

# **ATTACHMENT 1**

## **EMPLOYER POLICY/CERTIFICATE TEMPLATE**

*The Maryland Insurance Administration (MIA) has worked closely with the Family and Medical Leave Insurance (FAMLI) Division of the Maryland Department of Labor to develop this template for fully-insured Employer Private Insurance Plans (aka EPIPs or Private Plans) that satisfy the requirements of the FAMLI program under Title 8.3 of the Labor and Employment Article and COMAR Title 09, Subtitle 42, as well as insurance requirements under the Insurance Article and COMAR Title 31. Unless otherwise specified, all section references in this template are to the Labor and Employment Article of the Annotated Code of Maryland.*

*A fully-insured Private Plan must be a group product covering all employees. The entire contract must consist of a master policy, a group application, and a certificate of coverage that sets forth the essential elements of the group contract. A carrier is not required to directly issue an employee-specific certificate to each individual covered under the group contract, but the carrier must comply with COMAR 31.10.37.04 with respect to delivery of certificates. In order to reduce duplicity, a carrier may create a “wrap” policy as long as that policy includes an appropriate incorporation provision. A carrier will not be permitted to submit a contract on an insert page basis or sectional basis as described in COMAR 31.04.17.04, as the policy form number will also act as the Private Plan number for the FAMLI Program.*

*Policy form numbers must begin with “FAMLI” and end with a date in the format MM/YY (e.g. 12/25). Certificate form numbers must be the same as the Policy form number with a “-C” at the end. Form numbers must appear in the lower left corner of each page in the policy and certificate.*

*Any variability in the form must be bracketed and must be accompanied by a Statement of Variability explaining how the bracketed item will vary. [COMAR 31.01.17.04A(2)]*

*The Private Plan must comply with the same accessibility, language access, and translation requirements as the FAMLI Division per COMAR 09.42.03.03Q.*

*The employer policy forms must include the following items in substance. Carriers are not required to adopt the template language verbatim, except where expressly required herein. Italicized and/or bracketed text appearing throughout this template is intended solely to provide guidance to carriers for form filing purposes, and is not intended to be included in the final forms.*



## Policy/Certificate Face Page

The first page of the policy and the certificate must include:

1. The name and address of the insurance carrier and a title that clearly states the Policy provides Family and Medical Leave coverage.
2. A disclosure that reads verbatim:

The [This] Policy is intended to comply fully and completely with the Maryland Family and Medical Leave Insurance Program (“FAMLI Program”), Labor and Employment Article, § 8.3-101 *et seq.*, Annotated Code of Maryland, and COMAR Title 09, Subtitle 42, and will be interpreted and applied to be consistent with the requirements of the FAMLI Program. The [This] Policy is also intended to comply with the Insurance Article, Annotated Code of Maryland and COMAR Title 31. If any provision of the [this] Policy conflicts with or violates the FAMLI Program or Maryland Insurance law or regulation, the provisions of the FAMLI Program and Maryland Insurance law and regulation will control, unless the policy provisions are more advantageous to the Covered Individual in which case the policy terms will prevail.
3. A statement in the certificate that: (1) the policy is a contract between the carrier and the Policyholder; (2) the policy may be modified or terminated without the certificate holder’s notice or consent; (3) the certificate is subject to the provisions of the Policy and if there is a conflict, the Policy will control in all respects; and (4) the Policy is on file with the Policyholder and may be examined by the certificate holder at any reasonable time.
4. A statement that the Policy was delivered in the State of Maryland and is governed by Maryland laws. [§12-209, Insurance]
5. A provision detailing the exact period that is covered by the policy and all renewal rights offered by the carrier.
6. Prior to the officer signatures [COMAR 31.04.17.03M], a disclosure, in text size not smaller than the rest of the page, in bold print that reads verbatim:

**The [This] Policy provides benefits for family and medical leave only, as provided under the paid Family and Medical Leave Insurance (FAMLI) Program and does NOT provide benefits for any medical expenses.**

## **TABLE OF CONTENTS AND SCHEDULE OF BENEFITS**

*Each policy and certificate must include a Table of Contents directing the employer and employee to the main provisions in the policy/certificate.*

Each policy shall have a Schedule of Benefits that includes at least the following information:

1. The Policyholder Name
2. The Effective Date of the Policy
3. The Date the policy terminates
4. The benefits provided under the policy

The Schedule of Benefits should include representative specimen data when filed with the MIA for approval. [COMAR 31.04.17.03K]

*Definitions, exclusions, or other provisions may not be included in the Schedule of Benefits.*

## DEFINITIONS

*The following definitions must be verbatim in the policy and certificate. For wrap policies, these definitions only need to be in the certificate. Carriers may add any other necessary definitions as long as such definitions do not limit or conflict with the below required definitions. Exclusions, limitations or other provisions may not be included in the definitions.*

**Anchor Date:** The earlier of the date on which an application for benefits is complete or leave begins for a Covered Individual for which benefits may be paid. [§8.3-101(a-2) and COMAR 09.42.01.01B(3)]

**Application Year:** The 12-month period beginning on the Sunday of the calendar week in which leave begins. [§8.3-101(b) COMAR 09.42.01.01B(4)]

**Covered Employee:** An employee who has worked at least 680 hours performing services under employment located in Maryland over the four most recently completed calendar quarters for which quarterly reports have been required immediately preceding the Anchor Date. [§8.3-101(d) and COMAR 09.42.01.01B(13)].

**Covered Individual:** A Covered Employee. [COMAR 09.42.01.01B(14)]

**Deployment:** An Eligible Service Member acting under official orders who, on any day, is performing service in a training exercise or operation at a location or under circumstances that make it impossible or infeasible for the Eligible Service Member to spend off-duty time in the housing in which the Eligible Service Member resides when on garrison duty at the Eligible Service Member's permanent duty station or homeport. [§8.3-101(g) and COMAR 09.42.01.01B(16)]

**Domestic Partner:** The person with whom someone is in a Domestic Partnership. [COMAR 09.42.01.01B(18)]

**Domestic Partnership:** A relationship between two individuals who:

- a. Are at least 18 years old;
- b. Are not related to each other by blood or marriage within 4 degrees of consanguinity under civil law rule;
- c. Are not married or in a civil union or domestic partnership with another individual; and
- d. Agree to be in a relationship of mutual interdependence in which each individual contributes to the maintenance and support of the other individual and the relationship, even if both individuals are not required to contribute equally to the relationship. [COMAR 09.42.01.01B(19)]

**Division:** The Family and Medical Leave Insurance division of the Maryland Department of Labor. [COMAR 09.42.01.01B(17) and 09.42.01.02]

**Eligible Service Member:** An active Service Member or former Service Member. [§8.3-101(g-1)]

**Employee:** An individual who performs work for compensation. Employee does not mean an individual who meets the following requirements:

- a. The individual who performs the work is free from control and direction over its performance both in fact and under a contract;
- b. The individual customarily is engaged in an independent business or occupation of the same nature as that involved in the work; and
- c. The work is outside of the usual course of business of the person for whom the work is performed or it is performed outside of any place of business of the person for whom the work is performed. [COMAR 09.42.01.01B(20)]

**Employer:** A person or governmental entity that employs at least one individual who performs qualified employment in Maryland. Employer does not mean an individual who: is the sole owner of a sole proprietorship, limited liability company, C Corporation or S Corporation; and is the only individual employed by the sole proprietorship, limited liability company, C corporation or S Corporation. [§8.3-101(h) and COMAR 09.42.01.01B(21)]

**Family Member:**

1. A biological child, an adopted child, a foster child, or a stepchild of the Covered Individual;
2. A child for whom the Covered Individual has legal or physical custody or guardianship;
3. A child for whom the Covered Individual stands in loco parentis, regardless of the child's age;
4. A biological parent, an adoptive parent, a foster parent, or a stepparent of the Covered Individual or of the Covered Individual's spouse;
5. The legal guardian of the Covered Individual or the ward of the Covered Individual or of the Covered Individual's spouse;
6. An individual who acted as a parent or stood in loco parentis to the Covered Individual or the Covered Individual's spouse when the Covered Individual or the Covered Individual's spouse was a minor;
7. The spouse of the Covered Individual;
8. A Domestic Partner of the Covered Individual;
9. A biological grandparent, an adopted grandparent, a foster grandparent, or a stepgrandparent of the Covered Individual;
10. A biological grandchild, an adopted grandchild, a foster grandchild, or a stepgrandchild of the Covered Individual; or
11. A biological sibling, an adopted sibling, a foster sibling, or a stepsibling of the Covered Individual. [§8.3-101(i) and COMAR 09.42.01.01B(26)]

**Good Cause** means a demonstration by a Covered Individual that a failure to timely file for leave, a claim, or an appeal was due to: [COMAR 09.42.04.02B(7) and 09.42.05.01B(5)]

1. A Serious Health Condition that resulted in an unanticipated and prolonged period of incapacity and that prevented the Covered Individual from filing in a timely manner;
2. A demonstrated inability to reasonably access a means to file in a timely manner, such as due to a natural disaster, power outage, or a significant and prolonged Insurer or Division system outage; or
3. A demonstrated failure of the employer to provide the notification required under regulation to the Covered Individual.

**Incapacity:** The inability to perform at least one (1) essential job function, or to attend school or perform regular daily activities. [COMAR 09.42.01.01B(29)]

**Kinship Care:** Consists of: [COMAR 09.42.01.01B(32)]

1. Continuous 24-hour care and supportive services provided for a minor child placed by a child placement agency in the home of a kinship parent or kinship caregiver; or [§5-501(e), Family Law]
2. A living arrangement in which a relative of a child, who is not in the care, custody, or guardianship of the local department of social services, provides for the care and custody of the child due to a serious family hardship. [§4-122.1(a)(2), Education]

**Licensed Health Care Provider:**

1. A doctor of medicine or osteopathy who is authorized to practice medicine or surgery in a state and performing within the scope of their practice as defined under the state's law; or
2. 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 a state and performing within the scope of their practice as defined under the state's law;
3. Nurse practitioners, nurse midwives, clinical social workers and physician assistants who are authorized to practice in a state and who are performing within the scope of their practice as defined under the state's law; and
4. Any 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 their practice as defined under such law.

The phrase "authorized to practice in a state" means that the provider must be authorized to diagnose and treat physical or mental health conditions. [COMAR 09.42.01.01B(33)]

**Qualified Employment:** The provision of services entirely within Maryland by an employee to an employer; or the provision of services localized within Maryland under COMAR 09.42.02.04 by an employee to an employer. [COMAR 09.42.01.01B(36)]

**Qualifying Exigency:** Any of the following reasons for which leave may be needed by a Family Member of an Eligible Service Member:

- Because the Eligible Service Member has received notice of Deployment within 7 days before the Deployment is to begin;
- To attend a Uniformed Services event and related activities including family support programs related to the active duty of the Eligible Service Member;
- To arrange, provide or attend child care or school activities only when the Eligible Service Member is on active duty call or active duty status;
- To make financial and legal arrangements for the Eligible Service Member's absence or because of the absence;
- To attend counseling that is needed due to the active duty or call to active duty status of the Eligible Service Member and is provided by an individual who is not a licensed health care provider;
- To spend up to 15 calendar days with an Eligible Service Member who is on short-term temporary rest and recuperation leave during the period of Deployment;
- To attend post-Deployment activities including reintegration services for a period of 90 days immediately following the termination of active status;
- To attend to matters related to the death of the Eligible Service Member while on active duty status;
- To arrange for or provide alternative care for a parent of the Eligible Service Member when the parent is incapable of self-care and the covered active duty or call to active duty necessitates a change; or
- Because of any other issues that arise out of active duty or a call to active duty than an Employer and Covered Employee agree should be covered. [§8.3-101(m)]

**Serious Health Condition:** An illness, an injury, an impairment, or a physical or mental condition that:

- Requires inpatient care;
- Requires continuing treatment by a licensed health care provider; or
- Involves the donation of a body part, organ, or tissue, including preoperative or diagnostic services, surgery, post-operative treatment, and recovery. [§8.3-101(o)(1) and COMAR 09.42.01.01B(40)]

Serious Health Condition includes an illness, an injury, an impairment, or a physical or mental condition described above that continues over an extended period of time and requires intermittent treatment. [§8.3-101(o)(2)]

**Service Member:** An individual who is a member of:

1. the Uniformed Services; or
2. a reserve component of the Uniformed Services. [§9-901, State Government]

**Service Member's Next of Kin:** For an Eligible Service Member, is the nearest blood relative other than the service member's spouse, parent, son, or daughter, in the following order of priority: blood relatives who have been granted legal custody of the Eligible Service Member by court decree or statutory provisions, brothers and sisters, grandparents, aunts and uncles, and first cousins, unless the Eligible Service Member has specifically designated in writing another blood relative as their nearest blood relative for purposes of military caregiver leave under FMLA. [COMAR 09.42.01.01B(41)]

**Spouse:** The person to whom someone is legally married.

**Treatment:** With the exception of routine physical examinations, eye examinations, or dental examinations, examinations or testing to determine if a serious health condition exists or persists. Includes ongoing or periodic evaluations of a Serious Health Condition and actual treatment by a Licensed Health Care Provider. [§8.3-101(q) and COMAR 09.42.01.01B(43)]

**Uniformed Services:** Includes the Army, Navy, Air Force, Marine Corps, Space Force, Coast Guard, National Oceanic and Atmospheric Administration, and Public Health Service. [§9-901(l), State Government, as amended by SB279 Chpt. 5, Acts of 2025 and 37 U.S.C § 1-101(3)]

**Wages:**

1. for an employee, wages as defined in § 8-101 of the Labor & Employment Article of the Maryland Code; or
2. for a self-employed individual:
  - a. self-employment income, as defined in 26 U.S.C. § 1402(b); or
  - b. wages, as defined in § 8-101 of the Labor & Employment Article of the Maryland Code, earned from a C corporation or an S corporation if the income, pay, or leave is paid to the owner who is the sole employee of a C corporation or an S corporation

## **ELIGIBILITY AND EFFECTIVE DATE**

*In this section, the carrier shall detail the eligibility requirements for employees who would be eligible for coverage under the policy.*

Such eligibility requirements include all eligible employees by the employer who perform Qualified Employment [COMAR 09.42.03.03A]. Only employees are eligible for coverage. Spouses and family members are not eligible for coverage under the policy. [§8.3-705(a)(1)]

Reference to a standard of time shall specify time at the place the insured resides, or at the place the policy is delivered. [COMAR 31.10.01.03C]

*For the policy only:*

Include a statement that the policy takes effect as shown on the face page of the policy.

Include a provision indicating that new employees who satisfy applicable eligibility requirements are automatically added to the group originally insured. [COMAR 31.11.10.04K]

Include a provision that the carrier will provide to the group policyholder, for delivery to each employee, a statement that summarizes the essential features of the insurance coverage of the employee and that indicates to whom benefits under the policy are payable. [COMAR 31.11.10.04J]

*For the certificate only:*

Include a statement explaining when coverage takes effect for an employee.

## **BENEFITS**

### **Eligibility for Paid Family and Medical Leave Benefits**

*In this section, the carrier shall detail the eligibility requirements for Covered Individuals to receive benefits under the policy, consistent with the requirements of the FMLI Program. Provisions in this section must include, in substance, the following.*

### **Conditions of Eligibility for Benefits**

*This section must state that employees who qualify as Covered Individuals are eligible to take paid leave under the policy, and to receive Benefits during that leave for up to 12 weeks per Application Year for the following reasons [§8.3-702(a) and COMAR 09.42.04.05]:*

#### 1. Family Leave

- a. Bonding leave for the birth of a child, adoption, foster care or Kinship Care during the first year after the child's birth or placement. Includes leave used in anticipation of placement for the following events, provided they are substantiated by documentation required:
    - Court appearances
    - Legal appointments
    - Placement agency appointments;
    - Counseling appointments;
    - Medical appointments; or
    - Travel
  - b. Caring for a Family Member with a Serious Health Condition provided documentation from a Licensed Health Care Provider substantiating the time period requested is submitted with the request for leave.
  - c. Military caregiving for a Service Member with a Serious Health Condition who is the Covered Individual's Next of Kin and the Serious Health Condition resulted from, or was exacerbated by, military service. [§8.3-701(a)(1)(iv) and COMAR 09.42.04.03D] Documentation from a Licensed Health Care Provider substantiating the time period requested must be submitted with the request for leave.
2. Medical Leave for the Covered Individual's own Serious Health Condition. [§8.3-701(a)(1)(iii) and COMAR 09.42.04.03C]
  3. Qualified Exigency Leave arising out of the deployment of a Service Member who is a Family Member of the Covered Individual. [§8.3-701(a)(1)(v) and COMAR 09.42.04.03E].

### **Duration of Leave**

*This section must explain the duration of leave under the policy, which at a minimum must address in substance:*

1. Covered Individuals are eligible to take covered benefits for a maximum of [x weeks (*must be at least 12 weeks*)] in an Application Year. [§8.3-702(a) and COMAR 09.42.04.05A(1)]
2. Benefits are payable up to an additional [x weeks (*must be at least 12 weeks*)] to a Covered Individual if, during the same Application Year:
  - that Covered Individual received benefits for bonding leave and becomes eligible for benefits due to the Covered Individual's own Serious Health Condition; or [COMAR 09.42.04.05A(2)]
  - that Covered Individual received benefits due to their own Serious Health Condition and becomes eligible for benefits for bonding leave. [COMAR 09.42.04.05A(2)]
3. Leave may be approved for the lesser of: [COMAR 09.42.04.05A(3)]
  - 12 weeks;
  - The remaining FMLI leave balance for the Covered Individual for the Application Year;
  - The length of time requested; or
  - If applicable, the length of time supported by any required documentation.
4. When a Covered Individual is on leave and receiving benefits to care for a Family Member and that Family Member dies, benefits will continue until [x days (*must be at least 7 days*)] after the death of the Family Member or the previously approved end date for the leave, whichever date is soonest. The Covered Individual must provide notice of the date of death of the Family Member within [x hours (*must be at least 72 hours*)] of the Family Member's passing. [COMAR 09.42.04.05B(2)(b)]
5. Approved leave may be in the form of continuous leave or intermittent leave. [§8.3-701(c)(1)]
6. Intermittent Leave may be taken in increments of not less than 4 hours, unless the Covered Individual's scheduled shift is fewer than four (4) hours [COMAR 09.42.04.07B] or the Policy allows intermittent leave for less than 4 hours [§8.3-705]. If leave is taken on an intermittent leave schedule, an employer may not reduce the total amount of leave to which the Covered Individual is entitled beyond the amount of leave actually taken. [§8.3-701(c)(3) and (4)]
7. Leave shall run concurrently with eligible leave that may be taken by the Covered Individual under the federal Family and Medical Leave Act. [§8.3-702(b)]

### **Calculation of Weekly Benefit Amount and Use of Wages**

*This section must clearly state how the Weekly Benefit Amount payable to the Covered Individual is calculated.*

Benefits to be paid must be at least equal to the benefits that would be paid to Covered Individuals if the policyholder/employer was participating in the FMLI Program. [COMAR 09.42.03.03F]

The amount of family and medical leave insurance benefits will be based on the Covered Employee's Average Weekly Wage.

The Covered Employee's Average Weekly Wage is based on wages earned from the [employer][policyholder]. [§8.3-705(a)(2)(i)]

If the Covered Employee has worked less than 680 hours for the [employer][policyholder], then the Covered Employee's Average Weekly Wage will be determined by dividing the Covered Employee's total wages received by the Covered Employee in the highest of the previous four completed calendar quarters that precede the Anchor Date and for which quarterly reports have been required by 13. [§8.3-703(a)(1) and [§8.3-705(a)(2)(ii)]]

If the Covered Employee's wages are not on the policyholder's/employer's reports for at least 2 quarters, then calculation of the Covered Employee's average weekly wage will be based on the highest quarter of the most recent 4 quarters the Covered Employee worked for any employer. [COMAR 09.42.04.06A(2)]

The State Average Weekly Wage is the wage calculated by the Maryland Department of Labor. [§8.3-703(a)(2)]

For continuous leave, the weekly benefit shall be determined as follows: [§8.3-703(a) and COMAR 09.42.04.06B]

1. If the Covered Employee's Average Weekly Wage from the policyholder/employer is [XX (*must be at least 65 percent*)] percent or less of the State Average Weekly Wage, the benefit will be [X (*must be at least 90 percent*)] percent of the Covered Employee's Average Weekly Wage; or
2. If the Covered Employee's Average Weekly Wage is greater than [XX (*must be the same percent as specified in 1.*)] percent of the State Average Weekly Wage, the benefit will be [at least] the sum of:
  - a. [XX (*must be at least 90 percent*)]% of the Covered Employee's Average Weekly Wage up to [XX (*must be the same percent as specified in 1.*)]% of the State Average Weekly Wage; and
  - b. [XX (*must be at least 50 percent*)]% of the Covered Employee's Average Weekly Wage that is greater than [XX (*must be the same percent as specified in 1.*)]% of the State Average Weekly Wage up to the maximum benefit amount.

Changes to the State Average Weekly Wage and maximum benefit amount only apply to an Application Year with an Anchor Date that occurs on or after the date the increase becomes effective. [§8.3-703(c)(1)]

The benefit paid under the policy and any additional paid leave cannot total more than 100% of the Covered Employee's Average Weekly Wage. [§8.3-703(b)(2)]

The weekly benefit amounts must be: [§8.3-703(b)(3)]

1. At least \$50; and
2. May not exceed [
  - a. \$1,000 for the period beginning on the date announced by the Secretary of the Maryland Department of Labor and ending December 31, 2028, both inclusive;
  - b. ] for the 12-month period beginning January 1, 2029 and each subsequent 12-month period, the amount as determined and announced by the Maryland Department of Labor.

*Subsection (a) may be omitted from policies issued on or after January 1, 2029.*

The weekly benefit may increase as determined by the Maryland Department of Labor. Benefit increases apply only to an Application Year with an Anchor Date that occurs on or after the date the increase becomes effective. [§8.3-703 and COMAR 09.42.04.06B(2)]

For intermittent leave, the weekly benefit shall be determined as follows [COMAR 09.42.04.06C]:

1. Calculate the hourly benefit amount by dividing the weekly benefit amount calculated above, by the average number of hours worked per week during the highest of the previous four (4) completed calendar quarters for which quarterly reports have been required prior to the Anchor Date.
2. Calculate the benefit amount to be disbursed by multiplying the hourly benefit amount by the number of hours of intermittent leave taken in a week.

If the Covered Employee's wages are not on the policyholder's/employer's reports for at least 2 quarters, then calculation of the Covered Employee's average weekly wage will be based on the highest quarter of the most recent 4 quarters the Covered Employee worked for any employer. [COMAR 09.42.04.06A(2)]

For intermittent leave, on or before the first day of January, the benefit amount of every open and active claim shall be readjusted based on the new maximum weekly benefit amount. [COMAR 09.42.04.06D(4)]

## LIMITATIONS AND EXCLUSIONS

The policy may not impose additional conditions, restrictions, or barriers on the use of leave beyond those explicitly authorized by the FAML I Program and shall meet or exceed the rights, protections, and benefits provided under the FAML I Program. [§ 8.3-705(a)(1) and COMAR 09.42.03.03I]

Discretionary clauses are prohibited. [§ 12-211, Insurance]

### **Other Coverage**

*The policy may contain a provision addressing coordination of benefits with other programs and coverage, including FMLA and employer-provided leave, as permitted under COMAR 09.42.04.09.*

Covered Individuals receiving Unemployment Insurance benefits from the State are not eligible for benefits under the policy. [§ 8.3-702(e) and COMAR 09.42.04.09C(1)]

Covered Individuals receiving Worker's Compensation wage replacement benefits, other than compensation for a permanent partial disability under Title 9, Labor and Employer, are not eligible for benefits under the policy. [§ 8.3-702(e) and COMAR 09.42.04.09C(2)]

The policy cannot be issued to an employer that already has FAML I coverage in effect whether it is through the FAML I Program, a self-funded plan, or another fully insured private FAML I plan.

The policy cannot be used to supplement coverage under the FAML I Program, a self-funded plan or other fully insured private FAML I plan.

### **Termination**

*This section must describe the scenarios under which the policy may be terminated, and must explain the carrier's notification procedures related to a policy nonrenewal and termination.*

This provision must be consistent with the FAML I Program and COMAR 09.42.03.09 and must include, in substance, the following:

1. The policyholder may terminate this policy when:
  - The policy has been in effect for at least 1 year after the policy's effective date; or
  - When the Division withdraws its approval of this policy as an Equivalent Private Insurance Plan for the employer as detailed in COMAR 09.42.03.09B
2. The employer must notify the Division at least thirty (30) days before the

effective date of the termination.

The employer must notify its employees no later than thirty (30) days before the termination effective date.

Coverage shall continue through the termination's effective date.

Termination shall become effective on the first date of the calendar quarter following the expiration of the 30-day period.

3. A carrier may terminate the policy:
  - On the date premium is not paid when due, subject to the grace period in accordance with COMAR 31.11.10.04-I; and
  - On any premium due date, by giving the policyholder no less than 45 days' advance written notice if the policyholder fails to provide information on a timely basis or perform any obligations required by this policy and applicable law. [COMAR 31.11.10.04-I]

*The policy must include a Continuation of Benefits provision that addresses the following in substance:*

**Continuation of Benefits** [COMAR 09.42.03.09C(1)]

The [This] Policy will continue to pay benefits if a valid claim was filed before the effective date of termination until the total amount of the benefit claim is paid, the duration of leave ends, or the Application Year ends, whichever occurs first.

If the [this] Policy fails to pay benefits as required, the Covered Employee may seek relief with the Division as described in the Appeals section of the [this] Policy.

## **PREMIUMS**

*This section must include the following provisions.*

A provision that describes the length of time for which the rate in the policy is guaranteed, as well as the circumstances under which the carrier has the right to change the premium rate.

Premium Due Date provision that complies with COMAR 31.11.10.04N.

A Grace Period provision that contains in substance the following provision: "Grace Period: A grace period of 30 days will be granted for payment of each premium due after the first premium, unless the carrier does not intend to renew the policy beyond the period for which premium has been accepted and notice of the intention not to renew is delivered to the group policyholder at least 45 days before the premium is due. During the grace period the policy shall continue in force." [COMAR 31.11.10.04I]

## **Claims Provisions**

*This section must contain, in substance, the following provisions.*

### **Notice of Leave**

If the necessity for leave is foreseeable, the Covered Individual must provide notice to the Policyholder/Employer of the intention to take leave at least 30 days before the date the leave is to begin. [COMAR 09.42.04.08B(1)(a)] If the necessity for leave is not foreseeable or providing 30 days' notice is not possible, the individual shall provide the notice as soon as practicable. [§8.3-701(a)(2), COMAR 09.42.04.08B(1)(b)]

The employer/policyholder may waive this notice requirement. If the employer/policyholder did not invoke this notice requirement when notified of the claim by the carrier or failed to notify the Covered Individual that the employer/policyholder requires notice, then the employer/policyholder is deemed to have waived the notice requirement. [COMAR 09.42.04.08B(1)(c) and (d)]

### **Notice of Claim [Application for Claim]**

A Covered Individual experiencing a Qualifying Event is eligible to receive benefits if they provide the carrier with notice of claim and file a complete claim application within 90 days of taking leave that would qualify as FAMLl leave. [§8.3-701(b), COMAR 09.42.04.04A(1), and COMAR 31.11.10.04E]

If the Covered Individual files a claim application later than 90 days, they must demonstrate Good Cause in order for the claim application to be considered.

The carrier will not invalidate or reduce a claim if it is shown that there was Good Cause for the delay in submitting notice of claim, and if a complete claim application is filed within one (1) year of the end of the initial 90-day filing deadline. [COMAR 31.11.10.04C(2)(b) and COMAR 31.11.10.04E(2)]

Applications for claim may also be accepted up to 60 days prior to taking leave that would qualify as FAMLl leave. [COMAR 09.42.04.04A(2)]

### **Claim Forms**

*The Policy must include a provision for when claim forms—the claim application—will be provided to the Covered Individual to file for benefits as provided for in COMAR 31.11.10.04D.*

The provision should also state that the claim application will be on a form provided by the carrier. All information requested on the claim application must be completed before benefits can be paid. [§8.3-703(d)(3)]

A claim application can be updated for the following reasons if the Covered Individual provides the updates within 10 days of the change, or as soon as practicable with Good Cause shown:

1. Basis for leave;
2. Start date of leave;
3. Duration of leave;
4. End date of leave; or
5. Whether the covered Individual has begun to receive Worker's Compensation or Unemployment Insurance benefits. [COMAR 09.42.04.04C(2)]

Failure to provide these updates may result in a delay, underpayment, overpayment, or denial of benefits. [COMAR 09.42.04.04C(3)]

### **Cancelation of Claim Application**

A Covered Individual may withdraw the claim application if the Covered Individual no longer requires benefits. [COMAR 09.42.04.04D(1)]

If the leave period has already begun and the Covered Individual withdraws the claim application, the total amount of leave taken, not the total amount applied for, will be assessed against the Covered Individual's leave balance for the Application Year. [COMAR 09.42.04.04D(2)]

### **Claim Application Process**

Once the Covered Individual submits a claim application, the carrier shall notify the Covered Individual that the claim application was received. [COMAR 09.42.04.08C(1)]

If the claim application is incomplete, the carrier will notify the Covered Individual within five (5) business days of the date the claim application was submitted, that additional information is needed in order to process the claim application. [§8.3-703(d)(2) and COMAR 09.42.04.08C(2)]

Once the carrier receives a claim application, the carrier will notify the policyholder/employer of the claim application submission. [§8.3-703(d)(1) and COMAR 09.42.04.08D(1)] At the same time, the carrier will notify the Covered Individual that the policyholder/employer has been notified of the submitted claim application. [COMAR 09.42.04.08C(3)] The policyholder/employer will have five (5) business days to respond to the carrier. [COMAR 09.42.04.04B(7)(a)] If the policyholder/employer does not respond within five (5) business days, the carrier will consider the claim application complete. [COMAR 09.42.04.04B(7)(b)]

If the policyholder/employer responds within the five (5) business days and challenges the Covered Individual's eligibility, the carrier will notify the Covered Individual of the policyholder's/employer's response, [COMAR 09.42.04.08C(4)] and may request a

response from the Covered Individual to confirm eligibility for benefits. [COMAR 09.42.04.04B(7)(c)] Once the carrier receives a response from the Covered Individual, the carrier will consider the claim application complete. [COMAR 09.42.04.04B(7)(d)]

If benefits are approved and issued and then the policyholder/employer, after the 5 day notice period above, provides information that the Covered Individual is not eligible for benefits:

1. The Covered Individual is still entitled to the benefits he/she has already received;
2. Any further benefits will cease;
3. Job and anti-retaliation protections apply for the time period from approval of benefits to revocation of benefits. [COMAR 09.42.04.04B(7)(g)]

If leave has been retroactively approved and additional information as described above has been provided, then any benefits paid will be considered an overpayment and job and anti-retaliation protections may not apply. [COMAR 09.42.04.04B(7)(h)].

The completed claim application must include the following items: [COMAR 09.42.04.04B]

1. If seeking leave for bonding or to care for another, provide proof of the relationship. Proof can include:
  - a. An affidavit signed by the Covered Individual attesting to the qualifying relationship;
  - b. Copies of official orders, certifications, or registrations from a government entity; or
  - c. Copies of documentation from licensed foster care and/or adoption providers.
2. For leave for care or bonding with a child, provide the following: [COMAR 09.42.04.04B(5)(a)]
  - a. A certification of live birth;
  - b. Documentation of placement from a licensed child placement agency or government agency responsible for the child placement, and documentation of any court appearances, appointments, or travel in anticipation of placement, if applicable, including:
    - i. A court order; or
    - ii. Affidavit of an informal kinship care arrangement; or
  - c. Other reasonable documentation determined by the Division.
3. For leave to care for a Family Member's Serious Health Condition, provide a complete certification form approved by the Division from a licensed health care provider establishing: [COMAR 09.42.04.04B(5)(b)]
  - a. The first date on which the covered Individual took or intends to take leave from employment and whether the leave will or is intended to be taken for a continuous period of time or intermittently;

- b. Date of diagnosis;
  - c. The date on which the Serious Health Condition of the Family Member commenced;
  - d. The probable duration of the Serious Health Condition;
  - e. The appropriate facts related to the Serious Health Conditions within the knowledge of the licensed health care provider;
  - f. A statement that the Covered Individual needs to care for a Family Member and an estimate of the amount of time required to provide the care; and
  - g. If intermittent leave is requested, the expected frequency and duration of the intermittent leave.
4. For leave for the Covered Individual's own Serious Health Condition, provide a complete certification form approved by the Division from a licensed health care provider establishing: [COMAR 09.42.04.04B(5)(c)]
- a. The first date on which the covered Individual took or intends to take leave from employment and whether the leave will or is intended to be taken for a continuous period of time or intermittently;
  - b. The date on which the Serious Health Condition of the Covered individual commenced;
  - c. Treatment dates;
  - d. Period of incapacity;
  - e. The probable duration of the Serious Health Condition;
  - f. The appropriate facts related to the Serious Health Conditions within the knowledge of the licensed health care provider;
  - g. A statement that the Covered Individual is unable to perform the functions of the Covered Individual's position; and
  - h. If intermittent leave is requested, the expected frequency and duration of the intermittent leave.
5. For leave to care for an Eligible Service Member for whom the Covered Individual is next of kin with a Serious Health Condition, provide a complete certification form approved by the Division from a licensed health care provider establishing: [§8.3-302(4) and COMAR 09.42.04.04B(5)(d)]
- a. That the Serious Health Condition was caused, or exacerbated by, service in the Uniformed Services [COMAR 09.42.04.04B(5)(d)];
  - b. The first date on which the Covered Individual took or intends to take leave from employment and whether the leave will or is intended to be taken for a continuous period of time or intermittently;
  - c. The date on which the Serious Health Condition of the Eligible Service Member commenced or was exacerbated; [§8.3-403(c)(2)(ii)]
  - d. The probable duration of the Serious Health Condition;

- e. The appropriate facts related to the Serious Health Conditions within the knowledge of the licensed health care provider; and
  - f. If intermittent leave is requested, a statement that the Covered Individual needs to care for an Eligible Service Member and the expected frequency and duration of the intermittent leave. [§8.3-403(c)(2)(vi)]
6. For leave for a Qualifying Exigency arising out of the deployment of an Eligible Service Member who is a Family Member, include: [§8.3-302(5) and §8.3-701(a)(1)(v) and COMAR 09.42.04.04B(5)(e)]
- a. A copy of the Family Member's active duty orders or other documentation issued by the military that indicates that the Eligible Service Member is on covered active duty or call to covered active duty status, and
  - b. The dates of the Eligible Service Member's covered active duty service.

Once all information is provided and the application is complete, the carrier will approve or deny the claim application within 10 business days of receiving a complete claim application. [§8.3-703(d)(3) and COMAR 09.42.04.08C(5) and (6)]

If the claim application is approved, the carrier will notify the Covered Individual of the following:

1. The approved benefit amount;
2. When benefits begin;
3. When benefits end;
4. The length of the approved leave period;
5. The duration and frequency of intermittent leave, if applicable; and
6. The Covered Individual's appeal rights. [COMAR 09.42.04.08C(5)(g)]

If the claim application is denied (in full or in part), the carrier will notify the Covered Individual of the denial with notice that:

1. States concisely and simply:
  - a. The reasons for the denial;
  - b. The Covered Individual's appeal rights;
  - c. The facts that are asserted; or
  - d. If the facts cannot be stated in detail when the notice is given, the issues that are involved.
2. States the pertinent statutory and regulatory section under which the action was taken;
3. States that the Covered Individual has the opportunity to request a reconsideration, including:
  - a. What, if anything, the Covered Individual must do to receive a reconsideration; and
  - b. All relevant time requirements.

4. States the direct consequences, if any, or remedy of the Covered Individual's failure to exercise in a timely manner the opportunity for a reconsideration. [COMAR 09.42.04.08C(6)]

The carrier will also notify the policyholder/employer when:

1. A determination regarding a claim for benefits is made;
2. A reconsideration or an appeal of a determination regarding a claim for benefits is filed; or
3. A change is made to a determination regarding a claim for benefits. [COMAR 09.42.04.08D]

*Carriers must use the forms and templates mandated by the Division in accordance with COMAR 09.42.01.03A(2) and C. These forms and templates include:*

1. *The claim application;*
2. *Certification of qualifying event forms;*
3. *Proof of relationship template;*
4. *Good Cause exemption form; and*
5. *Intermittent leave use template.*

### **Payment of Benefits**

The first benefit payment will be within five (5) business days after the complete claim application is approved or leave has started, whichever is later. [COMAR 09.42.04.10A(1)] Subsequent payments will be made at least every two (2) weeks until the benefit period ends. [COMAR 09.42.04.10A(2)]

*The policy must include a provision that discusses how any overpayment will be collected or if such repayment can be waived as provided by COMAR 09.42.04.10B.*

Specifically, the carrier may seek repayment of benefits from a Covered Individual if:

1. The benefits were paid erroneously or as a result of willful misrepresentation by the Covered Individual; or
2. A claim for benefits is rejected after the benefits were paid.

Repayment may be waived if:

1. The error in payment was not due to any false statement, nondisclosure of material fact, or misrepresentation by a Covered Individual; or
2. The repayment would be against equity and good conscience or administrative efficiency. [§8.3-902(b)]

## **Cessation of Benefits**

*The section must describe when benefits will cease.*

This section may state that FAMLII benefits under the policy will cease when the Covered Individual is no longer eligible for benefits under the policy, or the Covered Individual has exhausted the maximum benefit period under the policy.

This section should also state that if fraud is proven, any benefit payment made will be considered an overpayment and subject to repayment as described in the Payment of Benefits section. [COMAR 09.42.04.11]

## **Denied Claims**

If a claim is denied the Covered Individual's appeal rights shall be identified in the denial.

## **Reconsideration**

Covered Individuals have the right to request reconsideration of a denied claim as follows: Requests for reconsideration of a denied claim for leave for the Covered Individual's own Serious Health Condition must be submitted by the Covered Individual to the carrier, in writing, within 180 days of the carrier's notice of claim denial. Requests for reconsideration of a denied claim for any other type of leave must be submitted by the Covered Individual to the carrier, in writing, within 30 days of the carrier's notice of claim denial:

1. Requests for reconsideration may be considered after 30 days of the carrier's notice of claim denial if the Covered Individual provides evidence of Good Cause for not submitting the request within the 30 day timeframe;
2. The request must include why the Covered Individual feels the denial is in error; and
3. Judicial review of any decision with respect to benefits under the policy will be allowed in a court of competent jurisdiction after the Covered Individual has exhausted all administrative remedies established by the Division. [§8.3-906, COMAR 09.42.05.03, and COMAR 31.10.30.02B(5) and .03B(3)]

## **Reconsideration Process**

When the Covered Individual files a request for reconsideration of a denied claim, the carrier will notify in a timely manner, the Covered Individual and the employer/policyholder of the reconsideration. [COMAR 09.42.05.03A(2))]

A review of the denied claim being reconsidered will be conducted by the carrier. The person conducting the review will not be the same person who issued the denial. [COMAR 09.42.05.03A(3)]

The carrier will issue a decision on the reconsideration within 10 business days of the filing for reconsideration. The Carrier may hold an informal conference, which will be

scheduled in enough time for the carrier to make their decision within the 10 business days required. [COMAR 09.42.05.03A(4), (5), and (6)]

### **Appealing a Denied Claim**

If the Reconsideration process renders an adverse determination, the Covered Individual may file an appeal with the Division within 30 days of receiving the adverse determination unless the Covered Individual can show Good Cause for filing after 30 days. The Division will be a party to all appeals, regardless of which entity made the adverse determination. [COMAR 09.42.05.03B]

When an appeal is filed, the Division will notify, in a timely manner, all parties to the adverse determination being appealed, including the carrier and the employer. [COMAR 09.42.05.03B(4)]

At the discretion of the Division, there may be an informal mediation process activated at the time of filing the appeal. [COMAR 09.42.05.03B(5)]

### **Hearings**

Absent unusual circumstances, a hearing will be held on the appeal within 30 days of filing the appeal. A written notice of a hearing will be provided to the parties involved in the appeal. [COMAR 09.42.05.03B(6) and (7)(2)(f) and (g)]

A party to the hearing may appear individually or, if permitted by law, through a representative. A party to the hearing may also be represented by an attorney authorized to practice law in Maryland. [COMAR 09.42.05.03B(8)]

Any notice, decision or other matter required to be sent to a party will also be sent to the party's attorney of record at the attorney's address. [COMAR 09.42.05.03B(8)(b)]

If a party is represented by an attorney or appears through an authorized representative, then examination and cross-examination of witnesses, and objections and motions on the party's behalf will be made solely by the attorney or the authorized representative. [COMAR 09.42.05.03B(8)(c)]

The Family and Medical Leave Division of the Maryland Department of Labor (Division), as a result of an appeal by a Covered Employee, may pay benefits from the FMLI Program to a Covered Employee whom the Policy was obligated to pay, if the Division determines both of the following:

1. Some benefit went unpaid; and
2. It is unlikely that the Covered Employee will otherwise be paid the benefits.

[COMAR 09.42.03.03S]

The [employer][policyholder] shall reimburse the FMLI Program for the amounts and the Division may pursue all legal means to collect the amounts from the

[employer][policyholder] if the Division pays benefits from the FAML I Program to a Covered Employee for whom the Policy was obligated to pay. [COMAR 09.42.03.03T]

If the FAML I Program pays benefits for which the insurer is liable under the terms of the policy, the insurer will reimburse the employer the amount of benefits.

### **Standard Provisions**

*Policies must contain standard provisions that address, in substance, the following. Other standard provisions, if applicable, may be allowed.*

1. Entire Contract provision as required by COMAR 31.11.10.04A.
2. Contestability provision as required by COMAR 31.11.10.04B. *Inapplicable clauses referring to statements made by an insured person to effectuate coverage may be omitted.*