Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, Pennsylvania 19192-2235

Client Endorsement to Oregon Paid Family Medical Leave Insurance Policy

Policy Number:	ORP-800522
Policyholder:	Roku, Inc.
Policy Effective Date:	January 1, 2024
Initial Premium Rate:	$0.730 per $100 of Covered Payroll
Rate Guarantee Period:	December 31, 2024

Benefit Provisions:
Payment to a Covered Individual

Benefits will be paid to the Covered Individual only. Benefits cannot be assigned, unless such assignment is required by operation of law, such as child support.

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1601 Chestnut Street
Philadelphia, Pennsylvania 19192-2235

POLICYHOLDER Roku, Inc.
POLICY NUMBER ORP-800522 (the "Policy")

Life Insurance Company of North America ("We", "Us" and "Our"), will pay the benefits specified in the Exhibits to this policy subject to the terms and provisions of this policy.

GROUP INSURANCE POLICY PROVIDING PAID LEAVE OREGON (PAID FAMILY MEDICAL LEAVE) EQUIVALENT BENEFITS

This policy is intended to provide Oregon paid family and medical leave insurance benefits ("Paid Leave Oregon" or "PFML Law") that comply with the requirements of ORS chapter 657B and Chapter 471 (hereinafter respectfully referred to as PFML Statute and Regulations) as promulgated by the Oregon Employment Department ("OED" or "The Department") that are pertinent to Equivalent Plans. If any policy provisions do not conform to the requirements of the PFML Statute and Regulations, then Life Insurance Company of North America will administer paid benefits consistent with, or in excess to, the PFML Statute and Regulations. The provisions of this Policy must conform to the requirements of the PFML Statute and Regulations. If there are any conflicts between the policy and the PFML Statute and Regulations, the PFML Statute and Regulations will be the controlling requirements, unless the policy provisions are more advantageous to the Covered Individual in which case the policy terms will prevail.

If there are any changes, amendments, or regulatory clarifications to the provisions of the PFML Statute and Regulations, this policy and all claims practices will be promptly updated. This policy should be reviewed and updated at least annually to comply with any changes, amendments or regulatory clarifications.

EFFECTIVE DATE
This policy will take effect on January 1, 2024.

POLICY ANNIVERSARIES

The first Policy Anniversary will be January 1, 2025. Subsequent Policy Anniversaries will be January 1, 2026 and each January 1 thereafter. The policy shall automatically renew on each Policy Anniversary with continued payment of premium.

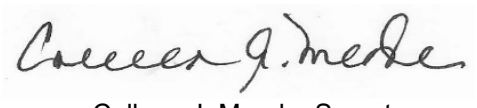
PREMIUM PAYMENTS

This policy, and the insurance provided under it, is issued in return for the payment of required Premiums. Premiums are payable at the home office of Life Insurance Company of North America or to its authorized agent. The first Premium is due on February 1, 2024. Any later Premiums are due monthly on the first day of each policy month. These dates are the Premium Due Dates. If Life Insurance Company of North America elects to terminate this Policy, We must provide at least 30 days' notice to the Policyholder and The Department prior to termination. If We elect to non-renew this Policy, We will provide at least 90 days' notice to the Policyholder and to The Department prior to non-renewing this Policy.

POLICY SITUS

This policy is issued for delivery in and governed by the laws of Oregon.

Signed as of this policy's effective date at Life Insurance Company of North America's home office in Pennsylvania.



Colleen J. Meade, Secretary

Scott Berlin, President

Non-Participating Renewable

IMPORTANT NOTICE(S):

Termination of this Policy by Us

During the first 12 months of this coverage being in force, We will only terminate coverage if the Policyholder fails to fulfill obligations under this policy, including the failure to pay premiums (subject to the Grace Period provision). We must provide at least 30 days' notice to the Policyholder and The Department prior to terminating this Policy. If We elect to non-renew this Policy, We must provide at least 90 days' notice to the Policyholder and to The Department prior to non-renewing this Policy.

A Covered Individual covered under this Policy shall retain all rights under ORS 657B and benefits will continue to be paid under the terms of the policy until the duration of PFML ends or the Benefit Year ends, whichever occurs first.

Department Termination of Equivalent Plan Approval

Under the terms of the PFML statute and regulations, The Department may, for cause, terminate the Equivalent Plan insured by this Policy. If so, the Policy will terminate in accordance with The Department's notice of such termination.

The Policyholder must notify all Employees of the Policy termination within ten business days of the date on the notice of termination sent by The Department.

After The Department terminates an Equivalent Plan, the Policyholder may not reapply for an Equivalent Plan approval within three years following the date of termination.

Policyholder Equivalent Plan Withdrawal or Termination of the Policy

The Policy will terminate automatically on the effective date of the Policyholder's withdrawal of its Equivalent Plan insured by this Policy.

The Policyholder may withdraw from an approved Equivalent Plan that has been in effect for at least one (1) year by submitting a withdrawal form online, by phone, or in another method prescribed by The Department.

The Policyholder may terminate the Policy effective on the last day of any calendar quarter by giving Us and The Department not less than 30 calendar days advance written notice which details the reason the Policy is being terminated.

Termination and Withdrawal by an Employer's successor in interest is subject to requirements outlined in OAR 471-070-2455.

The Employer 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.

Withdrawals by the Policyholder are effective on the date that is the later of:

- 30 calendar days after the date the withdrawal form is sent to The Department;
- the last day of the immediately following calendar quarter; and
- the date that the Equivalent Plan has been in effect for one year.

Employer Duties upon Termination

Upon the effective date of the termination of the Employer's Equivalent Plan insured by this Policy, the Policyholder must send to The Department any contributions withheld from Employee Wages that remain in the possession of the Policyholder minus an amount equal to the amount of any PFML Benefits due and any anticipated administrative expenses. Once all required PFML Benefits are paid, the Employer must immediately send to The Department any remaining contribution amounts for deposit into the PFMLI Trust Fund. Interest upon the contribution amount due shall accrue from the date of Equivalent Plan termination until paid to The Department, in accordance with ORS 657B.320(3).

Employer Duties upon Termination (Continued)

Upon the effective date of the Equivalent Plan insured by this Policy's termination, the Policyholder must begin paying to The Department Employee and Employer contributions, if required, in accordance with ORS 657B.150 and other applicable statutes and rules.

Within 30 calendar days after the effective date of the Policy termination, the Policyholder must send to The Department all reporting requirement information on PFML 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 the Policy termination.

Maximum Contribution Rate

If the Policyholder requires contributions toward premiums from Covered Individuals, this amount cannot be greater than the employee contribution that would be charged to employees under ORS 657B.150 and determined annually by The Department under OAR 471-070-3010. The Policyholder 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. The amount of wages withheld or diverted from Covered Individuals for contributions shall not be increased, except on an anniversary of the effective date of private plan or within thirty (30) days after The Department adjusts the contribution rate.

Penalty should Employer fail to file contribution reports when due

If the Policyholder fails to file or complete all required reports as described in OAR 471-070-3030 (quarterly/annual tax reports), The Department shall assess the penalty authorized by ORS 657B.910 (one percent of the Wages of the Employer's Employees in the preceding calendar year) on the Subject Wages. The Department shall send notice regarding penalty on or before October 20 of the year. The penalty shall become final on November 10 immediately following the assessment.

Employers with an approved Equivalent Plan are required to file combined payroll reports and provide Paid Leave Oregon wage information for all employees on Form 132 - Employee Detail Report and employee count information on Form OQ - Oregon Combined Quarterly Report.

On or after the date of the assessment, but prior to November 10 immediately following the assessment, the Employer may request waiver of the penalty based on good cause as defined in OAR 471-070-8530.

Employers Duty to Report Annual Aggregate Financial and Benefit Usage

Employers must submit an annual report on benefits usage, and employers who withhold employee contributions must additionally report financial information. The report is due on or before January 31 or along with the application for re-approval. Employers must submit an additional report at the time a plan is terminated or withdrawn. The Equivalent Plan report collects the following information:

- Number of the Oregon Paid Family and Medical Leave benefit applications received during each quarter and the qualifying purposes;
- Number of the Oregon Paid Family and Medical Leave benefit applications approved during each quarter, the qualifying purposes, and total amount of leave; and
- Number of the Oregon Paid Family and Medical Leave benefit applications denied during each quarter, the Qualifying Reason, the number of appeals made on denials, and the outcome of the appeals.

Upon request by The Department, we will report the above information on behalf of the Employer to The Department.

If the Employer withholds Employee contributions, they must also report the aggregate financial information:

- Total amount of employee contributions withheld during the year;
- Total plan expenses paid during the year, including the total benefit amount paid, and total Administrative Costs, if applicable;
- Balance of employee contributions held in trust at year end;
- Balance of benefits approved but not yet paid, if the plan is an employer administered plan; and

Employers Duty to Report Annual Aggregate Financial and Benefit Usage (Continued)

- Insurance premiums and Administrative Costs due for each quarter, but not yet paid.

Employer Requirement to Post Written Notice to Employees of Rights and Duties

The Policyholder must provide notice at time of hire and must display notice of the Oregon Paid Family and Medical Leave Employees Rights and Duties in accordance with ORS 657B.210(11)(c) and OAR 471-070-2330. This notice must be updated any time there is a change to the PFML law or procedures.

- The notice must be displayed in each of the buildings or worksites in areas that are accessible to and regularly frequented by Employees; and
- Must be provide to Employees assigned to remote work by hand delivery, regular mail, or electronic delivery, a copy of the notice to be displayed at each Employee's individual worksite. The notice must be delivered or sent to each Employee assigned to remote work upon the Employee's hire or assignment to remote work.

Electronic posting of the notice is not sufficient to satisfy posting requirements under this rule but may supplement worksite posting requirements.

The notice must be displayed in the language typically used to communicate with the Employee. If the Policyholder uses more than one language to communicate with the Employees assigned to a worksite, then they must display copies of the notice in each of the languages that would typically be used to communicate with the Employees assigned to that worksite.

An employer's failure to display or provide notice as required under this rule is an unlawful employment practice as provided in ORS 657B.070.

Employee Coverage Reporting Requests from The Department

Employers must respond to any request from The Department for information about current and prior employees employed in the Base Year within 10 calendar days from the date of the notice. This includes reporting changes to coverage when a plan becomes effective, is terminated, or withdrawn.

Job Protection and Health Insurance Continuation

The Policyholder has the obligation to ensure that Employees are afforded job protection if they are employed at least 90 consecutive calendar days prior to approved PFML. Anytime an Employee requests PFML, the Policyholder should address with the Employee whether the Employee is entitled to job protection under the Oregon Paid Family and Medical Leave statute and regulations, federal or Oregon Family Medical Leave Act (FMLA), other statutes (such as the Americans with Disabilities Act, the Pregnancy Discrimination Act, the Oregon Fair Employment Practice Act) or other company policies. The Policyholder is responsible for determining and communicating job protection eligibility.

During leave, the Policyholder must maintain any health care benefits the Employee had prior to taking such leave, for the duration of the leave, as if the Employee had continued in employment continuously during the period of leave. An Employer continuing health care insurance coverage for an employee on PFML may require that the Employee pay only the same share of premium costs during the leave that the Employee paid prior to the leave.

It is an unlawful employment practice to discriminate against an Eligible Employee who has invoked any provision of ORS 657B.060 or this rule. An Employee who alleges a violation of any provision of ORS 657B.060 or this rule may bring a civil action under ORS 659A.885 or may file a complaint with the Commissioner of the Bureau of Labor and Industries in the manner provided by ORS 659A.820.
See ORS 657B.060 and OAR 471-070-1330 for further description.

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CERTAIN RESPONSIBILITY OF THE POLICYHOLDER

For the purposes of this Policy, the Policyholder acts on their own behalf or as the employee's agent. Under no circumstances will you be deemed an agent of Life Insurance Company of North America.

Equivalent Plan Exemption Filing

It is the Policyholder's responsibility to file a Paid Leave Oregon equivalent plan application and any supporting documentation to The Department to obtain approval of their equivalent plan exemption. A separate application must be submitted and approved by The Department for each Business Identification Number.

Maintenance of Records

It is the Policyholder's responsibility to maintain sufficient records of the coverage under this Policy, including all additions, terminations, and changes. This information must be reported to Us regularly. The Policyholder must also maintain sufficient records of the essential details of each Covered Individual's insurance under this Policy, including wage and payment history.

Verification of Wages

The Policyholder is required to provide Life Insurance Company of North America with all required Wage information in order for a claim to be paid.
If required Wage information from prior employment or concurrent employment is not readily available to the Policyholder, Life Insurance Company of North America may request this information from the Covered Individual and/or will request consent from the Covered Individual to give Us authorization to obtain this information from The Department.

We reserve the right to examine these records at the place where they are kept during normal business hours or at a place mutually agreed upon by the Policyholder and Life Insurance Company of North America. Such records must be maintained by the Policyholder for at least 6 years after this Policy terminates.

If applicable, the Policyholder must furnish this information to Life Insurance Company of North America. The Policyholder may also be required to furnish these records to The Department upon their request.

The Policyholder may request information from Life Insurance Company of North America, including information about prior leaves taken by Covered Individuals and former Covered Individuals. The Policyholder is entitled to any information which is necessary to comply with Paid Leave Oregon.

PREMIUM RATE(S)

Calculation of Premium

Life Insurance Company of North America calculates premium consistent with the requirements of ORS 657B.

Premium Payment

All premiums are to be paid by the Policyholder to Life Insurance Company of North America on or before the Policy Effective Date and the Premium Due Dates, as stated on this Policy's face page. The Policyholder must pay premium in United States dollars. We may use any reasonable method to compute the premium due under the Plan. Premium payments should be sent to Our administrative office address.

Grace Period

Each Premium due after the Effective Date may be paid up to 31 days after its Premium Due Date. This period is known as the grace period. The insurance provided by this policy for which premium has not been paid will stay in effect during the grace period. We will notify the Policyholder in Writing that, if the Premium is not paid by the end of the grace period, such insurance will be subject to termination. If Life Insurance Company of North America fails to give Written notice to the Policyholder by the end of the grace period, such insurance will continue in effect until the date notice is given.

This provision serves as the required advance notice under the PFML Law that, if the Premium is not paid by the Premium Due Date or during the Grace Period, We will provide notice to the Policyholder and The Department and the plan will terminate the later of 30 days from notice of termination or the last day of the calendar quarter. The Policyholder is responsible for paying premium for coverage in effect during the Grace Period, any extension of such period, and any period for which insurance under this Policy was in effect and premium was not paid. If the Policy terminates for non-payment of premium, the Policyholder is responsible for providing advance notice to Covered Individuals and The Department and may be subject to additional payments, interest or penalties for not maintaining a private plan, as described in the TERMINATION OF THIS POLICY provision found in the IMPORTANT NOTICES section. If the Policy ends, the Policyholder will still owe Life Insurance Company of North America the Premium for the full period the Policy was in effect.

Renewals

Notice of new rates will be provided no less than 90 days prior to the renewal date. Such notice is not required if there is no change in premium rates at renewal.

Entire Contract

The entire contract is made up of the following:

- this policy and its Exhibits;
- the Policyholder's application; and
- all amendments and endorsements to this policy, if any.

Covered Individuals have the right to request this policy from the Policyholder, and may examine it, at a reasonable time and location.

Policy Changes

This Policy may be changed in whole or in part via an Amendment to the Policy. To be valid, an Amendment must be in writing, signed by an officer, and attached to this Policy. If the policy is amended, Life Insurance Company of North America will send the Policyholder all material Amendments at least 30 days prior to the proposed effective date of the Amendment.

No other person, including any agent, has authority to change or waive any part of this Policy.

In accordance with the requirements outlined in OAR 471-070-2210, the Employer is obligated to file with and secure approval from The Department changes to the Equivalent Plan insured by the Policy prior to the effective date of such changes.

If a Policy Amendment is not consistent with Paid Leave Oregon when the Policy has been submitted as part of an application for an equivalent plan exemption, The Department may withdraw the approval of your equivalent plan exemption. If an exemption is withdrawn, the Policyholder may be required to remit Contributions for your entire payroll retroactive to the start date of the Employer's or Covered Business Entity's approved exemption. The Policyholder may also be subject to additional interest and penalties established by The Department for not maintaining a private plan.

We may change the Policy, in whole or in part, when any change or clarification in law or governmental regulation affects our obligations under the Policy.

Any such change or amendment of the Policy may apply to current or future Covered Individuals.

Clerical Errors and Policy Administration

If Life Insurance Company of North America or the Policyholder makes a clerical error in keeping or providing the information, the Premium and/or benefits will be adjusted as warranted, according to the correct information. An error will not end insurance validly in effect, nor will it continue insurance validly ended or create insurance coverage where no coverage existed.

Any act undertaken by the Policyholder that relates to the insurance provided under this policy must be consistent with the terms of such insurance and with Life Insurance Company of North America's requirements.

Misstatement of Facts

If a Covered Individuals age or other data is misstated, or for any clerical error, an equitable adjustment in the premium or coverage due for the Covered Individual will be made. The true facts will be used to determine if and for what amount coverage should have been provided. Such adjustments will be limited to the 12-month period preceding the date we receive proof that an adjustment should be made.

Not in Lieu of Workers' Compensation

This Policy does not satisfy any requirement for Workers' Compensation insurance in Oregon.
In any week in which an employee is eligible to receive Workers' Compensation or unemployment benefits under ORS chapter 656 or 657, the employee is disqualified from receiving family and medical leave insurance benefits

Reinstatement

Life Insurance Company of North America does not allow for reinstatement of this Policy after it has been terminated by the Policyholder or Us. If We accept premium for the period after the date the Policy ends, such acceptance does not reinstate the Policy. Life Insurance Company of North America will refund any unearned premium as soon as reasonably possible, but in no event more than 30 days following receipt of the unearned premium.

Legal Actions

No legal action may be brought against Life Insurance Company of North America to recover on the Policy within sixty (60) days after written proof of loss has been given as required by the Policy. No action may be brought after three (3) years from the time written proof of loss is received.

Claims of Creditors

Except where prohibited by applicable law, benefits under this Policy will be exempt from execution, garnishment, attachment, or other legal or equitable process, for the debts or liabilities of the Covered Individuals or their beneficiaries.

Coordination of Leave

Any PFML must be taken concurrently with any leave taken by an Eligible Employee under ORS 659A.150 to 659A.186 or under the federal Family and Medical Leave Act of 1993 (P.L. 103-3) for the same purposes.

ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE ON COVERED INDIVIDUALS

Eligible Class(es)

An Eligible Person who meets the eligibility requirements of Paid Leave Oregon is defined under this policy as stated in **EXHIBIT 2 – SCHEDULE OF BENEFITS**.

Coverage Effective Date

Coverage will become effective for the Policyholder on the policy effective date as shown on the Policy face page.

An Eligible Person will become eligible under this policy on the later of:

- the policy effective date as shown on the Policy face page; and
- the date such person becomes a member of an eligible class.

Date Insurance for an Eligible Person Takes Effect

Insurance coverage under this Policy will go into effect on the Policy Effective Date,as shown on the Policy face page.

For Covered Individuals who become eligible for coverage after the Policy Effective Date, insurance will go into effect for each Covered Individual on the date that the individual becomes an Eligible Person.

Date Insurance for an Eligible Person Ends

The Covered Individual is no longer eligible for coverage under this Policy on the first of the following to occur:

1. the date this Policy terminates;
2. the date the Covered Individual no longer meets the meets the eligibility requirements defined under this policy;
3. the date the Covered Individual is no longer eligible for Paid Leave Oregon coverage pursuant to the PFML Law and terms of this Policy; or
4. the end of the period for which Premium has been paid for the Covered Individual due to employment ending.

We will provide coverage for a payable claim that occurs while the Covered Individual is covered under this Policy. Payments will continue for a claimant that began an approved claim while they were a Covered Individual until their approved leave duration has ended or their maximum period of time available has been exhausted even if insurance has ended.

Contributions

The Premium for this Policy may be funded by Contributions from Covered Individuals and the Policyholder, in accordance with ORS 657B. See the PREMIUMS RATE(S) section for details on the Premium rate, Contribution limits, and payment of Premium. If the Policyholder requires contributions toward premiums from Covered Individuals, this amount cannot be greater than the employee contribution that would be charged to employees under ORS 657B.150 and determined annually by The Department under OAR 471-070-3010. The Policyholder 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. 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.

Benefit Duration

The maximum durations of PFML Benefits in a Benefit Year available to a Covered Individual who has a Qualifying Reason are:

1. Medical Leave - Up to 12 weeks if a Covered Individual has a Serious Health Condition that prevents them from working.

2. Family Leave
   a. Up to 12 weeks for the birth, Adoption, or Foster Care placement of a Child.
      A Covered Individual may not exceed 12 weeks of Family Leave Benefits 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 of if a new Benefit Year starts during the first year following birth or initial placement.
   b. Up to 12 weeks to Care for a Family Member who has a Serious Health Condition.

3. Safe Leave - Up to 12 weeks for Safe Leave.

A Covered Individual is eligible for no more than 12 total weeks, in the aggregate, of PFML Benefits in a single Benefit Year. However, a Covered Individual may qualify for up to two additional weeks of PFML Benefits for limitations related to pregnancy, childbirth or a related medical condition, including but not limited to lactation, for a total amount of PFML not to exceed 14 weeks per Benefit Year.

Calculation of Weekly Benefit Amount and Use of Subject Wages

The Weekly Benefit Amount for Covered Individuals with a Qualifying Reason who earn equal to or less than 65% of the State Average Weekly Wage (SAWW) is 100% of the Average Weekly Wage.

The Weekly Benefit Amount for Covered Individuals with a Qualifying Reason whose Average Weekly Wage is more than 65% of the SAWW equals the sum of:

65% of the SAWW **+** 50% of the portion of the Average Weekly Wage that is above 65% of the SAWW.

The SAWW used in calculating the Weekly Benefit Amount applies for the entire Benefit Year, even if the SAWW changes during the Benefit Year.

The Policyholder or the Covered Individual will be required to submit all Wage information to Us.

PFML can be taken in Work Week or Workday increments for either consecutive or nonconsecutive periods.

Maximum Weekly Benefit Amount

The Weekly Benefit Amount will not exceed 120% of the SAWW.

Minimum Weekly Benefit Amount

The minimum weekly benefit is 5% of the SAWW.

Intermittent (Nonconsecutive) Leave Schedule

PFML may be taken on an Intermittent Leave Schedule as needed, Intermittent leave may be taken in increments of less than one (1) Workday, however, we will not pay in increments of less than one (1) Workday.

Paid Leave Allowance calculation

Utilization of Paid Leave Allowance under this policy will be determined by the rolling 12-month period measured backward by an employee’s first day of leave taken.

Oregon Paid Sick Leave Under ORS 653.606

PFML Benefits are in addition to the leave an Eligible Employee acquires under ORS 653.606. PFML Benefits are not reduced by paid sick leave the Eligible Employee is eligible for under ORS 653.606.

Payment to a Covered Individual

Benefits will be paid to the Covered Individual only. Benefits cannot be assigned, unless such assignment is required by operation of law, such as child support.

Supplemental Accrued Paid Leave or Wage Continuation While Receive PFML Benefits

If the Policyholder provides Accrued Paid Leave or other Wage continuation to the Covered Individuals during a period of PFML, the Policyholder is accountable for paying only the amount of Accrued Paid Leave or other Wage continuation that when combined with the Weekly Benefit Amount is equal to or less than the Covered Individual's Average Weekly Wage such that the Covered Individual does not receive more than 100% of their Average Weekly Wage. And Covered Individual must consent to use of Accrued Paid Leave during periods of PFML.

Simultaneous Coverage

A Covered Individual with Simultaneous Coverage at the start of their PFML shall apply separately under this policy and all other plans under which they are covered. The Policyholder may ask a Covered Individual whether they have additional Oregon PFML coverage but may not require that the Covered Individual provide details on the other employers or the plans. We, the Policyholder, or the Covered Individual may request information from The Department as described in OAR 471-070-2260.

Each Equivalent Plan is required to pay benefit amounts that are equal to or greater than the benefits offered under the state plan as described in OAR 471-070-2260 and ORS 657B.050 and applicable administrative rules. Upon request, The Department may provide information to Us or the Policyholder regarding prorated benefit amounts, if The Department is aware of Simultaneous Coverage. Each respective benefit amount shall be prorated by the average number of Workdays typically worked per week by the Claimant for each respective plan rounded to the nearest whole cent.

PFML Benefits will be equal to or greater than the prorated weekly benefit amount and may be further prorated when PFML is taken in Workday increments based on the number of Workdays of leave taken in the Work Week.

Employer Provided Sick or Other Paid Leave Time

If the Policyholder provides Accrued Paid Leave or other Wage continuation to the Covered Individual during a period of PFML, the Policyholder is accountable for paying only the amount of Accrued Paid Leave or other Wage continuation that when combined with the Weekly Benefit Amount is equal to or less than the Covered Individual's Average Weekly Wage such that the Covered Individual does not receive more than 100% of their Average Weekly Wage. A Covered Individual must consent to use of Accrued Paid Leave during periods of PFML.

Exclusions

In any week in which an employee is eligible to receive Workers' Compensation or unemployment benefits under ORS chapter 656 or 657, the employee is disqualified from receiving family and medical leave insurance benefits.

When the Covered Individual's Benefit Payments End

A Covered Individual's benefits payments under this policy end when:

- The Covered Individual is no longer eligible for family or medical leave.
- The Covered Individual no longer meets the requirements to be eligible for a qualifying leave.
- The Covered Individual has completed the maximum allowable duration of leave.
- The Covered Individual fails to provide proof of continued entitlement to PFML Benefits.
- The Covered Individual dies, effective upon date of death.

Termination of this policy will have no impact on eligibility for benefits under any approved leaves that began while the policy was in force, including any approved extensions for the same leave, regardless of whether the policy was in force at time of extension.

CLAIM PROVISIONS

Filing a Claim - Applications

The Covered Individual must submit both notice of leave and proof of claim.

Applications must be submitted to Us verbally, electronically or in writing in a form approved by Us within 30 calendar days of the date leave is requested and not later than 30 calendar days after the date leave commenced. Applications submitted to Us 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. Applications may be submitted up to one (1) year following the date leave commenced for demonstrated Good Cause.

"Good Cause" will exist if We determine that a reasonably prudent individual under the same or similar circumstances would have been prevented from filing a timely request. In determining whether good cause has been shown, We will consider all factors deemed relevant, including but not limited to:

- Whether the requestor received timely and adequate notice of the need to act;
- Administrative error by Us or our representatives;
- A demonstrated inability to reasonably access a means to file an application in a timely manner due to a natural disaster or a significant and prolonged system outage;
- The requestor's physical or mental impairment, particularly if the impairment is related to the request for paid leave;
- Whether the requestor acted diligently in submitting the request once the reason for the late request no longer existed;
- The total length of time that the action was untimely; and
- Whether the delay affects the ability for Us to determine the validity of the request

Covered Individuals should send the notice of leave and proof of claim forms to the Employer and to Us. If the Covered Individual chooses not to call Us to submit their application, they can send such forms to Us by mail to New York Life Benefit Solutions, P.O. Box 29050, Phoenix, AZ 85038-9050, via email at AbsenceManagement@newyorklife.com or online at www.myNYLGBS.com. Notice of leave or proof of claim sent to another location may not constitute valid notice or proof of claim. A claim may be delayed or denied if this notice of leave or proof of claim procedures are not followed.

After submitting an Application to Us, a Claimant must notify Us 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:

- First and last name;
- Mailing address;
- Telephone number;
- Current employment or self-employment;
- Average number of Workdays worked per Work Week;
- PFML schedule;
- Type of PFML taken; or
- Eligibility to receive Workers' Compensation under ORS chapter 656 or Unemployment Insurance benefits under ORS chapter 657.

Failure to notify Us of any changes to the information provided on an Application as specified in this section may result in a delay, denial, overpayment, or disqualification of PFML Benefits.

We may request that the Claimant provide written consent to Us to request or provide information to The Department, the Policyholder and/or the Health Care Provider in order to review the PFML claim, render a decision, and/or reporting.

Employee Notice of Leave to the Policyholder

The Claimant must provide written notice to the Employer at least 30 calendar days in advance of foreseeable PFML. Verbal notice must be provided to the Employer within 24 hours of unforeseeable leave related to an unexpected health condition, a premature birth or unexpected adoption or foster placement, or Safe Leave, followed by written notice within three (3) days after commencement of the unforeseeable leave. An eligible employee who takes safe leave shall give the employer reasonable advance notice of the individual's intention to take safe leave, unless giving the advance notice is not feasible.

Payment of Claims and Claim Decisions

We will comply with claim decision and payment timeframes set forth in the PFML statute and regulations. Claim decisions will be made within 14 calendar days of our receipt of Complete Application. Receipt of the Complete Application means the necessary information is sent to Us by certified mail or submitted to Us electronically or by any medium we authorize. Claim payments will be made to a Claimant within 7 calendar days of approving a Complete Application, however, if a Complete Application is approved before the onset of PFML leave beginning, we will commence payment of PFML Benefits as soon as PFML leave begins. Payment of PFML Benefits following initial approval will occur on a weekly basis. We may verify the leave taken prior to issuing a payment.

We will provide claim decisions that at minimum include:

- Identification of the Claimant;
- The date of our decision; and
- A statement either:
    - approving the Application, including the frequency, duration and amount of PFML Benefits, and a statement indicating how the Claimant may contact The Department to request the Average Weekly Wage that should be used in PFML Benefit calculation; or
    - denying the Application along with the reason(s) for the denial and an explanation of the Claimant's right to appeal the decision and instructions on how to submit an appeal.

We will provide claim decisions in writing, either in hard copy or electronically if the Claimant has opted for electronic notification.

For Proof of claim

The Covered Individual's proof of claim must include the following written consent, certifications and documentation requests specified below. Certifications and documentation requested by Us will not exceed those permitted under the PFML statute and regulations.

1. The type of leave and the date that the leave began;

2. A certification evidencing that the leave is for a qualifying reason;

3. If leave is for a Serious Health Condition, that the Covered Individual or Family Member is under the Continuing Treatment by a Health Care Provider, as well as the name, type of medical practice/specialty, phone number and address of the Health Care Provider;

4. If applicable, written consent from the Covered Individual for Us to share information we have or may reasonably require with the Policyholder, The Department, and with the Health Care Provider in order to process and evaluate the claim. If we do not need to share information in order to process the claim, we will not require this written consent;

5. For Medical Leave Benefits for a Serious Health Condition:

   A certification from a Health Care Provider that includes:

   - The Claimant's first and last name;
   - A summary of the appropriate medical facts within the knowledge of the Health Care Provider and statement that the Covered Individual has a Serious Health Condition;
   - The date on which the Serious Health Condition commenced or when the serious health condition created the need for Medical leave;
   - The probable duration of the Serious Health Condition;
   - A certification that the Covered Individual is unable to perform one or more of the essential functions of the Covered Individual's job with the Employer due to the Serious Health Condition; and
   - Information regarding the need for Intermittent Leave including a reasonable estimate of the frequency and duration and estimated treatment schedule, if applicable.
   - Other information as requested by us to determine eligibility for PFML Benefits or establish the Claimant has a Serious Health Condition that is permitted to be obtained under the PFML statute and regulations.

6. For Family Leave Benefits to Care for Family Member with a Serious Health Condition:

   A certification from a Health Care Provider that includes:

   - A statement of the relationship between the Covered Individual and the Family Member;
   - The first and last name of the Family Member;
   - The Claimant's first and last name
   - A summary of the appropriate medical facts within the knowledge of the Health Care Provider and a statement that the Family Member has a Serious Health Condition;
   - The date on which the Family Member's Serious Health Condition commenced or when the serious health condition created the need for Family leave;
   - The probable duration of the Family Member's Serious Health Condition;
   - A statement that the Covered Individual is needed to care for the Family Member; and
   - An estimate regarding the frequency and anticipated duration of time that the Covered Individual is needed to care for the Family Member for Intermittent Leave.
   - Other information as requested by us to determine eligibility for PFML Benefits or establish the Family Member (patient) has a Serious Health Condition that is permitted to be obtained under the PFML statute and regulations

7. For Family Leave Benefits for the Birth of a Child:

   A Claimant applying for PFML Benefits to bond with a Child during the first year after the Child's birth must provide one of the following forms of verification:

   - The Child's birth certificate;
   - A Consular Report of Birth Abroad;
   - A hospital admission form associated with delivery;
   - A statement from the Child's Health Care Provider stating the Child's birth date;
   - A statement from the Health Care Provider of the person who gave birth stating the Child's birth date; or
   - Another document approved by Us for this purpose

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

   A Claimant applying for PFML Benefits to bond with a Child during the first year after the placement of the Child through Foster Care or Adoption must provide one of the following forms of verification:

   - A copy of a court order verifying placement;
   - A letter signed by the attorney representing the Claimant that confirms the placement of the Child;
   - A document from the foster care, adoption agency or social worker involved in the placement that confirms the placement of the Child;
   - A document for the Child issued by the United States Citizenship and Immigration Services; or
   - Another document approved by Us for this purpose

   The verification required in sections 7 and 8 above must also show the following:

   - Claimant's first and last name as parent or guardian of the child after birth or placement of the child through foster care or adoption;
   - Child's first and last name; and
   - Date of the Child's birth or placement.

9. For a Claimant's Safe Leave

   A Claimant applying for PFML Benefits for Safe Leave must provide verification of the basis for the Safe Leave, including any of the following forms of documentation:

   - A copy of a federal agency or state, local, or tribal police report, or a formal complaint to a school's Title IX Coordinator indicating that the Claimant or the Claimant's Child was a victim of Domestic Violence, Harassment, Sexual Assault, or Stalking;
   - A copy of a protective order or other evidence from a federal, state, local, or tribal court, administrative agency, school's Title IX Coordinator, or attorney that the claimant or the Claimant's Child appeared in or was preparing for a civil, criminal, or administrative proceeding related to Domestic Violence, Harassment, Sexual Assault, or Stalking; or
   - Documentation from an attorney, law enforcement officer, Health Care Provider, licensed mental health professional or counselor, member of the clergy, or victim services provider that the claimant or the Claimant's Child was undergoing treatment or counseling, obtaining services, or relocating as a result of Domestic Violence, Harassment, Sexual Assault, or Stalking.

     In cases where a Claimant can demonstrate Good Cause for not providing one of the forms of documentation in section 9, the claimant may instead provide a written statement attesting that they are taking eligible Safe Leave. Good Cause for not providing the documentation is determined at our discretion and includes, but is not limited to, the following:

   - Difficulty obtaining verification due to a lack of access to services; or
   - Concerns for the safety of the Claimant or the Claimant's Child.

   In addition to the information required from a Claimant as outlined above, we may request that a Claimant provide additional information necessary to establish facts relating to eligibility or qualification for PFML Benefits. Unless a time frame is otherwise defined under statute or rule or is specified by Us, the Claimant must respond to all requests for information within the following time frames:

   - 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 our records.
   - 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.
   - When the response to the request for information is sent to Us 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 Us.

- The time frames specified above may be extended at our discretion when a Claimant can demonstrate they failed to provide a timely response for Good Cause. Good cause exists when the Claimant responds to Us 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.

Written Proof of Claim

We will evaluate a Covered Individual's written proof of claim to determine if a Covered Individual has provided satisfactory documentation and to determine the amount of any benefits that may be payable. If a Covered Individual fails to provide the required certification or other documentation or information sufficient to support a claim for benefits, such claim will be denied.

Information Required from the Policyholder

We require that the Policyholder, within ten (10) business days from the date the Policyholder receives notice that the Covered Individual has filed notice of Application for PFML benefits, provide Us with all relevant information or records We may request to evaluate the Covered Individual's claim. This information or records may include, but is not limited to, the following:

- Employment records for the Covered Individual, including but not limited to a description of the Covered Individual's position, work schedule, weekly hours worked, prior requests and approvals for leave for a Qualifying Reason, and amount of paid leave taken for a Qualifying Reason during the current Benefit Year;
- Wage history for the Benefit Year;
- Whether the Covered Individual will receive any paid or unpaid leave benefits during the requested leave period, including Accrued Paid Leave or other temporary disability or paid family or medical leave payments;
- Whether the Employer has approved or intends to approve the request for leave under the state or federal Family and Medical Leave Act or any other policy allowing for paid or unpaid leave;
- Any other relevant information or records related to the request for a claim for benefits under this Policy, including but not limited to, evidence of a fraudulent claim.

Information that the Policyholder May Request from Us

The Policyholder is entitled to request any information that We possess which is necessary in order for the Policyholder to comply with the PFML Statute and Regulations. To the extent permitted under state and federal law, we will provide any requested claims experience related to this policy.

Authority to Make Benefit Determinations

Life Insurance Company of North America shall serve as the claims review fiduciary with respect to this Policy. The claims review fiduciary has the discretionary authority to interpret this Policy and to determine eligibility for benefits and the amount of any benefits payable.

Recovery of Overpayments

We have the right to recover overpayments that occur due to:

- An error We make in processing the Covered Individual's claim;
- Payment, we made that should have been made under another plan; or
- The Covered Individual's receipt of Workers' Compensation or Unemployment Insurance for periods during which the Covered Individual has already received PFML Benefits under this Policy.

If We determine that We should have paid the Covered Individual a different benefit amount from the amount actually paid on the Covered Individual's claim, We will adjust the PFML Benefit accordingly. If We determine that We overpaid the Covered Individual's claim, then We will require that the Covered Individual repay Us in full. We will make reasonable arrangements with the Covered Individual to determine a method by which the Covered Individual will repay Us. We will not recover more money from the Covered Individual than the benefit amounts We paid to the Covered Individual.

If PFML Benefits are paid because of an error, we may waive, in whole or in part, the amount of any such payment for which recovery would be against equity, good conscience or administrative efficiency.

Prior to the recovery of the amount of any PFML Benefits under this section, we will notify the Claimant of:

- The day(s) or week(s) for which the PFML Benefits were paid; and
- That any amount subject to recovery due under this section may be collected by Us in a civil action against the Employer or Eligible Employee brought by Us.

The Claimant or the Policyholder may appeal a determination made under this section.

Claim Denials

If a claim is denied, We will provide the employee the following information:

- The specific reason for the denial;
- The specific law or section of the policy that caused the denial;
- What documentation was relied on for the denial;
- What documentation can be provided, if any, to reconsider the denial; and
- Reference to the reconsideration and appeal processes and timeframes.

Claim Cancellation

A claim for PFML Benefits may be cancelled at any time provided a request to cancel has been submitted to Us in a method approved by Us, and no leave under the policy was taken under the claim; PFML Benefits have not been paid for the claim; and no disqualification has been issued by Us and no appeal of a disqualification or denial has been requested.

Appeals

Claimants will be advised in writing by Us that they have the right to request an appeal to Us of an adverse PFML claim determination, including approval of a PFML duration that is less than the requested duration or a PFML Weekly Benefit Amount that is disputed within 20-calendar days of receipt of notice of the adverse determination. If circumstances beyond the Claimant’s control prevent filing an appeal within the 20-calendar day period, the appeal must be filed as soon as is reasonably possible.

If following the review of the appeal we uphold the adverse determination decision or if we fail to render an appeal decision within 20-calendar days of our receipt of an appeal, including all necessary information needed to complete the review, the Claimant has the right to pursue dispute resolution with The Department no later than:

- 20-calendar days from the Claimant’s receipt of notice of our appeal decision,
- 20-calendar days after the expiration of the 20-calendar day appeals timeframe if we fail to render a decision, or
- as soon as practicable if there is good cause for the delay.

Any determinations of overpayments are a reviewable benefit decision, and all Claimant disputes relating to overpayments (whether the Claimant is disputing the overpayment determination itself, or just the amount of the overpayment) must follow the process in this section.

We will advise the Claimant in writing how to contact The Department and will include an explanation of The Department's dispute resolution process as described in the Disputes and Request for Hearing section of the Group Policy if an appeal is denied.

Disputes and Request for Hearing

As required by ORS 657B.420, The Department will provide a dispute resolution process to assist in resolving disputes between Us and Employees regarding coverage and benefits provided under this policy if the appeal is not otherwise resolved.

Prior to The Department providing a dispute resolution process, We and the Employee must follow the appeal process under the policy.

In the event that We, the Employee or the Employer fail to resolve an appeal on a coverage or benefit decision through the Group Policy's appeal process, the Employee may request dispute resolution assistance through The Department. The dispute resolution request must:

- Be in writing, by phone, online, or in another format approved by The Department.
- Include a copy of our appeal decision and any documents related to the dispute, including documents supporting or referencing the decision.
- Be received within 20 calendar days of the issuance of the appeal decision, or as soon as practicable if there is good cause for the delay beyond 20 calendar days.

The Department shall review the dispute resolution request and issue an advisory decision based on the policy benefit requirements within 20 calendar days of the receipt of the dispute resolution request.

If we do 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.

The payment of any PFML Benefits not placed in issue by the request for the administrative hearing shall continue during the appeal process.

Good Cause for late appeal or dispute resolution request includes, but is not limited to, the following:

- Difficulty obtaining verification;
- Factors or circumstances beyond the Employee's, Employer's, our, or Department's reasonable control that prevented them from providing information;
- 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
- 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.

DEFINITIONS

Accrued Paid Leave means leave earned by or otherwise provided to a Covered Individual pursuant to a benefit plan or policy offered by the Policyholder, including, but not limited to, Sick Pay (including Oregon Paid Sick Leave), annual leave, Vacation Pay, personal leave, compensatory leave or Paid Time Off. Accrued paid leave shall not include a (i) disability policy or program of the Policyholder; or (ii) paid Family or Medical Leave policy of the Policyholder.

Administrative Costs means the costs incurred by an Employer or Us directly related to administering an equivalent Oregon Paid Family and Medical Leave insurance plan which include, but are not limited to, cost for accounting, recordkeeping, insurance policy premiums, 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, legal expenses, cost of benefits, or other costs not immediately related to the administration of the Equivalent Plan.

Alternate Base Year means the last four (4) completed Calendar Quarters preceding the Benefit Year.

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.

Average Weekly Wage means the Subject Wages earned by an Eligible Employee through their employment in Oregon during the Base Year or Alternate Base Year divided by 52.

Base Year means the first four (4) of the last five (5) completed Calendar Quarters preceding the Benefit Year.

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 (1) valid benefit year at a time.

Calendar Quarter means the period of three (3) consecutive calendar months ending on March 31, June 30, September 30, or December 31.

Care means Physical Assistance or Psychological Assistance as used for leave taken to care for a Family Member with a Serious Health Condition.

Carrier means New York Life Group Benefit Solutions, We and Us.

Care means a term used in ORS 657B.010(17)(a)(B) and 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

Child means a biological child, adopted child, stepchild or foster child of an Eligible Employee or of the Spouse or Domestic Partner; a person who is or was a legal ward of an Eligible Employee or of the Eligible Employee's Spouse or Domestic Partner; or a person who is or was in a relationship of in loco parentis with an Eligible Employee or with the Eligible Employee's Spouse or Domestic Partner. A child under this definition must be under age 18, or age 18 or older as an adult dependent substantially limited by a physical or mental impairment as defined by ORS 659A.104.

Claim means a period of PFML Benefits that starts with the date PFML begins based upon our receipt of a complete Application and continues through the duration of the approved PFML or until the approved PFML Benefits have been exhausted. A Covered Individual may have multiple claims in a Benefit Year but may not be approved for more than the period described in the Maximum PFML Payment Period.

Claimant means a Covered Individual that has submitted an Application or established a claim for PFML Benefits.

Complete Application means an Application that contains all of the required information under OAR 471-070-1100 as well as Wage information necessary to calculate PFML Benefits.

- Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

Covered Individual means an Employee who has earned at least $1,000 in Subject Wages during the Base Year; or if an Employee has not earned at least $1,000 during the Base Year, an Employee who has earned at least $1,000 in Subject Wages during the Alternate Base Year, and who meets the requirements of one (1) of the following categories:

- 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 PFML;
- was eligible for benefits under their previous Oregon employer's Paid Leave Oregon Equivalent Plan, who begin working for the Employer;
- was previously covered through Oregon's state plan for Paid Leave Oregon within 30 calendar days from the new employee's start date with the Employer; or
- was previously insured for Paid Leave Oregon through a different Paid Leave Oregon Equivalent Plan employer on the new employee's start date with the Employer; or
- entered the workforce in Oregon within 30 calendar days of the new employee's start date with the Employer. This 30-day requirement applies regardless of whether the new employee worked for a different employer in Oregon previously but did not acquire Paid Leave Oregon eligibility with that previous employer, whether the new employee is new to the workforce in general, or whether the new employee is relocating from another state to work in Oregon.

Employee means an individual performing services based in Oregon for the Employer for remuneration or under any contract of hire, written or oral, express or implied; and a home care worker as defined in ORS 410.600. Employee does not include: an independent contractor as defined in ORS 670.600; a participant in a work training program administered under a state or federal assistance program; a participant in a work-study program that provides students in secondary or postsecondary educational institutions with employment opportunities for financial assistance or vocational training; a railroad worker exempted under the federal Railroad Unemployment Insurance Act; a volunteer.

Employer means the Policyholder and any of its affiliates and subsidiaries listed as covered under this Policy.

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. Note, ORS 657B.210(8) requires that the Equivalent Plans remain in effect for a minimum of one (1) year.

Family Leave means leave taken under the Policy to care for a Family Member with a Serious Health Condition, for a Parent to bond with the Parent's child during the first year after the child's birth, adoption, or Foster Care placement.

Family leave does not mean leave described in ORS 659A.159 (1)(d) which provides for:

- care for a child of the Eligible Employee who is suffering from an illness, injury or condition that is not a Serious Health Condition but that requires home care;
- leave described in ORS 659A.159 (1)(e) which provides for leave to deal with death of a Family Member, attend a funeral or to make arrangements necessitated by the death of the Family Member, or grieving the death of a Family Member; or
- qualifying military exigency leave authorized under ORS 659A.093.

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

Family Member means the Spouse of a Covered Individual; a Child of a Covered Individual or the Child's Spouse or Domestic Partner; a Parent of a Covered Individual or the Parent's Spouse or Domestic Partner; a Sibling or stepsibling of a Covered Individual or the Sibling's or stepsibling's Spouse or Domestic Partner; a Grandparent of a Covered Individual or the Grandparent's Spouse or Domestic Partner; a Grandchild of a Covered Individual or the Grandchild's Spouse or Domestic Partner; a Domestic Partner of the Covered Individual; or any individual related by blood or affinity whose close association with a Covered Individual is the equivalent of a family relationship.

Foster Care means 24-hour care for children in substitution for and away from their Parents or guardian. Such placement is made by or with the agreement of Oregon, or any other state, commonwealth or territory as a result of a voluntary agreement between the Parent and guardian that the Child be removed from the home, or pursuant to a judicial determination of the necessity for Foster Care, and involves agreement between Oregon, or any other state, commonwealth or territory and foster family that the foster family will care for the Child. Although Foster Care may be with relatives of the Child, State action is involved in the removal of the Child from parental custody.

Good Cause means cause for the late submission of an Application is determined at our discretion and includes, but is not limited to, the following a Serious Health Condition that results in an unanticipated and prolonged period of Incapacity and that prevents an Claimant from timely filing an Application; or 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.

Grandchild means a Covered Individual's, or a Covered Individual's Spouse's or Domestic Partner's, child of the Child.

Grandparent means a Covered Individual's, or a Covered Individual's Spouse's or Domestic Partner's, parent of the Parent.

Harassment means 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.

Health Care Provider means 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 PFML, 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:

- 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;
- dentist;
- direct entry midwife;
- naturopath;
- nurse practitioner;
- nurse practitioner specializing in nurse-midwifery;
- optometrist;
- physician;
- physician's assistant;
- psychologist;
- registered nurse; or
- regulated social worker.

Health Care Provider also includes 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 Family Leave, Medical Leave or Safe Leave, including but not limited to a Christian Science practitioner.

Holiday means any of the holidays listed in ORS 187.010(1)(b)–(k) and (2), 187.020 and any holiday designated by the Employer, union contract, or otherwise.

Holiday Pay means any remuneration that the Employer pays an Employee for a Holiday, including, but not limited to, full or partial Paid Time Off or additional pay for work on a holiday.

Incapacity means is the inability to perform at least one (1) 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.

Intermittent Leave means leave taken in separate periods of time due to a single Qualifying Reason, rather than for one (1) continuous period of time. Intermittent leave may be taken in increments smaller than one (1) Workday, however, we will not pay in increments of less than one (1) Workday.

Medical Leave means PFML taken by a Covered Individual that is made necessary by the Covered Individual's own Serious Health Condition.

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

Parent means (a) the biological, adoptive, step or foster mother or father of the Covered Individual; (b) a person who was a foster parent of a Covered Individual when the Covered Individual was a minor; (c) a person designated as the legal guardian of a Covered Individual at the time the Covered Individual was a minor or required a legal guardian; (d) a person with whom a Covered Individual was or is in a relationship of in loco parentis; or (e) a parent of a Covered Individual's Spouse or Domestic Partner who meets a description under (a) to (d) of this subsection.

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

Paid Time Off means compensated time away from work provided by an Employer that the Employee can choose to use for any reason, including, but not limited to, vacation, sickness, and personal time.

PFML means Family Leave, Medical Leave and/or Safe Leave taken under the Group Policy.

PFML Benefits means Family Leave Benefits, Medical Leave Benefits and/or Safe Leave Benefits payable under the Group Policy.

Physical Assistance means assistance attending to a Family Member's basic medical, hygienic, 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.

Psychological Assistance means providing comfort, reassurance, counseling, or therapy to a Family Member, or completing administrative tasks for the Family Member, or arranging for changes in the Family

Member's care, such as transfer to a nursing home.

Qualifying Reason means any of the following reasons for which a Covered Individual is eligible for PFML Benefits:

- to bond with a Child during the first 12 months after the Child's birth, Adoption, or Foster Care placement;
- to care for a Family Member's Serious Health Condition;
- to address the Eligible Employee's own Serious Health Condition or
- for purposes of Safe Leave.

Safe Leave means a Covered Individual's PFML taken for any purpose described in ORS 659A.272, including leave to:

- seek legal or law enforcement assistance or remedies to ensure the health and safety of the Covered Individual or the Covered Individual's minor Child or dependent, including preparing for and participating in protective order proceedings or other civil or criminal legal proceedings related to Domestic Violence, Harassment, Sexual Assault or Stalking.
- seek medical treatment for or to recover from injuries caused by Domestic Violence or Sexual Assault to or Harassment or Stalking of the Covered Individual or the Covered Individual's minor Child or dependent.
- obtain, or to assist a minor Child or dependent in obtaining, counseling from a licensed mental health professional related to an experience of Domestic Violence, Harassment, Sexual Assault or Stalking.
- obtain services from a victim services provider for the Covered Individual or the Covered Individual's minor Child or dependent.
- relocate or take steps to secure an existing home to ensure the health and safety of the Covered Individual or the Covered Individual's minor Child or dependent.

Note: per ORS 659A.275 if the Covered Individual's leave creates an undue hardship on the Employer's business, they may limit the amount of leave a Covered Individual takes under ORS 659A.272.

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

Serious Health Condition means an illness, injury, impairment, or physical or mental condition of a Covered Individual or their Family Member that:

- Requires inpatient care in a medical care facility such as a hospital, hospice, or residential facility such as a nursing home or inpatient substance abuse treatment center;
- In the medical judgement 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; or
- Requires Constant or Continuing Care, including home care administered by a Health Care Provider.
- Involves a period of incapacity. “Incapacity” is the inability to perform at least one (1) essential job function, or to attend school or perform regular daily activities for more than three (3) 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 (1) of the following:
    - Two (2) or more treatments by a health care provider; or
    - One (1) treatment plus a regimen of continuing care.
- 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;
- 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;
- 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 (3) calendar days;
- Involves any period of disability due to pregnancy, childbirth, miscarriage or stillbirth, or period of absence for prenatal care; or
- 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.

Sexual Assault means as described in ORS 659A.272, means any sexual offense described in ORS 163.305 to 163.467, 163.472 or 163.525.

Sibling means the Covered Individual’s, or the Covered Individual’s Spouse’s or Domestic Partner’s, sibling or stepsiblings.

Sick Pay means remuneration paid by an Employer to an Employee for time away from work due to sickness, unless excluded as a fringe benefit under ORS 657.115.

Simultaneous Coverage means an Employee is considered to have simultaneous coverage when the Employee is covered by more than one (1) employer’s equivalent Oregon paid family medical leave plan at the same time or is covered by the state plan established under ORS 657B.340 and the Employer at the same time.

Spouse means a person to whom a Covered Individual is legally married.

Stalking means as described in ORS 659A.272, means:

- The crime of stalking described in ORS 163.732; or
- 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.

Stand-By Pay means remuneration paid by an Employer to an Employee who is required to be immediately available for work.

State 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:

- Set for each fiscal year beginning July 1 and ending June 30 of the following year; and
- Applied for the calculation of weekly benefit amounts for benefit years starting the first full week following July 1.

Subject Wages means Wages that are paid to an Eligible Employee and reported to The Department. Such Wages shall be assigned to the calendar quarter in which they are paid to the Employee, in the same manner that PFML insurance contributions are payable pursuant to ORS 657B.150 and 657B.010(13)

Vacation Pay means remuneration paid by an Employer to an Employee for time away from work provided by an Employer to an Employee to use for any reason the Employee chooses but does not include leave for sickness, compensatory time, holiday, or other special leave.

Wages has the meaning given that term in ORS 657.105 which defines wages for Unemployment Insurance. Wages means all remuneration for employment with the Employer, including the cash value, of all remuneration paid in any medium other than cash. The noncash remuneration paid for services performed in agricultural labor or domestic service are not considered remuneration or wages.

Wages include, but are not limited to:

- Commission or a guaranteed wage;
- Compensatory pay;
- Dismissal or separation allowances;
- Holiday Pay;
- Paid Time Off;
- Sick Pay;
- Stand-By Pay;
- Tips or gratuities;
- Vacation pay;
- Gifts received by an Employee from the Employer.
- Bonuses, fees and prizes if paid or given by the Employer to an Employee as compensation, reward, or added remuneration for services.
    - Bonuses, fees, and prizes shall be included in the payroll of the Employer at the time they are paid to the Eligible Employee. A bonus, fee, or prize paid or received during a calendar year shall be wages paid during the calendar year, and the Group Policy contribution rate for such year shall be applicable to any bonus, fee, or prize constituting wages.
- Dividends paid to a corporate officer or shareholder to the extent that those payments are reasonable compensation for services performed for the corporation.
- Subject to exclusions under ORS 657.115 and 657.125, Employer wage continuation provided to an Employee during a disability period, or Employer payment to an Employee of all or part of the difference between benefits or compensation received from an insurance carrier or State Accident Insurance Fund and the Employee's regular or usual wage.
- The cash value of all remuneration paid by the Employer in any medium other than cash, except for agricultural labor and domestic service, as defined in the wage definition administrative rule, and the specific exemptions enumerated in ORS 657.115 through 657.140.
    - Board, lodging, services, facilities or privileges furnished by an Employer shall be considered remuneration paid for services performed by an Employee unless it appears that furnishing of the same was not required by the terms of the contract of hire; written or oral, express or implied; and that the value thereof was not a material factor in the determination by either party of the amount of any cash remuneration payable for such services.

Wages do not include:

- Moneys paid to Employees to reimburse them for meal expenses in the event Employees are required to perform work after their regular office hours; and
- Amounts paid to Employees to reimburse them for traveling or other expenses actually incurred by them while performing service for the Employer.
- Pension income an Eligible Employee receives or is eligible to receive from employment or former employment with another employer.
- Compensation, reimbursement, fees, lodging, meals or other remuneration paid or provided to an Eligible Employee for services performed as a juror are not wages.
- Lump sum or other special payments to compensate an Employee for an accident sustained in the course of employment are not wages.
- Gifts, other than tips or gratuities, received by an Employee during the course of employment from persons other than their Employer are not wages.
- Employee benefits paid through a cafeteria plan, as defined in the Internal Revenue Code Section 125, are not wages if listed as excluded in ORS 657.115, even if paid through a payroll deduction.

Weekly Benefit Amount means the amount of wage replacement that will be paid to a Covered Individual for a Work Week while the Covered Individual is on Family Leave or Medical Leave under the terms of the Policy. The amount calculated and in effect on the first day of the Covered Individual's Claim shall be the weekly benefit amount under the Policy for the duration of the claim.

Workday means any day on which an Employee performs any work for the Employer and is an increment of a Work Week. The number of Workdays in a Work Week is based on the average number of Workdays worked by an Employee at all employment. There are a maximum of seven (7) Workdays in a Work Week. If a Workday spans two (2) calendar days, such as a shift beginning on day one (1) at 10 p.m. and ending on the next day at 5 a.m., the Workday will count on the calendar day in which the shift began.

Work Week means seven (7) days 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 Workdays in a work week is determined by counting the total number of Workdays 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.

Exhibit Number	Exhibit Type	Applies To	Effective Date
1	Schedule of Initial Premium Rates	All Covered Individuals	January 1, 2024
2	Schedule of Benefits	All Covered Individuals	January 1, 2024
3	List of Policyholder Subsidiaries, Affiliates, Divisions, Branches And Other Similar Entities	All Covered Individuals	January 1, 2024

EXHIBIT 1: SCHEDULE OF INITIAL PREMIUM RATES

The initial February 1, 2024 Premium rates for the insurance provided by this policy are as follows:

$0.730 per $100 of Covered Payroll

Rate Guarantee Period

These Premium rates will be in effect from January 1, 2024 to December 31, 2024.

EXHIBIT 2: SCHEDULE OF BENEFITS

Eligible Class(es): include the following class(es) of Eligible Persons:

Class 1:

- all the Policyholder's employees working in Oregon, who meet the minimum eligibility requirements under the PFML statute and regulations, whether minimum eligibility was initially met with the Policyholder or from a prior employer.

Duration of Paid Leave

If a Covered Individual is eligible for PFML Benefits, the Covered Individual is entitled to up to 12 total weeks in the aggregate, of benefits under the Policy in a single Benefit Year. However, a Covered Individual may qualify for up to two additional weeks of Medical Leave Benefits for limitations related to pregnancy, childbirth or a related medical condition, including but not limited to lactation, for a total amount of leave not to exceed 14 weeks per Benefit Year.

Refer to the section PAID LEAVE BENEFITS for additional information.

Waiting Period: None

Benefit Amount
Refer to the section PAID LEAVE BENEFITS for additional information.

Weekly Benefit: An amount the total of:

- **100%** of the portion of a Covered Individual's Average Weekly Wage that is equal to or less than 65% of the State Average Weekly Wage; and
- **50%** of the portion of a Covered Individual's Average Weekly Wage that exceeds 65% of the State Average Weekly Wage.

Maximum Weekly Benefit Amount: The maximum weekly benefit amount for any Covered Individual will be the amount equal to 120% of the State Average Weekly Wage

Minimum Weekly Benefit Amount: The minimum weekly benefit amount for any Covered Individual will be the amount equal to 5% of the State Average Weekly Wage.

EXHIBIT 3: LIST OF POLICYHOLDER SUBSIDIARIES, AFFILIATES, DIVISIONS, BRANCHES AND OTHER SIMILAR ENTITIES

The subsidiaries, affiliates, divisions, branches and other similar entities listed below are included for insurance under this policy as of the effective dates shown below. **The Policyholder** acts for all listed subsidiaries, affiliates, divisions, branches and other similar entities in all matters of this policy. Such actions bind all listed subsidiaries, affiliates, divisions, branches and other similar entities.

Life Insurance Company of North America and the Policyholder may, from time to time, agree to change this list. If change is needed, a policy amendment will be issued and attached to this policy to reflect the change to this Exhibit.

Name/Address of Subsidiary, Affiliate, Division, Branch and Other Similar Entity	**Effective Date**
None	