

12: Department of Labor

702: Maine Paid Family and Medical Leave Program

Chapter 1: Rules governing the Maine Paid Family and Medical Leave Program

Summary: The purpose of this chapter is to provide definitions and procedures for implementing the Paid Family and Medical Leave Program pursuant to 26 M.R.S. chapter 7, subchapter 6-C.

I. Definitions

A. Meaning of Terms. The following definitions are provided to clarify or to add to those codified in Title 26 § 850-A. Unless the context otherwise requires, terms used in regulations, interpretations, forms, and other official pronouncements issued by the Department shall be construed in the sense in which they are defined in the law, or in this or other regulations of the Department.

1. “Act” means the Act authorizing Paid Family and Medical Leave, 26 M.R.S. §§ 850-A - 850R.
2. “Administrator” has the same meaning as § 26 M.R.S. 850-A (1).
3. “Applicant” means an individual who is applying to obtain benefits under this rule.
4. “Authority” means the Paid Family and Medical Leave Benefits Authority established in 26 M.R.S. § 850-O.
5. “Business day” means any day that is not a Saturday, Sunday or a state holiday.
6. “Calendar week” means a period of seven consecutive calendar days, beginning on a Sunday.
7. “Continuous leave” means leave-occurring in blocks for consecutive days or weeks.
8. “Department” means the Maine Department of Labor.
9. “Days” means calendar days, unless otherwise specified in the Act, or in this rule.
10. “Employer” has the same meaning as 26 M.R.S. § 850-A (14). Additionally, “Employer” for the purpose of these rules, in the case of an employee leasing contractual arrangement described in 32 M.R.S. Ch. 125, means the client company as described in 32 M.R.S. Ch 125 §14051(1), and any reference to Federal Employer Identification Number (FEIN) means the FEIN of the client company.
11. “Family leave” means leave requested by an employee for the reasons set forth in 26 M.R.S. § 850-B (2) or 26 M.R.S. § 843 (4).

12. “Family member” has the same meaning as 26 M.R.S. § 850-A(19).
13. “Good cause” includes, but is not limited to, the following:
- A. A serious health condition that results in an unanticipated and prolonged period of incapacity and that prevents an individual from timely filing an application for benefits or a request to appeal;
 - B. A demonstrated inability to reasonably access a means to file an application or to request an appeal in a timely manner, such as an inability to file an application or request to appeal due to a natural disaster or a significant and prolonged closure of the Department’s offices;
 - C. A serious health condition of a family member that requires the unanticipated and prolonged presence of the individual filing an application or request to appeal and that prevents the individual from timely filing an application for benefits or a request to appeal;
 - D. Physical, intellectual, linguistic or other limitations including limited understanding of English that prevents the timely filing of an application or request to appeal; or
 - E. Circumstances beyond the control of the individual filing the application or requesting the appeal that made it impossible to timely file the application or request to appeal despite making a reasonable effort to do so.
14. “Health care provider” has the same meaning as 26 M.R.S. § 850-A (21) and includes but is not limited to all providers identified in 29 C.F.R § 825.125 (eff. Feb 6, 2013.)
15. “Intermittent leave” means an employee taking varying periods of leave and returning to work throughout a period of approved covered leave time. Intermittent leave may be planned (i.e., for routine appointments) or unplanned (i.e., for a flare-up of a serious health condition).
16. “Independent contractor” has the same meaning as 26 M.R.S. § 1043 (11) (E).
17. “Medical leave” means leave requested by an employee for the reasons set forth in 26 M.R.S. § 850-A (22).
18. “Program” means the Maine Paid Family and Medical Leave Program.
19. “Reduced schedule leave” means a leave schedule that reduces the typical number of days per workweek, or hours per workday, of an employee on a planned and consistent basis.
20. “Safe leave” means leave requested by an employee for the reasons set forth in 26 M.R.S. § 850-A (26)

21. “Scheduled workweek” means the number of hours an employee is scheduled to work in a particular week. For the purposes of this rule, a self-employed individual who has elected coverage and a salaried employee as defined by 26 M.R.S. § 663 (3) (K) have a scheduled workweek of 40 hours, Monday-Friday, 8 hours per day.
22. “State average weekly wage” has the same meaning as 26 M.R.S. § 850-A (30). For the purposes of this rule, the state average weekly wage amount is updated annually on July 1st.
23. “Tier 1 wages” means the amount of the covered individual’s reported gross weekly wage reported to the Administrator that is equal to or less than fifty percent (50%) of the state average weekly wage.
24. “Tier 1 benefits” means the percentage of the wage replacement a covered individual is entitled to earn on wages up to fifty percent (50%) of the state average weekly wage.
25. “Tier 2 wages” means the amount of the covered individual’s reported gross weekly wage reported to the Administrator that is more than 50 percent (50%) of the state average weekly wage.
26. “Tier 2 benefits” means the percentage of the wage replacement a covered individual is entitled to earn on wages that are more than 50 percent (50%) of the state average weekly wage as defined in this rule.
27. “Waiting period” means the period in which medical leave benefits are not payable for approved leave under this Act beginning for the first 7 calendar days at the start of leave.
28. “Wages” means all remuneration for personal services, including tips and gratuities, severance and terminal pay, commissions, and bonuses, but does not include remuneration for services performed by an independent contractor as defined by 26 M.R.S. § 1043 (11) (E). “Wages” are calculated in the same manner as Maine unemployment wages in 26 M.R.S. § 1043(19)(B-E) except that employees subject to wages include all employees with the exception of Section II (B) of these rules, and excludes wages above the 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. Wages include remuneration for services performed in the State or wages which are otherwise subject to Maine unemployment tax pursuant to 26 M.R.S. § 1043 (11) (A) and (D).
29. “Wages for self-employed individuals” has the same meaning as income as defined in 26 U.S.C. § 1402(b) (eff. Mar. 23, 2018)
30. “Weekly Benefit Amount” means the amount of wage replacement as calculated in 26 M.R.S. § 850-C (2) payable to a covered individual on a weekly basis while the covered individual is on family leave or medical leave, including prorated amounts for partial weeks of leave.

II. Coverage

A. Covered employees are:

1. Employees who earn wages paid in the State.

a. “Wages paid in the State” means all remuneration for personal services, including tips and gratuities, severance and terminal pay, commissions, and bonuses, but does not include remuneration for services performed by an independent contractor as defined by 26 M.R.S. § 1043 (11) (E). “Wages” are calculated in the same manner as Maine unemployment wages in 26 M.R.S. § 1043(19)(B-E) except that employees subject to wages include all employees with the exception of Section II (B) of these rules, and excludes wages above the 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. Wages include remuneration for services performed in the State or wages which are otherwise subject to Maine unemployment tax pursuant to 26 M.R.S. § 1043 (11) (A) and (D).

2. Individuals who elect coverage as set forth in the Act and in this rule.

B. The following types of employment are not covered by this Act:

1. Any employee subject to the Railroad Unemployment Insurance Act, 45 U.S.C. §§ 351 – 369, (eff. Nov. 10, 1988).

2. Incarcerated persons earning wages in a Maine correctional facility established in 34-A M.R.S. § 1001 (6) or a detention facility established in 34-A M.R.S. § 1001 (8-A).

3. Students that are earning wages as part of the federal Work-study Program and are enrolled in any University of Maine system established in 20-A M.R.S. § 10901, a community college established in 20-A M.R.S. § 12714, or any other public or private higher educational institution in the State of Maine.

4. Individuals who volunteer for an employer or governmental entity if the volunteer:

- a. Performs hours of service for the employer or governmental entity for civic, charitable or humanitarian reasons, without promise, expectation or receipt of compensation for services rendered. Although a volunteer may receive no compensation, a volunteer may be paid expenses, reasonable benefits or a nominal fee to perform such services;
- b. Offers services freely and without pressure or coercion, direct or implied, from an employer; and

- c. Is not otherwise employed by the same employer or governmental entity to perform the same type of services as those for which the individual proposes to volunteer.

5. Employees of the federal government, including employees of the United States Postal Service.

III. Use and types of Leave

A. A covered individual may take the following types of leave:

1. Continuous leave
2. Intermittent leave
3. Reduced Schedule leave

B. Use of Intermittent and Reduced Schedule leave.

1. Covered individuals may take up to 12 weeks of approved leave on either a continuous, intermittent or reduced schedule. Partial weeks or partial days of leave will be prorated against the employee's scheduled workweek.

2. Intermittent and reduced schedule leave may be taken by the covered individual in increments of not less than a scheduled workday. If a covered individual and their employer agree in writing, the covered individual may take intermittent or reduced schedule leave in smaller increments, except that the minimum increment is one hour. An employer is not required to agree to allow the use of increments of less than a scheduled workday but cannot refuse to allow the covered individual to use a full scheduled workday if refusing the use of a partial day. A covered individual who is self-employed and has opted into the fund must take leave in increments of one scheduled workday.

3. Payments will be prorated based on the number of hours of leave used by a covered individual and reported to the Administrator, divided by the number of hours the covered individual is scheduled to work in the week. If the covered individual's schedule is so variable that it is difficult to determine how many hours the covered individual would have worked in the week were it not for taking leave, the Administrator will determine the covered individual's scheduled workweek as the average number of hours worked by the covered individual in each of the previous 12 weeks. If the Administrator is not able to obtain information about the covered individual's previous 12 weeks of hours worked after reasonable attempts to obtain said information the Administrator will assume a schedule of Monday through Friday, 8 hours per day. For the purposes of this paragraph, "hours worked" means any hours the employee was or is scheduled to work, regardless of whether the employee actually worked those hours or used authorized leave to cover those hours.

4. A covered individual approved for intermittent leave is not required to file a separate application for each occurrence of intermittent leave but must report any leave taken to the Administrator within 15 days after each occurrence for the purposes of providing benefits. A covered individual must still inform their employer of any intermittent leave use according to the employer's reporting policies.

5. If an applicant applies to take intermittent or reduced schedule leave from two or more employers participating in the Fund, the applicant must provide, for each employer, a leave schedule agreed to by the applicant and the employer that provides information regarding the number of hours the applicant is scheduled or anticipated to work for a specific workweek and the number of hours the employee will use leave for on a reduced or intermittent basis for each workweek during leave for benefit proration. The Weekly Benefit Amount is prorated based on the number of hours of leave taken from any of the employers from whom the covered individual is on leave and the covered individual's scheduled hours for all of the employers from whom the covered individual is on leave. In the absence of such agreement, the Administrator will determine the applicant's scheduled hours.

IV. Eligibility

A. To receive benefits, a covered individual must:

1. Be a covered employee as defined in Section II;
2. Have earned wages paid in the State at least 6 times the state average weekly wage during the first 4 of the last 5 completed calendar quarters immediately preceding the first day of an individual's benefit year. For the purposes of these calculations, the state average weekly wage is that which was published effective on the July 1 immediately preceding the date of application for benefits or of the start of the leave, whichever is earlier.
3. Submit an application for benefits no more than 60 days before the anticipated start date of family leave and medical leave and no more than 90 days after the start date of family leave and medical leave;
4. Be employed as of the date of application for benefits if applying in advance of leave, or be employed as of the date of leave beginning if applying retroactively for leave;
5. Have not been declared ineligible pursuant to Section IX of this rule; and
6. Satisfy one of the qualifying reasons under the Act.

B. The following provisions apply regarding the eligibility to take leave:

1. A covered individual may take family leave immediately following medical leave if the medical leave is taken during pregnancy or recovery from childbirth and supported by documentation by a health care provider. If the covered individual is eligible as of the

start of the medical leave for pregnancy and recovery from childbirth, that eligibility status shall be retained for the purposes of family leave for bonding with a child immediately following the medical leave, regardless of the covered individual's eligibility data as of the first day of the family leave. The combined medical leave and family leave may not exceed the 12-week maximum of family and medical leave within a benefit year.

2. The 12 weeks of aggregate leave taken under this Act will be reduced by any leave taken under 29 U.S.C. § 2611 (eff. Dec. 20, 2019) or leave under 26 M.R.S. § 844 that was not taken concurrently with leave under this Act in the 12 month period preceding the start of leave.

3. When determining an employee's eligibility to obtain benefits, the number of days an employee has worked for an employer shall not be considered by the Administrator.

V. Notice and Undue Hardship

A. An employee must give reasonable notice to the employee's employer of the employee's intent to use leave. Thirty days written notice to the employer shall be presumed to constitute reasonable notice, unless an employer determines otherwise in accordance with subsection (V)(D). In the case of an emergency, illness or other sudden necessity, an employee shall make a good faith effort to provide written notice to the employer of the employee's intent to use leave as soon as is feasible under the circumstances. If the employee is incapacitated, notice may be provided by a family member or health care provider on behalf of the employee.

B. The employee's notice shall include the following information:

1. The reason for the leave being requested (e.g. family, medical, safe leave, qualifying exigency);

2. The type of leave needed (e.g. continuous, reduced schedule, or intermittent leave);

3. Actual or anticipated timing and duration of leave;

4. Any other relevant information regarding the employee's need to take leave. The employer may not require an employee's notice to be in or on a prescribed form as long as the information provided is sufficient. This notice must be in writing, which can include a standard form, letter, email, or text message provided to the employer.

C. If the employee and employer agree to a schedule of leave, the employer may waive the 10-day review of undue hardship on a form and manner provided by the department at the time of the employee's application of leave.

D. The employer may reasonably determine that the timing or duration of the leave creates an undue hardship. "Undue hardship" means a significant impact on the operation of the business or significant expenses, considering the financial resources of the employer, the size of the

workforce, and the nature of the industry that cannot be overcome with the amount of notice given. An employer's determination of undue hardship shall be considered reasonable if:

1. The employer provided a written explanation of the undue hardship to the employee, demonstrating, based on the totality of the circumstances, how the absence of the specific employee and the specific timing and/or duration of the employee's requested leave will cause significant impact on the operation of the business or significant expenses;
2. The employee retains the ability to take leave within a reasonable time frame relative to the proposed schedule; and
3. The employer has made a good faith attempt to work out a schedule for such leave that meets the employee's needs without unduly disrupting the employer's operations.
4. If medical leave is requested, the employer's proposed schedule must be sufficient to accommodate the healthcare needs of the employee in the judgment of the employee's healthcare provider.

VI. Process for Application and Approval of Benefits

A. To request paid family and medical leave benefits, an applicant shall submit an application for benefits in a manner approved by the Department. An application may be submitted online. The applicant must submit all information and documentation requested by the Administrator that is reasonably necessary to determine eligibility for leave. Requested information and documentation may include, as applicable to the type of leave requested:

1. Proof of personal identity;
2. Identifying information about all employers participating in the Fund from which the applicant is seeking leave;
3. Proof of identity of family member if the applicant is applying for paid family leave;
4. Information-regarding the existence of a significant personal bond, if the applicant is applying for family leave to care for an individual with a serious health condition with whom the applicant has a relationship as described in 26 M.R.S. § 850-A(19)(G). A significant personal bond is one that, when examined under the totality of the circumstances, is like a family relationship, regardless of biological or legal relationship. This bond may be demonstrated by, but is not limited to the following factors, with no single factor being determinative:
 - a. Shared personal financial responsibility, including shared leases, common ownership of real or personal property, joint liability for bills or beneficiary designations;

- b. Emergency contact designation of the employee by the other individual in the relationship or the emergency contact designation of the other individual in the relationship by the employee;
 - c. The expectation to provide care because of the relationship or the prior provision of care;
 - d. Cohabitation and its duration and purpose;
 - e. Geographic proximity; and
 - f. Any other factor that demonstrates the existence of a family-like relationship.
5. Reason for leave;
 6. Proposed scheduling of leave, including the first day of missed work and the expected duration of leave;
 7. A waiver signed by the employer that the proposed schedule of leave is not an undue hardship, if applicable;
 8. Documentation, to include the anticipated duration of leave, from a health care provider of the applicant's own serious health condition if seeking medical leave;
 9. Documentation, to include the anticipated duration of leave, from a health care provider of the family member's serious health condition if seeking family leave; and
 10. Other information and documentation reasonably requested by the Administrator.

B. The application will contain an Authorization Statement, which, if signed by the applicant or, in the case of applications for leave to care for a family member with a serious health condition, the applicant's family member, authorizes the Administrator to obtain medical information from the relevant health care provider as part of the verification process to obtain paid family or medical leave benefits. Applicants and their family members are not obligated to sign the Authorization Statement; however, if they decline to do so, the applicant is responsible for providing all required medical information from the relevant health care provider, and processing of the application may be delayed by any delay or failure to provide such information.

C. An application for safe leave must include a signed statement that the applicant meets the requirements for safe leave set forth in the Act.

D. A completed application must include a signed statement attesting that the information provided in support of the application for paid family or medical leave benefits is true and correct to the best of the applicant's knowledge.

E. A failure to provide reasonably necessary information or documentation may result in a delay in processing or denial of the application. Before denying a claim for incomplete information, the Administrator must provide the applicant an opportunity to provide the outstanding information. If such information is not provided within 10 business days of the Administrator's request, the application may be denied. The Administrator may deny an application for

incomplete information only if such information is reasonably necessary to determine whether the applicant is eligible for benefits under the Act, and the extent and timing of such benefits.

F. A complete application for paid family or medical leave benefits may be submitted to the Administrator no more than 60 days prior to the start of family and medical leave and no more than 90 days after the start date of family leave and medical leave.

G. The 90-day application deadline may be waived if the Administrator finds good cause exists. Good cause for the late submission of an application is at the discretion of the Administrator

H. The Administrator shall notify the employer in writing of an applicant's claim to obtain paid family or medical leave within 5 business days after a claim was filed. If there is an agreement as to the scheduling of leave, as mentioned in Section V B(5), the application will be processed immediately. If there is no agreement as to the scheduling of leave, as mentioned in Section V B(5), the application will go through an employer review as follows. Within 10 business days, the employer must submit any additional facts or information regarding the applicant's eligibility it wishes the Administrator to consider, and if the employer has determined that the proposed scheduling of the leave constitutes an undue hardship, the employer must also provide documentation supporting its determination pursuant to section V. Failure to claim an undue hardship during this time period shall be deemed a determination that the proposed schedule does not constitute an undue hardship. The Administrator shall review all determinations of undue hardship pursuant to section V. If the Administrator finds that the employer's determination is reasonable and the application would otherwise be approved, the Administrator shall impose a reasonable schedule provided by the employer. The employee shall be notified in writing by Administrator of the finding of undue hardship and the new provided schedule. If the Administrator finds that the employer's determination of undue hardship is not reasonable, the Administrator shall notify the employer in writing, and the application shall be processed in accordance with these rules with the employee's requested schedule. The employer or employee may appeal the Administrator's finding in this section pursuant to section XV within 15 business days from the date the decision is issued.

VII. Review of claims for benefits

A. The Administrator shall review a complete application and issue a determination to the covered individual. The review of the claim shall begin no later than the close of the 10 business days within which the employer is required to provide information to the Administrator. During those 10 business days, the Administrator will not begin the review if the employer has not yet provided requested information.

B. If an applicant is not approved to obtain benefits, the Administrator shall notify the applicant and the employer and state the reason or reasons for the denial in the notification. The Administrator's notice shall also inform the applicant that they are entitled to request a reconsideration of the Administrator's decision by notifying the Administrator-in writing within 15 business days from the date the notification is issued.

C. If the applicant is approved to obtain benefits, the Administrator shall notify the applicant and the employer as to the benefit amount, the amount of time for which the applicant has been approved to take paid family or medical leave, and the qualifying reason, along with information on when benefits will be paid, and contact information of the Administrator. The Administrator shall also inform the applicant that they are entitled to request a reconsideration of the decision if they do so in writing within 15 business days from the date the notification is issued.

D. If the applicant requests reconsideration, the Administrator shall review the request and the applicant's original application, using a separate reviewer from the initial consideration. The Administrator shall notify the employer of the applicant's request for reconsideration. The Administrator shall notify the applicant and employer in writing of the outcome of the reconsideration request. If reconsideration results in denial of benefits, the Administrator shall state the reason for the denial. If the applicant is aggrieved by the result of the reconsideration, the applicant may appeal the reconsideration decision pursuant to Section XV within 15 business days from the date the decision is issued. An applicant is not aggrieved if all requested benefits were approved.

E. If an applicant's claim is approved, the employer(s) from which they are taking leave will receive notification of the claim approval along with the approved timeframe of leave within 5 business days of the approval date.

F. All notifications from the Administrator to applicants and employers will be in writing, which may include email or electronic portal notifications.

VIII. Benefits

A. Calculation of Benefits:

1. The Weekly Benefit Amount paid to a covered individual is calculated based on a tiered wage system. The calculation of benefits will be determined by the Administrator using the applicant's Average Weekly Wage, as calculated based on the applicable earnings data reported to the Administrator by the employer or employers, or by the individual if the applicant is self-employed.

2. The Weekly Benefit Amount shall be calculated as follows:

- a. Tier 1 wages and benefit: the State Average Weekly Wage shall be multiplied by 50% and rounded up to the nearest whole dollar. This shall be the Tier 1 Wage Cap. The portion of the individual's average weekly wage that is less than or equal to the Tier 1 Wage Cap is multiplied by 90% and rounded up to the nearest whole dollar. This shall be the Tier 1 Benefit Amount. If the covered individual's average weekly wage does not exceed the Tier 1 Wage Cap, no additional calculation under Tier 2 is required.
- b. Tier 2 wages and benefit: the portion of the covered individual's average weekly wage that exceeds the Tier 1 Wage Cap shall be multiplied by 66%

and rounded up to the nearest whole dollar. This shall be the Tier 2 Benefit Amount.

- c. Weekly Benefit Amount: The Tier 1 Benefit Amount and the Tier 2 Benefit Amount shall be combined to equal the Calculated Weekly Benefit Amount. If the Calculated Weekly Benefit Amount exceeds the Maximum Weekly Benefit Amount, the Weekly Benefit Amount shall be the Maximum Weekly Benefit Amount; otherwise the Calculated Weekly Benefit Amount shall be the Weekly Benefit Amount.
- d. For the purposes of these calculations, the state average weekly wage is that which was published effective on the July 1 immediately preceding the date of application for benefits or of the start of the leave, whichever is earlier.

3. The Average Weekly Wage is calculated by dividing the reported wages for the applicant in their base period by 52. Once the Weekly Benefit Amount is established for a claim it will remain consistent through the life of the claim, subject to the subsection C below.

B. Payment of Benefits:

- 1. Approved benefits shall be paid to the covered individual by direct deposit into a checking or saving account in a financial institution in the United States. Alternatively, if the covered individual wishes to receive their approved Weekly Benefit Amount in the form of a debit card, the covered individual may request this on their application to obtain benefits.
- 2. Medical leave benefits are not payable to a covered individual for the first seven (7) consecutive calendar days beginning with the first day of leave.

C. Reduction and Proration of Benefits:

- 1. **Proration of Benefits.** Benefits shall be prorated for covered individuals taking leave for less than a full week as follows: the amount of time taken as leave will be divided by the amount of time the covered individual was scheduled to work for any employer in the week. The covered individual's prorated benefit amount shall be calculated separately for each week in which the covered individual reports use of leave equaling less than a full scheduled workweek.
- 2. **Reduction of Benefits.** For any week in which a covered individual is on family leave or medical leave, the covered individual's Weekly Benefit Amount must be reduced by the amount of wage replacement that the covered individual receives from a government program or law, including but not limited to unemployment insurance, workers compensation, other than for compensation received under 39-A M.R.S. § 213 for an

injury that occurred prior to the family leave or medical leave claim, and other state or federal temporary or permanent disability benefits laws, or from an employer's permanent disability program or policy for the same week.

3. The covered individual's Weekly Benefit Amount is not subject to reduction by any of the following:

- a. Any benefit received from SNAP, TANF, HEAP or similar programs;
- b. Wages received from any other employer from whom the covered individual is not on leave;
- c. Wages received from the employer from whom the covered individual is on leave for hours actually worked or authorized leave time used during the same week;
- d. Wages received from the employer if the employer voluntarily pays the difference between the covered individual's Weekly Benefit Amount and their typical weekly wage. If the employer voluntarily pays such wages, the employer may charge that time against the covered individual's leave balances; and
- e. Supplemental payments received from an employer's short term disability program or policy. to the extent that the payments combined with the PFML benefits do not exceed the individual's typical weekly wage.

IX. Fraud and Ineligibility

A. Definitions:

1. "PFML fraud" exists where a covered individual has obtained paid family or medical leave benefits based upon a willful false statement, willful misrepresentation of a material fact, or the willful withholding of a material fact or facts.
2. "Material fact" means a fact the truth or falsity of which would have a determinative effect on the approval or denial of a claim.

B. The Department shall investigate complaints or reports of suspected PFML fraud. The Department may also conduct random audits and reviews of submitted claims. A finding of PFML fraud shall be made based on a preponderance of the evidence. The following procedures may be followed in investigations of suspected PFML fraud:

1. Obtaining documentary evidence. Prior to interviewing an individual, the Department shall obtain all available documentation. An individual shall provide any requested documents within 21 days of receiving a request from the Department.
2. The Department may interview a covered individual after providing notice no less than ten (10) business days in advance. The notice of interview will be provided in

writing. The interview may be conducted in person or by phone at the discretion of the Department.

3. The Department shall make a finding of PFML fraud or, if fraud is not determined, dismiss the complaint, and shall notify the covered individual as to the outcome of the investigation. If the Department finds that the covered individual has committed PFML fraud, the covered individual's benefits, if currently active, shall immediately be suspended, and the covered individual shall be designated as ineligible pursuant to 26 M.R.S. § 850-D(5).

C. If the Department determines that PFML fraud has occurred that affected a covered individual but for which the covered individual was not responsible, such as identity theft by a third party, any weeks fraudulently used will not be charged against the covered individual's maximum leave benefits.

D. A covered individual found to have committed PFML fraud shall be designated as ineligible pursuant to 26 M.R.S. § 850-D (5) and disqualified from benefits for a period of one year from the date of the final determination. The Department may demand repayment of any benefits paid as a result of PFML fraud.

E. The Department shall notify the covered individual if it demands repayment of the amount due. The covered individual may request a waiver of repayment by notifying the Department, in writing, within 30 days after the notice of the repayment. The covered individual's request shall state the reasons for requesting a waiver of repayment. The Department shall have the discretion to waive repayment in whole or in part if recovery would be against equity and good conscience.

F. A covered individual may appeal a finding of PFML fraud, a demand for repayment, or a denial of a waiver request consistent with the procedures in Section XV of this rule within 15 business days from the date the decision is issued. A request for waiver of repayment does not constitute a request to appeal the demand for repayment unless a request to appeal is specifically included. Any repayment shall be tolled during the pendency of an appeal or a request for waiver. However, absent a showing that it would be against equity and good conscience, the covered individual's designation of ineligibility and immediate termination of current benefits shall not be tolled during the pendency of an appeal.

X: Premiums

A. The employer's premium amount and contribution report must be remitted quarterly on or before the last day of the month following the close of the quarter for which premiums have accrued. The contribution report must be on a form and in a manner approved by the Department, and all employers covered under this Act must register online for the program. Payment for premiums will be considered timely if postmarked or received electronically on or before the due date. If the due date falls on a Saturday, Sunday, or legal holiday, payment will be considered timely if postmarked on the next business day that is not a Saturday, Sunday, or legal holiday. Premium payments and

contribution reports may be remitted by an employee leasing company or authorized third party administrator on behalf of the employer.

B. For the purposes of determining when withholding for premiums begin, withholdings will begin on wages for the first pay period with a payment date in January 2025.

C. For the purposes of reporting wages on contribution reports, amounts will be reported to the nearest cent. For the purposes of calculating premiums owed, amounts will be rounded to the nearest whole dollar.

D. Premiums are required up to the contribution and benefit 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 the remitting of premiums for an employee results in an overpayment, a covered employee may seek a refund from the Department pursuant to a process set forth by the Department. A request for a refund may require documentation, such as a W-2 form(s) or another statement summarizing earnings and deductions.

E. An employer may seek a refund of a premium overpayment on behalf of covered employees employed by the employer and on behalf of the employer. If an overpayment of premiums is made by the employer, the employer may retain any portion of premiums made by the employer but also must return to its employees any portion of the reimbursed amount that it collected from its employees.

F. A self-employed individual that has elected coverage to obtain benefits must remit to the Department fifty percent (50%) of the premium on the self-individual's income to the Department. The premium amount will be determined on the self-employed individual's net income from the prior tax year divided by four for quarterly income. Premiums will be due on the last day of the month following the close of the quarter.

G. A tribal government that has elected coverage to obtain benefits on behalf of their employees must remit to the Department the premiums at the rate of non-tribal government employers to the Department on or before the last day of the month following the close of the quarter.

H. For the purposes of determining premium liability, any employer that employed 15 or more covered employees per that employer's Federal Employer Identification Number (FEIN) on their established payroll in 20 or more calendar workweeks in the 12-month period preceding September 30th of each year will be considered to be an employer of 15 or more employees for the calendar year thereafter. This count includes the total number of persons on establishment payrolls employed full or part time who received pay for any part of the pay period. Temporary and intermittent employees are included, as are any workers who are on paid sick leave, on paid holiday, or who work during only part of the specified pay period. On October 1, 2024, and October 1 of each year thereafter, the employer shall calculate its size for the purpose of determining premium liability for calendar year 2025 and each calendar year thereafter.

I. Employers with 15 or more covered employees shall remit one hundred percent (100%) of the premium but may deduct up to fifty percent (50%) of the premium from the employees' wages. Employers with fewer than 15 employees shall remit fifty percent (50%) of the premium but may

deduct up to fifty percent (50%) of the premium from employees' wages. An employer's determination as to whether or not to deduct premiums from employees' wages must apply to all employees, except as required for employees of separate collective bargaining agreements with the same employer. If an employer changes that determination, the employer must provide notice to all employees in writing at least seven (7) days prior to the employees' first affected paycheck.

J. An employer that has been approved for a private plan substitution is exempt from the requirements to remit premiums as specified in Section XIII of this rule. If an employer has not been approved for a private plan substitution, the employer is responsible for remitting premiums to the Fund.

K. Employers who deduct the employee share of the premium from wages must make the deductions from employees' regularly scheduled paychecks, except that an employee and employer may mutually agree to less frequent deductions as long as the agreement is voluntary and memorialized in writing. Deductions may not be made less frequently than quarterly, even if the employer and employee agree. Employers shall include in the employee's pay statement that a premium deduction for Paid Family and Medical Leave has been deducted from the employee's wages.

L. If an employer fails to deduct the required employee share of the premium from wages paid during a pay period, the employer is considered to have elected to pay that portion of the employee share. The employer shall not deduct this amount from a future paycheck of the employee for a different pay period. However, where there is a lack of sufficient employee net wages to cover the employee share of premiums for a pay period, the employer may deduct the uncollected portion of the employee share from one or more paychecks for future pay periods.

XI: Failure to Remit Premiums and Contribution Reports

A. An employer that has failed to remit premiums in whole or in part or failed to submit contribution reports on or before the last day of the month following the close of the quarter shall be assessed a penalty of 1.0 percent of the employer's total payroll for the quarter. The assessment imposed will apply to only the quarter in which the employer failed to remit premiums in whole or in part or submit contribution reports. In addition, the employer shall be liable for the full amount of family leave benefits and medical leave benefits paid to covered individuals for whom it failed to make premium contributions.

B. The Department will notify employers of any delinquent contribution reports no later than 15 days after premiums were due. If the employer fails to remit the delinquent payments or contribution reports on the due date established in the notice, an assessment will be imposed.

C. If an assessment is imposed for failure to pay, the employer may seek an appeal pursuant to Section XV of this rule.

D. A self-employed individual who elects coverage to obtain paid family or medical leave benefits and fails to submit premiums for at least two consecutive quarters as required in this rule may be disqualified from family leave benefits and medical leave benefits by the Department. Prior to disqualification, the Department shall notify the self-employed individual that premiums

have not been paid in full for at least two consecutive quarters. If the self-employed individual has failed to remit premiums to the Department after 30 days, the self-employed individual will be disqualified. The self-employed individual may appeal a disqualification pursuant to Section XV of this rule.

E. If the self-employed individual has demonstrated successful payments of the delinquent premiums and additional premiums equivalent to the number of quarters the self-employed individual failed or refused to remit premiums, the Department in writing must notify the self-employed individual of their reinstatement to obtain coverage for paid family or medical leave benefits.

Section XII: Elective Coverage

A. Elective coverage is available to self-employed individuals and tribal governments under the following conditions:

1. Electing coverage:
 - a. A self-employed individual who is a resident of the State of Maine may elect to obtain coverage for paid family or medical leave benefits for themselves by filing a notice of election form provided by the Department and providing a copy of their tax return for the previous year.
 - b. A tribal government may elect to obtain coverage for paid family and medical leave benefits as an employer for the tribal government's employees by filing a notice of election form provided by the Department.
 - c. Elective coverage must be for an initial period of not less than three years, renewable after the initial period in one-year increments.
2. Effect of electing coverage:
 - a. Approved elective coverage becomes effective on the first day of the first quarter following the approval of the self-employed individual or tribal government's election.
 - b. A self-employed individual who has elected for coverage may apply for benefits on the same basis as any other applicant, pursuant to section VI of this rule.
 - c. A tribal government that has elected for coverage shall be treated for the period of coverage as an employer in the meaning of the Act and these rules.
3. Wages:
 - a. For self-employed individuals electing coverage, wages are based on net earnings from all self-employment, including but not limited to, income reported to Maine on the personal income tax return from a prior tax year or as filed with the Maine Revenue Services. Applicable tax returns must be submitted annually to the Department by June 1.

b. A self-employed individual's reported wages must meet the minimum threshold for covered individuals in order to be eligible for PFML benefits. For tribal governments that have elected coverage, quarterly contribution reports must be submitted to the Department consistent with section X of this rule.

4. **Withdrawing or renewing coverage:**

- a. A self-employed individual or tribal government may withdraw from coverage on a form provided by the Department within 30 days following the end of the coverage period. The Department shall notify all elective coverage employers and individuals of the end date of their coverage period no later than 60 days before the end date. If the self-employed individual or tribal government does not withdraw during the specified period, their coverage renews for an additional one-year period.
- b. A self-employed individual may also withdraw from coverage within 30 days if they are no longer a self-employed individual.
- c. The effective date of any withdrawal under this section is 30 days after the filing of notice of withdrawal or the date of the Department's notification of approval of withdrawal, whichever is later.
- d. A self-employed individual or tribal government that has been covered but whose coverage has not been renewed may elect coverage again, beginning with an initial three-year period of coverage.

XIII: Substitution of Private Plans

A. Employer Substitution

1. An employer may request to substitute a substantially equivalent private plan pursuant to 26 M.R.S. § 850-H. The employer must identify when the proposed substitute plan is a) a fully-insured private plan, approved pursuant to section B, below, or b) a self-insured plan, approved pursuant to section C, below.
2. Applications for substitution may be made after April 1, 2025. Applications for substitution must be submitted online on a form provided by the Department. Substitutions are made in accordance with the employer's Federal Employer Identification Number (FEIN) and must provide coverage for all employees within that employer's FEIN. Applications for substitution may be accepted on a rolling basis. An application fee set by the Department must be included with the submission of the application. Beginning April 1, 2025, the application fee is \$250 for review of the application, and an additional \$250 administrative reimbursement fee if the application is approved for the substitution. The application fees may be increased by

the Department on January 1, 2026 or thereafter, based upon inflation or based upon a redetermination by the Department that the current application fees do not cover the actual cost for administering private plans. Any such increase in the application fees shall be posted on the Department's website.

3. An approved substitution is valid for a period of three years.
4. The exemption from the obligation of premiums begins on the first day of the quarter in which the substitution is approved, except if the application for substitution is submitted less than 30 days prior to the end of a quarter, in which case the exemption is effective on the first day of quarter following when the application for substitution was submitted, assuming it is an approval.
 - a. If employee withholdings were made prior to the substitution being approved, the employer must refund the withholdings to the effective date of the exemption within 30 days from the approval of the substitution and failure to do so may result in a revocation of substitution.
 - b. The employer is responsible for premiums provided under the Act and this rule until the effective date of exemption and premiums owed prior to the effective date of exemption must be remitted and are non-refundable.
 - c. While an employer must have entered a contractual obligation with a certified fully-insured plan or have submitted a bond if a self-insured plan to submit a substitution, the employer may choose to start benefit coverage by May 1, 2026 at the latest.
 - d. If an employer is found to have not commenced benefit coverage after May 1, 2026 for a substitution approved prior to that date, they will be responsible for paying retroactive premiums from the date of the start of the exemption to May 1, 2026 and cannot deduct the employee's share of the premium for these retroactive premiums.
 - e. For substitutions approved after May 1, 2026, benefit coverage must commence on the first day of the first month following the approval of a substitution.
5. Employers approved for a substitution may not request cancellation of their substitution prior to the substitution expiration date except by a demonstration to the Department of significant direct negative business impact. Significant direct negative business impact includes, but is not limited to, evidence of an unanticipated and unreasonable premium increase. If the Department approves the employer's request for cancellation, the employer may not re-apply for another substitution for three years from the date of cancellation.
6. During the duration of an employer's substitution, if an employer seeks to make any material change to the approved plan, the employer must notify the Department at

least 60 days in advance of the effective date of any proposed change and must receive written approval from the Department. A material change is any change which affects the rights, benefits or protections afforded to employees under the Act.

7. Following approval for substitution, the Department may conduct audits and/or investigate employee complaints to determine whether, in operation, the substituted plan provides the rights, benefits, and protections that are substantially equivalent to those provided in the Act. Failure to demonstrate adequacy of performance may lead to revocation of a private plan substitution in this rule.
8. If the employer's approved plan is canceled due to nonpayment of premium, the employer's approved substitution will be revoked. If an employer's substitution is revoked for any reason, the employer will be responsible for premiums, beginning with the first quarter following revocation. The employer is prohibited from seeking another substitution for a period of three years from the date of the revocation unless the Department allows a lesser period of time.
9. The Department shall notify employers in writing of the end date of their approved substitution sixty (60) days prior to the end date. Employers must submit an application for renewal thirty (30) days prior to the end date of their approved substitution. If the employer fails to apply to renew or if the renewal is denied, the employer must remit both the employer and employee contributions to the Fund calculated from the date of the prior exemption expiration, and the employer may not deduct the employees' portion from payroll.
10. An employer with an approved substitution must collect and submit all data required under 26 M.R.S. § 850-E (6) to the Department. The employer must submit this data no later than July 31 each year. Data reports prepared for fully insured private plans by insurance companies offering such plans to several employers may meet the requirement of this paragraph. Failure to submit data reports may result in revocation of the substitution.
11. An employer with an approved substitution must submit to the Department contribution reports for each employee on a quarterly basis online, pursuant to section X of this rule of this rule. Failure to file contribution reports may result in revocation of the substitution.
12. An employer with an approved substitution must provide appropriate tax forms for benefits to employees taking leave based on guidance from the Internal Revenue Service and Maine Revenue Services around the taxability of such benefits.
13. An employer may appeal a denial of substitution, a denial of cancellation, a revocation, or the issuance of any penalty for violation pursuant to section XV of this

rule within 15 business days from the date the decision of denial or revocation is issued.

B. Fully-Insured Private Plans

1. An insurer licensed in accordance with Title 24-A may offer fully-insured insurance plans that are substantially equivalent to the requirements of 26 M.R.S. 850-H and this Rule. The fully-insured plan must comply with all requirements of the Maine Insurance Code. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this State unless the policy form or certificate form has been filed with and approved by the Superintendent of Insurance in accordance with filing requirements and procedures prescribed by the Maine Insurance Code and applicable rules.
2. Policy cancellation and nonrenewal is subject to the requirements of the Maine Insurance Code and applicable rules. The employer shall notify the Department of the cancellation or nonrenewal at least 10 days before the termination takes effect.
3. An insurer may cease offering a fully-insured plan if:
 - a. Notice of the decision to cease offering such plans is filed with the Bureau of Insurance at least three (3) months prior to the cessation unless a shorter notice period is approved by the Superintendent of Insurance; and
 - b. If existing contracts are nonrenewed, notice must be provided to the policyholder six (6) months prior to nonrenewal.
4. An insurer that discontinues the availability of a policy form or certificate form issued pursuant to this rule shall not file for approval of a policy form or certificate form for a fully-insured plan for a period of five (5) years after the insurer provides notice to the Superintendent of Insurance of the discontinuance. The period of discontinuance may be reduced if the Superintendent of Insurance determines that a shorter period is appropriate.
5. An insurer may request certification of a proposed plan as substantially equivalent pursuant to 26 M.R.S. § 850-H by providing a copy of the proposed plan documents to the Department along with an application form and fee as determined by the Department. The Department may delegate to the Maine Bureau of Insurance (BOI) authority to review and approve plan applications for compliance with the Maine Insurance Code and for compliance with a Paid Family Medical Leave eligibility checklist jointly developed by the Department and the BOI. If after BOI review, the Department determines the insurer's proposed plan is substantially equivalent, the Department shall issue a certificate of eligibility.

C. Self-Insured Private Plans

1. An employer may request certification of a self-insured, employer provided plan as substantially equivalent pursuant to 26 M.R.S. § 850-H by providing a copy of the proposed plan documents to the Department along with an application form and fee as determined by the Department. The Department may use the checklist jointly developed with the assistance of the BOI to determine eligibility. If the Department deems that the self-insured plan is substantially equivalent the Department shall issue a certificate of eligibility.
2. An employer proposing to substitute a self-insured plan may apply for both certification and substitution simultaneously.
3. The employer must also furnish to the Department a bond, in an amount determined by the Department, with a surety company authorized to transact business in Maine. The employer must submit a certification form to the Department in the amount required at the time the application is submitted.

D. Determination of Substantial Equivalence

1. The Department, in consultation with the BOI as necessary, shall determine whether a proposed plan is substantially equivalent and therefore eligible for substitution. To meet the requirement that a private plan confer rights protections and benefits substantially equivalent to those provided to employees under the Paid Family Medical Leave Act, a private plan need not be identical to the provisions set forth in the Act.
2. The following minimum requirements must be met in order to be determined substantially equivalent:
 - a. The plan must provide for family leave and medical leave to be taken for: the covered individual's own serious health condition; safe leave; a qualifying exigency; bonding leave; to care for a family member who is a covered service member; to care for a family member with a serious health condition; and for any other reason set forth in 26 M.R.S. § 843(4);
 - b. The plan must provide leave to care for a family member and must account for all definitions of family listed in §850-A(19);
 - c. The plan must allow for at least 10 weeks of aggregate leave per benefit year;
 - d. The plan must allow a covered individual to take intermittent or reduced schedule leave, except that the requirements of section III(B) of this Rule need not be met;
 - e. The cost to employees of the plan may not be greater than the cost charged to employees under § 850-F of the Act; and

- f. The plan must provide an internal reconsideration process for denial of family leave benefits or medical leave benefits.
3. Any plan which does not meet the minimum criteria in paragraph 2 may not be determined as substantially equivalent and shall not be eligible for substitution. If all of the above criteria are met, the Department shall determine whether the plan provides the same or greater aggregate monetary benefit to employees. This shall be determined by comparing the plan's wage replacement amount multiplied by the maximum number of weeks to the maximum Weekly Benefit Amount under the Act multiplied by 12 weeks. If the former is equal to or greater, the plan may be determined to be substantially equivalent and therefore eligible for substitution.
4. Examples of a plan that is substantially equivalent but not identical include, but are not limited to, the following:
 - a. A plan that provides the amount of leave set forth in 850-B (4) during a 12-month period shall be found to be substantially equivalent even if that 12-month period is not calculated in a manner identical to a "benefit year" as defined in 26 M.R.S. § 850-A(5);
 - b. A plan that provides for intermittent or reduced schedule leave but requires that such leave may only be taken in minimum increments of four (4) hours may be found to be substantially equivalent;
 - c. A plan that calculates an employee's benefit using a different lookback period or based upon the employee's actual wages at the time that leave begins may be found to be substantially equivalent if the requirements of paragraph 3, above, are met.
5. Notwithstanding the above provisions, the following may not be determined as substantially equivalent and therefore shall not be eligible for substitution:
 - a. A plan which provides benefits only for the covered individual's own serious health condition, such as a short term or long term disability plan; and
 - b. A plan which consists of leave benefits provided pursuant to employer policy and which are subject to change at the employer's discretion; and
 - c. A plan that consists of leave benefits that need to be accrued (such as sick, vacation, or paid time off) that does not provide full coverage of benefits regardless of time with the employer or availability of accrued time.
6. The Department shall evaluate any appeal pursuant to § 850-H (5) in terms of whether it constitutes grounds for withdrawal of approval of substitution.

Section XIV: Returning From Leave

A. Any employee that has been employed with their employer for at least 120 consecutive calendar days is entitled, upon return from leave, to be restored by the employer to the position held by the employee when the leave commenced, or to be restored to an equivalent position with equivalent employment benefits, pay and other terms and conditions of employment. Whether a position is equivalent for the purposes of the Act shall be governed by 29 C.F.R. § 825.215 (eff. Feb. 6, 2013) subject to the limitations under 29 C.F.R. § 825.216 (eff. Feb. 6, 2013).

B. If an employee is on initial probation at the time that the employee begins leave, the employer may toll the employee's probationary period during the period of the employee's leave, including intermittent or reduced schedule leave, and doing so shall not be considered a violation of § 850-B (8) or § 850-J (2) of the Act.

C. If at any point an employee notifies the employer in writing that they do not intend to return to their job at the end of their leave, the employer is no longer obligated to hold the job open.

Section XV: Appeals

A. An aggrieved party may appeal the following issues to the Department within 15 business days from the date the decision is issued, except that the period within which an appeal may be filed may be extended for a period not to exceed an additional 15 business days, for good cause shown. Good cause for the late filing of an appeal is at the discretion of the Department. Issues which may be appealed are:

1. Denials of applications for benefits;
2. Issues as to the amount of benefits;
3. Findings that an employer determination of undue hardship is unreasonable;
4. Delay or denial of a claim for benefits due to a finding of reasonable undue hardship;
5. Any fine or penalty imposed, including fines related to late or non-payment of premiums;
6. Disqualification of a self-employed individual;
7. Disapproval or revocation of private plan substitutions;
8. Findings of fraud; and
9. Denial of waiver of overpayments.

- B. The Department shall appoint a qualified Hearing Officer, employed or contracted by the Department, to hear any appeal.
- C. Hearings on appeals conducted pursuant to this rule shall be adjudicatory proceedings, governed by the Maine Administrative Procedures Act (MAPA), 5 M.R.S. § 9051-9064.
- D. Hearings may be conducted by telephone or by video conference.
- E. The Hearing Officer shall issue such orders as are necessary for efficient and expeditious processing of an appeal. The Hearing Officer may require exhibits and/or witness lists to be filed in advance of the hearing.
- F. A Notice of Hearing must be issued to the appealing party, and to the extent applicable, the covered individual, the employer and the Administrator at least ten (10) business days before the date of the hearing.
- G. The Administrator must submit documents to the Hearing Officer relating to the issue on appeal and any reconsideration decision within 5 days after notification by the department. Such documents shall be provided to all parties. The Administrator is not required to appear at the hearing, unless directed to appear by the Hearing Officer.
- H. The Hearing Officer will make a decision de novo and is not required to defer to any decision by the Administrator. The Department may designate certain decisions by Hearing Officers to be precedent in similar appeals. The Department may issue written guidance, which will be publicly available, to ensure consistency between Hearing Officers in determining similar issues.
- I. Decisions of the Hearing Officer shall be in writing and shall state the Hearing Officer's findings of fact and basis for the decision. Decisions by the Hearing Officer shall constitute final agency action within the meaning of 5 M.R.S. § 8002 (4) and shall be reviewable in Superior Court pursuant to 5 M.R.S. § 11001 et. seq.

Section XVI: Advisory Rulings

- A. Advisory rulings may be made by the program with respect to the applicability of any statute or rule administered by the program.
- B. All requests for advisory rulings shall be made in writing and submitted to the director of the Paid Family and Medical Leave Program, 50 State House Station Augusta, Maine. The request must include the following:
 - 1. The name, address, and telephone number of the person requesting the ruling;
 - 2. Facts that establish the substantial interest of the requesting person to the program with respect to which the ruling is requested;
 - 3. The statute or rule of which an interpretation is requested;

4. All facts that are necessary to issue the advisory ruling;
 5. All assumptions that relate to the advisory ruling; and
 6. A statement indicating whether to the requester's knowledge, the issue upon which an advisory ruling is sought is the subject of a pending matter with respect to adjudication of claims for benefits, application for substitution of private plans, enforcement of penalties including revocation of substitution regarding private plans, a pending appeal to which the requested person is an aggrieved party or a prior advisory ruling.
- C. The director of the program may request from any person securing an advisory ruling any additional information that is necessary. Failure to supply such additional information shall be cause for the program to decline to issue an advisory ruling.
- D. Issuance of advisory rulings by the program is discretionary and will be determined on a case-by-case basis. The program shall either issue a written advisory ruling or notify the requester of the reasons that an advisory ruling will not be rendered no later than 60 days from the date all information necessary to make a ruling was submitted to the director of the program.
- E. The program may decline to issue an advisory ruling if any administrative or judicial proceeding is pending with the person requesting the ruling on the same factual grounds. The program may decline to issue an advisory ruling if such a ruling may harm the program interest in any litigation in which it is or may be a party.
- F. No advisory ruling shall be binding upon the program provided that in any subsequent enforcement action initiated by the department, any person's reliance on such ruling shall be considered in mitigation of any penalty sought to be assessed.

STATUTORY AUTHORITY:

26 M.R.S. § 850 – Q

EFFECTIVE DATE:

January 1, 2025

FISCAL IMPACT ON MUNICIPALITIES AND COUNTIES:

minimal costs for reporting requirements