State of Oregon
Employment Department
Paid Family and Medical
Leave Insurance

March 24, 2023

# Paid Leave Oregon

# Proposed Oregon Administrative Rules - Batch 7

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# BENEFITS & ASSISTANCE GRANTS

*ORS 657B.010 through ORS 657B.120 establishes benefit claim administration for Paid Leave Oregon. The below rules provide further details on aspects of benefits, such as weekly claims, child support offsets, benefits to a deceased individual, and self-employed benefits.*

*ORS 657B.200 establishes assistance grants for employers with fewer than 25 employees for when an employee takes Paid Leave. The assistance grant rule expands the application to include federal employer identification number. All administrative rules may be expanded, reorganized, or deleted before formal rulemaking. If an administrative rule is being amended, the amended changes are show in red below.*

## 471-070-1000 – Benefits: Definitions [Amended]

(1) "Application" means the process in which an individual submits the required information and documentation described in OAR 471-070-1100 to request benefits for a period of leave. Approval of an application establishes a claim.

(2) "Average weekly wage" means the amount calculated by the department as the state average weekly covered wage under ORS 657.150 (4)(e) as determined not more than once per year. The average weekly wage is:

(a) Set for each fiscal year beginning July 1 and ending June 30 of the following year;

(b) Applied for the calculation of weekly benefit amounts starting the first full week following July 1;

(c) Applied for the entire benefit year after a new benefit year is established, even if the average weekly wage amount changes when the new fiscal year begins.

(3) "Benefit year" means a period of 52 consecutive weeks beginning on the Sunday immediately preceding the day that family, medical, or safe leave commences for the claimant, except that the benefit year shall be 53 weeks if a 52-week benefit year would result in an overlap of any quarter of the base year of a previously filed valid claim. A claimant may only have one valid benefit year at a time.

(4) "Calendar quarter" means the period of three consecutive calendar months ending on March 31, June 30, September 30, or December 31.

(5) "Care," as the term is used in ORS 657B.010(17)(a)(B), means physical or psychological assistance as used for leave taken to care for a family member with a serious health condition.

(a) "Physical assistance" means assistance attending to a family member's basic medical, activities of daily living, safety, or nutritional needs when that family member is unable to attend to those needs themselves, or transporting the family member to a health care provider when the family member is unable to transport themselves.

(b) "Psychological assistance" means providing comfort, reassurance, companionship to a family member, or completing administrative tasks for the family member, or arranging for changes in the family member's care, such as, but not limited to, transfer to a nursing home.

(6) "Child" as the term is used for family leave to care for and bond with a child during the first year after the child's birth, foster placement, or adoption, and as the term is used for a safe leave purpose described in ORS 659A.272, means an individual described in ORS 657B.010(6) and that is:

(a) Under the age of 18; or

(b) Age 18 or older as an adult dependent substantially limited by a physical or mental impairment as defined by ORS 659A.104.

(7) "Claim" means a period of Paid Family and Medical Leave Insurance (PFMLI) benefits that starts with an approved application for benefits and continues through the duration of the approved leave until the approved leave or benefit amount has been exhausted or the approved timeframe for the leave has been reached. A claimant may have multiple claims in a benefit year, but may not be approved for more than the allowable benefit or leave amount as described in OAR 471-070-1030.

(8) "Claimant" means an individual who has submitted an application or established a claim for benefits.

(9) "Consecutive leave" means leave taken in a continuous period of time, without interruption, based upon a claimant's regular work schedule from all employers for a single qualifying purpose. A claimant who is taking consecutive leave cannot perform work for any employer during the leave period.

(10) "Domestic violence," as the term is used for a safe leave purpose described in ORS 659A.272, means abuse or the threat of abuse, as abuse is defined in ORS 107.705.

(~~10~~11) "Eligible employee's average weekly wage" means an amount calculated by the department by dividing the total wages earned by an eligible employee during the base year by 52 weeks.

(~~11~~12) "Harassment," as the term is used for a safe leave purpose described in ORS 659A.272, means the crime of harassment described in ORS 166.065.

(~~12~~13) "Health care provider" means:

(a) A person who is primarily responsible for providing health care to the claimant or the family member of the claimant before or during a period of PFMLI leave, who is licensed or certified to practice in accordance with the laws of the state or country in which they practice, who is performing within the scope of the person's professional license or certificate, and who is:

(A) A chiropractic physician, but only to the extent the chiropractic physician provides treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated to exist by X-rays;

(B) A dentist;

(C) A direct entry midwife;

(D) A naturopath;

(E) A nurse practitioner;

(F) A nurse practitioner specializing in nurse-midwifery;

(G) An optometrist;

(H) A physician;

(I) A physician's assistant;

(J) A psychologist;

(K) A registered nurse; or

(L) A regulated social worker.

(b) A person who is primarily responsible for the treatment of the claimant or the family member of the claimant solely through spiritual means before or during a period of PFMLI leave, including but not limited to a Christian Science practitioner.

(14) "Intermittent leave" means leave taken periodically in separate blocks of time for an entire work day or work week from all employers. A claimant who is taking intermittent leave can perform work for an employer on work days they are not taking leave.

(15) "Leave from work" means a claimant's approved absence from employment during the claimants typically scheduled work day or work week.

(16) "Self-employed individual's average weekly income" means the amount calculated by the department by dividing the combined total of an individual's taxable income from self-employed, on which contributions have been paid under OAR 471-070-2030, and subject wages, if any, earned during the base year, by 52 weeks.

(~~13~~17) "Serious health condition" means an illness, injury, impairment, or physical or mental condition of a claimant or their family member that:

(a) Requires inpatient care in a medical care facility such as, but not limited to, a hospital, hospice, or residential facility such as, but not limited to, a nursing home or inpatient substance abuse treatment center;

(b) In the medical judgment of the treating health care provider poses an imminent danger of death, or that is terminal in prognosis with a reasonable possibility of death in the near future;

(c) Requires constant or continuing care, including home care administered by a health care professional;

(d) Involves a period of incapacity. "Incapacity" is the inability to perform at least one essential job function, or to attend school or perform regular daily activities for more than three consecutive calendar days. A period of incapacity includes any subsequent required treatment or recovery period relating to the same condition. The incapacity must involve one of the following:

(A) Two or more treatments by a health care provider; or

(B) One treatment plus a regimen of continuing care.

(e) Results in a period of incapacity or treatment for a chronic serious health condition that requires periodic visits for treatment by a health care provider, continues over an extended period of time, and may cause episodic rather than a continuing period of incapacity, such as, but not limited to, asthma, diabetes, or epilepsy;

(f) Involves permanent or long-term incapacity due to a condition for which treatment may not be effective, such as, but not limited to, Alzheimer's Disease, a severe stroke, or terminal stages of a disease. The employee or family member must be under the continuing care of a health care provider, but need not be receiving active treatment;

(g) Involves multiple treatments for restorative surgery or for a condition such as, but not limited to, chemotherapy for cancer, physical therapy for arthritis, or dialysis for kidney disease that if not treated would likely result in incapacity of more than three calendar days;

(h) Involves any period of disability due to pregnancy, childbirth, miscarriage or stillbirth, or period of absence for prenatal care; or

(i) Involves any period of absence from work for the donation of a body part, organ, or tissue, including preoperative or diagnostic services, surgery, post-operative treatment, and recovery.

(~~14~~18) "Sexual Assault," as the term is used for a safe leave purpose described in ORS 659A.272, means any sexual offense or the threat of a sexual offense as described in ORS 163.305 to 163.467, 163.472 or 163.525.

(~~15~~19) "Stalking," as the term is used for a safe leave purpose described in ORS 659A.272, means:

(a) The crime of stalking or the threat of the crime of stalking as described in ORS 163.732; or

(b) A situation that results in a victim obtaining a court's stalking protective order or a temporary court's stalking protective order under ORS 30.866.

(~~16~~20) "Subject Wages" means PFMLI wages that are paid and reported for an employee, as defined in ORS 657B.010(13), or an employee of a tribal government who has elected coverage under ORS 657B.130.

(~~17~~21) "Willful" and "willfully" means a knowing and intentional act or omission.

(~~18~~22) "Willful false statement" means any occurrence where:

(a) A claimant or employer makes a statement or submits information that is false;

(b) The claimant or employer knew or should have known the statement or information was false when making or submitting it;

(c) The statement or submission concerns a fact that is material to the rights and responsibilities of either the claimant or the employer under ORS chapter 657B; and

(d) The claimant or employer made the statement or submitted the information with the intent that the department would rely on the statement or information when taking action.

(~~19~~23) "Willful failure to report a material fact" means any occurrence where:

(a) A claimant or employer omit or fails to disclose information;

(b) The claimant or employer knew or should have known that the information should have been provided;

(c) The information concerns a fact that is material to the rights and responsibilities of either the claimant or the employer under ORS chapter 657B; and

(d) The claimant or employer omitted or did not disclose the information with the intent that the department would take action based on other information or a lack of information.

(~~20~~24) "Work day" means any day on which an employee performs any work for an employer and is an increment of a work week. The number of work days in a work week is based on the average number of work days worked by an employee at all employment. There are a maximum of seven work days in a work week. If a work day spans two calendar days, such as a shift beginning on day one at 10 p.m. and ending on the next day at 5 a.m., the work day will count on the calendar day in which the shift began.

(~~21~~25) "Work week" means a seven day period beginning on a Sunday at 12:01 a.m. and ending on the following Saturday at midnight. If a claimant works a variable or irregular schedule, the number of work days in a work week is determined by counting the total number of work days worked in the preceding 12 work weeks and dividing the total by 12 and rounding down to the nearest whole number. If the employee has not been employed by the employer for at least 12 weeks, the number of weeks the employee has been employed from the date of hire to the first day of leave shall replace 12 in the calculation.

[Stat. Auth.: ORS 657B.090, 657B.120, 657B.340; Stats. Implemented: ORS 657B.010, 657B.090, 657B.120]

## 471-070-1010 – Benefits: Eligibility and Qualification for Benefits [Amended]

(1) For an individual to be eligible to receive Paid Family and Medical Leave Insurance (PFMLI) benefits, the individual must:

(a) Be one of the following:

(A) An employee;

(B) A self-employed individual who has elected coverage under ORS 657B.130 and in accordance with OAR 471-070-2010 and whose coverage is currently in effect; or

(C) An employee of a tribal government, where the tribal government has elected coverage under ORS 657B.130 and where the tribal government's coverage is currently in effect.

(b) Earn at least:

(A) $1,000 in subject wages, as defined in OAR 471-070-1000, in either the base year or alternate base year;

(B) $1,000 in taxable income from self-employment, as defined in OAR 471-070-2000, in either the base year or alternate base year; or

(C) $1,000 in a combination of subject wages and taxable income from self-employment in either the base year or alternate base year.

(c) Contribute to the PFMLI Fund established under ORS 657B.430 in accordance with ORS 657B.150 and OAR 471-070-2030 during the base year or alternate base year, as applicable;

(d) Experience a qualifying purpose for benefits under ORS 657B.020;

(e) Have current Oregon employment or self-employment for which they are requesting leave from work;

(A) For an individual to be considered as requesting leave from work, the individual must:

(i) Be expected to work a typical work day or week;

(ii) Be unable to perform services for their employment due to a qualifying purpose under ORS 657B.020; and

(iii) Not receive some or all of their wages or taxable income from self-employment while unable to perform services for their employment due to a qualifying purpose.

(B) An individual may not be considered requesting leave from work if they are unable to perform services for their employment regardless of the qualifying purpose.

*Example 1:* Rory is a seasonal employee for a vegetable farm in the Willamette Valley between February and November. Rory is not expected to work at the farm in December and January but is still an employee of the vegetable farm and does not have other paid employment during this time. Rory does not qualify for PFMLI benefits in December and January because Rory is not requesting leave from work as Rory is not expected to work and perform services at the vegetable farm and does not miss any wages during that time.

*Example 2:* Selena is an instructor at Oregon State University with a 9-month contract that begins in September and ends in June. Selena also teaches summer courses at the University of Oregon on Monday, Tuesday, and Thursday between June and September. Oregon State University does not expect Selena to teach during summer break, but the University of Oregon does. Selena qualifies for PFMLI benefits for a qualifying purpose on Mondays, Tuesdays, and Thursdays during summer break because Selena is requesting leave from work as Selena is expected to work at the University of Oregon on these days and would not receive wages while unable to perform services.

*Example 3:* Fiona works at a restaurant as a server and is typically expected to work a five day work week Monday through Friday. Monday and Tuesday Fiona is serving an adult in custody sentence and on Thursday and Friday Fiona needs to take care of their father who has a serious health condition. Fiona qualifies for PFMLI benefits on Thursday and Friday as Fiona is requesting leave from work and is expected to work on these days and would not receive wages while unable to perform services due to a qualifying purpose. Fiona does not qualify for PFMLI benefits on Monday and Tuesday, even if they have a qualifying purpose, because Fiona is not requesting leave from work as Fiona is unable to perform services regardless of the qualifying purpose.

*Example 4:* Jack works as a store manager for a clothing store and is typically expected to work a five day work week from Tuesday through Saturday. Jack was approved for four weeks of PFMLI benefits to bond with a child after birth. After two weeks of bonding leave, Jack starts a six-month adult in custody sentence. Jack does not qualify for PFMLI benefits during the remaining two weeks of leave because Jack is not requesting leave from work during adult in custody time as Jack is unable to perform services for their employment regardless of the qualifying purpose. Once Jack completes the adult in custody sentence and resumes employment, Jack may again qualify for PFMLI benefits for a qualifying purpose.

(f) Submit an application for benefits in accordance with all requirements under ORS 657B.090 and OAR 471-070-1100;

(g) Have not exceeded their maximum paid leave and benefit amounts under ORS 657B.020 and OAR 471-070-1030 in the active benefit year; and

(h) Have no current disqualifications from receiving benefits due to:

(A) The individual being eligible to receive Workers' Compensation under ORS chapter 656, or Unemployment Insurance benefits under ORS chapter 657; or

(B) A director determination under ORS 657B.120 that the individual previously willfully made a false statement or willfully failed to report a material fact in order to obtain benefits.

(2) An individual may not exceed 12 weeks of paid leave per child for the purpose of caring for and bonding with the child during the first year after the birth or initial placement of the child, regardless if a new benefit year starts during the first year following birth or initial placement.

*Example ~~15~~:* Juan files an application for benefits for seven weeks of paid leave and is approved by the department to care for a family member with a serious health condition and begins a benefit year on November 5, 2023. After returning from this leave, Juan has five weeks of leave remaining in the balance of their benefit year. In March 2024, Juan and their partner adopt a child. Juan submits an application for benefits to the department and is approved for the remaining five weeks of paid leave in the benefit year in order to care for and bond with the newly adopted child. Juan's benefit year expires on November 2, 2024 and Juan submits a new application for benefits to the department. Juan is approved for leave to care for and bond with the same child and starts a new benefit year. Because Juan already bonded with the same child for five weeks in the prior benefit year, Juan may only take leave to care for and bond with that child for up to an additional seven weeks in the new benefit year.

*Example ~~26~~:* Julie files an application for benefits and is approved for leave for their own serious health condition and begins a benefit year on September 17, 2023. Julie takes two weeks of leave to recover from the serious health condition and then returns to work. In June 2024, Julie gives birth to twins. Julie submits an application for benefits to the department and is approved for ten weeks of leave to care for and bond with the first twin. Julie's benefit year expires on September 14, 2024 and then Julie submits another application for benefits to the department and is approved for twelve weeks of leave to care for and bond with the second twin, starting a new benefit year.

[Stat. Auth.: ORS 657B.340; Stats. Implemented: ORS 657B.015, 657B.020]

## 471-070-1100 – Benefits: Application for Benefits [Amended]

(1) To request Paid Family and Medical Leave Insurance (PFMLI) benefits provided under the state plan established in ORS 657B.340, a claimant must submit an application for benefits. An application must be submitted online or by another method approved by the department. For the application to be approved by the department, the application must be complete and must include, but is not limited to, the following:

(a) Claimant information, including:

(A) First and last name;

(B) Date of birth;

(C) Social Security Number or Individual Taxpayer Identification Number; and

(D) Contact information, including mailing address and telephone number.

(b) Documentation ~~verifying~~ or other information sufficient to establish the claimant's identity;

(c) Information about the claimant's current employment or self-employment for which they are requesting leave from work:

(A) Business name(s) and dates of employment or self-employment;

(B) Business address and contact information for all employers or self-employed businesses;

(C) Average number of work days worked per work week; and

(D) Any current breaks from work or anticipated future breaks from work that are unrelated to PFMLI leave.

(d) Information about the notice given to any employers under ORS 657B.040 and OAR 471-070-1310, if applicable, and the date(s) any notice was given;

(e) Information about the claimant's leave schedule, including:

(A) Employer(s) from which leave is being taken;

(B) Anticipated leave dates; and

(C) Whether the leave is to be taken in consecutive~~,~~ or ~~nonconsecutive,~~ intermittent periods.

(f) The type of leave taken by the claimant, which must be one of the following:

(A) Family leave;

(B) Medical leave; or

(C) Safe leave.

(g) Verification of the reason for the leave, including:

(A) For family leave to care for or bond with a child, verification consistent with OAR 471-070-1110;

(B) For family leave to care for a family member with a serious health condition, verification consistent with OAR 471-070-1120 and an attestation that the claimant has a relationship equal to "family member" under ORS 657B.010 and is caring for a family member with a serious health condition;

(C) For medical leave, verification consistent with OAR 471-070-1120; or

(D) For safe leave, verification consistent with OAR 471-070-1130.

(h) If the claimant is requesting up to two additional weeks of leave for limitations related to pregnancy, childbirth or a related medical condition, documentation that the claimant is currently pregnant or was pregnant within the year prior to the start of the additional two weeks of leave;

(i) Information about the claimant's eligibility to receive Workers' Compensation under ORS chapter 656 or Unemployment Insurance benefits under ORS chapter 657; and

(j) A written or electronically signed statement declaring under oath that the information provided in support of the application for PFMLI benefits is true and correct to the best of the individual's knowledge.

(2) An employee who has PFMLI coverage solely through an employer with an equivalent plan approved under ORS 657B.210 must apply for PFMLI benefits by following the employer's equivalent plan application guidelines.

(3) An employee who is simultaneously covered by more than one employer's equivalent plan approved under ORS 657B.210, or that is simultaneously covered by the state plan and at least one employer with an equivalent plan, must apply separately under all plans they are covered under and from which they are taking leave by following the respective application guidelines for each plan.

(4) A complete application for PFMLI may be submitted to the department up to 30 calendar days prior to the start of family, medical, or safe leave and up to 30 calendar days after the start of leave. Applications submitted outside of this timeframe, either early or late, will be denied, except in cases where a claimant can demonstrate an application was submitted late for reasons that constitute good cause under section (~~6~~5) of this rule.

(5) ~~In cases where good cause for the late submission of an application, the department may accept the application up to one year after the start of leave.~~ Good cause exists when a claimant ~~demonstrates~~ establishes by satisfactory

evidence submitted to the department that factors or circumstances beyond the claimant's control prevented the claimant from submitting a completed application within the required timeframe under section (4) of this rule.

~~(6)~~ Good cause for the late submission of an application is determined at the discretion of the department and includes, but is not limited to, the following:

(a) A serious health condition that results in an unanticipated and prolonged period of incapacity and that prevents an individual from timely filing an application; or

(b) A demonstrated inability to reasonably access a means to file an application in a timely manner, such as an inability to file an application due to a natural disaster or a significant and prolonged department system outage.

(6) If the department determines the claimant demonstrated good cause for late submission of an application, the department may accept the application up to one year after the start of leave.

[Publications: Contact the Oregon Employment Department for information about how to obtain a copy of the publication referred to or incorporated by reference in this rule.]

[Stat. Auth.: ORS 657B.090, 657B.100, 657B.340; Stats. Implemented: ORS 657B.090, 657B.100]

## 471-070-1120 – Benefits: Verification of a Serious Health Condition [Amended]

A claimant applying for Paid Family and Medical Leave Insurance (PFMLI) benefits for their own serious health condition or to care for a family member with a serious health condition must submit verification of the serious health condition from a health care provider that includes:

(1) The health care provider's first and last name, type of medical practice/specialization, and their contact information, including mailing address and telephone number;

(2) The patient's first and last name;

(3) The claimant's first and last name, when different from the patient identified in section (2) of this rule;

(4) The approximate date on which the serious health condition commenced or when the serious health condition created the need for leave;

(5) A reasonable estimate of the duration of the condition or recovery period for the patient;

(6) A reasonable estimate of the frequency and duration of intermittent leave and estimated treatment schedule, if applicable; and

(7) Other information as requested by the department to determine eligibility for the PFMLI benefits; including:

(a) For medical leave, information sufficient, including a diagnosis, to establish that the claimant has a serious health condition; or

(b) For family leave, information sufficient, including a diagnosis, to establish that the claimant's family member has a serious health condition.

[Stat. Auth.: ORS 657B.090, 657B.340; Stats. Implemented: ORS 657B.090]

## 471-070-1200 – Benefits: Claim Processing; Additional Information [Amended]

In addition to the information required from a claimant under OAR 471-070-1100 and OAR 471-070-~~14301~~1205, the department may request that a claimant provide additional information necessary to establish facts relating to eligibility or qualification for benefits. Unless a time frame is otherwise defined under statute or rule or is specified by an authorized department representative, the claimant must respond to all requests for information within the following time frames:

(1) 14 calendar days from the date of the request for information, if the request was sent by mail to the claimant's last known address as shown in the department's records.

(2) 10 calendar days from the date of the request for information, if the request was sent by telephone message, ~~fax,~~ email, or other electronic means.

(3) When the response to the request for information is sent to the department by mail, the date of the response shall be the date of the postmark affixed by the United States Postal Service. In the absence of a postmarked date, the date of the response shall be the most probable date of mailing as determined by the department.

(4) The time frames specified in sections (1) and (2) of this rule may be extended at the department's discretion when a claimant can demonstrate they failed to provide a timely response for good cause. Good cause exists when the claimant responds to the department as soon as practicable and establishes by satisfactory evidence that circumstances beyond the claimant's control prevented the claimant from providing a timely response, including, but not limited to, an incapacitating serious health condition or a situation related to safe leave.

[Stat. Auth.: ORS 657B.090, 657B.340; Stats. Implemented: ORS 657B.090]

## 471-070-1205 – Benefits: Weekly Claims

(1) A claimant taking Paid Family and Medical Leave Insurance (PFMLI) benefits on an intermittent leave schedule or for more than one qualifying purpose as described in OAR 471-070-1430, must file a weekly claim in order to receive PFMLI benefits for that week.

(2) For a weekly claim to be approved, the weekly claim must be complete and include, but is not limited to, the following information:

(a) The dates of the work week being claimed;

(b) The number of work days of leave taken for each leave type specified under 657B.020;

(c) The number of days worked during the work week;

(d) Claimant's eligibility to receive Workers' Compensation under ORS chapter 656 or Unemployment Insurance benefits under ORS chapter 657 for the work week;

(e) Any changes to employment, including any new employment or employment that has ended since the benefit application or last weekly claim; and

(f) A written or electronically signed statement declaring under oath that the information provided in support of the weekly claim is true and correct to the best of the claimant's knowledge.

(3) The weekly claim must be submitted only after that work week has ended and no later than 30 calendar days following the end of the work week in which the family, medical, or safe leave was taken. Weekly claims submitted after

30 calendar days will be denied, except in cases where a claimant can demonstrate a weekly claim was submitted late for reasons that constitute good cause under section (5) of this rule.

(4) For claimants receiving intermittent leave benefits, the sum of the number of work days worked during a week, combined with the number of days of leave taken in the work week on the weekly claim report shall not exceed the average number of work days that the claimant would typically work in their work week, as reported on the application for benefits.

*Example:* Eddie submits an application for benefits that states their typical work week consists of four work days. The weekly benefit amount is $875.00. Eddie submits their first weekly claim report and reports three days worked and three days of leave, for a total combination of six days of work and leave reported. Because the weekly benefit amount is based on the typical work week provided on Eddie's initial application for benefits, Eddie will only be paid for one of the three days of leave reported on the weekly claim report as Eddie worked three days out of a typical four day work week; therefore, the sum of the days worked and the days of leave cannot be more than four days. The benefit amount paid for the first week of leave to Eddie is $218.75 [($875.00 weekly benefit amount divided by 4 work days) x 1 day of payable leave].

(5) Good cause exists when a claimant establishes by satisfactory evidence submitted to the department that factors or circumstances beyond the claimant's control prevented the claimant from submitting a weekly claim within the required timeframe under section (3) of this rule. Good cause for the late submission of a weekly claim is determined at the discretion of the department and includes, but is not limited to, the following:

(a) A serious health condition that results in an unanticipated and prolonged period of incapacity and that prevents a claimant from timely filing a weekly claim; or

(b) A demonstrated inability to reasonably access a means to file a weekly claim in a timely manner, such as an inability to file a weekly claim due to a natural disaster or a significant and prolonged department system outage.

(6) If the department determines the claimant demonstrated good cause for late submission of a weekly claim, the department may accept the weekly claim up to one year after the leave was taken.

[Stat. Auth.: ORS 657B.340; Stats. Implemented: ORS 657B.020, 657B.090]

## 471-070-1210 – Benefits: Updates to a Claim for Leave [Amended]

(1) After submitting an application for benefits as specified in OAR 471-070-1100, a claimant must notify the department within 10 calendar days of any changes to the information provided on their application and provide additional information, if applicable, including, but not limited to, changes to the claimant's:

(a) First and last name;

(b) Mailing address;

(c) Telephone number;

(d) Current employment or self-employment;

(e) Average number of work days worked per work week;

(f) Leave schedule;

(g) Type of leave taken; or

(h) Eligibility to receive Workers' Compensation under ORS chapter 656 or Unemployment Insurance benefits under ORS chapter 657.

(2) During an open claim, the claimant's average number of work days worked per work week will stay throughout the entire claim unless the claimant has a current employment or self-employment change or adds a new type of leave taken. Any such change shall affect only those benefits payable for dates after the date on which the department receives notice of such change as described in OAR 471-070-1210, or the effective date of the leave if later, if the change is approved.

(3) Failure to notify the department of any changes to the information provided on an application for benefits as specified in section (1) of this rule may result in a delay, denial, overpayment, or disqualification of weekly benefits.

[Publications: Contact the Oregon Employment Department for information about how to obtain a copy of the publication referred to or incorporated by reference in this rule.]

[Stat. Auth.: ORS 657B.090, 657B.340; Stats. Implemented: ORS 657B.090, 657B.100]

## 471-070-1310 – Benefits: Employee Notice to Employers Prior to Commencing Leave [Amended]

(1) Except as provided in ORS 657B.040(5) when advance notice to the employer is not feasible for safe leave, an eligible employee must give notice to their employer when commencing a period of family, medical, or safe leave.

(2) If the leave is foreseeable, an eligible employee must give oral notice at least 30 calendar days before commencing leave and an employer may require an eligible employee to give written notice at least 30 calendar days before commencing ~~a period of paid family, medical, or safe~~ leave. Examples of foreseeable leave include, but are not limited to, an expected birth, planned placement of a child, or a scheduled medical treatment for a serious health condition of the eligible employee or a family member of the eligible employee.

(~~2~~3) If the leave is not foreseeable, an eligible employee may commence leave without 30 calendar days advance notice. However, the eligible employee must give oral notice to the employer within 24 hours of the commencement of the leave and must provide written notice within three days after the commencement of leave. Leave circumstances that are not foreseeable include, but are not limited to, an unexpected serious health condition of the eligible employee or a family member of the eligible employee, a premature birth, an unexpected adoption, an unexpected foster placement by or with the eligible employee, or for safe leave.

(~~3~~4) An employer may require a written notice to include:

(a) Employee's first and last name;

(b) Type of leave;

(c) Explanation of the need for leave; and

(d) Anticipated timing and duration of leave.

(45) Written notice includes, but is not limited to, handwritten or typed notices, and electronic communication such as text messages and email that is consistent with the employer's known, reasonable, and customary policies. Whether leave is to be ~~continuous~~ consecutive or is to be taken intermittently, notice need only be given one time, but the employee shall advise the employer as soon as practicable if dates of scheduled leave change, are extended, or were initially unknown.

(~~5~~6) An employer that requires eligible employees to provide written notice before the eligible employee commences leave, must outline the requirements in the employer's written policy and procedures. A copy of the written policy and procedure must be provided to all eligible employees at the time of hire and each time the policy and procedure changes and in the language that the employer typically uses to communicate with the employee. If the employer requires the employee to provide written notice, the policy and procedures must include a description of the ~~penalties~~ benefit reduction under section (~~9~~10) of this rule that may be imposed by the department for not complying with the employer's notice requirements.

(~~6~~7) An employee does not need to expressly mention the Paid Family and Medical Leave Insurance program when giving their employer written or oral notice under this rule.

(~~7~~8) The department will notify the employer pursuant to OAR 471-070-1320(1) when a claimant has applied for paid family, medical, or safe leave benefits. The employer may respond to the notice from the department within 10 calendar days from the date on the department's notice to report if the claimant did not provide the required notice under this rule. The employer may respond to the department's notice either online or by another method approved by the department.

(~~8~~9) If the employer does not respond to the department's notice as described in section (~~7~~8) of this rule within 10 calendar days from the date on the department's notice, the claimant's application for benefits shall be processed using the information available in the department's records.

(~~9~~10) If the department determines that the claimant did not provide the required leave notice to the employer, the department may impose a ~~penalty~~ benefit reduction by issuing a decision and reducing the first weekly benefit amount payable under ORS 657B.090 by 25 percent. The first benefit payment issued will be reduced by the entire amount of the reduction. If the first benefit payment issued is less than the entire amount of the reduction, the subsequent benefit payment(s) will be reduced until the entire reduction has been applied. ~~The penalty will be a 25 percent reduction, except when it would reduce the weekly benefit amount below the minimum benefit amount provided in ORS 657B.050(2)(b). The claimant may appeal the imposition of the penalty in accordance with ORS 657B.410 and applicable administrative rules.~~

*Example 1:* Sanomi did not provide the required notice to their employer about taking consecutive family leave. Sanomi's weekly benefit amount is $140. Sanomi is taking leave from work for family leave for all the work days within the first week. ~~A~~The 25 percent benefit reduction ~~of their benefit amount in the first week~~ equals $35 ($140 weekly benefit amount x .25 reduction). ~~so~~ Sanomi's first benefit payment would have been $140, but will ~~the first weekly benefit amount would~~ be reduced to $105 ($140 benefit payment - $35 reduction). Because the first benefit payment is more than the amount of the reduction, the entire reduction is applied to the first benefit payment. ~~However, the minimum weekly benefit amount is $120, so Sanomi's first weekly benefit payment would be $120 instead.~~

~~(10) For leave taken in increments of less than a full work week, the total penalty amount shall be divided by the number of work day increments contained in a work week and deducted from benefits paid for that number of work days.~~

*Example 2:* Joy did not provide the employer with the required leave notice about taking intermittent medical leave. Joy normally works an average of ~~four~~ six work days in a work week and ~~was~~ is unable to work ~~the entire week~~ one of those days each week due to taking medical leave. Joy's weekly benefit amount is $~~400~~600, which is prorated to $100 per work day of leave ~~because Joy only works an average of four days in a work week~~($600 weekly benefit amount / 6 days per week). The ~~penalty~~ amount of the benefit reduction is $~~25~~150 ~~per work day~~ ($~~100~~600 weekly benefit amount x .25 reduction). Joy's first benefit payment would have been $100 because one day of leave from work during that week is taken. However, the first benefit payment is reduced to $0 after the reduction amount is applied ($100 first week

benefit payment - $150 reduction). The second benefit payment would have been $100 because one day of leave from work during the second week is taken. However, the second benefit payment is reduced to $50 after the remaining reduction amount is applied ~~amount is reduced to $75~~ ($100 second week benefit payment - $50 remaining reduction). ~~per work day minus $25 penalty per work day) for each of the first four work days of leave taken, as four days equals one work week.~~ The third benefit payment is not reduced as the entire amount of the reduction has been applied.

(11) The claimant may appeal the imposition of the benefit reduction in accordance with ORS 657B.410 and applicable administrative rules.

(~~11~~12) The employee may request a waiver of the benefit reduction ~~penalty~~ for good cause. Good cause will be found when the employee establishes, by satisfactory evidence, that factors or circumstances beyond the employee's reasonable control prevented the employee from providing the required notice to the employer. Good cause includes, but is not limited to, an incapacitating serious health condition or a situation related to safe leave, for which the employee provided notice to the employer as soon as was practicable.

(~~12~~13) If an employee receives their first weekly benefit payment, and the department subsequently determines that proper notice to the employer was not made by the employee, an amount equal to the 25 percent benefit reduction ~~penalty~~ will be considered an erroneous overpayment, and that ~~penalty~~ amount of the reduction may be collected from the employee in accordance with ORS 657B.120.

[Stat. Auth.: ORS 657B.040, 657B.340; Stats. Implemented: ORS 657B.040]

## 471-070-1420 – Benefits: Leave Periods and Increments [Amended]

(1) A claimant may request family, medical, or safe leave provided under ORS chapter 657B in either consecutive~~,~~ or ~~nonconsecutive,~~ intermittent periods of leave.

(2) Leave may be taken and benefits may be claimed in increments that are equivalent to one work day or one work week, as defined in OAR 471-070-1000. When claiming an increment of less than a full work week, the number of work days that can be reported during a week is established by the average number of work days typically worked per week by the claimant.

(3) When benefits are claimed in an increment that is equivalent to one work day or one work week, leave must be taken from all employers and from all self-employed work for the entirety of that period to receive benefits.

*Example 1:* Kelsey is taking family leave and is currently an employee at a university and an architecture firm. Kelsey works for the university in the morning of her work day and the architecture firm in the evenings on the same work day. Kelsey must take leave from both places of employment for the work day in order to claim benefits for the work day. If Kelsey only missed work from the university due to the family leave for that one work day, it would not qualify for benefits.

*Example 2:* Chloe is taking medical leave and is currently an employee at a department store and a self-employed delivery driver. Chloe works four work days total per work week: Monday and Tuesday at the department store and Wednesday and Saturday as a self-employed delivery driver. Chloe must take leave for all four work days from both jobs in order to claim a full work week of benefits. If Chloe only missed work on Monday and Saturday due to medical leave, Chloe would qualify for benefits for two work days instead of a work week.

[Stat. Auth.: ORS 657B.340; Stats. Implemented: ORS 657B.020, 657B.090]

## 471-070-1430 – Benefits: Simultaneous Qualifying Purposes

(1) A claimant may take Paid Family and Medical Leave Insurance (PFMLI) for more than one qualifying purpose under ORS 657B.020 during the same week, provided the claimant submits a separate and complete application as described in 471-070-1100 for each qualifying purpose, is for a different qualifying event, and is approved to take leave for each qualifying purpose.

(2) The multiple qualifying events taken within the same week can be for the same type of qualifying purpose; for example, a claimant may take family leave for two different family members, each with their own serious health condition.

(3) A claimant shall not receive a PFMLI benefit payment for more than one type of qualifying purpose taken on a single work day.

(4) For any week in which a claimant takes leave for more than one qualifying purpose, that claimant must file a weekly claim, as described in OAR 471-070-1205, to receive PFMLI benefits.

[Stat. Auth.: ORS 657B.340; Stats. Implemented: ORS 657B.020]

## 471-070-1440 – Benefits: Weekly Benefit Proration [Amended]

(1) A claimant who takes leave in work day increments shall be paid a prorated benefit amount based on the number of work days of leave taken in the work week.

(2) The benefit amount paid for a work day is calculated by dividing the claimant's weekly benefit amount by the average number of work days that the claimant would typically work in their work week.

(3) The total benefit amount paid for leave taken in work day increments is calculated by multiplying the benefit amount paid for a work day, rounded to the nearest whole cent, by the number of work days of leave taken for the work week, ~~rounded to the nearest whole cent, and~~ not to exceed the weekly benefit amount.

*Example 1:* Allison submits an application for benefits that states their typical work week consists of five work days. The weekly benefit amount is $1,000.00. Allison states on the application that they will take leave for three of the five days that Allison typically worked in the work week for six weeks. The ~~weekly~~ benefit amount paid to Allison for ~~the six~~each week~~s~~ is $600 [($1,000.00 weekly benefit amount divided by 5 work days) x 3 days on leave in the work week]. Assuming nothing changes, Allison will receive a total benefit amount of $3,600 [($600 weekly benefit amount paid) x 6 weeks].

*Example 2:* Lamar submits an application for benefits that states their typical work week consists of three work days and they will take leave for one of the three days in each of the four weeks. The weekly benefit amount is $400.00. The ~~weekly~~ benefit amount paid ~~for~~ each week to Lamar is $133.33 [($400.00 weekly benefit amount divided by 3 work days) x 1 day on leave in the work week]. Assuming nothing changes, Lamar will receive a total benefit amount of $533.32 [($133.33 weekly benefit amount paid) x 4 weeks].

[Stat. Auth.: ORS 657B.090, 657B.340; Stats. Implemented: ORS 657B.090]

## 471-070-1445 – Benefits: Self-Employed Benefit Calculation

(1) For any self-employed individual who elects Paid Family and Medical Leave Insurance (PFMLI) coverage under OAR 471-070-2010 and pays contributions as provided in OAR 471-070-2030, the weekly benefit amount that an individual may qualify for is determined as follows:

(a) If the self-employed individual's average weekly income is equal to or less than 65 percent of the average weekly wage, the individual's weekly benefit amount shall be 100 percent of the self-employed individual's average weekly income.

(b) If the self-employed individual's average weekly income is greater than 65 percent of the average weekly wage, the individual's weekly benefit amount is the sum of:

(A) 65 percent of the average weekly wage; and

(B) 50 percent of the self-employed individual's average weekly income that is greater than 65 percent of the average weekly wage.

(2) Notwithstanding section (1) of this rule:

(a) The maximum weekly benefit amount is 120 percent of the average weekly wage.

(b) The minimum weekly benefit amount is five percent of the average weekly wage.

(3) If a self-employed individual is taking less than a full week of leave, the department will prorate the weekly benefit amount as specified in OAR 471-070-1440.

[Stat. Auth.: ORS 657B.340; Stats. Implemented: ORS 657B.050]

## 471-070-1450 – Benefits: Benefit Payment Methods

(1) Paid Family and Medical Leave Insurance (PFMLI) Benefits shall be paid by such method as the director may approve.

(2) The department's primary payment method to any claimant approved to receive PFMLI benefits shall be through direct deposit into a checking or savings account in a financial institution in the United States as an electronic funds transfer. "Electronic funds transfer" has the same meaning as provided in ORS 293.525.

(3) Claimants who do not apply for direct deposit will be paid by a stored value card, including but not limited to, ReliaCard Visa.

(4) If the department determines that it is not feasible to issue payment to a claimant through direct deposit or a stored value card, then the department may issue a check to the claimant.

[Stat. Auth.: ORS 293.525, 657B.340; Stats. Implemented: ORS 293.525, 657B.050]

## 471-070-1460 – Benefits: Lost, Stolen, or Destroyed Benefit Checks

(1) When a benefit check has been lost, stolen, or destroyed and for purposes of this rule:

(a) A benefit check is "lost" if the claimant never received an issued check, and the check's whereabouts is unknown or it was received and cannot be found.

(b) A benefit check is "stolen" if the claimant never received an issued check, or it was received and the check was taken or cashed by another without the authorization of the payee, whether or not the other person's identity is known.

(c) A benefit check is "destroyed" if an issued check has not been cashed and has been rendered nonnegotiable.

(d) "Forgery" of a benefit check has the same meaning as provided in ORS 165.007 and further defined in 165.002.

(2) If a benefit check has been issued but not cashed and the claimant completes a written sworn statement that the benefit check was lost, stolen, or destroyed, the check will be reissued in compliance with ORS 293.475 if at least ten calendar days from the date the original check was issued has elapsed. If the original check and replacement check are both received and cashed by the claimant, the claimant shall be liable for repayment of the overpayment to the department.

(3) If the benefit check has been issued and cashed and it is alleged that the check was not signed by the claimant or the claimant's authorized agent, a determination will be made on the validity of the endorsement:

(a) If the endorsement is determined to be the claimants or the claimant's authorized agent, the director will notify the claimant by letter and no replacement check will be issued;

(b) In the case of forgery, or an unauthorized, non-valid, or lack of endorsement, a replacement check will be issued if the claimant is due benefits, unless the claimant participated in forgery, received any portion of the benefits, or benefited from the funds.

(c) The department will advise the State Treasurer of the forged check.

[Stat. Auth.: ORS 657B.340; Stats. Implemented: ORS 293.475]

## 471-070-1465 – Benefits: Payment of Benefits Due to a Deceased Individual

(1) In the event of the death of a claimant to whom a Paid Family and Medical Leave Insurance (PFMLI) benefit application was received by the department in accordance with OAR 471-070-1100 and PFMLI benefits are due under this chapter, but the benefits remain unpaid, in whole or in part, such benefits may be paid to any individual designated in section (4) of this rule by submitting a written request to the department.

(2) When the estate is not in probate and the claimant is entitled to benefit payments that the sum is not in excess of $10,000, benefit payments may be made to survivors by classes described in section (4) of this rule upon filing a written request as described in section (3) of this rule.

(3) A written request to the department must include, but is not limited to, the following information:

(a) Claimant's first and last name;

(b) Claimant's Social Security Number or Individual Taxpayer Identification Number;

(c) Claimant's Paid Leave ID number, if known;

(d) Date of Death;

(e) Survivor's first and last name;

(f) Survivor's contact information, including mailing address and telephone number;

(g) Relationship to claimant;

(h) Evidence of authority;

(A) Next of kin (spouse, child, or parent);

(B) Court order granting appointment of administrator; or

(C) Executor of will.

(i) Documentation to establish survivor identification; and

(j) Proof of claimant's death.

(4) If the department receives more than one written request for the benefit payment due to a deceased individual, the unpaid benefit payment will be issued in the following order of precedence if the sum of the benefit payments is less than $10,000:

(a) Surviving spouse;

(b) Trustee of a revocable inter vivos trust created by the decedent;

(c) Children;

(d) Parents;

(e) Brothers and sisters;

(f) Nephews and nieces.

(5) When the estate is in probate and the claimant is entitled to benefit payments or the sum of the benefit payments is in excess of $10,000, the estate has to go through probate before the benefit payments can be dispersed by the department.

(6) Request for unpaid PFMLI benefits must be submitted within six (6) months from the claimant's date of death. If the request is submitted outside of this timeframe, the request will be denied, except in cases where a survivor can demonstrate the request was submitted late for reasons that constitute good cause under section (7) and (8) of this rule.

(7) Good cause for the late submission of a request for benefits is determined at the discretion of the department and includes, but is not limited to, the following:

(a) A serious health condition that results in an unanticipated and prolonged period of incapacity and that prevents a survivor from timely submitting a written request for benefits;

(b) A demonstrated inability to reasonably access a means to file a request for the survivor benefits in a timely manner, such as an inability to file the written request for benefits due to a natural disaster or a significant and prolonged department system outage;

(c) Determination of survivorship was in litigation; or

(d) The estate was in probate.

(8) If the department determines the survivor has submitted proper evidence of authority for good cause as described in section (7) of this rule, the department may accept the request for reissue of benefits due up to one year from the claimant's date of death.

(9) No benefit checks will be reissued to survivors other than those listed in sections (1) through (4) of this rule. In the absence of a valid request for reissue of benefit payments due, the benefit check(s) will be canceled and the monies permanently returned to the PFMLI Trust Fund.

[Stat. Auth.: ORS 657B.090, 657B.340; Stats. Implemented: ORS 293.490, 657B.090]

## 471-070-1470 – Benefits: Benefit Payment Offsets

(1) After the calculations described in OAR 471-070-1440 and 471-070-2270 occur, the weekly benefit payment is further reduced, as applicable, by the priories stated in section (2) of this rule before the department issues the weekly benefit payment to the claimant.

(2) The priority of additional offsets to the weekly benefit payment are:

(a) The benefit reduction described under ORS 657B.040 and OAR 471-070-1310.

(b) Federal personal income tax withholdings described under OAR 471-070-1480.

(c) State personal income tax withholdings described under OAR 471-070-1480.

(d) Child support orders described under OAR 471-070-1490.

(e) Funds due to entities that serve a garnishment or levy on the Oregon Employment Department.

(f) Paid Family and Medical Leave Insurance benefit overpayments described under ORS 657B.120 and OAR 471-070-1510.

(3) Weekly benefit payments of less than $1.00, after all offsets, will not be issued to the claimant.

[Stat. Auth.: ORS 657B.340; Stats. Implemented: ORS 657B.050]

## 471-070-1480 – Benefits: Federal and State Voluntary Tax Withholding

(1) A claimant receiving Paid Family and Medical Leave Insurance (PFMLI) benefits can elect to voluntarily have federal or state personal income tax withholding. To elect voluntary withholding, the claimant must notify the department on an approved method.

(2) When the department receives the claimants notification requesting withholding, the department will:

(a) Withhold at a rate of 10 percent for federal personal income taxes pursuant to IRC section 3402 (p) for future benefit payments issued.

(b) Withhold at a rate of eight percent for Oregon personal income taxes for future benefit payment issued.

(3) The amount of voluntary withholding from a claimant benefit payment will be rounded to the nearest cent.

(4) The amount of voluntary withholding from a claimant benefit payment will be held in the PFMLI Trust fund and:

(a) Transferred to the Internal Revenue Service in the time and manner required for withholdings under IRC section 3402.

(b) Transferred to the Department of Revenue in the time and manner provided by the Department of Revenue under ORS chapter 316 and rule.

(5) The election will remain in effect until the claimant submits to the department an authorization for tax withholding form indicating the department to stop withholding. The withholding will stop with the next benefit payment issued after the authorization to stop is received by the department.

(6) The PFMLI program shall provide information to a claimant about the total federal and state personal income tax withheld for the calendar year from PFMLI benefit payments on the Form 1099 no later than January 31st following the calendar year.

March 24, 2023
[Stat. Auth.: ORS 657B.340; Stats. Implemented: ORS 657B.050]

## 471-070-1490 – Benefits: Child Support Withholding Obligations

(1) The Director of the Employment Department may enter into an interagency agreement with the Division of Child Support of the Department of Justice to withhold from the Paid Family and Medical Leave Insurance (PFMLI) benefits due the claimant the amount of child support due.

(2) If the department determines a claimant is qualified for PFMLI benefits and finds the claimant owes child support obligations, the department shall deduct and withhold an amount from PFMLI benefits as determined by the Division of Child Support.

(3) Any amount deducted and withheld under section (2) of this rule shall for all purposes be treated as if it were paid to the claimant as PFMLI benefits.

(4) The amount deducted and withheld will be submitted on behalf of the claimant to the Division of Child Support for distribution to the recipient.

(5) A claimant who has had child support withheld, shall have appeal rights for the withholding. However, the appeal is limited to the issue of the authority of the Employment Department to deduct and withhold and the accuracy of the amount so deducted and withheld.

(6) The appeal for the child support withheld must be filed as described in OAR 471-070-8005 no later than 60 calendar days after the delivery date of the affected benefit payment and is confined to the issues provided in section (5) of this rule.

[Stat. Auth.: ORS 657B.340; Stats. Implemented: ORS 657B.400]

## 471-070-1510 – Benefits: Repayment of Overpaid Benefits; Interest [Amended]

(1) The director may issue an assessment to a claimant for an overpayment each time a claimant receives Paid Family and Medical Leave Insurance (PFMLI) benefits to which the claimant was not entitled.

(2) If the director determines that a claimant has received benefits to which the claimant was not entitled:

(a) The claimant may be required to repay the amount of benefits that the claimant was overpaid; and

(b) The director may secure the repayment of the overpaid benefits through the deduction from future benefits otherwise payable to the claimant under ORS 657B.100~~; and~~

~~(c) The director may deduct all or any part of the claimant's future weekly benefits up to the amount of the prior overpayment~~.

(3)

(a) If the department determines that a claimant is at fault for an overpayment, due to the claimant's error, false statement, or failure to report a material fact, then the claimant may be liable for interest on the overpayment amount. Interest that the claimant is liable for shall be paid and collected at the same time repayment of benefits is made by the individual, at the rate of one percent per month or fraction of a month. Interest will accrue, beginning on the first day of the month that begins 60 calendar days after the administrative decision establishing the overpayment becomes final.

(b) If the department determines that a claimant is not at fault for an overpayment, then the claimant shall not be liable for interest on the amount to be repaid as a result of the overpayment.

(4) If the director deducts the claimant's future weekly benefits under section (2)(b) of this rule, the deduction shall be from the claimant's future weekly benefits up to the amount of the prior overpayment. The deduction will begin with the first benefit payment issued after the overpayment becomes final.

(5) If there are multiple benefit overpayment segments, the deduction described in section (4) of this rule will apply to the oldest warranted debt first. Once all warranted debt is paid, the deduction will apply to the oldest non-warranted debt.

(6)~~(a)~~ Deductions from PFMLI benefits under section (2)(b) of this rule shall be applied solely to the amount of overpaid benefits for which the claimant is liable.

~~(b) Amounts collected through other means shall be applied first to penalties, then interest, and then to the overpaid benefit amount.~~

(~~7~~5) Deductions for the repayment of benefits paid erroneously may be deducted from benefits due to the claimant with no time limitations.

[Stat. Auth.: ORS 657B.120, 657B.340; Stats. Implemented: ORS 657B.120]

## 471-070-3710 – Assistance Grants: Application Requirements [Amended]

(1) An employer may apply for an assistance grant only:

(a) After an eligible employee has been approved by the department for family leave, medical leave or safe leave; and

(b) Prior to the end of the fourth month following the last day of the eligible employee's period of leave.

(2) An application for a grant must be submitted online or by another method approved by the department. The grant application must be complete and include the following:

(a) Information about the employer applying for the grant, including:

(A) Business Identification Number or Federal Employer Identification Number;

(B) Business name;

(C) Business address; and

(D) Business contact person's name and contact information;

(b) Information about the eligible employee taking leave for which the employer is requesting the grant, including but not limited to:

(A) First and last name;

(B) Claim identification number;

(C) Start date of the leave; and

(D) End date or expected leave end date;

(c) Information about the grant being requested, including:

(A) Type of grant requested; and

(B) Grant amount requested, when applicable;

(d) Written documentation demonstrating that the employer:

(A) Hired a replacement worker to replace an eligible employee on family leave, medical leave or safe leave, including the replacement worker's name, start date, and Social Security Number or Individual Taxpayer Identification Number; or

(B) Incurred significant additional wage-related costs due to an eligible employee's use of leave and the amount, Including, but not limited to, receipts, personnel or payroll records, or sworn statements; and

(e) Acknowledgement that:

(A) The employer is required to pay the employer contribution for a period of eight calendar quarters in accordance with OAR 471-070-3750; and

(B) The employer could be required to repay an assistance grant if employer is later deemed to be ineligible in accordance with OAR 471-070-3850.

(3) An employer that receives a grant under ORS 657B.200(1)(b) may submit a revised grant application requesting an additional grant under ORS 657B.200(2).

(a) The revised grant application must contain:

(A) A revised leave end date or revised expected leave end date showing an extension of the initial period of leave requested; and

(B) Written documentation demonstrating that a replacement worker was hired to replace an eligible employee on family leave, medical leave or safe leave including the replacement worker's name, start date, and Social Security Number or Individual Taxpayer Identification Number.

(b) The revised grant application submitted under this section will not count against an employer's application limit under ORS 657B.200(3).

(4) An incomplete application will not be reviewed by the department until and unless it is completed and will not count against an employer's application limit under ORS 657B.200(3).

(5) The department may deny an application for a grant for reasons that include, but are not limited to, the employer's failure to demonstrate that:

(a) The employer hired a replacement worker or incurred significant additional wage-related costs; or

(b) The replacement worker hired or significant additional wage-related costs incurred was due to an employee's use of family leave, medical leave or safe leave.

(6) A denied grant application will count against an employer's application limit under ORS 657B.200(3).

[Publications: Contact the Oregon Employment Department for information about how to obtain a copy of the publication referred to or incorporated by reference in this rule.]

March 24, 2023

[Stat. Auth.: ORS 657B.200, 657B.340; Stats. Implemented: ORS 657B.200]

# CONTRIBUTIONS & RECOVERY

*ORS 657B.150 establishes wage reporting and contributions payment requirements for employers and employees and ORS 657B.190, 657B.320, 657B.370, 657B.910, 657B.920, and others establish consequences for employers that fail to report and make payments. This section of the administrative rules expand on recovery and how withholding of contributions occur. All definition sections may be expanded and reorganized before formal rulemaking. If an administrative rule is being amended, the amended changes are show in red below.*

## 471-070-0010 – Definitions [Amended]

(1) "Final" means a decision made under this chapter is in effect as of the end of the timeframe to request a hearing as described in OAR 471-070-8005 unless the individual files a request for a hearing with the department regarding the decision within the allowed timeframe.

(2) "Paid Leave Oregon" means the Paid Family and Medical Leave Insurance program as described under ORS chapter 657B.

(3) "Volunteer" as used in ORS 657B.010(13)(b)(E), means an individual who performs services for a public agency or private non-profit organizations for civic, charitable, or humanitarian reasons, without promise, expectations or receipt of compensation for services rendered, during the hours worked.

[Stat. Auth.: ORS 657B.340; Stats. Implemented: ORS 657B.010, 657B.340]

## 471-070-0470 – Wages: Paid Leave Oregon Benefits

Paid Leave Oregon benefits issued by the Employment Department, employer or administrator through an approved equivalent plan, are not wages.

[Stat. Auth.: ORS 657B.340; Stats. Implemented: ORS 657B.010]

## 471-070-3000 – Contributions: Definitions [Amended]

~~(1) "Legal Fees" means fees attributed to the recording or processing of a Distraint warrant on behalf of the department for the purposes of collecting Paid Family and Medical Leave Insurance (PFMLI) contributions pursuant to ORS 657B.300 and search fees attributed to garnishments issued to financial institutions pursuant to ORS 18.790.~~

~~(2)~~ "Maximum wage amount" means the maximum employee wages per employer subject to Paid Family and Medical Leave Insurance (PFMLI) contributions per calendar year.

[Stat. Auth.: ORS 657B.340; Stats. Implemented: ORS 657B.150~~, 657B.300~~]

## 471-070-3040 – Contributions: Withholding of Employee Contributions [Amended]

(1) An employer may not deduct from the employee's subject wages more than the maximum allowable amount of 60 percent of the total contribution rate described in OAR 471-070-3010 for a pay period rounded to the nearest cent.

(2) When performing the calculation described in section (1) of this rule, the intermediate steps shall not be rounded, only the final step shall be rounded to the nearest cent.

*Example:* On February 2, 2023 Jennifer earned $1,769.89 in subject wages for the pay period. The employer calculates Jennifer's contributions by multiplying the subject wages by the total contribution rate of 1% (not rounded) by the employee contribution rate of 60% (rounded to the nearest cent). The total potential contribution is $17.6989 ($1,769.89 x 0.01 = $17.6989, not rounded). Jennifer's employee portion of the potential contribution is $10.62

($17.6989 x 0.60 = $10.61934, rounded to the nearest cent is $10.62). The employer's contribution (if a large employer) is $7.08 ($17.6989 x 0.40 = $7.07956, rounded to the nearest cent is $7.08).

(~~3~~2) If an employer fails to deduct the maximum allowable employee share of the contribution rate for a pay period, the employer is considered to have elected to pay that portion of the employee's contribution that the employer failed to deduct, and the employer is liable to pay that portion of the employee share under ORS 657B.150(5) or ORS 657B.210(5) for that pay period if not corrected within the quarter. The employer may deduct from the employee's subject wages the amount they failed to deduct within the quarter.

(~~4~~3) An employer may elect to pay the employee's contribution, in whole or in part, and must provide a written notice, policy, or procedure to the employee or enter into a collective bargaining agreement with the employee specifying that the employer is electing to pay the employee contribution, making the employer liable for that portion of the employee contribution. The employer must give written notice of an update to its notice, policy, or procedure or amendment to its collective bargaining agreement to the employee at least one pay period prior to any reduction by the employer of the employee contribution amount that the employer previously elected to pay.

(~~5~~4) If an employer has elected to pay, in whole or in part, the employee portion of contributions as stated in section (~~4~~3) of this rule, the employer may not deduct the amount the employer elected to pay from a future paycheck of the employee.

[Stat. Auth.: ORS 657B.340; Stats. Implemented: ORS 657B.150, 657B.210]

## 471-070-3310 – Contributions: Application of Payments [Repeal]

~~(1) "Designated payments" are payments received by the department specifying a specific quarter(s) or Distraint warrant.~~

~~(2) "Undesignated payments" are payments received by the department that are not specified for a specific quarter(s) or Distraint warrant.~~

~~(3) Except as otherwise provided by statute, or as directed by a court of competent jurisdiction, payments made to the department by or on behalf of an employer for Paid Family and Medical Leave Insurance (PFMLI) contributions; and legal fees (as defined in OAR 471-070-3000), penalties and interest related to those PFMLI contributions; in accordance with the provisions of ORS chapter 657B shall be identified by the department as either "Designated Payments" or "Undesignated Payments" and will be credited to the employer's account in the following order of priority:~~

~~(a) Undesignated Payments:~~

~~(A) To the oldest unwarranted unpaid quarter balance in the following order:~~

~~(i) Penalties;~~

~~(ii) Interest; and then~~

~~(iii) PFMLI Contributions.~~

~~(B) After the payment amounts under subsection (a)(A) of this rule have been applied, any remaining amounts shall then be credited to the most recent unpaid Distraint warrant in the following order:~~

~~(i) Legal Fees;~~

~~(ii) Penalties;~~

~~(iii) Interest; and then~~

~~(iv) PFMLI Contributions.~~

~~(b) Designated Payments:~~

~~(A) Legal Fees;~~

~~(B) Penalties;~~

~~(C) Interest; and then~~

~~(D) PFMLI Contributions.~~

~~(4) The department may identify categories of indebtedness for internal accounting procedures and may retire each category separately in the order of priority set forth in section (3) of this rule.~~

~~(5) Nothing in this rule shall be construed in any way as abridging or limiting the authority or powers of the director granted under ORS chapter 657B.~~

~~(6) The employees listed in OAR 471-070-0550 may act on behalf of the director for purposes of section (4) and (5) of this rule.~~

~~(7) Notwithstanding any instructions to the contrary by or on behalf of the employer, payments will be applied in the manner specified in this rule.~~

~~(8) Credit balances will be treated as payments for purposes of this rule.~~

~~[Stat. Auth.: ORS 657B.340; Stats. Implemented: ORS 657B.120, 657B.150, 657B.320, 657B.430, 657B.910]~~

## 471-070-5200 – Due Dates for Balances Owed to the Department

Unless otherwise specified in statute or administrative rule, balances owed to the department under ORS chapter 657B is considered due and delinquent as of the date the decision causing the balance due owing becomes final, as defined in OAR 471-070-0010.

[Stat. Auth.: ORS 657B.340; Stats. Implemented: ORS 657B.340]

## 471-070-5210 – Application of Payments

(1) “Designated payments” are payments received by the department specifying a specific debt, distraint warrant, or quarter(s) in the case of contributions.

(2) “Legal fees” means fees attributed to the recording or processing of a distraint warrant on behalf of the department for the purpose of collecting amounts owed under ORS chapter 657B pursuant to ORS 657B.300 and search fees attributed to garnishments issued to financial institutions pursuant to ORS 18.790.

(3) “Undesignated payments” are payments received by the department that are not specified for a debt, distraint warrant, or quarter(s) in the case of contributions.

(4) Except as otherwise provided by statute, or as directed by a court of competent jurisdiction, payments made to the department by or on behalf of an individual or employer for amounts owed under ORS chapter 657B; legal fees, and related penalties; in accordance with the provisions of ORS chapter 657B shall be identified by the department as either

"Designated payments" or "Undesignated payments" and will be credited to the individual's or employer's account in the following order of priority:

(a) Undesignated payments:

(A) To the oldest unwarranted unpaid balance in the following order:

(i) Penalties;

(ii) Interest; and then

(iii) Principle.

(B) After the payment amounts under subsection (a)(A) of this rule have been applied, any remaining amounts shall then be credited to the most recent unpaid warranted balance in the following order:

(i) Legal Fees;

(ii) Penalties;

(iii) Interest; and then

(iv) Principle.

(b) Designated payments:

(A) Legal Fees;

(B) Penalties;

(C) Interest; and then

(D) Principle.

(5) The department may identify categories of indebtedness for internal accounting procedures and may retire each category separately in the order of priority set forth in section (4) of this rule.

(6) Nothing in this rule shall be construed in any way as abridging or limiting the authority or powers of the director granted under ORS chapter 657B.

(7) The employees listed in OAR 471-070-0550 may act on behalf of the director for purposes of section (5) and (6) of this rule.

(8) Notwithstanding any instructions to the contrary by or on behalf of the individual or employer, payments will be applied in the manner specified in this rule.

(9) Credit balances will be treated as payments for purposes of this rule.

[Stat. Auth.: ORS 657B.340; Stats. Implemented: ORS 657B.040, 657B.120, 657B.150, 657B.240, 657B.300, 657B.320, 657B.330, 657B.370, 657B.430, 657B.910, 657B.920]

## 471-070-8530 – Good Cause for Failure to File Reports or Pay Contributions [Amended]

(1) As used in ORS 657B.910 and 657B.920 and OAR 471-070-8520, good cause for failure to file all required reports or to pay all contributions due will be found when the employer establishes, by satisfactory evidence, that factors or

circumstances beyond the employer's reasonable control caused the delay in filing the required report or paying the contribution due.

(2) In determining good cause under section (1) of this rule, the director may consider all circumstances, but shall require at a minimum, that the employer:

(a) Prior to the date the report or contributions were due, gave notice to the department, when reasonably possible, of the factors or circumstances which ultimately caused the delay;

(b) Filed the required report or paid the contributions due within seven calendar days after the date determined by the director to be the date the factors or circumstances causing the delay ceased to exist;

(c) Made a diligent effort to remove the cause of the delay and to prevent its recurrence; ~~and~~

(d) Provided an official police report, or other documentation acceptable to the director or an authorized representative, that was made within 20 calendar days of a criminal act, or discovery of the act, if the delay was due to a criminal act by any party~~.~~; and

(e) Provided copies of timely filed reports and proof of all related payments to another jurisdiction, if the delay was due to making contributions to the incorrect jurisdiction. Good cause will be considered if within 30 calendar days of the date the department or employer determines the contributions are due to the Paid Family and Medical Leave Insurance Trust Fund instead of another jurisdiction, filed the required report and paid the contributions due.

(3) In applying sections (1) and (2) of this rule, a lack of funds on the part of the employer shall not constitute good cause.

(4) In applying sections (1) and (2) of this rule, failure to notify the department of an updated mailing address shall not constitute good cause.

[Stat. Auth.: ORS 657B.340; Stats. Implemented: ORS 657B.910, 657B.920]

## 471-070-8540– Penalty Amount When Employer Fails to File Report [Amended]

(1) If an employer fails to file all required reports within the time period described in ORS 657B.920(2), the department may assess a late filing penalty in addition to any other amounts due.

(2) The penalty shall be 0.02 percent of the employer's employees total Paid Family and Medical Leave Insurance (PFMLI) subject wages for the late report rounded to the nearest $100. If the penalty is calculated to be less than $100, the amount will be the minimum $100.

*Example:* Athena's Yoga and Piyo Studio has 20 employees with total PFMLI subject wages for first quarter of 2024 of $120,000. Athena does not file the 2024 Oregon Quarterly Tax Report for the first quarter. The department sends a written notice warning on May 10, 2024, to Athena's Yoga and Piyo Studio, but they do not correct the deficiency by filing the needed report. A penalty of $24 (0.0002 x $120,000 PFMLI subject wages) is calculated by the department. But since the minimum penalty is $100, the penalty imposed by the department is $100.

(3) The penalty is final 20 calendar days from the date on which the department assessed the late filing penalty, unless the employer files a request for hearing as described in OAR 471-070-8005.

[Stat. Auth.: ORS 657B.340; Stats. Implemented: ORS 657B.920]

# EQUIVALENT PLANS

*ORS 657B.210 to 657B.260 establishes that an employer may apply to offer an equivalent plan for Paid Leave Oregon benefits for its employees and sets requirements for the application process, provision of benefit, and withdrawal and termination of an equivalent plan. Further details are provided in the rules in this section to describe the timeframe the equivalent plan employers have to respond to the department's letters and when the final payments are due if the equivalent plan is withdrawn or terminated. All administrative rules may be expanded, reorganized, or deleted before formal rulemaking. If an administrative rule is being amended, the amended changes are show in red below.*

## 471-070-2200 – Equivalent Plans: Definitions [Amended]

(1) "Administrative Costs" means the costs incurred by an employer directly related to administering an equivalent plan which include, but are not limited to, cost for accounting, recordkeeping, insurance policy premiums, legal expenses, and labor for human resources' employee interactions related to the equivalent plan. Administrative costs do not include rent, utilities, office supplies or equipment, executive wages, cost of benefits, or other costs not immediately related to the administration of the equivalent plan.

(2) "Administrator" means either an insurance carrier/company, third-party administrator, or payroll company acting on behalf of an employer to provide administration and oversight of an approved equivalent plan.

(3) "Declaration of Intent" means a legally binding, signed agreement from an employer documenting the employer's intent and commitment to provide an approved equivalent plan with an effective date of September 3, 2023.

(4) "Employer administered equivalent plan" means an equivalent plan in which the employer offers a private plan where the employer assumes all financial risk associated with the benefits and administration of the equivalent plan, whether it is administered by the employer or a third-party administrator.

(5) "Equivalent plan" means a Paid Family and Medical Leave Insurance (PFMLI) plan approved by the department that provides benefits that are equal to or greater than the benefits provided by the Oregon PFMLI program established under ORS 657B.340.

(6) "Fully insured equivalent plan" means an equivalent plan in which the employer purchases an insurance policy from an insurance company approved to sell PFMLI products by the Oregon Department of Consumer and Business Services (DCBS) Division of Financial Regulation and the benefits related to the plan are administered through the insurance policy.

(7) "Successor in interest" means an employer who is transferred or otherwise acquires all or substantially all of the components parts of a business, including the employees necessary to carry on day to day operations and essential business functions in the same manner and for the same purposes as carried on prior to the acquisition or transfer ~~successor to another's interest in property, organization, trade, or business that is carried on and controlled substantially as it was before the transfer in which there is a complete transfer to the successor of the organization, trade, or business, and substantially all of its assets~~.

(8) "Substantial reduction in personnel," as used in ORS 657B.260 and applicable administrative rules, means a situation in which the number of employees employed by the predecessor of the organization, trade, or business is reduced by at least 33 percent by the successor in interest.

[Stat. Auth.: ORS 657B.340; Stats. Implemented: 657B.210, 657B.260~~, 657B.340~~]

## 471-070-2210 – Equivalent Plans: Application Requirements and Effective Date [Amended]

(1) An employer must submit a separate application and receive department approval for an employer administered equivalent plan or a fully insured equivalent plan for each Business Identification Number. The application must be submitted to the department online or by another method prescribed by the department. An incomplete application will not be reviewed by the department.

(2) For an equivalent plan to be reviewed by the department, the equivalent plan application must include the following:

(a) Information about the employer applying for the equivalent plan, including:

(A) Business Identification Number and Federal Employer Identification Number;

(B) Business name;

(C) Business address; and

(D) Business contact's name and contact information;

(b) A copy of the employer administered equivalent plan or in the case of a fully insured equivalent plan, a copy of the insurance policy or the insurance product and the selected variables the employer is choosing;

(c) A completed questionnaire attesting that the plan meets all requirements for equivalent plans; and

(d) Other information as required on the department's equivalent plan application form.

(3) Employers must pay a nonrefundable $250 application fee with every:

(a) Application for approval of a new equivalent plan; or

(b) Application for reapproval or amendment of an equivalent plan that has substantive amendments to the equivalent plan that was originally approved by the department.

(4) Employers must pay a nonrefundable $150 application fee with every application for reapproval of an equivalent plan that has no changes or only non-substantive amendments to the equivalent plan that was originally approved by the department.

(5) There is no fee for either of the following:

(a) Application for amendment of an equivalent plan that has substantive or non-substantive amendments to the equivalent plan that were required by Oregon, local, or federal law changes or changes to the contribution rate and maximum wage amount as described in OAR 471-070-3010;

(b) Application for amendment of an equivalent plan that has non-substantive amendments to the equivalent plan that was originally approved by the department.

(6) "Substantive amendments" to an equivalent plan that was originally approved by the department as used in sections (3), (5), and (11) of this rule include, but are not limited to, any of the following:

(a) Changing from a fully insured equivalent plan to an employer administered equivalent plan;

(b) Changing from an employer administered equivalent plan to a fully insured equivalent plan;

(c) Changing the fully insured equivalent plan insurance policy to reduce benefits or leave types, regardless of whether the new plan is from the same insurance provider or another insurance provider;

(d) Changing the questionnaire answers for the equivalent plan; or

(e) Changing the employer administered equivalent plan to reduce benefits or leave types.

(7) "Non-substantive amendments" as used in section (4), (5), and (11) of this rule include, but are not limited to, any of the following:

(a) Updating solvency documents for employer administered plans;

(b) Updating the application for an equivalent plan that does not amend the equivalent plan, includes, but is not limited to, the following:

(A) Changing business or contact information, or

(B) Correcting typographical errors; or

(c) Increasing benefits or leave types, regardless of whether the new plan is from the same insurance provider or another insurance provider.

(8) Approved equivalent plans become effective:

(a) For new equivalent plans, on the first day of the calendar quarter immediately following the date of approval by the department; and

(b) For amendments to a previously approved equivalent plan, on the first day of the calendar quarter immediately following the date of approval of the amendment by the department. If approval of the amendment is denied, the employer must continue to follow the originally approved equivalent plan.

(9) An application for reapproval must be submitted by an employer annually for a three-year period following the original effective date of the plan. The application for reapproval is due 30 days prior to the anniversary of the original effective date of the approved equivalent plan

*Example:* ABC Corporation submitted an equivalent plan application to the department on February 4, 2023. The department sent an approval letter for the equivalent plan that was dated March 5, 2023 and the equivalent plan becomes effective on April 1, 2023. The application for reapproval is due on March 1 of 2024, 2025, and 2026; 30 days prior from the original anniversary of the effective date of April 1st.

(10) For the purposes of determining the reapproval requirement, the equivalent plan approval date and effective date are the first day of the calendar quarter immediately following the date of the original approval letter from the department.

(11) After the three-year period following the original effective date of the plan, an application for reapproval must be submitted anytime a substantive amendment occurs. When a substantive amendment occurs after the three-year period, a reapproval application must be submitted by an employer as described in section (9) of this rule. For a non-substantive amendments, a copy of the revised equivalent plan must be submitted to the department at the time the change becomes effective.

(12) In addition to the information required in this rule, the department may request additional information necessary to establish facts relating to eligibility for an equivalent plan. Unless a timeframe is otherwise defined under statute or

rule or is specified by an authorized department representative, the employer must respond to all requests for information within the following time frames:

(a) 14 calendar days from the date of the request for information, if the request was sent by mail to the employer's last known address as shown in the department's records.

(b) 10 calendar days from the date of the request for information, if the request was sent by telephone, email, or other electronic means.

(13) When the response to the request for information is sent to the department by mail, the date of the response shall be the date of the postmark affixed by the United States Postal Service. In the absence of a postmarked date, the date of the response shall be the most probable date of mailing as determined by the department.

[Publications: Contact the Oregon Employment Department for information about how to obtain a copy of the publication referred to or incorporated by reference in this rule.]

[Stat. Auth.: ORS 657B.~~220~~210, 657B.340; Stats. Implemented: ORS 657B.210~~, 657B.220~~, 657B.230]

## 471-070-2220 – Equivalent Plans: Plan Requirements [Amended]

In order for an equivalent plan to be approved by the department, the plan must at a minimum:

(1) Cover all Oregon employees who have been continuously employed with the employer for at least 30 calendar days, regardless of hours worked, including full-time, part-time, temporary workers hired by the employer, and replacement employees hired to temporarily replace eligible employees during PFMLI leave. Any employees who were eligible for benefits under their previous Oregon employer's equivalent plan, who begin working for a new employer with an approved equivalent plan must be automatically covered for benefits under the equivalent plan offered by the new employer as described in ORS 657B.250;

(2) Provide family leave as described in ORS 657B.010(17) and applicable administrative rules;

(3) Provide medical leave as described in ORS 657B.010(19) and applicable administrative rules;

(4) Provide safe leave as described in ORS 657B.010(21) and applicable administrative rules;

(5) Allow eligible employees to take family leave, medical leave, or safe leave in a benefit year for periods of time equal to or longer than the duration of leave provided under ORS 657B.020;

(6) Provide eligible employees weekly benefit amounts equal to or greater than benefits provided under ORS 657B.050;

(7) Allow family leave, medical leave, or safe leave to be taken in increments or nonconsecutive periods as provided under ORS 657B.090;

(8) Impose no additional conditions or restrictions on the use of family leave, medical leave, or safe leave beyond those explicitly authorized by ORS chapter 657B and applicable administrative rules;

(9) Provide that the employee contributions withheld by an equivalent plan shall not be greater than the employee contributions that would be charged to employees under ORS 657B.150 and determined annually under OAR 471-070-3010;

(10) Ensure employee contributions that are received or retained under an equivalent plan are used solely for equivalent plan expenses, are not considered part of an employer's assets for any purpose, and are held separately from all other employer funds;

(11) Meet all equivalent plan requirements provided in ORS 657B.210 and applicable administrative rules;

(12) Provide for decisions on benefit claims, to be in writing, either in hard copy or electronically if the employee has opted for electronic notification. Decisions on benefit claim approvals must include the amount of leave approved, the weekly benefit amount, and a statement indicating how the employee may contact the department to request the eligible employee's average weekly wage amount if the employee believes the benefit amount may be incorrect. Denial decisions must include the reason(s) for denial of benefits along with an explanation of an employee's right to appeal the decision and instructions on how to submit an appeal.

(13) Provide an appeal process to review benefit decisions when requested by an employee that also requires the employer or administrator to issue a written decision. The employee must have at least ~~20~~ 60 calendar days from the date of the written denial to request an appeal with the employer or administrator, if applicable, or as soon as practicable if there is good cause for the delay beyond the ~~20~~ 60 calendar days as described in OAR 471-070-2400(7). The employee, and the employer, or administrator have 20 calendar days from the date the appeal is received, or as soon as practicable if there is good cause as described in OAR 471-070-2400(7), to resolve the appeal and for the employer or administrator to issue a written appeal determination letter along with an explanation of the department's dispute resolution process as described in OAR 471-070-2400 if an appeal is denied;

(14) Provide that the equivalent plan employer or administrator must make all reasonable efforts to make a decision on whether to allow the claim and issue the first payment of any benefits to an employee within two weeks after receiving the claim or the start of leave, whichever is later. Subsequent benefit payments must be provided weekly by a fully insured equivalent plan and benefit payments may be paid according to the existing paycheck schedule for employees under an employer administered equivalent plan; and

(15) Ensure a written notice poster for the equivalent plan as described in OAR 471-070-2330, will be given to all eligible employees, at the time of hire and each time the policy or procedure changes, in the language that the employer typically uses to communicate with the employee.

[Stat. Auth.: ORS 657B.340; Stats. Implemented: ORS 657B.210]

## 471-070-2400 – Equivalent Plans: Disputes between an Equivalent Plan Employer and Employee, Request for Hearing [Amended]

(1) As required by ORS 657B.420, the department will provide a dispute resolution process to assist in resolving disputes between employers or equivalent plan administrators, as applicable, and employees regarding coverage and benefits provided under an employer's approved equivalent plan if the appeal with the employer or administrator is not otherwise resolved.

(2) Prior to the department providing a dispute resolution process, the employee and employer or administrative must follow the equivalent plan appeal process described in OAR 471-070-2220(13).

(3) In the event that the employee and employer or administrator are unable to resolve an appeal on a coverage or benefit decision through the equivalent plan's appeal process, the employee may request a dispute resolution assistance through the department. The dispute resolution request must:

(a) Be in writing, by phone, online, or in another format approved by the department.

(b) Include a copy of the employer or administrator appealable decision and any documents related to the dispute, including documents supporting or referencing the employer's or administrator's decision.

(c) Be received within ~~20~~ 60 calendar days of the issuance of the appealable decision, or as soon as practicable if there is good cause as described under section (7) of this rule, for the delay beyond ~~20~~ 60 calendar days.

(4) The department shall review the dispute resolution request and issue an advisory decision based on the equivalent plan benefit requirements within 20 calendar days of the receipt of the dispute resolution request.

(5) If the employer or administrator does not comply with the department's administrative dispute decision, the employee may still submit a wage claim with the Oregon Bureau of Labor and Industries under ORS chapter 652.

(6) The payment of any benefits not placed in issue by the request for the administrative hearing shall continue during the appeal process.

(7) Good cause for late appeal or dispute resolution request includes, but is not limited to, the following:

(a) Difficulty obtaining verification;

(b) Factors or circumstances beyond the employee's, employer's, administrator, or department's reasonable control that prevented them from providing information;

(c) A serious health condition that results in an unanticipated and prolonged period of incapacity and that prevents the employee or employer from timely providing information; or

(d) A demonstrable inability to reasonably access a means to respond in a timely manner, such as an inability to file a leave report due to a natural disaster or a significant and prolonged outage.

[Stat. Auth.: ORS 657B.420; Stats. Implemented: ORS 183.635, 657B.420]

## 471-070-2450 – Equivalent Plans: Termination by the Department [Amended]

(1) The department may terminate an employer's equivalent plan due to reasons that include, but are not limited to:

(a) Misuse of employee contributions withheld or retained by the employer;

(b) Failure to adhere to the department approved equivalent plan or to report substantive equivalent plan changes to the department;

(c) Failure to adhere to applicable Paid Family and Medical Leave Insurance (PFMLI) program requirements, including but not limited to OAR 471-070-2220 and equivalent plan reporting requirements;

(d) Failure to file for reapproval as required in OAR 471-070-2210;

(e) Employer insolvency;

(f) Termination of the insurance policy by the plan administrator;

(g) Closure of a business; or

(~~g~~h) Failure to respond timely to the department's reasonable inquires for information about the equivalent plan.

(2) If the plan administrator plans to terminate an employer's insurance policy, the administrator must provide notice to the department at least 30 calendar days prior to the termination date. The termination date must be effective on the last day of a calendar quarter. The administrator's notice to the department should include:

(a) The original effective date of the fully insured equivalent plan policy; and

(b) The effective date of the termination requested by the administrator.

(3) If the department seeks to terminate an equivalent plan, the department will send the employer and administrator, if applicable, a notice of termination to the employer's last known address, or electronically when permitted, if the employer has opted for electronic notification, as shown in the department's records. The notice must provide:

(a) The reason(s) for the termination;

(b) Instructions on how to resolve the reason(s) for termination; and

(c) The effective date of termination, which must be the last day of a calendar quarter, absent further specified action by or on behalf of the employer.

(4) An employer may appeal the notice of termination in accordance with ORS 657B.410 and applicable administrative rules within 20 calendar days of the notice of termination.

(5) The employer or administrator must notify all employees of any equivalent plan termination within ten business days of the date on the notice of termination sent by the department.

(6) All applicable equivalent plan requirements, including but not limited to those outlined within OAR 471-070-2220 and equivalent plan reporting requirements, remain in effect until the effective date of any termination.

(7) The employer or administrator must pay or continue to pay benefits under the terms of the equivalent plan to eligible employees that were approved for or receiving benefits under the equivalent plan on the effective date of termination until the total amount of the benefit claim is paid, the duration of leave ends, or the benefit year ends, whichever occurs first. If the employer or administrator does not pay the benefits, the employee may file an appeal with the employer as described in OAR 471-070-2220(13) and then a dispute resolution request with the department as described in OAR 471-070-2400.

(8) Within 30 calendar days after the effective date of the termination of an equivalent plan, the employer must send to the department all reporting requirement information on benefit claims paid and administrative expenses incurred from the date of the last report provided to the department under the equivalent plan reporting requirements to the date of termination.

*Example:* Donald Mouse Partnership's equivalent plan became effective April 1, 2023. On January 31, 2024, Donald Mouse Partnership provided the aggregate equivalent plan information from April 1, 2023 to December 31, 2023. The equivalent plan is terminated effective March 1, 2024. By April 1, 2024, Donald Mouse Partnership must send the aggregate equivalent plan information from January 1, 2024 to February 29, 2024.

(9) ~~Upon the effective date of the termination of an equivalent plan, the employer must send to the department~~ Once the department receives the reporting requirements specified in section (8) of this rule, the department will provide an invoice of the contribution amounts due. The contribution amount due is calculated based on any contributions withheld from employee's wages that remain in the possession of the employer upon the effective date of the termination, minus an amount equal to the amount of any benefits due to be paid as required under section (7) of this rule and any anticipated administrative expenses. Once all required benefits are paid under section (7) of this rule, the employer must immediately send to the department any remaining contribution amounts due for deposit into the PFMLI Trust Fund.

(a) The decision for the contributions due become final on the effective date of termination, unless the employer requests an appeal in accordance with section (4) of this rule.

(b) Interest upon the contribution amount due from the employer shall accrue from the date of ~~termination~~ invoice(s) until paid to the department, in accordance with ORS 657B.320(3).

(10) Upon the effective date of an equivalent plan termination, the employer must begin paying employee and employer contributions, if required, in accordance with ORS 657B.150 and other applicable statutes and rules.

(11) After the department terminates an equivalent plan, the employer may not reapply for an equivalent plan approval within three years following the date of termination.

[Stat. Auth.: ORS 657B.340; Stats. Implemented: ORS 657B.210, 657B.220, 657B.240]

## 471-070-2460 – Equivalent Plans: Employer Withdrawal [Amended]

(1) An employer may withdraw from an approved equivalent plan that has been in effect for at least one year by submitting a withdrawal form online, by phone, or in another method prescribed by the department.

(2) The employer must provide notice to the department by submitting a withdrawal form at least 30 calendar days prior to the effective date of withdrawal. The effective date of the withdrawal is the later of one of the following dates:

(a) A date that is at least 30 calendar days after the date the withdrawal form is sent to the department and that is the last day of the immediately following calendar quarter; or

(b) The date that the equivalent plan has been in effect for one year.

(3) The employer or administrator must provide notice of the withdrawal from an equivalent plan to its employees at least 30 calendar days prior to the effective date of withdrawal. The notice, at a minimum, must include the effective date of the equivalent plan withdrawal and information about the state plan in accordance with ORS 657B.440.

(4) All equivalent plan requirements, including but not limited to those included in OAR 471-070-2220 and the equivalent plan reporting requirements, remain in effect until the effective date of the withdrawal, except as specified in section (5) of this rule.

(5) The employer or administrator must pay or continue to pay benefits under the terms of the equivalent plan to eligible employees that were approved or receiving benefits under the equivalent plan on the effective date of the withdrawal until the total amount of the benefit claim is paid, the duration of leave ends, or the benefit year ends, whichever occurs first. If the employer or administrator does not pay the benefits, the employee may file an appeal with the employer as described in OAR 471-070-2220(13) and then a dispute resolution request with the department as described in OAR 471-070-2400.

(6) Within 30 calendar days after the effective date of the withdrawal of an equivalent plan, the employer must send to the department all reporting requirement information on benefit claims paid and administrative expenses incurred from the last report provided to the department under the equivalent plan reporting requirements to the date of the withdrawal.

*Example:* XYZ Partnership's equivalent plan became effective July 1, 2023. On January 31, 2024, XYZ Partnership provided the aggregate equivalent plan information from July 1, 2023 to December 31, 2023. XYZ Partnership requested a withdrawal from the equivalent plan with an effective date of November 1, 2024 as the partnership is no longer in

business. By December 1, 2024, XYZ Partnership must send the aggregate equivalent plan information from January 1, 2024 to October 31, 2024.

(7) ~~Upon withdrawal of an equivalent plan, the employer must immediately send to the department~~Once the department receives the reporting requirements specified in section (6) of this rule, the department will provide an invoice of the contribution amounts due. The contribution amount due is calculated based on any contributions withheld from employee's wages that remain in the possession of the employer upon the effective date of the withdrawal, minus an amount equal to the amount of any benefits due to be paid as required under section (5) of this rule and any anticipated administrative expenses. Once ~~the~~ all required benefits are paid under section (5) of this rule, the employer must immediately send to the department any remaining contribution amounts due for deposit into the PFMLI Trust Fund.

(a) The contributions due become final on the effective date of the withdrawal.

(b) Interest upon the amount due from the employer shall accrue from the date of the ~~withdrawal~~ invoice(s) until paid to the department, in accordance with ORS 657B.320(3).

(8) Upon the effective date of the withdrawal of an equivalent plan, the employer must begin paying employee and employer contributions, if required, in accordance with ORS 657B.150 and other applicable statutes and rules.

[Publications: Contact the Oregon Employment Department for information about how to obtain a copy of the publication referred to or incorporated by reference in this rule.]

[Stat. Auth.: ORS 657B.240, 657B.340; Stats. Implemented: ORS 657B.240]