in the Premium Rider. Premium for this Policy is paid quarterly in arrears. The first premium is due first day of the month following the quarter. Subsequent premiums are due on the first day of the month following each subsequent quarter. Premium payments must be made to our home office or to a location we designate, using a payment method we accept. We will consider premium to be paid on the date we receive it.

PREMIUM CHANGES

We reserve the right to change premium rates any time after:

a) the most recent premium rate guarantee date described in this Policy;
b) there is an increase or decrease of 10% or more in the Employer's Covered Individual population or the number of Covered Individual's insured under this Policy*;*
c) our liability or cost of administration is changed due to a change in federal, state, or local law, statute or regulation;
d) this Policy's terms are changed;
e) coverage is reinstated following the Employer's failure to pay premium during the grace period;
f) a division, subsidiary, associated company, affiliated company or an eligible class is added to or deleted from this Policy;
g) we decide to non-renew a class of business; or
h) there is a change which materially affects the risk for insurance provided by this Policy.

We must give the Employer at least 45 days advance written notice of any premium rate change.

TERMINATION

Following at least 30 days advance written notice to the Employer, we have the right to terminate the Policy if:

a) the number of Covered Individuals insured is less than 10 or less than 75% of those eligible for insurance;
b) the Employer does not perform one or more of its duties under the Policy;
c) our liability or cost of administration is changed due to a change in federal, state, or local law, statute or regulation;
d) there is an increase or decrease of 10% or more in the Employer's Covered Individual population or the number of Covered Individuals insured under the Policy*;*
e) a division, subsidiary, associated company, affiliated company or an eligible class is added to or deleted from this Policy;
f) we decide to non-renew a class of business; or
g) there is a change which materially affects the risk for insurance provided by this Policy.

The Employer has the right to terminate the Policy at any time, subject to PFML statute and regulations. The Employer must give us written notice of at least 31 days before the date this Policy is to terminate, unless the Employer gives us written notice that the Policy will terminate during the grace period.

The Policy will automatically terminate the day after the last day of the grace period if the Employer fails to pay its portion of the premium.

If the Policy terminates for any reason:

a) all unpaid premiums up to the date of termination are due, including premiums for the grace period or any part of the grace period; and
b) all unpaid premiums are due no later than the date of termination.

Termination of the Policy will not affect benefits otherwise payable for a claim incurred while the Policy is in force.

REINSTATEMENT AFTER TERMINATION

If the Policy terminates for any reason, the Employer may request to reinstate it within 90 days of the termination. We will reinstate only if:

a) an authorized representative in our home office agrees in writing to reinstate the Policy;
b) the Employer agrees in writing to accept any written conditions of reinstatement that we impose;
c) all past due premiums are paid, including any premium for the time insurance was in effect during the grace period; and
d) the premium due from the date of reinstatement until the next premium due date is paid.

If the Policy is reinstated, we will notify the DFML and will reinstate the Policy without a gap in coverage, subject to the conditions as described above.

EMPLOYER RESPONSIBILITIES

The Employer will notify:

a) both the Covered Individual and us when the Covered Individual's insurance under this Policy ends if the Covered Individual ceases to be eligible for insurance under this Policy;
b) each Covered Individual and us when insurance under this Policy ends if this Policy is terminated and is not replaced by another policy or plan with no interruption in coverage; and
c) us when the amount of insurance coverage for which a Covered Individual is eligible changes.

Notice shall be provided within 31 days from the date insurance ends or the amount of insurance coverage changes for the Covered Individual. Notice to the Covered Individual shall include information about any options available to continue or obtain insurance.

If we do not receive notice under a) above within this 31 day time period, we may require the Employer to reimburse us for the amount of any claims paid on behalf of any ineligible person during the time the person was ineligible. The Employer must reimburse us for claims under this provision within 60 days after receipt of our written request for payment.

The Employer is responsible for keeping the following records:

a) persons insured by classification and any persons eligible but not insured;
b) the amount of money the Employer contributes toward premiums;
c) beneficiary designation information, if applicable;
d) wage or pay history; and
e) any other information or essential details of coverage which we may reasonably request.

The Employer will provide, as we require, any information on our forms which is needed for insurance administration. The Employer is responsible for enrolling eligible persons for coverage under this Policy and performing other administrative duties agreed to by us. The Employer will perform its responsibilities in accordance with the terms of this Policy and our policies and procedures. The Employer may delegate some of its responsibilities to a third party.

The Employer and any third party utilized by the Employer to perform such administrative functions, act on behalf of the Employer and do not represent us or act on our behalf or as our agent. The Employer and such third party have no authority to alter or expand our liability under this Policy and have no authority to waive, modify or compromise any defense or right we may have under this Policy.

The Employer agrees to indemnify and hold us harmless from and against any and all claims, actions, damages, liability and expenses, including, without limitation, reasonable attorneys' fees, arising from or related to the failure of the Employer, or a third party to whom the Employer has delegated its responsibilities, to perform its responsibilities in accordance with the terms of this Policy or our policies and procedures.

The Employer will provide us with copies of these records within a reasonable time period, but no later than 15 business days from the date of the request. These records must be open to us for inspection at any reasonable time. The Employer must keep these records for a minimum of three years after the Policy terminates and must furnish them to the DFML upon request.

EMPLOYER OBLIGATIONS

Employer obligations may be found in the PFML statute and regulations. These obligations may or may not extend to a Covered Individual if they are a Covered Contract Worker. An Employee may contact the Employer regarding any obligations that may be available to them. The Employer obligations may include the following.

Job and Employee Benefits Protection

The Employer will grant job protection to which the Employee is entitled under the PFML statute and regulations. If an Employee takes leave under the PFML statute and regulations, they will, upon returning to Employment at the close of a period of approved leave, be restored to their 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.

Continuation of Employer-Related Health Insurance Benefits

The Employer will continue to contribute to the Employee's employment-related health insurance benefits, if any, at the level and under the conditions of coverage that would have been provided if they had continued working continuously for the duration of leave, as required under the PFML statute and regulations.

Continuation of Other Employee Benefits

The Employer will continue the Employee's rights, if any, to vacation time, sick leave, bonuses, advancement, seniority, length-of-service credit or other Employment Benefits, plans, or programs upon their return to Employment as required under the PFML statute and regulations.

EFFECTIVE ELIGIBILITY DATE OF INSURANCE COVERAGE

In order for the Employer to qualify for an exemption from Contributions to the Trust Fund, insurance must begin no later than the first day of the next calendar quarter immediately following the date of approval of the private plan exemption effective date or the Covered Individual's date of hire following the approved private plan exemption effective date for leaves of absence for:

a) a Covered Individual who is unable to work due to his or her own Serious Health Condition;
b) a Covered Individual to bond with a Child during the first 12 months after the Child's birth, Adoption, or Foster Care placement;
c) a Covered Individual due to a Qualifying Exigency arising out of a Family Member's Active Duty or impending Active Duty in the Armed Forces;
d) a Covered Individual to care for a Family Member who requires medical care as a result of a Sickness or Injury related to Family Members' active service in the Armed Forces; and
e) a Covered Individual to care for a Family Member with a Serious Health Condition.

POLICIES

We will issue and deliver the Policy to the Employer; the Employer will deliver a copy of the Policy to each Covered Individual. The Policy describes the benefits, terms, conditions, exclusions and limitations of the insurance provided.

SCHEDULE

This Schedule describes some of the terms and conditions of the Policy including, but not limited to, the maximum amounts of benefits payable under the Policy, exclusions, and limitations. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of this Policy and the PFML statute and regulations.

The benefits described in this Schedule are effective only if a Covered Individual is eligible for the insurance, becomes covered and remains covered as described in this Policy and according to the terms and conditions of the Policy. Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Policy.

POLICY INFORMATION

Eligibility Waiting Period:	As stated in the PFML statute and regulations
When Insurance Begins:	The day a Covered Individual becomes Actively Eligible
When Insurance Ends:	Insurance ends: a) the day the Covered Individual is no longer eligible for insurance under the Policy; b) the day the Policy terminates; or c) in accordance with the GRACE PERIOD provision
Combined Maximum Benefit Period under the Policy:	26 weeks, including the Waiting Period

FAMILY LEAVE BENEFITS

Weekly Benefit Amount Calculation:	As stated in the PFML statute and regulations
Maximum Weekly Benefit Amount:	As stated in the PFML statute and regulations
Maximum Benefit Period for Family Leave:	12 weeks, including the Waiting Period
Maximum Benefit Period for Service Member Care Leave:	26 weeks, including the Waiting Period

MEDICAL LEAVE BENEFITS

Weekly Benefit Amount Calculation:	As stated in the PFML statute and regulations
Maximum Weekly Benefit Amount:	As stated in the PFML statute and regulations
Maximum Benefit Period for Medical Leave:	20 weeks, including the Waiting Period

ELIGIBILITY FOR FAMILY OR MEDICAL LEAVE INSURANCE

When Insurance Begins

A Covered Individual becomes insured on the day they become Actively Eligible (Eligibility Date). Eligibility restrictions must be as favorable as the PFML statute and regulations.

When Insurance Ends

Insurance will end on the earliest of the day:

a) a Covered Individual is no longer eligible for insurance under the Policy;
b) the Policy terminates; or
c) insurance ends in accordance with the GRACE PERIOD provision.

WAITING PERIOD

The Waiting Period begins on the first day of each Family or Medical Leave and is required for each application for benefits. The initial 7 consecutive calendar day Waiting Period for Family or Medical Leave will count against the Maximum Benefit Period of Paid Family or Medical Leave in a Benefit Year. This means that benefits will be reduced by the length of the Waiting Period in a Benefit Year.

The Waiting Period is 7 consecutive calendar days. If the Covered Individual's Family Leave immediately follows Medical Leave for recovery from childbirth, there is no Waiting Period and benefits begin immediately.

If the Covered Individual's approved Family or Medical Leave claim is paid on an Intermittent Leave or Reduced Leave Schedule, the Waiting Period shall be 7 consecutive calendar days and begins on the first day of the leave, not the aggregate accumulation of the required number of days.

VERIFICATION OF WAGES

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 the purposes of determining whether they meet the Financial Eligibility Test of M.G.L. c. 175M, § 1.

WEEKLY BENEFIT AMOUNT CALCULATION

Benefits are paid according to the PFML statute and regulations. A Covered Individual's Average Weekly Wage includes Wages from the Employer during the Base Period provided that they satisfy the requirements of the Financial Eligibility Test, if applicable. In no event will a Covered Individual's Weekly Benefit Amount be more than the amount stated in the PFML statute and regulations.

LEAVE ALLOTMENT

The leave allotment under a private plan shall be based on a Covered Individual's Average Working Week with the Employer or Covered Business Entity.

OTHER INCOME SOURCES

A Covered Individual's Weekly Benefit Amount will be reduced by Other Income Sources listed below.

A Covered Individual's Weekly Benefit Amount will be reduced by the amount of:

a) benefits under any government program or law, including unemployment benefits under M.G.L. c. 151A, or workers' compensation benefits under M.G.L. c. 152, other than for permanent partial disability incurred prior to the Covered Individual's Family or Medical Leave application for benefits;
b) any other state or federal benefits for temporary or permanent disability; and

c) benefits under the Employer's or Covered Business Entity's permanent disability policy or program;

which a Covered Individual receives or is eligible to receive as a result of the Qualifying Reason for their Family or Medical Leave.

A Covered Individual's Weekly Benefit Amount will be reduced by the amount of benefits under:

a) the Employer's or Covered Business Entity's temporary disability policy or program;
b) the Employer's or Covered Business Entity's family or medical leave policy; and
c) any Wages received from another Employer or Covered Business Entity or through self-employment;

which a Covered Individual receives or is eligible to receive as a result of the Qualifying Reason for their Family or Medical Leave in the 12-month period prior to filing an application for benefits, when combined with a Covered Individual's Weekly Benefit Amount, exceeds 100% of their Average Weekly Wage. The Weekly Benefit Amount will be reduced by such amount to the extent the Weekly Benefit Amount exceeds 100% of a Covered Individual's Average Weekly Wage.

EXPLANATION OF OTHER INCOME SOURCES

Other Income Sources that are paid in a lump sum will be prorated on a weekly basis over a period for which the sum is given. If no time period is stated, the sum will be prorated on a weekly basis over the lesser of the following:

a) the benefit period shown in the MAXIMUM BENEFIT PERIOD provision; or
b) 12 equal payments.

If Other Income Sources are paid on a retroactive basis, we may reduce or suspend the Weekly Benefit Amount to recover any overpayment.

Until the Covered Individual has signed our Reimbursement Agreement we may:

a) estimate their Other Income Sources; and
b) reduce their Weekly Benefit Amount by that amount.

If we reduce a Covered Individual's benefit on this basis, we will restore their Weekly Benefit Amount and refund any underpayment to them in a lump sum.

MAXIMUM BENEFIT PERIOD

The maximum number of weeks that benefits are payable in a Benefit Year are:

a) up to 20 weeks, including the Waiting Period, for a period of Medical Leave;
b) up to 12 weeks, including the Waiting Period, for a period of Family Leave, except to care for a Family Member who is a Covered Service Member; and
c) up to 26 weeks, including the Waiting Period, for a period of Family Leave to care for a Family Member who is a Covered Service Member.

The maximum number of weeks that benefits are available for any combined period of Family or Medical Leave is 26 weeks, including the Waiting Period.

INTERMITTENT LEAVE OR REDUCED LEAVE SCHEDULE

A Covered Individual may take Intermittent Leave or a 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, Family Leave may be taken on an Intermittent Leave or Reduced Leave Schedule only if the Covered Individual and the Employer mutually agree;
b) for Family Leave to care for a Family Member's Serious Health Condition or to care for a Family Member who is a Covered Service Member, Family Leave may be taken on an Intermittent Leave 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, Family Leave may be taken on an Intermittent Leave or Reduced Leave Schedule if the Covered Individual elects to take Intermittent Leave for this purpose; or
d) for Medical Leave due to the Covered Individual's own Serious Health Condition, Medical Leave may be taken on an Intermittent Leave or a Reduced Leave Schedule if the Health Care Provider determines it is medically necessary.

Intermittent Leave must be taken in increments consistent with the Employer's or Covered Business Entity's established policy used to account for other forms of leave. The Employer or Covered Business Entity require that the minimum increment of time that Family or Medical Leave can be taken is in 15 minutes. We will not provide benefits until the Covered Individual submits at least an accumulative amount of 8 hours of Family or Medical Leave to us for review.

WHEN FAMILY OR MEDICAL LEAVE BENEFITS END

Benefits will be paid during a period of Family or Medical Leave, until the earlier of the day:

a) the Covered Individual dies;
b) the Covered Individual is no longer eligible to receive benefits under the PFML statute and regulations; or
c) the benefit period shown in the MAXIMUM BENEFIT PERIOD provision ends.

If the Covered Individual is receiving Family or Medical Leave benefits on the day the Policy terminates, benefits will continue subject to the PFML statute and regulations.

BENEFITS FOR FORMER EMPLOYEES

If an individual has been separated from the Employer or Covered Business Entity for less than 26 weeks and:

a) they remain unemployed on the date that an application for benefits is filed, the individual shall submit an application for benefits with the Employer or prior Covered Business Entity; or
b) they have become employed by a different employer or contracted with a different Covered Business Entity at the time that an application for benefits is filed, the individual shall submit an application for benefits with their new employer or Covered Business Entity. If the new employer or Covered Business Entity has a private plan exemption, the individual must submit the application for benefits to the private plan in accordance with the requirement established by their new employer or Covered Business Entity.

If an individual submitting an application for benefits identifies themselves as a former Employee, the Employer, Covered Business Entity or Carrier may inquire as to whether the individual is currently employed or has gained employment following separation from the Employer or Covered Business Entity.

EXTENSION OF FAMILY OR MEDICAL LEAVE BENEFITS

A Covered Individual may submit a request for extension of Family or Medical Leave benefits to us. This extension must be received by us prior to the expiration of the original approved leave, or as soon as reasonably possible. A Covered Individual must include all information reasonably required by us in accordance with the PFML statute and regulations, including the following:

a) the reason for the extension;
b) the requested duration of the extended leave;
c) the date on which they provided notice of the request for the extension; and
d) a newly completed or updated health care certification for Family or Medical Leave in accordance with 458 CMR 2.08(5).

We will notify the Employer of the extension request not more than five business days following our receipt of the completed request. We may provide to the Employer:

a) the requested duration for the extension;
b) whether the newly requested leave is continuous, a Reduced Leave Schedule, or an Intermittent Leave; and
c) any other information or record we deem relevant to verifying and otherwise processing the claim.

We may require the Employer to provide us all relevant information or records requested within ten business days from the date we receive the request for extension of leave. This information may include:

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

FITNESS FOR DUTY

If the Employer requires a Covered Individual to obtain a fitness for duty certificate in order to return to work at the end of a period of Medical Leave, the fitness for duty certification must comply with the PFML statute and regulations. If a fitness for duty certification is not received the Employer may delay restoration of employment until received according to 458 CMR 2.11(2). Prior to the Covered Individual's return to work, the Employer may request a certification up to once every 30 calendar days if reasonable safety concerns exist, based on their underlying medical condition.

SUBSTITUTION OF EMPLOYER PROVIDED PAID LEAVE

The Employer may not require a Covered Individual to use any sick or other Accrued Paid Leave or paid time off prior to initiating a claim under the Policy or while they are eligible for or receiving Family or Medical Leave benefits. If a Covered Individual chooses to use any sick or other Accrued Paid Leave or paid time off available from the Employer, the Family or Medical Leave will run concurrently with that accrued leave. The Employer should be contacted for additional information.

PREMIUMS AND RATE GUARANTEE

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

PREMIUMS

All Eligible MA Partners

The total monthly Paid Family Leave premium for each $100 of Wages for each Covered Individual is $0.130.

The total monthly Paid Medical Leave premium for each $100 of Wages for each Covered Individual is $0.620.

Premium is payable for Wages up to the Social Security Wage Base. This amount represents both the Employer's and Covered Individual's Contributions.

Social Security Wage Base means the amount 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.

RATE GUARANTEE DATE

January 1, 2028 or any date thereafter agreed to in writing by our authorized representative in our home office.

PREMIUM ALLOCATION

The total amount of premium paid or remitted by the Employer for this Policy and any other group insurance policy the Employer has with us or any of our affiliates ("Other Policy") will be allocated to this Policy and each Other Policy on a pro-rata basis. This means that if the Employer does not pay or remit the full premium that is due for this Policy or any Other Policy by the due date, the full amount of premium for this Policy and each Other Policy will be past due, resulting in termination of this Policy and each Other Policy in accordance with the applicable grace period for this Policy and each Other Policy.

PREMIUM PAYMENTS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

PAYMENT OF PREMIUM THROUGH PAYROLL DEDUCTION

A Covered Individual is responsible for the payment of their share of the premiums for their insurance under the Policy, not to exceed the maximum Covered Individual Contributions allowed in the PFML statute and regulations.

Premium is automatically deducted from the Covered Individual's pay by the Employer, then remitted to us, as authorized by them during the enrollment process. The Employer should be contacted for information regarding their deductions.

Payment of premium does not guarantee eligibility for coverage.

GRACE PERIOD

There is a grace period of 31 days for payment of premium. This means that if premium is not paid on or before the date it is due, the premium must be paid in the 31-day grace period that follows. We consider premium to be paid on the date we receive it.

Insurance will stay in force during the grace period as long as premium is paid before the end of the grace period. If we receive written notice requesting cancellation of insurance on a current or future date, the grace period will not apply. Coverage will end on the cancellation date specified in such notice, as long as the full premium has been paid up to that date.

If premium is not paid by the end of the grace period, insurance will end the day after the last day of the grace period.

PREMIUM AND PREMIUM CHANGES

The premium for insurance under the Policy is a monthly rate.

CLAIMS PROVISIONS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Policy.

PROOF OF LEAVE

Written proof of Family or Medical Leave must be given to us within the timeframe required under the PFML statute and regulations for benefits to be payable. A claim form can be requested from the Plan Administrator, from us or obtained on our website. Benefits may be reduced if a claim form is submitted 90 days or more after leave has commenced. A Covered Individual may be required to provide us consent to share information with the Employer and the Health Care Provider in order to process the claim.

HOW TO OBTAIN PLAN BENEFITS

Forward the completed claim form and certification as described in the PROOF OF LEAVE provision to:
Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-833-928-2179

A Covered Individual is responsible for any fees charged by their physician for completing a claim form.

CLAIM ASSISTANCE

For assistance with filing a claim or an explanation of how a claim was paid, contact:
Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-833-928-2179

CERTIFICATIONS

All claims for benefits must be supported by a certification evidencing that the leave is for a Qualifying Reason.

Family Leave to Care for a Family Member with a Serious Health Condition

The certification must be from a Health Care Provider that includes:

a) the name and address of the Family Member;
b) a statement confirming the relationship between the Covered Individual and the Family Member;
c) a statement that the Family Member has a Serious Health Condition;
d) the date on which the Family Member's Serious Health Condition commenced;
e) the probable duration of the Family Member's Serious Health Condition;
f) a statement that the Covered Individual needs to care for the Family Member;
g) for Intermittent Leave or a Reduced Leave Schedule, a statement from a Health Care Provider that such leave is medically necessary;
h) an estimate regarding the frequency and probable duration that the Covered Individual will need to care for the Family Member;
i) information from the Covered Individual that proves to our satisfaction the identity of the Family Member; and
j) any other information that may be required by us to adjudicate the claim consistent with the requirements of the PFML statute and regulations.

Family Leave for the Birth of a Child

The certification must include:

a) the Child's birth certificate; or
b) a statement from the Child's Health Care Provider stating the Child's birth date; or
c) a statement from the Health Care Provider or the person who gave birth stating the Child's birth date; and
d) for Intermittent Leave or a Reduced Leave Schedule, the Covered Individual must certify that they and the Employer mutually agree to the leave schedule; and

e) any other information that may be required by us to adjudicate the claim consistent with the requirements of the PFML statute and regulations.

Family Leave for the Placement of Child for Adoption or Foster Care

We will require that:

a) the certificate must be from the Child's Health Care Provider, 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;
b) if the Covered Individual's status as an adoptive or foster parent changes while an application for benefits is pending or while they are receiving benefits, the Covered Individual must provide written notice to us within 5 business days of such change in status;
c) for Intermittent Leave or a Reduced Leave Schedule, the Covered Individual must certify that they and the Employer mutually agree to the leave schedule; and
d) any other information that may be required by us to adjudicate the claim consistent with the requirements of the PFML statute and regulations.

Family Leave for a Qualifying Exigency

The certificate must include**:**

a) a copy of the Family Member's Active Duty orders; or
b) a letter of impending activation from the Family Member's commanding officer; or
c) other documentation in circumstances where, for Good Cause shown, the Covered Individual is unable to produce the documentation specified in in a) or b) directly above; and
d) a statement confirming the Covered Service Member is a Family Member; and
e) information from the Covered Individual that proves to our satisfaction the identity of the Family Member; and
f) the name and address of the Family Member being cared for; and
g) the dates or period of time for which leave is requested; and
h) the underlying reason for the exigency leave; and
i) any other information that may be required by us to adjudicate the claim consistent with the requirements of the PFML statute and regulations.

Family Leave to Care for a Family Member who is a Covered Service Member

The certificate from the Covered Service Member's Health Care Provider must include:

a) the date on which the Covered Service Member's Serious Health Condition commenced;
b) the probable duration of the Serious Health Condition;
c) a statement that the Covered Individual is needed to care for the Covered Service Member;
d) an estimate regarding the frequency and probable duration that the Covered Individual will need to care for the Covered Service Member;
e) an attestation by the Covered Service Member's Health Care Provider and the Covered Individual that the Serious Health Condition is connected to the Covered Service Member's military service;
f) a statement confirming the Covered Service Member is a Family Member;
g) information from the Covered Individual that proves to our satisfaction the identity of the Family Member;
h) the name and address of the Family Member being cared for;
i) for Intermittent Leave or a Reduced Leave Schedule, a statement from the Covered Service Member's Health Care Provider that such leave is medically necessary; and
j) any other information that may be required by us to adjudicate the claim consistent with the requirements of the PFML statute and regulations.

Medical Leave for a Serious Health Condition

The certification must be from a Health Care Provider that includes:

a) a statement that the Covered Individual has a Serious Health Condition;
b) the date on which the Serious Health Condition commenced;
c) the probable duration of the Serious Health Condition;
d) other information required by us, including a certification by the Health Care Provider that the Covered Individual is unable to work due to the Serious Health Condition; and
e) for Intermittent Leave or a Reduced Leave Schedule, a statement from a Health Care Provider that such leave is medically necessary.

CLAIM REVIEW PROCESS

Claim Review
Claim review and appeals are handled according to the PFML statute and regulations.

Appeal
If a Family or Medical Leave claim is denied, the Covered Individual has a reasonable opportunity to appeal the claim review decision.

To appeal a denied claim, the Covered Individual or their authorized representative must notify us within 10 days after receiving notice of our determination and ask that we reconsider our original benefit decision. If the Covered Individual needs more time due to circumstances beyond their control and we agree that the 10 day duration cannot be met, an extension of time may be granted. The Covered Individual's appeal request must be submitted to us in writing or electronically and should state the reasons they believe the claim denial was incorrect. The Covered Individual should also include any additional information, documents or other materials that might allow us to change our original decision. Send the appeal request to us at our Omaha, Nebraska address shown in the CLAIM ASSISTANCE provision.

If we deny the appeal, we will provide a written denial and direct the Covered Individual to appeal to the DFML.

Notice
If the administration of the Policy is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Covered Individual may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of their claim or to ask questions about their rights under ERISA.

PAYMENT OF CLAIMS

Benefits will be paid not more than 14 calendar days after we receive acceptable written Proof of Leave and any other required supporting information, unless the determination occurs more than 14 calendar days prior to the onset of leave or eligibility, in which case benefits will be paid as soon as leave or eligibility begins. For intermittent leave, we may require verification that the leave was taken prior to paying benefits. All presumptions will be made in favor of the availability of leave and the payment of leave benefits, as required by the PFML statute and regulations.

MODE OF PAYMENT

Benefits will be paid weekly by us directly to the Covered Individual or through the Employer. If the Employer pays benefits to the Covered Individual directly while on leave, we will pay the benefits to the Employer as reimbursement.

OVERPAYMENTS

If it is found that we paid more benefits than required under the Policy, we have the right to a refund from the Covered Individual or the recipient of benefits.

We also have a right to a refund for any payments due to:

a) fraud or misrepresentation;
b) any error we make in processing a claim;
c) the Covered Individual or their agent's failure to provide complete information;
d) the Covered Individual not being eligible for coverage; or
e) the Covered Individual's receipt of or right to payment from Other Income Sources.

The Covered Individual or the recipient of benefits must reimburse us in full. We will determine the repayment method, including without limitation, reducing or withholding their Weekly Benefit Amount or any benefits payable to them under this or any other group insurance policy issued by us. We will credit any such payments to the refund until the refund is fully recovered.

If it is found that we paid less benefits than required under the Policy, we will make additional payment(s), as necessary.

AUTHORITY TO INTERPRET POLICY

The following applies only when the administration of the Policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

By purchasing the Policy, the Employer grants us the discretion and the final authority to construe and interpret the Policy. This means that we have the authority to decide all questions of eligibility and all questions regarding the amount and payment of any Policy benefits within the terms of the Policy as interpreted by us. Benefits under the Policy will be paid only if we decide, in our discretion, that a person is entitled to them. In making any decision, we may rely on the accuracy and completeness of any information furnished by the Employer, the Covered Individual or any other third party. Our interpretation of the Policy as to the amount of benefits and eligibility will be binding and conclusive on all persons.

The Employer further grants us the authority to delegate to third parties, our affiliates, and any third party administrator with whom we have contracted to provide claims administration and other administrative services, the discretionary authority granted in the Policy. The Employer expressly grants such third party the full discretionary authority granted to us under this Policy.

The Covered Individual or their beneficiary has the right to request a review of our decision. If, after exercising the Policy's review procedures, the Covered Individual or their beneficiary's claim for benefits is denied or ignored, in whole or in part, they or their beneficiary may file suit and a court will review their or their beneficiary's eligibility or entitlement to benefits under the Policy.

STANDARD PROVISIONS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Policy.

INSURANCE CONTRACT

The insurance contract consists of:

a) the Policy (which includes any riders and amendments);
b) the Employer's signed application (if applicable); and
c) any signed application for the Covered Individual (if applicable).

CHANGES IN THE INSURANCE CONTRACT

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time we and the Employer both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

a) does not require the Covered Individual's consent; and
b) must be:
    1. in writing;
    2. made a part of the Policy; and
    3. signed by our authorized representative in our home office.

A change may affect any class of Covered Individuals included in the Policy.

Any change under the PFML statute and regulations affecting the insurance contract (including reducing or terminating benefits or increasing premium costs) may take effect immediately and be without notice.

INCONTESTABILITY

We will not contest this Policy after it has been in force for two years during the Covered Individual's lifetime, except for nonpayment of premium.

Statements in an application are considered representations and not warranties. We will not use any statements in the Covered Individual's application to deny a claim or to contest the validity of this insurance unless we provide them, their beneficiary or legal representative with a copy of that application.

MISSTATEMENT OF AGE

If a Covered Individual's age is misstated, we may adjust the premium or the benefits payable. An adjustment of the benefits payable will be based on what the premium would have purchased at the correct age.

LEGAL ACTIONS

No legal action can be brought until at least 60 days after we have been given written proof of Family or Medical Leave. No legal action can be brought more than three years after the date written proof of Family or Medical Leave is required, unless otherwise required by state law in the Covered Individual's state of residence.

CONFORMITY WITH STATE AND FEDERAL LAW

Any provision of the Policy which, on its effective date, is in conflict with the law of the federal government or the state in which a Covered Individual resides on such date is hereby amended to conform to the minimum requirements of such law.

DEFINITIONS

The defined terms used in this Policy are shown in this section. With the exception of *our, we, us, they, them and their*, we have capitalized these terms wherever they appear to make them easier for the Covered Individual to find.

The definitions set forth below apply to both the singular and plural versions of the defined term.

Accrued Paid Leave means 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:

a) sick leave;
b) annual leave;
c) vacation leave;
d) personal leave;
e) compensatory leave; or
f) paid time off.

Accrued paid leave shall not include:

a) 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 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, for the purposes of administering paid leave under M.G.L. c. 175M, and 458 CMR 2.00.

Actively Eligible means the Covered Individual is eligible for insurance in accordance with:

a) the Employer's rules of eligibility as approved by our authorized representative in our home office;
b) the terms and conditions of this Policy; and
c) the definition of a Covered Individual under the PFML statute and regulations.

If the Employer's rules of eligibility for insurance conflict with any of the terms and conditions of this Policy, the terms and conditions of this Policy section control. Any changes to the Employer's rules of eligibility after the Policy Effective Date will not be effective for purposes of becoming or remaining eligible for insurance unless such changes have been approved by our authorized representative in our home office.

Adoption means 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.

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. For a Self-Employed Individual, average weekly wage shall mean 1/26 of the total earnings of the Self-Employed Individual from the two highest quarters of the 12 months preceding such individual's application for benefits under M.G.L. c. 175M. If an individual has multiple Employers, the average weekly wage will be calculated for each Employer or Covered Business Entity separately.

Average Working Week means 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 means the last four completed calendar quarters within the previous five calendar quarters immediately preceding the date a complete application for benefits is filed for a qualified period of paid Family and Medical Leave. A completed calendar quarter is one for which an employment and wage detail report has been or should have been filed for Employers who have not received an exemption from Contributions to the Trust Fund, pursuant to 458 CMR 2.04(1)-(2).

Benefit Year means the period of 52 consecutive weeks beginning on the Sunday immediately preceding the first day paid Family or Medical Leave commences for a Covered Individual.

Child means 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.

Continuing Treatment by a Health Care Provider means 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;

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; or
3. the requirement for treatment by a Health Care Provider means an in-person or telehealth visit to a Health Care Provider. The first (or only) in-person or telehealth treatment visit must take place within seven calendar days of the first day of incapacity.
4. treatment visits or a regimen of continuing treatment is necessary within the 30 calendar day period shall be determined by the Health Care Provider; or
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 the Covered Individual's Family Member must be under the continuing supervision of, but need not be receiving active treatment by, a Health Care Provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.
e) Conditions requiring multiple treatments. Any period of absence to receive multiple treatments (including any period of recovery therefrom) from a Health Care Provider or from a provider of health care services under orders of, or on referral by, a Health Care Provider, for:
    1. restorative surgery after an accident or other injury; or
    2. a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, *etc.*), severe arthritis (physical therapy), or kidney disease (dialysis).
f) Absences attributable to incapacity under Continuing Treatment by a Health Care Provider in b) or c) above qualify for leave even though the Covered Individual or Family Member does not receive treatment from a Health Care Provider during the absence, and even if the absence does not last more than three consecutive, full calendar days.
g) Cosmetic treatments are not Serious Health Conditions unless inpatient hospital care is required or unless complications develop.

Contributions mean the payments made by the 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, or contributions to a private plan while the private plan is in effect.

Covered Business Entity means 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 means 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;
c) who resides in Massachusetts; and
d) who is not classified as an independent contractor as defined by M.G.L. c. 151A, § 2.

Covered Individual means those workers that are included under the Policy. Covered individuals must include the following individuals who meet the eligibility requirements of the PFML statute and regulations:
a) all the Employer's Employees providing services in Massachusetts, including fulltime, part-time, permanent, temporary, on call, per diem or seasonal Employees who meet the minimum eligibility requirements under the MA PFML law;

b) former Employees of the Employer for not more than 26 weeks after separation or until re-employed, whichever comes first; and
c) all Covered Contract Workers, if applicable, if the Employer is a Covered Business Entity.

Covered Service Member means 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. otherwise on the temporary disability retired list for a serious injury or illness that was incurred by the member in the line of duty on Active Duty in the Armed Forces, or a serious injury or illness that existed before the beginning of the member's Active Duty and was aggravated by service in the line of duty on Active Duty in the Armed Forces; or
b) a Former Member of the Armed Forces, including a former member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy for a serious injury or illness that was incurred by the member in line of duty on Active Duty in the Armed Forces, or a serious injury or illness that existed before the beginning of the member's Active Duty and was aggravated by service in line of duty on Active Duty in the Armed Forces and manifested before or after the member was discharged or released from service.

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

Domestic Partner means a person not less than 18 years of age who:
a) is dependent upon the Covered Individual for support as shown by either unilateral dependence or mutual interdependence that is evidenced by a nexus of factors including, but not limited to:
    1. common ownership of real or personal property;
    2. common householding;
    3. children in common;
    4. signs of intent to marry;
    5. shared budgeting; and
    6. the length of the personal relationship with the Covered Individual; or
b) has registered as the domestic partner of the Covered Individual with any registry of domestic partnerships maintained by the Employer of either party, or in any state, county, city, town or village in the United States.

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

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

Employer means the employer policyholder. The term Employer shall have the same meaning as provided in M.G.L. c. 151A § 1(i), provided, however, that:
a) an individual employer shall be determined by the Federal Employer Identification Number; and
b) the Department of Early Education and Care shall be deemed the employer of family child care providers, as defined in M.G.L. c. 15D, § 17(a); provided further, that the PCA Quality Home Care Workforce Council established in M.G.L. c. 118E, § 71 shall be the employer of personal care attendants, as defined in M.G.L. c. 118E, § 70.

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

Employment Benefits means 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.

Family Leave means leave taken by a Covered Individual to care for a Family Member with a Serious Health Condition, to bond with a Child during the first 12 months after the Child’s birth, Adoption, or Foster Care placement, to care for a Family Member who is a Covered Service Member, or because of a Qualifying Exigency arising out of the fact that Family Member is on Active Duty or has been notified of an impending call or order to Active Duty in the Armed Forces.

Family Leave Benefits means wage replacement paid to a Covered Individual while the Covered Individual is on Family Leave under the Policy.

Family Member means 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.

Family or Medical Leave, Family and Medical Leave means Family Leave and/or Medical Leave as defined under the PFML statute and regulations.

Financial Eligibility Test means a demonstration that, the individual has satisfied the financial eligibility requirements of subsection (a) of section 24 of Chapter 151A, provided that all such employment has been localized within Massachusetts. Wages received from multiple employers or Covered Business Entities within the base period can be aggregated to determine financial eligibility for leave.

Former Member of the Armed Forces means 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.

Foster Care means 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 in which the child resides as a result of a voluntary agreement between the parent and guardian that the child be removed from the home, or pursuant to a judicial determination of the necessity for foster care and involves agreement between the state and foster family that the foster family will care for the child. Although foster care may be with relatives of the child, state action is involved in the removal of the child from parental custody.

Good Cause means 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.

Grandchild means a child of the Covered Individual's Child.

Grandparent means a parent of the Covered Individual's Parent.

Health Care Provider means an individual licensed by the state, commonwealth, or territory in which the individual practices medicine, surgery, dentistry, chiropractic, podiatry, midwifery or osteopathy, and includes 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 under state law 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; and
d) a health care provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is performing within the scope of the person's practice as defined under such law.

Intermittent Leave means 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.

Maximum Weekly Benefit Amount means the maximum dollar amount of benefit a Covered Individual may receive per week as shown in the Schedule.

Medical Leave means leave taken by a Covered Individual due to a Serious Health Condition.

Medical Leave Benefits means wage replacement paid to a Covered Individual while the Covered Individual is on Medical Leave under the Policy.

Minimum Weekly Benefit Amount means the minimum amount of wage replacement that may be paid to a Covered Individual on a weekly basis while the Covered Individual is on Family and Medical Leave, as provided in M.G.L. c. 175M, § 3.

Other Income Source(s) has the meaning set forth in the Other Income Sources provision of the Schedule.

Our, We, Us means United of Omaha Life Insurance Company.

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

Plan Administrator means the person or entity designated as the plan administrator for the Employer's Family and Medical Leave plan.

Policy means this document that describes the benefits, terms, conditions, exclusions and limitations of the insurance provided issued to the Employer by us.

Policy Anniversary means January 1 of each Policy Year.

Policy Effective Date means January 1, 2021.

Policy Year means the period commencing on the Policy Effective Date and ending on the next succeeding Policy Anniversary and, thereafter, each 12-month period commencing on the Policy Anniversary.

Qualifying Exigency means 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 of or other needs to the service member's child or other family member, making financial or legal arrangements for the service member, attending counseling, attending service events or ceremonies, spending time with the service member during a rest and recuperation leave or following return from deployment or making arrangements following the death of the service member.

Qualifying Reason means 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 means a leave schedule that reduces the usual number of hours per workweek, or hours per workday, of a Covered Individual.

Reimbursement Agreement means the written agreement that we may provide to a Covered Individual, at our option, in which they agree to repay us any overpayment resulting from their receipt of Other Income Sources.

Self-Employed Individual means 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 means 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.

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.

Sibling means the biological, adoptive, step-brother or step-sister of a Covered Individual.

Spouse means the person to whom a Covered Individual is legally married. Spouse also includes the Covered Individual's civil union partner or equivalent, as recognized and allowed by law in their jurisdiction of residence.

State Average Weekly Wage means 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.

Their, Them, They means the Covered Individual who may be eligible or insured under the Policy.

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

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

Waiting Period means the period of time taken for Family or Medical Leave, which must be satisfied before you are eligible to receive benefits. The waiting period is shown in the Schedule and administered according to the PFML statute and regulations.

Weekly Benefit Amount means the amount of wage replacement that will be paid to a Covered Individual on a weekly basis while the Covered Individual is on Family and Medical Leave under the terms of the Policy.

Massachusetts Paid Family and Medical Leave Benefits

Bollus Lynch, LLP

Group Number: G000BNQL

United of Omaha Life Insurance Company

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