RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

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POLICYHOLDER: Saks and Company LLC **POLICY NUMBER:** MA PFML 168068

POLICY EFFECTIVE DATE: January 1, 2021

POLICY TERM: 12 months; renewable in 12 month periods thereafter, pursuant to the TERMINATION OF THIS POLICY provision

POLICY ANNIVERSARY DATES: January 1, 2022 and each January 1 thereafter.

PREMIUM DUE DATES: The first Premium is due on the Policy Effective Date. Further Premiums are due monthly, in advance, on the 1st day of each month.

Reliance Standard Life Insurance Company has issued a policy of Massachusetts Paid Family and Medical Leave Insurance (referred to as the "Policy") to the Policyholder. We agree to provide the benefits under this Policy in consideration of the payment of Premium and a signed Application. This Policy provides Paid Family and Medical Leave Benefits ("PFML Benefits") for Covered Individuals pursuant to the requirements of M.G.L. c. 175M and 458 CMR 2.00 ("PFML Law"). When used in this Policy, "we," "our," or "us" means Reliance Standard Life Insurance Company and "you" or "yours" means the Policyholder. The Policy uses initial caps for defined terms and insures those individuals who meet the eligibility requirements of the Policy. The insurance is subject to the terms and conditions of this Policy.

Read this Policy carefully and contact us promptly if you have questions. This Policy is delivered in and is governed by the laws of the State of Massachusetts. The Policy has been approved under the authority of the Massachusetts Department of Insurance (DOI) and issued pursuant to the standards developed by the Massachusetts Department of Family and Medical Leave (DFML) for this type of coverage. If any Policy provisions do not conform to the requirements of the PFML Law, or if there are any changes, amendments, or regulatory clarifications to the provisions of the PFML Law that affect the provisions of this Policy, then the Policy is hereby amended to conform to such standards and will be considered consistent as of the effective date of the relevant changes, amendments, or regulatory clarifications. We will review this Policy at least annually to ensure it is in compliance and will promptly update this Policy and all claims practices to be consistent with the PFML Law.

The PFML Law differs from the provisions of the federal Family and Medical Leave Act ("FMLA"). The provisions of this Policy conform to the requirements of the Massachusetts PFML Law.

This Policy is signed by our President and Secretary.

Secretary

President

MASSACHUSETTS PAID FAMILY AND MEDICAL LEAVE INSURANCE

Non-Participating

IMPORTANT NOTICES

TERMINATION OF THIS POLICY: You may cancel this Policy by furnishing written notice to us, the DFML, and all Covered Individuals at least 30 days prior to the effective date of such termination. The Policy will be terminated on the first day day of the first calendar quarter immediately following the date of the termination.

We may cancel this Policy with written notice to you and the DFML at least 60 days prior to the date of cancellation if:

(1) fewer than 1 Employee is insured for coverage under the Policy; or
(2) you do not promptly provide us with information that we need to fail to perform any of your obligations that related to this Policy.

In addition, if we decide not to renew this Policy, we may cancel this Policy on the next calendar anniversary of the Policy Effective Date by furnishing written notice to you and the DFML at least 60 days prior to the date of cancellation.

Termination of this Policy will not affect any claim which was covered prior to termination, subject to the terms and conditions of this Policy. Any termination notice sent by us will include an explanation of the reason why the Policy is being terminated and the date of the termination. The termination notice will also include a reminder that the DFML Law requires that you provide at least 30 days advance notice of the termination of this Policy to the DFML and all Covered Individuals.

We may also cancel the Policy if you fail to pay the required Premium by the end of the Grace Period, pursuant to the terms of the GRACE PERIOD provision in the PREMIUMS section of this Policy. You will still owe us any Premium that is not paid up to the date this Policy is cancelled. We will return, pro-rata, any part of the Premium paid beyond the date this Policy is cancelled.

NOTE: If this Policy is terminated during the term of an approved DFML exemption period and you do not obtain other private coverage from another source, you may be required to remit Contributions to the State Plan for your entire payroll retroactive to the start date of your approved exemption or retroactive to October 1, 2019 for policies effective on January 1, 2021. If you fail to maintain a private plan as approved by the DFML or if you have an approval withdrawn by the DFML, you may be required to repay to the Trust Fund the cost of the total amount of benefits paid to Covered Individuals who received benefits from the Trust Fund and may be subject to additional interest and penalties established by the DFML for not maintaining a private plan.

MAXIMUM CONTRIBUTION RATE: If you require Covered Individuals to contribute toward the payment of Premium, this amount cannot exceed the maximum portion of Contributions for Covered Individuals as described in the PFML Law. The maximum amount of the Covered Individual's Contribution is subject to an annual adjustment by the DFML Director as specified in M.G.L. c. 175M, Section 7(e).

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CERTAIN RESPONSIBILITIES OF THE POLICYHOLDER

For the purposes of this Policy, you act on your behalf or as the Employee's agent. Under no circumstances will you be deemed our agent.

PRIVATE PLAN EXEMPTION FILING: It is your responsibility to file a DFML exemption application and any supporting documents with the DFML to obtain approval of your private plan exemption.

MAINTENANCE OF RECORDS: It is your 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. You must also maintain sufficient records of the essential details of each Covered Individual's insurance under this Policy, including Wage and payment history.

You are required to provide us with all required Wage information in order for us to pay a claim. If the Covered Individual has not been employed by you for more than one year at the time the Covered Individual submits a claim under this Policy, this Wage information must include the Covered Individual's Wages from all prior employers for whom the Covered Individual was employed during the last four calendar quarters. If the Covered Individual is in concurrent employment with both you and another Massachusetts employer who provides PFML coverage under a private plan at the time the Covered Individual submits a claim under this Policy, this Policy and the concurrent employer's private plan will share the payment of the PFML benefit payable. Each plan will pay a proportionate share of the total benefit calculated using all of the Covered Individual's Wages. If required Wage information from prior employment or concurrent employment is not readily available to you, we may request this information from the Covered Individual and/or will require the Covered Individual to give us authorization to obtain this information from the DFML.

We reserve the right to examine these records at the place where they are kept during normal business hours or at a place mutually agreeable to you and us. Such records must be maintained by you for at least 3 years after this Policy terminates.

If applicable, you must furnish this information to us within 15 days of our request. You may also be required to furnish these records to the DFML upon their request.

REPORTING OF ELIGIBILITY AND COVERAGE AMOUNTS: It is your responsibility to notify us on a timely basis of all individuals eligible for coverage under this Policy, of all individuals whose eligibility for coverage ends, and of all changes in individual coverage amounts.

It is your responsibility to provide accurate census and Wage information on all Covered Individuals on or before the Policy Effective Date and each Policy Anniversary Date, if we request such information.

TIMELY PAYMENT OF PREMIUMS: It is your responsibility to pay all Premiums required under this Policy when due. Any change in the Premium contribution basis must be approved by us.

JOB AND EMPLOYEE BENEFITS PROTECTION: You have an obligation under the PFML Law to ensure that all Covered Individuals, other than former employees or covered contract workers, if they are covered under the Policy, retain the job protection and non-retaliation provisions guaranteed by the PFML Law. A current Covered Individual who has taken approved Family or Medical Leave under this Plan shall be restored to the Covered Individual's previous position or to an equivalent position, with the same status, pay, Employment Benefits, length-of-service credit and seniority as of the date of leave. You are not required to restore a Covered Individual who has taken leave under this Policy to the previous or to an equivalent position if other Covered Individuals of equal length of service credit and status in the same or equivalent positions have been laid off due to economic conditions or other changes in operating conditions affecting Employment during the period of leave. However, the Covered Individual who has taken leave must retain any preferential consideration for another position to which the Covered Individual was entitled as of the date of leave. Leave periods taken pursuant to this Policy will not be treated as credited service for purposes of benefit accrual, vesting and eligibility to participate.

CONTINUATION OF EMPLOYER-RELATED HEALTH INSURANCE BENEFITS: You have an obligation under the PFML Law to continue to pay your share if the Covered Individual's health insurance benefits during a period of leave at the level and under the same conditions of coverage that would have been provided if the Covered Individual continued working continuously for the duration of the qualified leave period. This obligation does not apply to former employees or covered contract workers if they are included in the Policy.

CONTINUATION OF OTHER EMPLOYEE BENEFITS: You have the obligation under the PFML Law to ensure that a Covered Individual who returns to work for the Employer or Covered Business Entity after a qualified leave period retains the right to accrue vacation time, sick leave, bonuses, advancement, seniority, length-of-service credit or other employee benefit plans or programs at the same level the Covered Individual had prior to leave. This obligation does not apply to former employees or covered contract workers if they are included in the Policy.

NOTICE OF PFML COVERAGE: It is your responsibility to provide Covered Individuals with any notice required under the PFML Law, including but not limited to giving Covered Individuals a summary of rights and obligations under the PFML Law and displaying a PFML poster in the workplace.

RETALIATION: It is unlawful for you to retaliate by discharging, firing, suspending, expelling, disciplining, through the application of attendance policies or otherwise, threatening or in any other manner discriminating against a Covered Individual for any of the following:

(1) exercising any right to which such individual is entitled under this Policy or the PFML Law with the purpose of interfering with the exercise of any right to which such individual is entitled under this Policy or PFML Law; or

(2) filing a complaint or instituting or causing to be instituted a proceeding under or related to this section; or

(3) testifying or about to testify in an inquiry or proceeding or giving or about to give information connected to any inquiry or proceeding relating to the PFML Law.

Nothing in this Policy or the PFML Law shall limit your ability to reasonably communicate with a Covered Individual who is approved for leave benefits.

INTERACTION WITH OTHER LAWS AND COMPANY POLICIES: Leave taken under this Policy runs concurrently with leave taken under other applicable state and federal leave laws, including but not limited to, the Commonwealth's Parental Leave Act, the FMLA, and the Commonwealth's Earned Sick Time Act when the leave is for a qualified reason under those acts.

GENERAL PROVISIONS

ENTIRE CONTRACT: The entire contract between you and us is this Policy and any attached amendments, and your Application (a copy of which is attached at issue).

CHANGES TO THE POLICY: 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. We will send the DFML all proposed 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.

If a Policy Amendment is not consistent with the PFML Law when the Policy has been submitted as part of an application for a private plan exemption, the DFML may withdraw the approval of your private plan exemption. If an exemption is withdrawn, you may be required to remit Contributions for your entire payroll retroactive to either October 1, 2019 or the start date of the Employer's or Covered Business Entity's approved exemption and you may be required to repay to Trust Fund the cost of total amount of benefits paid to Covered Individuals who received benefits from the Trust Fund. You may also be subject to additional interest and penalties established by the DFML for not maintaining a private plan.

INCONTESTABILITY OF THE POLICY: Any statement made by you to obtain insurance is a representation and not a warranty. The validity of this Policy shall not be disputed after the Policy has been in effect for two years from the Policy Effective Date, except:

(1) in situations when Premium has not been paid; or
(2) for fraudulent misrepresentations made with actual intent to deceive or willfully withholding a material fact in order to obtain coverage.

Disputing the validity of this Policy shall be prohibited if statements made by the applicant in applying for this Policy are not material to the risk accepted and do not appear in a written application made a part of the Policy and signed by the person making the statement.

CLERICAL ERROR: Clerical errors in connection with this Policy or delays in keeping records for this Policy, whether by you, us, the plan administrator, or a Covered Individual:

(1) will not terminate insurance that would otherwise have been in effect; and
(2) will not continue insurance that would otherwise have ceased or should not have been in effect.

MISSTATEMENT OF FACTS: If a Covered Individual's 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.

REINSTATEMENT: We do not allow for reinstatement of this Policy after it has been terminated by you or by us. If we accept premium for the period after the date the Policy ends, such acceptance does not reinstate the Policy. We 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 us 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 when prohibited by Massachusetts law, the benefits provided under this Policy are exempt from execution, garnishment, attachment, or other legal or equitable process, for the debts or liabilities of the Covered Individuals or their beneficiaries.

PREMIUMS

PAID FAMILY AND MEDICAL LEAVE RATE: The Premium due will be a percentage of the eligible monthly Wages then in force.

We will furnish to you the Premium Rate on the Policy Effective Date and when it is changed. We have the right to change the Premium Rate:

(1) when the extent of coverage is changed by amendment;
(2) when a new law or a change in any existing law is enacted which applies to the coverage under the Policy;
(3) on any Premium Due Date after the first Policy Anniversary; or
(4) on any Premium Due Date if your entire group's Wages or number of Covered Individuals changes by 15% or more.

We will not change the Premium Rate due to (3) or (4) above more than once in any twelve (12) month period. We will tell you in writing at least 31 days before the date a Premium Rate change is effective. A change may take effect on an earlier date if you agree to it. New Premium Rates will apply only to Premiums due on or after the date the rate change takes effect.

Premium contributions will not be taken from Wages above the contribution and base limit established annually by the federal Social Security Administration for purposes of the Federal Old-Age, Survivors, and Disability Insurance program limits pursuant to 42 U.S.C. 430.

If you require Covered Individuals to contribute toward the payment of Premium, this amount cannot exceed the maximum portion of Contributions for Covered Individuals as described in the PFML Law. The maximum amount of the Covered Individual's Contribution is subject to an annual adjustment by the DFML Director as specified in M.G.L. c. 175M, Section 7(e).

PREMIUM PAYMENT: All Premiums are to be paid by you to us on or before the Policy Effective Date and the Premium Due Dates, as stated on this Policy's face page. You 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 listed on the Policy face page.

GRACE PERIOD: Except for the first month's premium, you may pay the Premium up to 31 days after the date it is due. This 31 day period is called a Grace Period. Insurance provided under the Policy will stay in effect during the Grace Period, unless you have given us advance written notice of intent to end insurance under the Policy, in accordance with the terms of the Policy. If you replace the Policy with coverage under the State Plan or another private plan but do not give us written notice of intent to end the Policy, the Grace Period provision of the Policy will apply.

This provision serves as the required 31 day advance notice under the PFML Law that, if the Premium is not paid by the Premium Due Date or during the Grace Period, this Policy will terminate automatically on the last day of the Grace Period. You are 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, you are responsible for providing advance notice to Covered Individuals and the DFML 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 of the GENERAL PROVISIONS section. If the Policy ends, you will still owe us the Premium for the full period the Policy was in effect.

PREMIUM CHANGES: If a Covered Individual status changes occur during a month, then you must report the changes on the next Premium Due Date following the change. Any premium increase or decrease will become due at this same time, but will not be pro-rated daily. If you pay premium on other than a monthly basis, changes in premiums will result in a monthly pro-rated adjustment on the next Premium Due Date.

If appropriate, we will make adjustments to rectify any premium overpayment or underpayment made to us. However, in no event will an adjustment be made for a period more than the current Policy year and the prior Policy year unless changes are the result of fraudulent information.

WAIVER OF PREMIUM: No premium is due us for a Covered Individual while that Covered Individual is receiving PFML Benefits under the Policy. Once PFML Benefits cease, Premium Payments must begin again if insurance is to continue.

ELIGIBILITY FOR COVERAGE

ELIGIBILITY REQUIREMENTS: Eligibility under this Policy is limited to Covered Individuals, as defined in this Policy, who meet the eligibility requirements of the PFML Law.

EFFECTIVE DATE OF COVERAGE: Insurance coverage under this Policy will go into effect on the Policy Effective Date, as shown on the Policy Cover page.

In order for the Employer or Covered Business Entity to qualify for an exemption from Contributions to the Trust Fund, the Effective Date of Coverage must begin no later than January 1, 2021, for the following paid leaves:

- Medical Leave for Covered Individuals who are unable to work due to their own Serious Health Condition;
- Family Leave for Covered Individuals to bond with a Child during the first 12 months after the Child's birth, adoption, or foster care placement;
- Family Leave for Covered Individuals for a Qualifying Exigency arising out of the fact that the Covered Individual's Family Member is a current member of the Armed Forces; and
- Family Leave for Covered Individuals to care for a Family Member who is or was a member of the Armed Forces and who requires medical care as a result of an illness or injury related to Family Members' active service.

And no later than July 1, 2021, for the following paid leave:

- Family Leave for Covered Individuals to care for a Family Member with a Serious Health Condition.

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 eligible for such coverage under the PFML Law and the terms of this Policy.

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

(1) the date the Policy terminates;
(2) the date the individual no longer meets the definition of Covered Individual;
(3) the date the individual is no longer eligible for PFML coverage pursuant to the PFML Law and the terms of this Policy; or
(4) the end of the period for which Premium has been paid for the Covered Individual.

We will provide coverage for a payable claim that occurs while the Covered Individual is covered under the Policy.

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

a. If the Covered Individual remains unemployed on the date that claim for benefits is filed, the Covered Individual shall submit a claim for benefits with their former Employer or Covered Business Entity.
b. If the Covered Individual has become employed by a different employer or contracted with a covered business entity at the time that that a claim for benefits is filed, the Covered Individual shall submit a claim for benefits with their current employer or covered business entity.
    i. If the new employer or covered business entity has a private plan exemption, the covered individual shall submit the claim for benefits to the private plan in accordance with the requirements established by their employer or covered business entity. Employers or covered business entities that have been approved for a private plan exemption may require a Covered Individual to provide verification of wages earned with an Employer or covered business entity in the Commonwealth for purposes of determining whether that Covered Individual meets the financial eligibility requirements of M.G.L. c. 175M, § 1.
c. c. If an individual submitting a claim for benefits identifies themselves as a former employee, we or, if applicable, the employer or covered business entity that has been approved for an exemption, may inquire as to whether the individual is currently employed.

CONTRIBUTIONS: The Premium for this Policy is funded by Contributions from Covered Individuals and you, in accordance with the PFML Law. See the PREMIUMS section for details on the Premium rate, Contribution limits, and payment of Premium. If Covered Individuals contribute to the cost of the coverage, the Employee portion of the Contribution will not exceed the maximum rate allowed under the PFML Law.

The total Premium is allocated between Family Leave and Medical Leave. Current allocations of Premium and Contribution rates can be obtained from the Employer or Covered Business Entity or on the DFML's website at https://www.mass.gov/orgs/department-of-family-and-medical-leave. The Contribution rate may be adjusted annually, not later than October 1, by the Director of the DFML for the upcoming Calendar Year.

BENEFIT PROVISIONS

INSURING CLAUSE: We will pay a weekly PFML Benefit if you:

(1) are a Covered Individual as defined under the PFML Law and this Policy;
(2) are eligible for a leave covered under this Policy;
(3) have completed the Waiting Period, if any; and
(4) submit satisfactory proof of your claim to us, including the required documentation and Certifications, as applicable.

All presumptions under this Policy will be made in favor of the availability of leave and the payment of leave benefits.

WAITING PERIOD: No PFML Benefits will be paid to a Covered Individual during the first 7 calendar days after the date on which job protected leave begins. This Waiting Period for paid leave benefits counts against the Maximum Duration of Benefits in a Benefit Year. However, the Waiting Period does not apply to (1) Family Leave immediately following Medical Leave for pregnancy or recovery from childbirth, if supported by documentation by a Health Care Provider; or (2) an approved extension of a claim for Family or Medical Leave.

Where the approved claim involves leave on an Intermittent Leave or Reduced Leave schedule, the Waiting Period shall be 7 consecutive calendar days, beginning with the first day of Intermittent Leave or Reduced Leave, and not the aggregate accumulation of 7 days of leave.

A Covered Individual may utilize Accrued Paid Leave during the unpaid Waiting Period.

PFML BENEFIT CALCULATION: The weekly PFML Benefit paid under this Policy meets the minimum requirements of the PFML Law and will equal or exceed the benefits that would be paid to Covered Individuals if participating under the State Plan.

BENEFIT PERCENTAGE: The PFML Benefit is calculated using the Covered Individual's Average Weekly Wage at the time of filing of a request for leave, as follows:

- Multiply the portion of a Covered Individual's Average Weekly Wage that is equal to or less than 50% of the State Average Weekly Wage by 80%; and
- Multiply the portion of a Covered Individual's Average Weekly Wage that is more than 50% of the State Average Weekly Wage by 50%.

The PFML Benefit will not change during the term of the approved leave period, subject to a pro-rated or reduced amount as described under the Pro-Rating Leave Allotments provision and the Other Income provision.

MAXIMUM PFML BENEFIT: The Maximum PFML Benefit that is payable is 64% of the State Average Weekly Wage, not to exceed $850 per week, reduced by Other Income Benefits. This limit may be adjusted annually by the DFML pursuant to the requirements of the PFML Law. A Covered Individual with multiple employers or covered business entities is not required to take PFML from each employer or covered business entity during a single period of PFML.

MAXIMUM DURATION OF BENEFITS: PFML Benefits will not be paid beyond the Maximum Duration of Benefits, as follows:

Total leave per Benefit Year, for both Family and Medical Leave: Beginning January 1, 2021, Covered Individuals are eligible for up to 26 total weeks, in the aggregate, including the Waiting Period(s), if any, of Family and Medical Leave Benefits in a Benefit Year. A Covered Individual's leave duration will be based on the Covered Individual's Average Working Week with the Employer or Covered Business Entity.

Family Leave:

1. Covered Individuals are eligible for up to a total of 12 weeks, including the Waiting Period(s), if any, of Family Leave in a Benefit Year for the following leave reasons:

    i. Beginning January 1, 2021, to bond with a Child during the first 12 months after the birth, Adoption, or Foster Care placement of a Child;

ii. Beginning January 1, 2021, due to a Qualifying Exigency arising out of the fact that a Family Member is on active duty or has been notified of an impending call to active duty in the Armed Forces;

iii. Beginning July 1, 2021, to care for a Family Member with a Serious Health Condition.

2. Beginning January 1, 2021, Covered Individuals are eligible for up to 26 weeks, including the Waiting Period(s), if any, of Family Leave in a Benefit Year to care for a Family Member who is or was a member of the Armed Forces and who requires medical care as a result of an illness or injury related to the Family Member's active service.

Medical Leave:

Beginning January 1, 2021, Covered Individuals are eligible for up to 20 weeks, including the Waiting Period(s), if any, of Medical Leave in a Benefit Year if the Covered Individual has a Serious Health Condition that incapacitates the individual from work.

If the Covered Individual chooses to utilize Accrued Paid Leave instead of PFML Benefits under this Policy, this use will run concurrently with and count toward the Maximum Duration of Benefits. See the SUBSTITUTION OF EMPLOYER PROVIDED ACCRUED PAID LEAVE section below.

PRO-RATING LEAVE ALLOTMENTS: A week of leave for Family or Medical Leave is based on the number or hours or days a Covered Individual works. When a Covered Individual works a part-time schedule or variable hours, the amount of leave that a Covered Individual uses is determined on a pro rata or proportional basis.

If a Covered Individual's schedule varies from week to week to such an extent that an Employer or Covered Business Entity is unable to determine with certainty how many hours the Employee would otherwise have worked (but for taking leave as authorized by this Policy), a weekly average of the hours scheduled over the 12 months prior to the beginning of the leave period will be used for calculating the leave entitlement. This calculation may change to ensure compliance with the PFML Law and claims procedure regulations issued by the DFML.

If a Covered Individual takes leave on an Intermittent Leave or on a Reduced Leave schedule basis pursuant to the provisions in the PFML Law and this Policy, there will be a proportionate reduction in the Covered Individual's available allotment of leave taken under the Maximum Duration of Benefits.

SUBSTITUTION OF EMPLOYER PROVIDED PAID LEAVE: The Covered Individual is not required to first utilize any available Accrued Paid Leave or leave through an Extended Illness Leave Bank program before being eligible for PFML Benefits, nor is the Covered individual required to use available Accrued Paid Leave during the Maximum Duration of Benefits.

If the Covered Individual chooses to utilize Accrued Paid Leave or leave through an Extended Illness Leave Bank program, this use will run concurrently with and count toward the Maximum Duration of Benefits. Covered Individuals who choose to use Accrued Paid Leave or leave through an Extended Illness Leave Bank program are required to follow your notice and certification processes related to the use of such leave. Covered Individuals may not be compensated with PFML Benefits pursuant to the PFML Law or this Policy for a period of time for which they received compensation through the utilization of such Accrued Paid Leave.

OFFSETS FOR OTHER INCOME BENEFITS: The Gross PFML Benefit will be reduced by Other Income Benefits. Other Income Benefits means the weekly amount of wages, wage replacement or leave that a Covered Individual on Paid Family or Medical Leave receives for that period from any of the following:

(a) any government program or law, including unemployment benefits under M.G.L. c. 151A, or Workers' Compensation under M.G.L. c. 152, other than for permanent partial disability incurred prior to the Family or Medical Leave claim. This offset also includes, but is not limited to, family and/or medical leave benefits provided by the state or federal government, as well as benefits received as wage replacement from Social Security, the Jones Act, Railroad Retirement, and disability benefits under a governmental retirement plan such as STRS or PERS;

(b) under any veterans or military disability benefit law or other state or federal temporary or permanent disability benefits law, including but not limited to benefits issued pursuant to state disability benefits law;

(c) a permanent disability policy or program of an Employer or Covered Business Entity;

(d) a temporary disability policy or program of the Employer or Covered Business Entity, including but not limited to a short term disability plan sponsored by the Employer or Covered Business Entity, which, when added to the Covered Individual's Gross PFML Benefit, exceeds the Covered Individual's Average Weekly Wage;

(e) a paid family or medical leave policy of the Employer or Covered Business Entity which, when added to the Covered Individual's Gross PFML Benefit, exceeds the Covered Individual's Average Weekly Wage.

(f) any wages received from another employer or covered business entity or through self-employment, which, when added to the Covered Individual's Gross PFML Benefit, exceeds the Covered Individual's Average Weekly Wage.

A Covered Individual's family or medical leave allotment as described under the Maximum Duration of Benefits provision shall be proportionately reduced by the amount of family or medical leave taken by the Covered Individual for any qualifying reason during the benefit year. . However, any leave taken by the Covered Individual for the same qualifying reason prior to January 1, 2021, shall not count against the Covered Individual's weekly benefit amount and/or leave allotment.

The Covered Individual's Gross PFML Benefit shall also be reduced by any paid family or medical leave received from any source for any qualifying reason in the 12 month period prior to filing a claim for PFML benefits. However, any leave taken by the Covered Individual for the same qualifying reason prior to January 1, 2021, shall not count against the Covered Individual's weekly benefit amount and/or leave allotment.

If Other Income Benefits are paid in a lump sum, the sum will be prorated over the period of time to which the Other Income Benefits apply. If no period of time is given, the sum will be prorated on a weekly basis according to its nature and purpose, but not beyond the end of your Maximum Duration of Benefits.

EMPLOYER REIMBURSEMENT: If an Employer or Covered Entity makes payments to a Covered Individual during a period of family or medical leave that are equal to or greater than the benefit amount payable under this Policy, such Employer or Covered Entity may be reimbursed from us out of any benefits due to the Covered Individual or that become due.

To qualify for reimbursement, the Employer or Covered Entity must have made payments from: (i) a temporary disability policy or program of an Employer or Covered Entity; or (ii) a paid family or medical leave policy of an Employer or Covered Entity; or (iii) an Extended Illness Leave Bank.

The policy, program or Extended Illness Leave Bank must be granted to the Covered Individual for a Qualifying Reason under the PFML Law, that is separate from and in addition to any Accrued Paid Leave that is made available to the Covered Individual.

An Employer or Covered Entity will not be eligible for reimbursement from us for any payments to a Covered Individual where the Covered Individual has elected to utilize Accrued Paid Leave whether it is in lieu of applying for benefits under this Policy or supplementary to the Employer or Covered Entity's: (i) temporary disability policy or program; or (ii) medical leave policy.

The Employer or Covered Entity will be required to produce evidence that payments to Covered Individuals were made for a Qualifying Reason and are consistent with this Policy provision.

EXCLUSIONS: The following exclusions apply to payment of PFML Benefits under this Policy:

(1) We will not pay a PFML Benefit for any individual who does not meet the definition of Covered Individual as defined in this Policy; *
(2) We will not pay a PFML Benefit for any period of leave that began before the Covered Individual is covered under this Policy;
(3) We will not pay a PFML Benefit for any period of leave if benefits would not have been payable for that period of leave if participating under the State Plan;
(4) We will not pay a PFML Benefit for a Serious Health Condition caused or contributed to by cosmetic treatments or cosmetic surgery unless inpatient hospital care is required or complications develop;
(5) We will not pay a PFML Benefit during any period when the Covered Individual is receiving Accrued Paid Leave; and
(6) We will not pay a PFML Benefit if the notice of leave or proof of claim procedures included in this Policy are not followed, as detailed in the "FILING A CLAIM" section of the CLAIMS PROCEDURES provision.
(7) We will not pay a PFML Benefit for a Serious Health Condition caused or contributed to by a Substance Use Disorder unless the Covered Individual is being treated for such condition by a health care provider, provider of health care services on referral by a health care provider or by a program licensed or approved by the Massachusetts Department of Public Health. An absence because of the Covered Individual's use of the substance, rather than for treatment does not qualify for a PFML Benefit.

*EXCEPTION ON JANUARY 1, 2021: The Policy will not pay Family and Medical Leave Benefits for any period of leave that began before the Covered Individual becomes eligible under this Policy. However, on January 1, 2021, we will make a one-time exception and will allow Covered Individuals who are otherwise eligible but are out on Family or Medical Leave on January 1, 2021, to submit a claim under this Policy. We will use the 2020 start date of the Covered Individual's leave to determine if the Waiting Period has been satisfied and the definition of Average Weekly Wage. If approved, the Family and Medical Leave Benefits for that period of leave will begin effective January 1, 2021. No benefits will be payable for any period of leave prior to January 1, 2021. All other terms and conditions of this Policy apply.

TERMINATION OF BENEFITS: PFML Benefit payments to a Covered Individual will stop on the earliest of:

(1) the Covered Individual is no longer eligible for Family or Medical Leave under this Policy;
(2) for Medical Leave, the Covered Individual no longer has a Serious Health Condition or is not receiving Continuing Treatment by a Health Care Provider for any Serious Health Condition that is the reason for the leave;
(3) for Family Leave to care for a Family Member with a Serious Health Condition, the Family Member no longer has a Serious Health Condition or is not receiving Continuing Treatment by a Health Care Provider for any Serious Health Condition that is the reason for the leave;
(4) the Covered Individual has died;
(5) the Covered Individual fails to furnish the required authorizations, documentation or Certifications; or
(6) the Covered Individual has completed the Maximum Duration of Benefits under the Policy.

INTERMITTENT LEAVE OR REDUCED LEAVE SCHEDULE: The Covered Individual may take leave on an Intermittent Leave or Reduced Leave schedule basis, subject to the following:

(1) For Family Leave to bond with a Child during the first twelve months after the Child's birth, Adoption, or Foster Care placement: you and the Covered Individual must both agree to a period of Intermittent Leave or Reduced Leave before PFML Benefits are payable.

(2) For Family Leave to care for a Family Member's Serious Health Condition or to care for a Family Member who is a Covered Service Member: the Covered Individual must submit a Health Care Provider certification that the Intermittent Leave or Reduced Leave schedule is medically necessary before PFML Benefits are payable.

(3) For Family Leave due to a Qualifying Exigency arising out of a Family Member's active duty or impending call to active duty in the Armed Forces: PFML Benefits are payable if the Covered Individual elects to take Intermittent Leave or Reduced Leave for this purpose.

(4) For Medical Leave due to the Covered Individual's own Serious Health Condition: the Covered Individual must submit a Health Care Provider certification that the Intermittent Leave or Reduced Leave schedule is medically necessary before PFML Benefits are payable.

Weekly Benefit Adjustment. A Covered Individual who takes leave on an Intermittent Leave or Reduced Leave schedule basis shall receive a PFML Benefit that is reduced in direct proportion to the Intermittent Leave usage or Reduced Leave schedule. The Maximum PFML Benefit will also be reduced in direct proportion to the Intermittent Leave usage or Reduced Leave schedule.

Impact on Leave Allotments. Taking leave on an Intermittent Leave or Reduced Leave schedule basis pursuant to this section will result in a proportionate reduction in the Covered Individual's available allotment of leave under the Maximum Duration of Benefits.

Agreed-to Intermittent Leave or Reduced Leave Schedule. A Covered Individual (other than a former Employee) who is approved for and takes leave on an Intermittent Leave or Reduced Leave schedule basis and who fails to work during the times or on the schedule agreed to with you may be subject to discipline by your company. We may seek a refund from the Covered individual or offset any future benefit payments where we have determined that the Covered Individual has received wages or qualifying payments from both the Employer or Covered Business Entity and benefits under this Policy for the same period.

Variation in Work Schedule. In the event that a Covered Individual's work schedule varies from week to week, the maximum weekly benefit amount shall be calculated based on the average of number of hours worked from the two highest quarters of the 12 months preceding such Covered Individual's claim for benefits. A Covered Individual shall not be eligible for benefits in excess of the number of hours so determined by us. For purposes of intermittent leave, benefits may be prorated on an hourly basis utilizing the average number of hours worked during the 12 months preceding such Covered Individual's claim for benefits.

Benefit Year. The benefit year for a Covered Individual who received benefits for an Intermittent Leave will start, following our approval for continued benefits, on the Sunday immediately preceding the first absence following the exhaustion of the prior benefit year.

EXTENSION OF PAID LEAVE BENEFITS: The Covered Individual may submit a request for an extension of paid Family or Medical Leave using forms prescribed by us. This request must be filed with us at least 14 calendar days prior to the expiration of the original approved leave unless the Covered Individual provides Good Cause to allow a late filed request for extension.

The Covered Individual's request for an extension of leave is limited to any period of paid Family or Medical Leave the Covered Individual remains eligible for in the Benefit Year. The request for an extension must include the following information:

(1) The reason for the extension;
(2) The requested duration of the extended leave;
(3) The date on which the Covered Individual provided notice of the request for the extension; and
(4) A newly completed or updated Health Care Certification for medical or family leave, pursuant to the standards provided in 458 CMR 2.08(5), to support the request for extension.

We will notify you of a Covered Individual's request for an extension not more than five business days following receipt of a completed request. Our notice to you will include the following:

(1) The requested duration for the extension;
(2) Whether the newly requested leave is continuous or intermittent; and
(3) Any other information we deem relevant to verifying and otherwise processing the claim.

Within ten business days from the date we provide you with notice of the Covered Individual's request for extension of leave, you must provide us with all requested relevant information or records. This information may include the following:

(1) Whether the Covered Individual will receive any paid leave benefits from you during the requested extended leave period;
(2) Whether you have approved or intend to approve the request for extension under the Family and Medical Leave Act of 1993 (29 U.S.C. 2601 et. seq.) or any other policy allowing for paid or unpaid leave; and
(3) Any other relevant information or records related to the request for extension, including but not limited to, evidence of a fraudulent claim.

As noted previously, the Waiting Period will not apply to an approved extension of benefits. Any extension of a Claim will be limited to any period of paid Family or Medical Leave the Covered Individual remains eligible for in the Benefit Year.

A request for an extension of leave will be subject to the Claim Provisions section of this Policy and other claim procedures established by us, in compliance with the PFML Law.

You may seek a medical recertification of the Covered Individual's Serious Health Condition following the expiration of the initial period of incapacity cited in the healthcare certification or where an intermittent leave has extended for a period of more than 6 months from the approval by us, whichever occurs first.

CLAIM PROVISIONS

FILING A CLAIM: The Covered Individual must submit both notice of leave and proof of claim.

Notice of leave:

(a) A Covered Individual must give at least 30 calendar days' notice to the Employer or Covered Business Entity of the anticipated start date of Family or Medical Leave. Notice must be provided as soon as practicable if a delay is beyond the Covered Individual's control. Such notice must be given prior to submitting a claim to us. We will not accept a claim unless notice was given to the Employer or Covered Business Entity first.

(b) We will require a Covered Individual to comply with the Employer's or Covered Business Entity's usual and customary notice and procedural requirements for leave, absent unusual circumstances.

(c) Notice of the Covered Individual's need for Family or Medical Leave must be made to the Employer or Covered Business Entity before submitting a claim to us for to us for Family or Medical Leave benefits. We will not accept a claim unless notice to the Employer or Covered Business Entity was made as described in (a) above.

(d) Where Covered Individual does not comply with the notice requirement in (a) above or follow the Employer's or Covered Business Entity's usual notice and procedural requirements, and no unusual circumstances justify the failure to comply, protected leave and the claim for may be delayed or denied by us.

(e) When planning medical treatment, the Covered Individual must consult with the Employer or Covered Business Entity prior to submitting a claim to us and make a reasonable effort to schedule the treatment so as not to disrupt unduly the Employer's or Covered Business Entity's operations, subject to the approval of the health care provider.

(f) If, for reasons beyond the Covered Individual's reasonable control, the Covered Individual cannot provide us with at least 30 calendar days notice then the Covered Individual must provide notice as soon as is practicable. We will notify a Covered Individual's Employer or Covered Business Entity, if applicable, not more than five business days after a claim is filed and will facilitate the disclosure and exchange of relevant information or records regarding the claim. Our notice to an Employer or Covered business Entity will contain:
   1. the Covered Individual's full name and other identifying information;
   2. the type of leave requested;
   3. the expected duration of the leave;
   4. whether the request is for continuous or intermittent leave;
   5. any certification as required herein, supporting the need for the Family or Medical Leave; and
   6. any other information relevant to claim.

Proof of claim: Claim forms and other information needed to provide written proof of the Covered Individual's claim for PFML Benefits should be filed within 90 calendar days after the start of the leave. Covered Individuals can access claim forms from the Employer or Covered Business Entity or electronically from us at https://rslclaims.com/. If a claim is filed more than 90 calendar days after the start of leave, the Covered Individual may receive reduced benefits. This 90 calendar day limit may be extended if the Covered Individual shows Good Cause for the delay in accordance with DFML exemptions due to a Serious Health Condition of the Covered Individual that prevented the Covered Individual from providing the required certification within the 90 calendar days or due to other reasons beyond the Covered Individual's control.

Covered Individuals should send the notice of leave and proof of claim forms to the Employer or Covered Business Entity and to us. The Covered Individual can send such forms to us by mail to Reliance Standard Claims, P.O. Box 8330, Philadelphia, PA 19101-8330, by email to ClaimsIntake@rsli.com, by fax to (267)256-4262, or electronically to https://rslclaims.com/. Notice of leave or proof of claim sent to another location will 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.

The Covered Individual's proof of claim must include the following written consent, certifications and documentation requests, provided at the Covered Individual's expense within the proof of claim timeframes:

(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 and address of the Health Care Provider;

(4) Written consent from the Covered Individual for us to share information we have or may reasonably require with the Policyholder or Employer or Covered Business Entity, the DFML, and, if applicable, with the Health Care Provider in order to process and evaluate the claim;

(5) For Medical Leave Benefits for a Serious Health Condition: A certification from a Health Care Provider that includes:

(a) A summary of the appropriate medical facts within the knowledge of the Health Care Provider and a statement that the Covered Individual has a Serious Health Condition;

(b) The date on which the Serious Health Condition commenced;

(c) The probable duration of the Serious Health Condition;

(d) 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 or Covered Business Entity due to the Serious Health Condition; and

(e) Information regarding the need for Intermittent Leave or Reduced Leave, including a statement that such leave or schedule is medically necessary where the claim for benefits is for leave on an Intermittent Leave or Reduced Leave schedule.

(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) A statement confirming the relationship between the Covered Individual and the Family Member;
(b) The name and address of the Family Member;
(c) 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;
(d) The date on which the Family Member's Serious Health Condition commenced;
(e) The probable duration of the Family Member's Serious Health Condition;
(f) Information from the Covered Individual that proves to our satisfaction the identity of the Family Member
(g) A statement that the Covered Individual is needed to care for the Family Member; and
(h) An estimate regarding the frequency and anticipated duration of time that the Covered Individual is needed to care for the Family Member;

(7) For Family Leave Benefits for the Birth of a Child:
(a) The Child's birth certificate; or
(b) A statement from the Child's Health Care Provider stating the Child's birth date; or
(c) A statement from the Health Care Provider of the person who gave birth stating the Child's birth date.

In the case of multiple births, no more than 12 weeks of leave benefits total are available in a benefit year.

(8) For Family Leave Benefits for Placement of a Child for Adoption or Foster Care:
(a) A certification from the Child's Health Care Provider or from an Adoption or Foster Care agency involved in the placement or the department of children and families that confirms the placement and the date of placement; and
(b) Written notice from the Covered Individual of any change of status as an adoptive or foster parent while an application for benefits is pending or while the Covered Individual is receiving benefits. In this instance, the Covered Individual, within five business days of such change in status, is required to provide us with written notice of the change. The Massachusetts Department of Children and Families may confirm in writing the Covered Individual's status as an adoptive or foster parent while an application for benefits is pending or while the Covered Individual is receiving benefits;

(9) For Family Leave Benefits for a Qualifying Exigency arising from a Family Member on Active Military Duty or Notification of an Impending Call or Order to Active Duty in the Armed Forces:
(a) A copy of the Family Member's active duty orders; or
(b) A letter of impending activation from the Family Member's commanding officer; or
(c) Other documentation in circumstances where, for Good Cause shown, the Covered Individual is unable to produce the active duty orders or letter of impending activation; and
(d) A statement of the family relationship between the Covered Service Member and the Covered Individual requesting benefits;
(e) Information from the Covered Individual that proves to our satisfaction the identity of the Family Member;
(f) The name and address of the family member being cared for;
(g) The dates or period of time for which leave is requested; and
(h) The underlying reason for the Qualifying Exigency.

(10) For Family Leave Benefits to Care for a Family Member who is a Covered Service Member: A certification from the Covered Service Member's Health Care Provider that includes:
   (a) A summary of the appropriate medical facts within the knowledge of the Health Care Provider and a statement that the Covered Service Member has a Serious Health Condition;
   (b) The date on which the Covered Service Member's Serious Health Condition commenced;
   (c) The probable duration of the Serious Health Condition;
   (d) A statement that the Covered Individual is needed to care for the Covered Service Member;
   (e) An estimate of the amount of time the Covered Individual will be needed to care for the Covered Service Member;
   (f) An attestation by the Covered Service Member's Health Care Provider and the Covered Individual that the Serious Health Condition is connected to the Covered Service Member's military service;
   (g) A statement of the family relationship between the Covered Service Member and the Covered Individual;
   (h) Information from the Covered Individual that proves to our satisfaction the identity of the Family Member; and
   (i) Name and address of the Family Member being cared for.

LEAVE FOR SUBSTANCE USE DISORDER: A substance use disorder may be a serious health condition. Family or medical leave may only be taken for treatment for substance use disorder by a health care provider, by a provider of health care services on referral by a health care provider, or by a program licensed or approved by the Massachusetts Department of Public Health. An absence because of the Covered Individual's use of the substance, rather than for treatment, does not qualify for leave.

WRITTEN PROOF OF LOSS: We will evaluate a Covered Individual's written proof of claim to determine if a Covered Individual has provided satisfactory proof of loss 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.

INCONTESTABILITY OF COVERAGE: A Covered Individual must attest to the truthfulness of all statements and submissions made to us for a claim for PFML Benefits, including an amendment or extension of a claim. Any statement that the Covered Individual makes to obtain coverage will be deemed a representation and not a warranty. No misrepresentation by the Covered Individual will be used to reduce or deny a claim or to deny the validity of the Covered Individual's coverage after the Covered Individual's coverage has been in effect for two continuous years during the Covered individual's lifetime, unless it was a fraudulent misrepresentation made with actual intent to deceive or the Covered Individual willfully withheld a material fact in order to obtain benefits.

Disputing the validity of the Covered Individual's coverage shall be prohibited if statements made by the Covered Individual are not material to the risk accepted and are not in writing and signed by the Covered Individual. However, we have the right at any time to assert as a defense to a claim that the Covered Individual was not eligible to become covered because the Covered Individual did not meet the eligibility requirements for this coverage under this Policy or the MA PFML Law.

REQUIRED INFORMATION FROM THE EMPLOYER: We require that the Employer or Covered Business Entity, within ten business days from the date the Employer or Covered Business Entity receives notice that the Covered Individual has filed notice of claim 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 if not limited to, the following:

(1) 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;

(2) Wage history for the Benefit Year;

(3) Whether the Covered Individual will receive any paid or unpaid leave benefits from the Employer or Covered Business Entity during the requested leave period, including Accrued Paid Leave or other temporary disability or paid family or medical leave payments;

(4) Whether the Employer or Covered Business Entity has approved or intends to approve the request for leave under the FMLA or any other policy allowing for paid or unpaid leave;

(5) Whether the Covered Individual will be receiving any other wage replacement benefits as set forth under the OFFSETS FOR OTHER INCOME BENEFITS provision in this Policy; and

(6) 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.

PAYMENT OF CLAIMS: Within 14 calendar days after we receive satisfactory proof of loss from a Covered Individual, we will notify the Covered Individual of our claims decision. We will provide contemporaneous notice to the Employer or Covered Business Entity, if applicable, if we approve a Covered Individual's claim for PFML Benefits. This notice will include the reason for the approved leave, the duration of the approved leave, the expiration of the approved leave, and for Intermittent Leave and Reduced Leaves, the frequency and duration of the leave benefits.

We will pay any PFML Benefits due within 14 calendar days after approving the claim. If our claim determination occurs more than 14 calendar days before the onset of eligibility, we will begin payment of PFML Benefits as soon as the Covered Individual is eligible for benefits. PFML Benefits will be paid not less frequently than weekly for each period as we become liable.

We will pay benefits to the Covered Individual, if living. Benefit payments that become due, or if any amount for which we are liable remains unpaid after the Covered Individual's death, will be made to the Covered Individual's estate.

For each period of leave, a Covered Individual who has been approved for PFML Benefits must comply with the Employer's or Covered Business Entity established attendance and call-in procedures applicable to the Covered Individual's position with the Employer or Covered Business Entity.

AUTHORITY TO MAKE BENEFIT DETERMINATIONS: Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to this Policy. The claims review fiduciary has the discretionary authority to interpret the Policy and to determine eligibility for benefits and the amount of any benefits payable. Decisions by the claims review fiduciary shall be complete, final and binding on all parties, subject to the APPEALS PROCEDURES section of this Policy and the PFML Law.

AMENDMENT OF BENEFITS: Following an approval of a claim for PFML Benefits under this Policy, if there is a change in relevant circumstances that would justify an extension, reduction, or other modification of the period of leave or the amount of PFML Benefits, both you and the Covered Individual have an affirmative obligation to notify us within 7 calendar days of said change.

RECOVERY OF OVERPAYMENTS: We have the right to recover overpayments that occur due to:

(1) Fraud;

(2) An error we make in processing the Covered Individual's claim;

(3) Payment we made that should have been made under another plan; or

(4) The Covered Individual's receipt of Other Income Benefits for periods during which the Covered Individual has already received PFML Benefits under this Policy.

We have the right to obtain any information relating to sources of Other Income Benefits. 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 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.

APPEAL OF AN ADVERSE BENEFIT DETERMINATION: The Covered Individual may appeal to us any adverse benefit decision we may make on all or part of the Covered Individual's claim. This appeal must be in writing and must be received by us within 10 calendar days of the Covered Individual's receipt of notice of the adverse determination. We may extend the 10 day filing period where a Covered Individual establishes to our satisfaction that circumstances beyond the Covered Individual's control prevented the filing of a request for an appeal within the prescribed 10 day filing period.

The Covered Individual may appeal to the DFML any adverse benefit decision we may make on all or part of the Covered Individual's claim after the claim has been appealed to us first as set forth above. This appeal must be in writing and must be received by the DFML, as provided under the PFML Law, within 10 calendar days of the Covered Individual's receipt of notice of the adverse determination. The Covered Individual must also send us a complete copy of the appeal. The DFML may extend the 10-day filing period where an individual establishes to the satisfaction of the DFML that circumstances beyond the individual's control prevented the filing of a request for an appeal within the prescribed 10-day filing period. We must furnish any documentation in connection with the appeal to the DFML within 10 business days of their request. Following the DFML's issuance of a final decision on the appeal, a Covered Individual may take a further appeal by filing a complaint in the district court for the county in the Commonwealth where the Covered Individual resides or was last employed. More information regarding appeals can be obtained from the DFML at its website https://www.mass.gov/orgs/department-of-family-and-medical-leave.

CERTIFICATIONS FOR A SERIOUS HEALTH CONDITION: For leaves that require a Serious Health Condition, the Covered Individual must submit a certification of the Serious Health Condition from a Health Care Provider as outlined under the FILING A CLAIM section, above, and as permitted under the PFML Law. If we determine that a certification lacks required information, or is not accurate or authentic, or is otherwise insufficient, we may contact the Health Care Provider and require that the Health Care Provider verify, supplement, or otherwise amend the information in the certification. Any medical or health information required under this Policy will be confidential and shall not be disclosed except as needed in the administration of the claim or except with permission from the Covered Individual who provided it, unless disclosure is otherwise required by law.

FITNESS FOR DUTY AT CLOSE OF MEDICAL LEAVE PERIOD: If the Covered Individual's leave was caused by the Covered Individual's own Serious Health Condition, and the Covered Individual is in Employment with you, you may require that the Covered Individual obtain and present certification from the individual's Health Care Provider that the individual is able to resume work. You may seek the fitness-for-duty certification only with regard to the particular health condition that caused the Covered Individual's need for leave. You may require that such certification include information from the Health Care Provider addressing the Covered Individual's ability to perform the essential functions of the position.

You must provide notice to the Covered Individual in accordance with the PFML Law if a fitness-for-duty certification will be required prior to return to work following Medical Leave. If you will require a detailed certification addressing the Covered Individual's ability to perform the essential functions of the position, you must also provide a job description or other list of essential functions along with the notice to the Covered Individual.

You may delay restoration until a Covered Individual submits a required fitness-for-duty certification, unless you failed to provide the notice required. If you provide the notice required, a Covered Individual who does not provide a fitness-for-duty certification following the approved leave period is no longer entitled to reinstatement.

DEFINITIONS

This section defines certain terms appearing in this Policy.

The following words shall have the following meanings, unless the context clearly requires otherwise. Terms defined under the Federal Family Medical Leave Act of 1993, as amended, and its implementing regulations shall be treated as persuasive, supplementary authority when those definitions are not facially inconsistent with the terms adopted in M.G.L. c. 175M and 458 CMR 2.00.

Accrued Paid Leave means leave earned by or otherwise provided to a Covered Individual pursuant to a benefit plan or policy offered by an Employer or Covered Business Entity, if applicable, including, but not limited to, sick leave, annual leave, vacation leave, personal leave, compensatory leave, paid time off, or salary continuation. Accrued paid leave shall not include a: (i) disability policy or program of an employer or covered business entity; or (ii) paid family, or medical leave policy of an employer or covered business entity.

Active Duty means for the purposes of administering paid leave under this Policy, full-time duty in the active military service of the United States and full-time National Guard duty and deployed to a foreign country.

Adoption means legally and permanently assuming the responsibility of raising a child as one's own. The source of an adopted child (*i.e.*, whether from a licensed placement agency or otherwise) is not a factor in determining eligibility for leave.

Average Weekly Wage shall have the same meaning as provided in M.G.L. c. 151A, § 1(w); provided, however, that Average Weekly Wage shall be calculated using all Wages from the Base Period; and provided further, that in the case of a self-employed individual, Average Weekly Wage shall mean 1/26 of the total earnings of the self-employed individual from the two highest quarters of the 12 months preceding such individual's application for benefits under M.G.L. c. 175M. The Average Weekly Wage does not include Wages above the contribution and base limit established annually by the federal Social Security Administration for purposes of the Federal Old-Age, Survivors, and Disability Insurance program limits pursuant to 42 U.S.C. 430. If an individual has multiple employers, the Average Weekly Wage will be calculated for each employer or covered business entity separately.

Average Working Week means the average number of hours worked from the two highest quarters of the 12 months preceding such individual's application for benefits under M.G.L. c175M.

Base Period means the last four completed calendar quarters within the previous five calendar quarters immediately preceding the date a claim is filed for a qualified period of paid family or medical leave. A completed calendar quarter is one for which an employment and wage detail report has been or should have been filed for employers or Covered Business Entities who have not received an exemption from contributions to the Trust Fund, pursuant to 458 CMR 2.04(1)-(2).

Benefit Year means the period of 52 consecutive weeks beginning on the Sunday immediately preceding the first day that any job-protected leave under the PFML Law commences for the Covered Individual.

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

Child means a biological, adopted or foster child, a stepchild or legal ward, a child to whom the Covered Individual stands *in loco parentis*, or a person to whom the Covered Individual stood in loco parentis when the person was a minor child.

Continuing Treatment by a Health Care Provider includes any one or more of the following:

(a) Incapacity and treatment. A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:

1. Treatment two or more times, within 30 calendar days of the first day of incapacity, unless extenuating circumstances exist, by a Health Care Provider, by a nurse under direct supervision of a Health Care Provider, or by a provider of health care services (*e.g.*, physical therapist) under orders of, or on referral by, a Health Care Provider; or
2. Treatment by a Health Care Provider on at least one occasion, which results in a regimen of continuing treatment under the supervision of the Health Care Provider. Treatment includes examination to determine if there is a Serious Health Condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations. A regimen of continuing treatment includes a course of prescription medication or therapy requiring specialized equipment to resolve or alleviate the health condition.
3. The requirement for treatment by a Health Care Provider means an in-person visit or telehealth visit to a Health Care Provider. The first (or only) in-person visit or telehealth visit must take place within seven calendar days of the first day of incapacity.
4. Whether additional treatment visits or a regimen of continuing treatment is necessary within the 30 calendar day period shall be determined by the Health Care Provider.
5. The term extenuating circumstances means circumstances beyond the Covered Individual's control that prevent the follow-up visit from occurring as planned by the Health Care Provider. Whether a given set of circumstances are extenuating depends on the facts. For example, extenuating circumstances exist if a Health Care Provider determines that a second in-person visit is needed within the 30 calendar day period, but the Health Care Provider does not have any available appointments during that time period.

(b) Pregnancy or Prenatal Care. Any period of incapacity due to pregnancy, or for prenatal care.

(c) Chronic Conditions. Any period of incapacity or treatment for such incapacity due to a chronic Serious Health Condition. A chronic Serious Health Condition is one which:
(1) Requires periodic visits (defined as at least twice per calendar year) for treatment by a Health Care Provider, or by a nurse under direct supervision of a Health Care Provider;
(2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
(3) May cause episodic rather than a continuing period of incapacity (*e.g.*, asthma, diabetes, epilepsy, *etc.*).

(d) Permanent or Long-term Conditions. A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The Covered Individual or Family Member must be under the continuing supervision of, but need not be receiving active treatment by, a Health Care Provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

(e) Conditions Requiring Multiple Treatments. Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a Health Care Provider or by a provider of health care services under orders of, or on referral by, a Health Care Provider, for:
1. Restorative surgery after an accident or other injury; or
2. A condition that would likely result in a period of incapacity of more than three consecutive, full calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, *etc.*), severe arthritis (physical therapy), or kidney disease (dialysis).

(f) Absences attributable to incapacity under Continuing Treatment by a Health Care Provider (b) or (c) qualify for leave even though the Covered Individual or the covered Family Member does not receive treatment from a Health Care Provider during the absence, and even if the absence does not last more than three consecutive, full calendar days.

(g) Cosmetic treatments are not Serious Health Conditions unless inpatient hospital care is required or unless complications develop.

Contributions means the payments made by an employer, a covered business entity, or a self-employed individual to the Family and Employment Security Trust Fund, as required by M.G.L. c. 175M, or contributions to a private plan while the private plan is in effect.

Covered Business Entity means a business or trade that contracts with self-employed individuals for services and is required to report the payment for services to such individuals on IRS Form 1099-MISC for more than 50% of its workforce.

Covered Contract Worker means a self-employed individual who performs services as an individual entity, resides in Massachusetts, and performs services in Massachusetts for whom an Employer or Covered Business Entity is:

(a) required to report payment for services on IRS Form 1099-MISC; and
(b) required to remit contributions to the Family and Employment Security Trust Fund pursuant to the requirements of M.G.L. c. 175M, § 6.

The 1099 MISC worker must not be an independent contractor as defined by M.G.L. c. 151A, § 2.

Covered Individual means a worker that is covered under this Policy. Covered Individuals must include the following individuals who meet the eligibility requirements of the PFML Law:

(1) All the Employer's Employees providing services in Massachusetts, including full-time, part-time, permanent, temporary, on call, per diem or seasonal employees who meet the minimum eligibility requirements under the PFML Law;
(2) Former Employees of the Employer for not more than 26 weeks after separation or until re-employed, whichever comes first; and
(3) Massachusetts 1099-MISC contract workers, if applicable, working for the Employer, if the Employer is a Covered Business Entity.

Covered Service Member means either:

(a) a member of the Armed Forces, as defined in M.G.L. c. 4, § 7, including a member of the National Guard or Reserves, who is:

    1. undergoing medical treatment, recuperation or therapy;

    2. otherwise in outpatient status; or

    3. is otherwise on the temporary disability retired list for a serious injury or illness that was incurred by the member in the line of duty on active duty in the Armed Forces, or a serious injury or illness that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces; or

(b) a former member of the Armed Forces, including a former member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy for a serious injury or illness that was incurred by the member in line of duty on active duty in the Armed Forces, or a serious injury or illness that existed before the beginning of the member's active duty and was aggravated by service in line of duty on active duty in the Armed Forces and manifested before or after the member was discharged or released from service.

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

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

Domestic Partner means a person not less than 18 years of age who:

(a) is dependent upon the Covered Individual for support as shown by either unilateral dependence or mutual interdependence that is evidenced by a nexus of factors including, but not limited to:

1. common ownership of real or personal property;
2. common householding;
3. children in common;
4. signs of intent to marry;
5. shared budgeting; and
6. the length of the personal relationship with the Covered Individual; or

(b) has registered as the domestic partner of the Covered Individual with any registry of domestic partnerships maintained by the employer of either party, or in any state, county, city, town or village in the United States.

Earnings from Self-employment, or Income from Self-Employment, shall have the same meaning as "net earnings from self-employment", as defined in the Internal Revenue Code at 26 U.S.C. § 1402(a) as amended and in effect for the taxable year, and the implementing regulations at 26 CFR § 1.1402 (a).

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

Employer means the Policyholder. The term Employer shall have the same meaning as provided in M.G.L. c. 151A § 1(i); provided, however, that

(a) an individual employer or Covered Business Entity shall be determined by the Federal Employer Identification Number;

(b) the Department of Early Education and Care shall be deemed the employer of family child care providers, as defined in M.G.L. c. 15D, § 17(a); provided further, that the PCA Quality Home Care Workforce Council established in M.G.L. c. 118E, § 71 shall be the employer of personal care attendants, as defined in M.G.L. c. 118E, § 70;

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

Employment Benefits means all benefits provided or made available to Covered Individuals by an Employer or Covered Business Entity, if any, including, but not limited to, group life insurance, health insurance, disability insurance, sick leave, annual or vacation leave, educational benefits and pensions.

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

Family Leave means leave taken to care for a Family Member with a Serious Health Condition, for a parent to bond with the parent's child during the first 12 months after the child's birth, adoption, or foster care placement, to care for a Family Member who is a Covered Service Member, or because of a Qualifying Exigency arising out of the fact that a Family Member is on active duty or has been notified of an impending call or order to active duty in the Armed Forces.

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

Family Member means the Spouse, Domestic Partner, Child, Parent or Parent of a Spouse or Domestic Partner of the Covered Individual; a person who stood *in loco parentis* to the Covered Individual when the Covered Individual was a minor Child; or a Grandchild, Grandparent or Sibling of the Covered Individual.

Financial Eligibility Test means a demonstration that, over the 12 months preceding an individual's claim for benefits, the individual has received total wages as an employee or payments for service as a covered contract worker from Massachusetts Employers or Massachusetts Covered Business Entities that in the aggregate equal or exceed 30 times the individual's weekly benefit amount as determined under 458 CMR 2.12, below, and that in the aggregate are not less than the dollar amount calculated annually by the Department of Unemployment Assistance pursuant to M.G.L. c. 151A, § 24(a).

Wages received from multiple employers or covered business entities within the base period can be aggregated to determine financial eligibility for leave.

Former Member of the Armed Forces means an individual who was a member of the Armed Forces, including a member of the National Guard or Reserves, and was discharged or released at any time during the five-year period prior to the first date the Covered Individual files a claim to care for the former member of the Armed Forces.

Foster Care means 24-hour care for children in substitution for and away from their parents or guardian. Such placement is made by or with the agreement of Massachusetts or any other state, commonwealth, or territory as a result of a voluntary

agreement between the parent and guardian that the child be removed from the home, or pursuant to a judicial determination of the necessity for foster care, and involves agreement between Massachusetts or any other state, commonwealth, or territory and foster family that the foster family will care for the child. Although foster care may be with relatives of the child, State action is involved in the removal of the child from parental custody.

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

Grace Period means the period of time following the Premium Due Date, except for the first premium, during which the Policy will be continued in force and premium payment may be made.

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

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

Gross PFML Benefit means the Policy's weekly PFML Benefit before it is integrated with Other Income Benefits.

Health Care Provider means an individual licensed by the state, commonwealth or territory in which the individual practices to practice medicine, surgery, dentistry, chiropractic, podiatry, midwifery or osteopathy, and including the following:

(a) Podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice in by a State and performing within the scope of their practice as defined under the law of that state, commonwealth, or territory;

(b) Nurse practitioners, nurse-midwives, clinical social workers and physician assistants who are authorized to practice under the law of that state, commonwealth, or territory and who are performing within the scope of their practice as defined under State law;

(c) Christian Science Practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts.

(d) A Health Care Provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is performing within the scope of the person's practice as defined under such law.

Incapacity means an inability to perform the functions of one's position, or where the Covered Individual is a former employee, to perform the functions of one's most recent position or other suitable employment as that term is defined under M.G.L. c. 151A, § 25(c), due to the Serious Health Condition, treatment therefor, or recovery therefrom.

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

Intermittent Leave means leave taken in separate periods of time due to a single qualifying reason, rather than for one continuous period of time. Examples of Intermittent Leave include leave taken on an occasional basis for medical appointments or leave taken several days at a time spread over a period of months. Intermittent leave shall be taken in increments consistent with the established policy of the Employer or Covered Business Entity uses to account for use of other forms of leave; provided, however, that we will not pay in increments of less than 15 minutes. A Covered Individual shall not be permitted to apply for payment for benefits associated with intermittent leave until they have 8 hours of accumulated leave time unless more than 30 calendar days has lapsed since the initial taking of such leave.

Job Protected Leave means the period of time described in 458 CMR 2.16 (1) immediately following the first date on which an employee commences the taking of any type of leave that is associated with a qualifying reason regardless of whether a claim for benefits has been submitted to us in connection therewith or whether that leave is paid or unpaid. Employees who do not file a claim for benefits with us but use any other type of leave including accrued paid leave or unpaid leave approve by an employer, leave under a (i) temporary disability policy or program on an employer; or (ii) paid family, or medical leave policy of an employer; or (iii) an Extended Illness Leave Bank provided by an employer, and taken for a qualifying reason,

will be entitled to job protected leave as of the date of commencing such leave and that leave will run concurrently with the leave period provided in M.G.G. c. 175M.

Maximum Weekly Benefit means the maximum weekly PFML Benefit amount as described in M.G.L. c. 175M, §3(b)(2). The maximum may be adjusted annually not later than October 1 of each year to take effect on January 1 of the year following such adjustment.

Maximum Duration of Benefits means the total available period of leave available in a Benefit Year under the PFML Law.

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

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

Minimum Weekly Benefit Amount means the minimum amount of wage replacement that may be paid to a Covered Individual on a weekly basis while the Covered Individual is on family or medical leave, as provided in M.G.L. c. 175M, § 3. The PFML Benefits described in the BENEFIT PROVISIONS section of this Policy will always meet or exceed the Minimum Weekly Benefit Amounts.

Net PFML Benefit means the Policy's weekly PFML Benefit after it is integrated with Other Income Benefits.

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

Pay Period means the shortest pay period used by a business or trade for regular payments to any group of Covered Individuals of the business or trade.

PFML Benefits means the Paid Family and Medical Leave Benefits payable for Covered Individuals pursuant to M.G.L. c. 175M and 458 CMR 2.00 ("PFML Law").

Policy means the group Paid Family and Medical Leave Insurance coverage described in this document and issued to the Policyholder.

Policyholder means the entity named on the cover page of the Policy to whom this Policy is issued.

Qualifying Exigency means a need arising out of a Covered Individual's Family Member's active duty service or notice of an impending call or order to active duty in the Armed Forces, including, but not limited to, providing for the care or other needs of the military member's child or other Family Member, making financial or legal arrangements for the military member, attending counseling, attending military events or ceremonies, spending time with the military member during a rest and recuperation leave or following return from deployment or making arrangements following the death of the military member.

Qualifying Earnings means: (a) wages paid to an employee; (b) payments by covered business entities to covered contract workers; and (c) earnings from self-employment on which a self-employed individual is making contributions pursuant to 458 CMR 2.06.

Qualifying Reason means any of the following reasons for which a Covered Individual is eligible for family or medical leave benefits: to bond with a Child during the first 12 months after the Child's birth, adoption, or foster care placement; to care for a Family Member's Serious Health Condition; to care for a Family Member who is a covered service member; a Qualifying Exigency arising out of a Family Member's active duty or impending call to active duty in the Armed Forces; or the Covered Individual's own Serious Health Condition that incapacitates the individual from performing the essential functions of the individual's job.

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

Self-employed individual means a sole proprietor, sole member of a limited liability company or limited liability partnership or an individual whose net profit or loss from a business is required to be reported to the Massachusetts Department of Revenue; provided, however, that such individual resides in Massachusetts.

Serious Health Condition means an illness, injury, impairment or physical or mental condition that involves:

(a) inpatient care in a hospital, hospice or residential medical facility; or
(b) continuing treatment by a Health Care Provider.

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

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

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

Wages shall have the same meaning as provided in M.G.L. c. 151A, § 1(s).This includes Qualifying Earnings and earnings from the Employer or Covered Business Entity and from other employment during the Base Period, if those earnings would be included in the Base Period of a qualifying claim for PFML benefits under the State Plan.

Weekly Benefit Amount means the amount of wage replacement paid to a Covered Individual on a weekly basis while the Covered Individual is on family or medical leave, as provided in M.G.L. c. 175M, § 3.

RELIANCE STANDARD LIFE INSURANCE COMPANY
Philadelphia, Pennsylvania

POLICY RIDER

POLICYHOLDER: Saks and Company LLC
POLICY NUMBER: MA PFML 168068
EFFECTIVE DATE: January 1, 2021

It is hereby understood and agreed that Policy Form LRS-9581-0720 to which this Rider is attached is amended as follows:

1. The following item is added to BENEFIT PROVISIONS - OFFSETS FOR OTHER INCOME BENEFITS:

   (g) Accrued Paid Leave which, when added to the Covered Individual's Gross PFML Benefit, exceeds the Covered Individual's Average Weekly Wage.

2. Item 5 under BENEFIT PROVISIONS – EXCLUSIONS is removed in its entirety.

This Rider will terminate on the date the Group Policy terminates. It is subject to all the terms of the Group Policy that are not inconsistent herein.

In witness whereof, we have caused this Rider to be signed by our Secretary.

Secretary