CHAPTER 1093

An Act to amend and reenact §§ 38.2-107.2, 38.2-135, 38.2-316, and 38.2-1800 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-107.3 and by adding in Title 60.2 a chapter numbered 8, consisting of sections numbered 60.2-800 through 60.2-818, relating to paid family and medical leave insurance program established; notice requirements; civil action; penalty.

[H 1207]

Approved April 22, 2026

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-107.2, 38.2-135, 38.2-316, and 38.2-1800 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-107.3 and by adding in Title 60.2 a chapter numbered 8, consisting of sections numbered 60.2-800 through 60.2-818, as follows:

§ 38.2-107.2. Private family leave insurance.

~~"Family~~ *"Private family* leave insurance" means an insurance policy issued to an employer related to a benefit program provided to an employee to pay for a percentage or portion of the employee's income loss due to (i) the birth of a child or adoption of a child by the employee; (ii) placement of a child with the employee for foster care; (iii) care of a family member of the employee who has a serious health condition; or (iv) circumstances arising out of the fact that the employee's family member who is a service member is on active duty or has been notified of an impending call or order to active duty. ~~Family~~ *Private family* leave insurance may be written as an amendment or rider to a group disability income policy, included in a group disability income policy, or written as a separate group insurance policy purchased by an employer.

§ 38.2-107.3. Paid family and medical leave insurance.

"Paid family and medical leave insurance" means an insurance policy issued to an employer that meets the minimum requirements necessary for approval pursuant to § 60.2-816 to qualify as a private plan through which such employer may fulfill its obligations under the paid family and medical leave insurance program (§ 60.2-800 et seq.), as determined by the Virginia Employment Commission.

§ 38.2-135. Classes of insurance companies may be licensed to write.

Except as otherwise provided in this title and subject to any conditions and restrictions imposed therein, any insurer licensed to transact the business of insurance in the Commonwealth, other than life insurers and title insurers, may be licensed to write one or more of the classes of insurance enumerated in Article 2 (§ 38.2-101 et seq.) of this chapter that it is authorized under its charter to write, except life insurance, industrial life insurance, credit life insurance, variable life insurance, modified guaranteed life insurance, annuities, variable annuities, modified guaranteed annuities, and title insurance. An insurer licensed to write life insurance shall not be licensed to write any additional class of insurance except modified guaranteed life insurance, variable life insurance, annuities, modified guaranteed annuities, variable annuities, credit life insurance, credit accident and sickness insurance, accident and sickness insurance, industrial life insurance, ~~and~~ *private* family leave insurance, *and paid family and medical leave insurance.* An insurer licensed to write title insurance shall not be licensed to write any additional class of insurance. However, any life insurer that has been licensed to write and has been actively engaged in writing life insurance and any additional class of insurance set out in Article 2 (§ 38.2-101 et seq.) of this chapter continuously during a period of 20 years immediately preceding July 1, 1952, may continue to be licensed to write those classes of insurance. No company shall write any class of insurance unless it has a current annual license from the Commission to do so.

§ 38.2-316. Policy forms to be filed with Commission; notice of approval or disapproval; exceptions.

A. No policy of life insurance, industrial life insurance, variable life insurance, modified guaranteed life insurance, group life insurance, *private* family leave insurance, *paid family and medical leave insurance,* accident and sickness insurance, or group accident and sickness insurance; no annuity, modified guaranteed annuity, pure endowment, variable annuity, group annuity, group modified guaranteed annuity, or group variable annuity contract; no health services plan, legal services plan, dental or optometric services plan, or health maintenance organization contract; no dental plan organization dental benefit contract; and no fraternal benefit certificate nor any certificate or evidence of coverage issued in connection with such policy, contract, or plan issued or issued for delivery in Virginia shall be delivered or issued for delivery in the Commonwealth unless a copy of the form has been filed with the Commission. In addition to the above requirement, no policy of accident and sickness insurance ~~or~~*, private* family leave insurance, *or paid family and medical leave insurance* shall be delivered or issued for delivery in the Commonwealth unless the rate manual showing rates, rules, and classification of risks applicable thereto has been filed with the Commission.

B. Except as provided in this section, no application form shall be used with the policy or contract and no rider or endorsement shall be attached to or printed or stamped upon the policy or contract unless the form of such application, rider or endorsement has been filed with the Commission. No individual certificate and no enrollment form shall be used in connection with any group life insurance policy, group accident and sickness insurance policy, group annuity contract, group variable annuity contract, *group private family leave insurance policy,* or group *paid* family *and medical* leave insurance policy unless the form for the certificate and enrollment form have been filed with the Commission.

C. 1. None of the policies, contracts, and certificates specified in subsection A shall be delivered or issued for delivery in the Commonwealth and no applications, enrollment forms, riders, and endorsements shall be used in connection with the policies, contracts, and certificates unless the forms thereof have been approved in writing by the Commission as conforming to the requirements of this title and not inconsistent with law.

2. In addition to the above requirement, no premium rate change applicable to individual accident and sickness insurance policies, subscriber contracts of health services plans, dental or optometric services plans, or fraternal benefit contracts providing individual accident and sickness coverage as authorized in § 38.2-4116 shall be used unless the premium rate change has been approved in writing by the Commission. No premium rate change applicable to individual or group Medicare supplement policies shall be used unless the premium rate change has been approved in writing by the Commission.

D. The Commission may disapprove or withdraw approval of the form of any policy, contract or certificate specified in subsection A, or of any application, enrollment form, rider or endorsement, if the form:

1. Does not comply with the laws of the Commonwealth;

2. Has any title, heading, backing or other indication of the contents of any or all of its provisions that is likely to mislead the policyholder, contract holder or certificate holder; or

3. Contains any provisions that encourage misrepresentation or are misleading, deceptive or contrary to the public policy of the Commonwealth.

E. Within 30 days after the filing of any form requiring approval, the Commission shall notify the organization filing the form of its approval or disapproval of the form which has been filed, and, in the event of disapproval, its reason therefor. The Commission, at its discretion, may extend for up to an additional 30 days the period within which it shall approve or disapprove the form. Any form received but neither approved nor disapproved by the Commission shall be deemed approved at the expiration of the 30 days if the period is not extended, or at the expiration of the extended period, if any; however, no organization shall use a form deemed approved under the provisions of this section until the organization has filed with the Commission a written notice of its intent to use the form together with a copy of the form and the original transmittal letter thereof. The notice shall be filed in the offices of the Commission at least 10 days prior to the organization's use of the form.

F. If the Commission proposes to withdraw approval previously given or deemed given to the form of any policy, contract or certificate, or of any application, rider or endorsement, it shall notify the insurer in writing at least 15 days prior to the proposed effective date of withdrawal giving its reasons for withdrawal.

G. Any insurer or fraternal benefit society aggrieved by the disapproval or withdrawal of approval of any form may proceed as indicated in § 38.2-1926.

H. This section shall not apply to any special rider or endorsement on any policy, except an accident and sickness insurance policy that relates only to the manner of distribution of benefits or to the reservation of rights and benefits under such policy, and that is used at the request of the individual policyholder, contract holder or certificate holder.

I. The Commission may exempt any categories of such policies, contracts, and certificates and any applicable rate manuals from (i) the filing requirements, (ii) the approval requirements of this section, or (iii) both such requirements. The Commission may modify such requirements, subject to such limitations and conditions which the Commission finds appropriate. In promulgating an exemption, the Commission may consider the nature of the coverage, the person or persons to be insured or covered, the competence of the buyer or other parties to the contract, and other criteria the Commission considers relevant.

J. In lieu of complying with the requirements of subsections A, B, and C, any legal services organization operating, conducting, or administering a legal services plan may provide the Commission with an informational filing regarding a subscription contract, enrollment form, rider, or endorsement used by the legal services organization in connection with a legal services plan offered in the Commonwealth together with written notice of its intent to use the form. Upon providing such informational filing and notice, the legal services organization may use the subscription contract, enrollment form, rider, or endorsement without its prior approval by the Commission. This subsection shall not limit the authority of the Commission to review a legal services plan and any subscription contract, enrollment form, rider, or endorsement used in connection therewith and to disapprove the use of such form for any of the grounds set forth in subsection D.

K. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to set standards for policy and other form submissions required by this section or § 38.2-3501.

§ 38.2-1800. Definitions.

As used in this chapter, *unless the context requires a different meaning*:

"Agent," "insurance agent," "producer," or "insurance producer," when used without qualification, means an individual or business entity that sells, solicits, or negotiates contracts of insurance or annuity in the Commonwealth.

"Appointed agent," "appointed insurance agent," "appointed producer," or "appointed insurance producer," when used without qualification, means an individual or business entity licensed in the Commonwealth to sell, solicit, or negotiate contracts of insurance or annuity of the classes authorized within the scope of such license and who is appointed by a company licensed in the Commonwealth to sell, solicit, or negotiate on its behalf contracts of insurance of the classes authorized within the scope of such license and, if authorized by the company, may collect premiums on those contracts.

"Business entity" means a partnership, limited partnership, limited liability company, corporation, or other legal entity other than a sole proprietorship.

"Dental plan organization authority" means the authority in the Commonwealth to sell, solicit, or negotiate dental benefit contracts on behalf of dental plan organizations licensed under Chapter 61 (§ 38.2-6100 et seq.).

"Dental services authority" means the authority in the Commonwealth to sell, solicit, or negotiate dental services plan contracts on behalf of dental services plans licensed under Chapter 45 (§ 38.2-4500 et seq.).

"Filed" means received by the Commission.

"Health agent" means an agent licensed in the Commonwealth to sell, solicit, or negotiate insurance as defined in §§ 38.2-107.2~~, 38.2-108, and~~ *through* 38.2-109, and including contracts issued by insurers, health services plans, health maintenance organizations, dental services plans, optometric services plans, and dental plan organizations licensed in the Commonwealth.

"Home protection insurance authority" means the authority in the Commonwealth to sell, solicit, or negotiate home protection insurance as defined in § 38.2-129 on behalf of insurers licensed in the Commonwealth.

"Home state" means the District of Columbia and any state or territory of the United States, except Virginia, or any province of Canada, in which an insurance producer maintains such person's principal place of residence or principal place of business and is licensed by that jurisdiction to act as a resident insurance producer.

"Legal services insurance authority" means the authority in the Commonwealth to sell, solicit, or negotiate legal services insurance as defined in § 38.2-127 on behalf of insurers licensed in the Commonwealth.

"License" means a document issued by the Commission authorizing an individual or business entity to act as an insurance producer for the lines of authority specified in the document. Except as provided in § 38.2-1833, the license itself does not create any authority, actual, apparent or inherent, in the licensee to represent, commit, or bind an insurer.

"Licensed agent," "licensed insurance agent," "licensed producer," or "licensed insurance producer," when used without qualification, means an individual or business entity licensed in the Commonwealth to sell, solicit, or negotiate contracts of insurance or annuity of the classes authorized within the scope of such license.

"Life and annuities insurance agent" means an agent licensed in the Commonwealth to sell, solicit, or negotiate life insurance and annuity contracts as defined in §§ 38.2-102, 38.2-103, 38.2-104, 38.2-105.1, 38.2-106, and 38.2-107.1, respectively, ~~and~~ *private* family leave insurance as defined in § 38.2-107.2, *and paid family and medical leave insurance as defined in § 38.2-107.3* on behalf of insurers licensed in the Commonwealth.

"Limited burial insurance authority" means the authority in the Commonwealth to sell, solicit, or negotiate burial insurance society membership where the certificates of membership are used solely to fund preneed funeral contracts on any individual, on behalf of insurers licensed under Chapter 40 (§ 38.2-4000 et seq.); or to represent an association referred to in § 38.2-3318.1, limited to soliciting members of that association for association group life insurance certificates where the funds are used solely to fund preneed funeral contracts.

"Limited lines credit insurance agent" means an agent licensed in the Commonwealth whose authority is restricted to selling, soliciting, or negotiating, on behalf of insurers licensed in the Commonwealth, one or more of the following coverages to individuals through a master, corporate, group or individual policy: (i) credit life insurance and credit accident and sickness insurance, but only to the extent authorized in Chapter 37.1 (§ 38.2-3717 et seq.); (ii) credit involuntary unemployment insurance as defined in § 38.2-122.1; (iii) credit property insurance, as defined in § 38.2-122.2; (iv) mortgage accident and sickness insurance; (v) mortgage redemption insurance; (vi) mortgage guaranty insurance; and (vii) any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation and that the Commission specifically determines may be sold, solicited, or negotiated by those holding a limited lines credit insurance agent license. Each insurer that sells, solicits or negotiates any of the coverages set forth in this definition shall provide to each individual whose duties will include selling, soliciting or negotiating such coverages a program of instruction that may, at the discretion of the

Commission, be submitted for approval by the Commission or reviewed by the Commission subsequent to its implementation.

"Limited lines life and health agent" means an individual or business entity authorized by the Commission whose license authority to sell, solicit, or negotiate is limited to the following, or any other type of authority that the Commission may deem it necessary to recognize for the purposes of complying with § 38.2-1836: dental services authority; limited burial insurance authority; mutual assessment life and health insurance authority; optometric services authority; and dental plan organization authority. Limited lines life and health insurance shall not include life insurance, health insurance, property insurance, casualty insurance, private family leave insurance, *paid family and medical leave insurance,* and title insurance.

"Limited lines property and casualty agent" means an individual or business entity authorized by the Commission whose license authority to sell, solicit, or negotiate is limited to the following, or any other type of authority that the Commission may deem it necessary to recognize for the purposes of complying with § 38.2-1836: home protection insurance authority; legal services insurance authority; mutual assessment property and casualty insurance authority; ocean marine insurance authority; pet accident, sickness and hospitalization insurance authority; portable electronics insurance authority; self storage insurance authority; and travel insurance. Unless otherwise defined, "limited lines property and casualty insurance" shall not include life insurance, health insurance, property insurance, casualty insurance, private family leave insurance, *paid family and medical leave insurance,* and title insurance.

"Mortgage accident and sickness insurance authority" means the authority in the Commonwealth to sell, solicit, or negotiate mortgage accident and sickness insurance on behalf of insurers licensed in the Commonwealth.

"Mortgage guaranty insurance authority" means the authority in the Commonwealth to sell, solicit, or negotiate mortgage guaranty insurance on behalf of insurers licensed in the Commonwealth.

"Mortgage redemption insurance authority" means the authority in the Commonwealth to sell, solicit, or negotiate mortgage redemption insurance on behalf of insurers licensed in the Commonwealth. As used in this chapter, "mortgage redemption insurance" means a nonrenewable, nonconvertible, decreasing term life insurance policy written in connection with a mortgage transaction for a period of time coinciding with the term of the mortgage. The initial sum shall not exceed the amount of the indebtedness outstanding at the time the insurance becomes effective, rounded up to the next $1,000.

"Motor vehicle rental contract enroller" means an unlicensed hourly or salaried employee of a motor vehicle rental company that is in the business of providing primarily private motor vehicles to the public under a rental agreement for a period of less than six months, and receives no direct or indirect commission from the insurer, the renter or the vehicle rental company.

"Motor vehicle rental contract insurance agent" means a person who (i) is a selling agent of a motor vehicle rental company that is in the business of providing primarily private passenger motor vehicles to the public under a rental agreement for a period of less than six months and (ii) whose license in the Commonwealth is restricted to selling, soliciting, or negotiating only the following insurance coverages, and solely in connection with and incidental to the rental contract:

1. Personal accident insurance that provides benefits in the event of accidental death or injury occurring during the rental period;

2. Liability coverage sold to the renter in excess of the rental company's obligations under § 38.2-2204, 38.2-2205, or Title 46.2, as applicable;

3. Personal effects insurance that provides coverages for the loss of or damage to the personal effects of the renter and other vehicle occupants while such personal effects are in or upon the rental vehicle during the rental period;

4. Roadside assistance and emergency sickness protection programs; and

5. Other travel-related or vehicle-related insurance coverage that a motor vehicle rental company offers in connection with and incidental to the rental of vehicles.

The term "motor vehicle rental contract insurance agent" does not include motor vehicle rental contract enrollers.

"Mutual assessment life and health insurance authority" means the authority in the Commonwealth to sell, solicit, or negotiate mutual assessment life and accident and sickness insurance on behalf of insurers licensed under Chapter 39 (§ 38.2-3900 et seq.), but only to the extent permitted under § 38.2-3919.

"Mutual assessment property and casualty insurance authority" means the authority in the Commonwealth to sell, solicit, or negotiate mutual assessment property and casualty insurance on behalf of insurers licensed under Chapter 25 (§ 38.2-2500 et seq.), but only to the extent permitted under § 38.2-2525.

"NAIC" means the National Association of Insurance Commissioners.

"Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

"Ocean marine insurance authority" means the authority in the Commonwealth to sell, solicit, or negotiate

those classes of insurance classified in § 38.2-126, except those classes specifically classified as inland marine insurance, on behalf of insurers licensed in the Commonwealth.

"Optometric services authority" means the authority in the Commonwealth to sell, solicit, or negotiate optometric services plan contracts on behalf of optometric services plans licensed under Chapter 45 (§ 38.2-4500 et seq.).

"Personal lines agent" means an agent licensed in the Commonwealth to sell, solicit, or negotiate insurance as defined in §§ 38.2-110 through 38.2-114, 38.2-116, 38.2-117, 38.2-118, 38.2-124, 38.2-125, 38.2-126, 38.2-129, 38.2-130, and 38.2-131 for transactions involving insurance primarily for personal, family, or household needs rather than for business or professional needs.

"Pet accident, sickness and hospitalization insurance authority" means the authority in the Commonwealth to sell, solicit, or negotiate pet accident, sickness and hospitalization insurance on behalf of insurers licensed in the Commonwealth.

"Property and casualty insurance agent" means an agent licensed in the Commonwealth to sell, solicit, or negotiate both personal and commercial lines of insurance as defined in §§ 38.2-107.2, *38.2-107.3*, 38.2-110 through 38.2-122.2, and 38.2-124 through 38.2-134 on behalf of insurers licensed in the Commonwealth.

"Resident" means (i) an individual residing in Virginia; (ii) an individual residing outside of Virginia whose principal place of business is in Virginia, who is able to demonstrate to the satisfaction of the Commission that the laws of his home state prevent him from obtaining a resident agent license in that state, and who affirmatively chooses to qualify as and be treated as a resident of Virginia for purposes of licensing and continuing education, both in Virginia and in the state in which the individual resides, if applicable; (iii) a partnership duly formed and recorded in Virginia; (iv) a corporation incorporated and existing under the laws of Virginia; (v) a limited liability company organized and existing under the laws of Virginia; or (vi) a foreign business entity that is not licensed as a resident agent in any other jurisdiction, and that demonstrates to the satisfaction of the Commission that its principal place of business is within the Commonwealth of Virginia.

"Restricted nonresident health agent" means a nonresident agent whose license authority in his home state does not include all of the authority granted under a health agent license in Virginia. The license issued to such agent shall authorize the agent to sell, solicit, or negotiate in Virginia, on behalf of insurers licensed in Virginia, only those kinds or classes of insurance for which the agent is authorized in his home state.

"Restricted nonresident life and annuities agent" means a nonresident agent whose license authority in his home state does not include all of the authority granted under a life and annuities agent license in Virginia. The license issued to such agent shall authorize the agent to sell, solicit, or negotiate in Virginia, on behalf of insurers licensed in Virginia, only those kinds or classes of insurance for which the agent is authorized in his home state.

"Restricted nonresident personal lines agent" means a nonresident agent whose license authority in his home state does not include all of the authority granted under a personal lines agent license in Virginia. The license issued to such agent shall authorize the agent to sell, solicit, or negotiate in Virginia, on behalf of insurers licensed in Virginia, only those kinds or classes of insurance for which the agent is authorized in his home state.

"Restricted nonresident property and casualty agent" means a nonresident agent whose license authority in his home state does not include all of the authority granted under a property and casualty agent license in Virginia. The license issued to such agent shall authorize the agent to sell, solicit, or negotiate in Virginia, on behalf of insurers licensed in Virginia, only those kinds or classes of insurance for which the agent is authorized in his home state.

"Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurer.

"Settlement agent" means a person licensed as a title insurance agent and registered with the Virginia State Bar pursuant to Chapter 10 (§ 55.1-1000 et seq.) of Title 55.1.

"Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular class of insurance from one or more insurers.

"Surety bail bondsman" means a person licensed as a surety bail bondsman pursuant to Article 11 (§ 9.1-185 et seq.) of Chapter 1 of Title 9.1.

"Surplus lines broker" means a person licensed pursuant to Article 5.1 (§ 38.2-1857.1 et seq.) of this chapter, and who is thereby authorized to engage in the activities set forth in Chapter 48 (§ 38.2-4805.1 et seq.).

"Terminate" means the cancellation of the relationship between an insurance producer and the insurer, or the termination of an insurance producer's authority to transact insurance.

"Title insurance agent" means an agent licensed in the Commonwealth to sell, solicit, or negotiate title insurance, and performing all of the services set forth in § 38.2-4601.1, on behalf of title insurance companies licensed under Chapter 46 (§ 38.2-4600 et seq.).

"Uniform Application" means the current version of the NAIC Uniform Application for resident and nonresident producer licensing.

"Uniform Business Entity Application" means the current version of the NAIC Uniform Business Entity Application for resident and nonresident business entities.

"Variable contract agent" means an agent licensed in the Commonwealth to sell, solicit, or negotiate variable life insurance and variable annuity contracts on behalf of insurers licensed in the Commonwealth.

"Viatical settlement broker" means a person licensed pursuant to Chapter 60 (§ 38.2-6000 et seq.), in accordance with Article 6.1 (§ 38.2-1865.1 et seq.) of this chapter, and who is thereby authorized to engage in the activities set forth in Chapter 60 (§ 38.2-6000 et seq.).

CHAPTER 8.

PAID FAMILY AND MEDICAL LEAVE INSURANCE PROGRAM.

§ 60.2-800. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Armed Forces" means the Armed Forces of the United States, the Reserves of the Armed Forces of the United States, or the Virginia National Guard.

"Benefit year" means the period of 52 calendar weeks beginning on the start date of leave, except that the benefit year shall be 53 weeks if filing of a new valid claim would result in overlapping any quarter of the base period of a previously filed new claim.

"Child" includes a child of any age, including an adult child.

"Commissioner" means the Commissioner of the Virginia Employment Commission.

"Covered individual" means any individual other than an employee of the Commonwealth who:

1. Either:

a. Meets the minimum monetary eligibility criteria set forth in subdivision A 1 of § 60.2-612; or

b. Is self-employed, elects coverage, and meets the requirements of § 60.2-802;

2. Meets the administrative requirements outlined in this chapter and in regulations; and

3. Submits an application.

"Covered service member" means either (i) a member of the Armed Forces who is (a) undergoing medical treatment, recuperation, or therapy; (b) otherwise in outpatient status; or (c) otherwise on the temporary disability retired list for a serious injury or illness that was incurred by the member in the line of duty while 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, or (ii) a former member of the Armed Forces who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness that was incurred by the member in the line of duty while 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 and manifested before or after the member was discharged or released from service.

"Domestic partner" means a person not younger than 18 years of age who (i) 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 (a) common ownership of real or personal property, (b) common householding, (c) children in common, (d) signs of intent to marry, (e) shared budgeting, and (f) the length of the personal relationship with the covered individual, or (ii) 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.

"Employer" has the same meaning as provided in § 60.2-210, except that, for the purposes of this chapter, "employer" does not include the Commonwealth.

"Family and medical leave benefits" means the benefits provided under the terms of this chapter.

"Family member" means a child, grandchild, grandparent, parent, sibling, spouse, or domestic partner of an employee, including those with step, foster, or adopted relationships, and includes any individual (i) who regularly resides in the employee's home or where the relationship creates an expectation that the employee care for such individual and (ii) who depends on the employee for care. "Family member" does not include an individual who simply resides in the home with no expectation that the employee care for the individual.

"FMLA" means the federal Family and Medical Leave Act, 29 U.S.C. § 2601 et seq.

"Fund" means the Family and Medical Leave Insurance Trust Fund established under § 60.2-805.

"Health care provider" means a person licensed under the law of the jurisdiction in which such person practices to provide medical or emergency services, including any person defined as a health care provider under § 32.1-276.3, emergency room personnel, licensed clinical social workers, and other providers permitted by the Commissioner.

"Military member" means a member of the Armed Forces.

"Next of kin" has the meaning ascribed thereto in § 101(17) of the FMLA, 29 U.S.C. § 2611(17).

"Qualifying exigency leave" means leave based on 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 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.

"Retaliatory personnel action" means the denial of any right guaranteed under this chapter or the taking of any adverse action, including any threat, discharge, suspension, demotion, or reduction of hours, against a covered individual for the exercise of any right guaranteed under this chapter, or reporting or threatening to report a covered individual's suspected citizenship or immigration status or the suspected citizenship or immigration status of a family member of the covered individual to a federal, state, or local agency. "Retaliatory personnel action" also includes interference with or punishment for in any manner participating in or assisting an investigation, proceeding, or hearing under this chapter.

"Safety services" means:

1. Legal or law-enforcement assistance or remedies to ensure the health and safety of an individual, including preparing for and participating in protective order proceedings or other civil or criminal legal proceedings related to domestic violence, harassment, sexual assault, or stalking;

2. Medical treatment, recovery services, or mental health counseling for injuries caused by domestic violence, pervasive harassment, sexual assault, or stalking;

3. Services from a victim services provider; and

4. Relocation and home security services to ensure the safety of an individual who has experienced domestic violence, pervasive harassment, sexual assault, or stalking.

"Serious health condition" means an illness, injury, impairment, pregnancy, recovery from childbirth, or physical or mental condition that involves inpatient care in a hospital, hospice, or a residential medical care facility or continuing treatment by a health care provider.

"Workweek" means a calendar week.

§ 60.2-801. Paid family and medical leave insurance program.

A. By January 1, 2028, the Commission shall establish and administer a paid family and medical leave insurance program. By April 1, 2028, the Commission shall begin collecting contributions as provided in this chapter. By December 1, 2028, the Commission shall begin receiving claims and paying family and medical leave benefits to covered individuals.

B. Information contained in the files and records relating to a claimant under this chapter are confidential and not open to public inspection other than to public employees in the performance of their official duties. However, such claimant or an authorized representative of such claimant may review such files and records or receive specific information from such records upon the presentation of such claimant's signed authorization.

C. The Department of Human Resource Management shall modify its policies to ensure that its policies relating to family and medical leave for employees of the Commonwealth, including parental leave under § 2.2-1210, provide employees of the Commonwealth with leave benefits equal to or greater than the leave benefits provided to a covered individual under the paid family and medical leave insurance program pursuant to this chapter, including as described in subdivision A 1 of § 60.2-816.

§ 60.2-802. Eligibility for benefits; certification.

A. Beginning December 1, 2028, family and medical leave benefits shall be payable to any covered individual who is authorized to work in the United States at the time they apply for family and medical leave pursuant to this chapter and:

1. Because of birth, adoption, or placement through foster care, is caring for a new child during the first year after the birth, adoption, or placement of that child;

2. Is caring for a family member with a serious health condition;

3. Has a serious health condition that makes the covered individual unable to perform the functions of the position of such individual's employment;

4. Is caring for a covered service member who is the covered individual's next of kin or other family member;

5. Is eligible for qualifying exigency leave arising out of the fact that a family member of the covered individual is on active duty, or has been notified of an impending call or order to active duty, in the Armed Forces; or

6. Is seeking safety services for the covered individual or a family member. Leave to seek safety services under this subdivision shall be payable for a maximum of four weeks in a benefit year for any covered individual.

B. A claim for family and medical leave benefits shall include supporting certifications as required by the following:

1. For a claimant seeking family and medical leave benefits due to a serious health condition, certification from a physician or health care provider (i) describing such condition, (ii) stating the date on which such condition commenced or is expected to commence and the probable duration of such condition, (iii) including a statement that such claimant is unable to perform job functions due to such condition, and (iv) including other appropriate medical facts as required by the Commission.

2. For a claimant seeking family and medical leave benefits due to the serious health condition of a family member, certification from a physician or health care provider (i) describing such condition, (ii) stating the date on which such condition commenced or is expected to commence and the probable duration of such

condition, (iii) including a statement that such condition requires such claimant to care for such family member and an estimated duration of such care, and (iv) including other appropriate medical facts as required by the Commission.

3. For a claimant seeking family and medical leave benefits due to the birth of a child, certification in the form of either (i) such child's birth certificate or (ii) another document issued by a health care provider or physician stating such child's birth date.

4. For a claimant seeking family and medical leave benefits due to the placement of a child with such claimant for adoption or foster care, certification in the form of a document issued by such child's health care provider or physician, by an adoption or foster care agency involved in such placement, or by other individuals as required by the Commission that verifies the occurrence and date of such placement.

5. For a claimant seeking family and medical leave benefits for qualifying exigency leave, certification including (i) a copy of the family member's active-duty orders, (ii) other documentation issued by the Armed Forces, or (iii) other documentation as required by the Commissioner.

6. For a claimant seeking family and medical leave benefits in order to care for a family member who is a covered service member, certification including (i) the date on which the serious health condition commenced or is expected to commence, (ii) the probable duration of the condition, (iii) the appropriate medical facts within the knowledge of the health care provider as required by the Commission, (iv) a statement that the claimant is needed to care for the family member, (v) an estimate of the amount of time that the claimant is needed to care for the family member, and (vi) an attestation by the claimant that the health condition is connected to the covered service member's military service as required by this chapter.

7. For a claimant seeking family and medical leave benefits to seek safety services, a certification including (i) medical records or a statement from a health care provider; (ii) a protection order, police report, or court order; (iii) a statement from a victim services provider; or (iv) other documentation as required by the Commissioner.

C. A self-employed person electing coverage within 26 weeks of becoming self-employed will be eligible to receive benefits without a waiting period. A self-employed person who elects coverage after 26 weeks shall be eligible for benefits after a waiting period of 52 weeks before such benefits shall be paid.

D. Any medical or health information required under this section shall be confidential and shall not be disclosed except with permission from the claimant providing such information unless disclosure is otherwise required by law. Nothing in this section shall be construed to require a claimant to provide as certification any information from a health care provider that would be in violation of § 32.1-127.1:03, § 1177 of the federal Social Security Act, 42 U.S.C. § 1320d-6, or the regulations promulgated under § 264(c) of the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191.

§ 60.2-803. Duration of benefits.

A. Family and medical leave benefits shall be payable under § 60.2-801 for a maximum of 12 weeks in a benefit year for any covered individual.

B. Family and medical leave benefits shall be payable to a covered individual starting the first calendar day in a benefit year that such covered individual meets the eligibility requirements of § 60.2-802.

C. The first payment of family and medical leave benefits shall be made to a covered individual no later than two weeks after (i) the Commission has approved an initial claim pursuant to this chapter or (ii) the duration of leave pursuant to an approved claim pursuant to this chapter has commenced, whichever occurs later. Subsequent payments shall be made at least every two weeks thereafter.

§ 60.2-804. Amount of benefits.

A. A covered individual's weekly benefit amount shall be 80 percent of such covered individual's average weekly wages during the base period as defined in § 60.2-204, or 80 percent of such covered individual's average weekly wages during the quarters in which such covered individual worked if less than five quarters, subject to the maximum specified in subsection D.

B. For a self-employed person electing coverage under § 60.2-815, the weekly benefit amount shall be 80 percent of such covered individual's average weekly net earnings during the base period as defined in § 60.2-204, or 80 percent of such covered individual's average weekly net earnings during the quarters in which such covered individual worked if less than five quarters, subject to the maximum specified in subsection D.

C. A covered individual's minimum weekly benefit amount shall not be less than $100 per week except that if such covered individual's average weekly wage is less than $100 per week, the weekly benefit amount shall be such covered individual's full wage.

D. A covered individual's maximum weekly benefit amount shall be 100 percent of the state average weekly net earnings, as described in subsection B of § 65.2-500. By September 30 of each year, the Commission shall adjust the maximum weekly benefit to reflect any changes in such state average weekly wage. The adjusted maximum weekly benefit amount shall take effect on the following January 1.

E. Claims pursuant to this chapter shall be payable for at least eight hours of family and medical leave accrued in one workweek unless the Commission sets a lower threshold.

§ 60.2-805. Family and Medical Leave Insurance Trust Fund; appropriation prohibition;

reimbursement.

A. There is hereby created in the state treasury a special nonreverting fund to be known as the Family and Medical Leave Insurance Trust Fund. The Fund shall be established on the books of the Comptroller. All payroll contributions remitted pursuant to this chapter, all funds appropriated for the purposes of the Fund, and any gifts, donations, grants, bequests, and other funds shall be paid into the state treasury and credited to the Fund. Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund.

B. Moneys in the Fund shall be used solely for the payment of benefits under the paid family and medical leave insurance program established by the Commission pursuant to this chapter, the administration of such program, and any start-up costs associated with such program, including any required payment as provided in subsection D.

C. The General Assembly shall not appropriate or transfer any of the payroll contributions remitted to the Fund for any purpose other than purposes provided for in this section.

D. Any moneys provided in the appropriation act for the purposes of establishing the paid family and medical leave insurance program shall be repaid from the Fund to the general fund by January 1, 2034.

E. Expenditures and disbursements from the Fund shall be made by the State Treasurer on warrants issued by the Comptroller upon written request signed by the Commissioner or his designee.

§ 60.2-806. Contributions.

A. Payroll contributions to the Fund shall be authorized in order to finance the payment of benefits under and the administration of the paid family and medical leave insurance program.

B. Beginning on April 1, 2028, each employer shall remit to the Fund contributions in the form and manner determined by the Commission. No later than October 1, 2027, and annually thereafter, the Commissioner shall fix the contribution rate for the coming calendar year in the manner described in this subsection, taking into account the repayment requirement provided for in subsection D of § 60.2-805. For calendar years 2028 and 2029, the Commissioner shall fix such contribution rate based on sound actuarial principles. For calendar year 2030 and thereafter, the Commissioner shall first certify and publish the following information:

1. The total amounts of the previous fiscal year's expenditures for (i) family and medical leave benefits paid and (ii) the administration of the paid family and medical leave insurance program;

2. The total amount remaining in the Fund at the close of such fiscal year; and

3. The amount by which the contribution rate shall be adjusted to ensure that the projected balance of the Fund as a percentage of total program expenditures does not fall below 40 percent. The contribution rate adjustment, if any, made as the result of the Commissioner's certification and report under this subsection shall supersede the rate previously set forth and shall become effective on January 1 of the following calendar year.

C. A self-employed person electing coverage under § 60.2-815 shall be responsible for the employer's share of contributions set forth in subsection B on that individual's income from self-employment. Such self-employed person shall provide documentation to the Commission demonstrating that such self-employed person is authorized to work in the United States when beginning payroll contributions.

D. Each employer of more than 10 employees shall (i) deduct from each employee's wages an amount equal to 50 percent, or such lesser percentage as may be agreed upon by such employer and employee, of the contribution required per employee pursuant to subsection B and (ii) remit the full contribution required per employee pursuant to subsection B to the Commission for deposit into the Fund.

E. Each employer of 10 or fewer employees shall deduct from each employee's wages an amount equal to 50 percent of the contribution per employee required of an employer of more than 10 employees pursuant to subsection B. Such employer of 10 or fewer employees shall remit such deducted amount to the Commission for deposit into the Fund and shall not be required to make additional contributions.

F. No deduction made pursuant to this section shall cause an employee's wage, after such deduction, to fall below the minimum wage required to be paid to such employee by any applicable statute, regulation, rule, or ordinance. This subsection shall not be construed to reduce any employee's rights, benefits, protections, or privileges under this chapter.

G. Contributions under this section shall not be required for an employee's wages or an individual's income from self-employment above the contribution and benefit base limit established annually by the Social Security Administration for purposes of the federal Old-Age, Survivors, and Disability Insurance Benefits program limits pursuant to 42 U.S.C. § 430.

§ 60.2-807. Reduced leave schedule.

A. A covered individual shall have the option to receive paid family and medical leave benefits on an intermittent or reduced leave schedule in which all of the leave authorized under this chapter is not taken sequentially. Family and medical leave benefits for an intermittent or reduced leave schedule shall be prorated and coordinated between the employee and employer.

B. Such covered individual shall make a reasonable effort to schedule paid family and medical leave

taken pursuant to this section so as not to unduly disrupt the operations of such covered individual's employer. Such covered individual shall provide such employer with prior notice of the schedule on which such covered individual will be taking the leave, to the extent practicable. Paid family and medical leave taken pursuant to this section shall not result in a reduction of the total amount of leave to which a covered individual is entitled beyond the amount of leave actually taken.

§ 60.2-808. Leave and employment protection; remedies.

A. Any covered individual who receives family and medical leave benefits and has been employed with the covered individual's current employer for at least 120 days prior to the commencement of such individual's paid family and medical leave shall, upon the expiration of such leave, be entitled to restoration by the employer to the position held by such covered individual when such leave commenced, or to a position with equivalent seniority, status, employment benefits, pay, and other terms and conditions of employment, including fringe benefits and service credits, to which the covered individual had been entitled at the commencement of such leave.

B. During any leave taken pursuant to this chapter, an employer shall maintain any health care benefits to which a covered individual was entitled prior to taking such leave as if the covered individual had continued working continuously from the date such covered individual commenced the leave until the date such covered individual returns from leave, and such covered individual shall continue to pay his share of the cost of health care benefits as required prior to the commencement of the leave.

C. Any employer that violates this section or § 60.2-809 shall be liable to any affected covered individual for:

1. Damages equal to:

a. The amount of:

(1) Any wages, salary, employment benefits, or other compensation denied or lost to such covered individual due to the violation; or

(2) In a case in which wages, salary, employment benefits, or other compensation has not been denied or lost to the covered individual, any actual monetary losses sustained by the covered individual due to the violation, such as the cost of providing care, up to a sum equal to 12 weeks of wages or salary for the covered individual;

b. Interest on the amount described in subdivision a, calculated at the legal rate; and

c. An additional amount as liquidated damages equal to the sum of the amount described in subdivision a and the interest described in subdivision b, except that if an employer who has violated this section or § 60.2-809 proves to the satisfaction of the court that the act or omission that violated this section or § 60.2-809 was in good faith and that the employer had reasonable grounds for believing that the act or omission was not a violation of this section or § 60.2-809, such court shall reduce the amount of the liability to the amount and interest determined under subdivisions a and b, respectively, and impose no additional penalties; and

2. Such equitable relief as may be appropriate, including employment, reinstatement, and promotion.

D. Except as provided in subsection E, an action may be brought for a violation of this section or § 60.2-809 not later than one year after the date of the last event constituting the alleged violation for which the action is brought.

E. In the case of such action brought for a willful violation of this section or § 60.2-809, such action may be brought within three years of the date of the last event constituting the alleged violation for which such action is brought.

F. The Commissioner of Labor and Industry may investigate any alleged violation of this section with the consent of an employee or interested third party, or at the discretion of the Commissioner of Labor and Industry. The Commissioner of Labor and Industry may institute administrative or, upon referral to the Attorney General, court proceedings to remedy any alleged violation of this section and may seek and collect any remedies available under this section. Any such damages shall be paid as restitution to any affected employee entitled thereto. In the course of an investigation, the Commissioner of Labor and Industry may issue subpoenas.

§ 60.2-809. Retaliatory personnel actions prohibited.

A. No employer or other person shall interfere with, restrain, or deny the exercise of, or the attempt to exercise, any right protected under this chapter.

B. No employer, employment agency, employee organization, or other person shall take retaliatory personnel action or otherwise discriminate against an individual due to such individual's lawful exercise of rights protected under this chapter. Such rights include the right to request, file for, apply for, or use benefits provided for under this chapter; the right to communicate to the employer or any other person or entity that such individual (i) intends to file a claim, a complaint with the Commission or a court, or an appeal or (ii) has testified in, intends to testify in, or has otherwise assisted in any investigation, hearing, or proceeding under this chapter; the right to inform any person about any employer's alleged violation of this chapter; and the right to inform any individual of the individual's rights under this chapter.

C. It is unlawful for an employer's absence control policy to count paid family and medical leave taken

under this chapter as an absence that may lead to or result in discipline, discharge, demotion, suspension, or any other adverse action.

D. Protections of this section shall apply to any person who mistakenly but in good faith alleges a violation of this chapter.

E. This section shall be enforced as provided in subsections C through F of § 60.2-808.

§ 60.2-810. Coordination of benefits; applicability of chapter.

A. Leave taken with wage replacement under this chapter that also qualifies as leave under the FMLA shall run concurrently with leave taken under the FMLA.

B. An employer may require that payments made pursuant to this chapter be made concurrently or otherwise coordinated with payments made or leave allowed under the terms of disability or family care leave under a collective bargaining agreement or employer policy. Such employer shall give employees written notice of this requirement.

C. Nothing in this chapter shall be construed to limit or reduce an employer's obligation to comply with a collective bargaining agreement, an employer policy, or any other provision of law requiring more generous leave.

D. No provision of this chapter shall apply to an employer or employee as such terms are defined in 45 U.S.C. § 351.

E. An individual's right to leave under this chapter shall not be diminished by a collective bargaining agreement entered into or renewed, or an employer policy adopted or retained, after January 1, 2027. Any agreement by an individual to waive the individual's rights under this chapter is void as against public policy.

§ 60.2-811. Notice requirements.

A. An employer shall provide written notice as prescribed in this subsection to each employee upon hiring and annually thereafter. An employer shall also provide such written notice to an employee when such employee requests leave pursuant to this chapter or when the employer acquires knowledge of an employee's intent to take leave that may meet the eligibility requirements of § 60.2-802. Such notice shall include (i) a statement of an employee's right to family and medical leave benefits pursuant to this chapter and the terms under which such benefits may be used; (ii) the amount of family and medical leave benefits available; (iii) the procedure for filing a claim for family and medical leave benefits; (iv) a statement of the right to job protection and benefits continuation under § 60.2-808; (v) a statement that discrimination and retaliatory personnel actions against a person for requesting, applying for, or using family and medical leave benefits are prohibited under § 60.2-809; and (vi) a statement that the employee has a right to file a complaint for a violation of this chapter. An employer shall also display and maintain a poster provided by the Commission in a conspicuous place accessible to employees at the employer's place of business that contains the information required by this section in English, Spanish, and any language that is the first language spoken by at least five percent of the employer's workforce. The Commissioner may adopt regulations to establish additional requirements concerning the means by which employers shall provide such notice.

B. An employee seeking to take leave under the provisions of this chapter shall notify his employer as soon as practicable.

§ 60.2-812. Appeals.

A. The Commissioner shall establish a system for appeals within 90 days of a denial of a claim for family and medical leave benefits.

B. Judicial review of any decision with respect to family and medical leave benefits shall be permitted in a court of competent jurisdiction after a party aggrieved thereby has exhausted all administrative remedies established by the Commissioner.

C. The Commissioner shall implement procedures to ensure confidentiality of all information related to any claims filed or appeals taken to the maximum extent permitted by applicable laws.

§ 60.2-813. Enforcement.

A. Contributions required by the provisions of § 60.2-806 that are unpaid on the date on which they are due and payable, as prescribed by the Commissioner under this chapter, shall bear interest at the rate of one and one-half percent per month from and after such date until payment plus accrued interest is received by the Commission. Interest collected pursuant to this chapter shall be paid into the Fund. An employer who fails to timely remit a contribution or any portion thereof under § 60.2-806 shall be solely responsible for the interest due under this section.

B. If, after notice, any employer defaults in any payment of contributions or interest, the amount due shall be collected by civil action in the name of the Commissioner. The employer adjudged in default shall pay the fees and costs of such action. Civil actions brought under this chapter to collect contributions or interest or any penalty from an employer shall be heard by the court at the earliest possible date. Such civil actions may be brought against any officer, employee, or agent of a corporation or partnership in his individual, personal capacity when that person willfully fails to cause the employer to pay the appropriate contributions or interest and he had the authority to do so. No person shall be subject to this section unless it is proved that such person (i) knew of the failure or attempt to make such payment and (ii) had authority to prevent such

failure or attempt. In addition to the foregoing remedies, the Commissioner shall have such other remedies as are available to the Tax Commissioner and county and city treasurers for the collection of taxes generally. The Commissioner is authorized to compromise, settle, and adjust any contributions, including interest, or any penalty assessed against any employer where in the judgment of the Commissioner the best interests of the Commonwealth will be promoted or served. The Commissioner may in such cases accept in full settlement of the contributions assessed an amount less than that assessed.

C. When an unsatisfied execution has been returned by an officer, and the employer against whom the judgment has been obtained on which the execution was issued continues in default of payment of contributions, or any portion thereof, such employer may be enjoined from operating and doing business in the Commonwealth until such contributions have been paid. The Circuit Court of the City of Richmond shall have exclusive original jurisdiction to grant such injunction upon the complaint of the Commissioner. Notice of the time and place when the application for the injunction will be made shall be served on the employer and a copy of the bill of complaint shall be served with the notice.

§ 60.2-814. Fraud, erroneous payments, and disqualification for benefits; penalty.

A. In addition to any other appropriate charges under Title 18.2, an individual who willfully or with intent to defraud makes or causes to be made, directly or indirectly through any agent or agency, any false statement with the intent to obtain family and medical leave benefits is guilty of a Class 1 misdemeanor and shall be disqualified from family and medical leave benefits for five years.

B. An individual shall be disqualified from family and medical leave benefits for three years if the individual is determined by the Commissioner to have recklessly made a false statement or misrepresentation regarding a material fact, or willfully failed to report a material fact, to obtain benefits under this chapter.

C. If family and medical leave benefits are paid erroneously or as a result of willful misrepresentation, or if a claim for family and medical leave benefits is rejected after benefits are paid, the Commission may seek repayment of benefits from the recipient.

§ 60.2-815. Elective coverage.

A. A self-employed person, including a sole proprietor, partner, or joint venturer, may elect coverage under this chapter for an initial period of not less than three years. The self-employed person shall file a notice of election in writing with the Commissioner, as required by the Commission. Such election shall become effective on the date such notice is filed, provided that such self-employed person agrees to supply any information concerning income that the Commission deems necessary.

B. A self-employed person who has elected coverage may withdraw from coverage within 30 days after the end of the three-year period of coverage, or at such other times as the Commissioner may prescribe by rule, by filing written notice with the Commissioner, such withdrawal to take effect not sooner than 30 days after filing such notice.

§ 60.2-816. Private employer plans; exemption from contributions.

A. Employers may apply to the Commission for approval to meet their obligations under this chapter through a private plan that provides paid family and medical leave benefits equal to or greater than the benefits provided under this chapter. The Commission may approve such private plan if the Commission determines that such private plan:

1. Confers all of the same rights, protections, and benefits provided to covered individuals under this chapter, including:

a. The provision of family and medical leave benefits for all purposes specified in subsection A of § 60.2-802;

b. The provision of family and medical leave benefits for the maximum number of weeks required in § 60.2-803 per benefit year;

c. The provision of family and medical leave benefits as specified in subdivision A 3 § 60.2-802 for a covered individual with a serious health condition;

d. A wage replacement rate for all family and medical leave benefits that equals or exceeds the rate required by subsection A of § 60.2-804;

e. A maximum weekly family and medical leave benefit amount that equals or exceeds the amount specified in subsection D of § 60.2-804 and a minimum weekly family and medical leave benefit amount that equals or exceeds the amount specified in subsection C of § 60.2-804;

f. The provision of family and medical leave benefits on an intermittent basis as specified in § 60.2-807;

g. No additional conditions or restrictions on family and medical leave benefits, or leave taken in accordance with such benefits, beyond those explicitly authorized by this chapter or regulations issued pursuant to this chapter;

h. The provision of family and medical leave benefits to any employee covered under such private plan who would otherwise be eligible for such benefits pursuant to this chapter; and

i. An employee contribution amount that does not exceed the amount such employee would otherwise contribute for family and medical leave benefits pursuant to § 60.2-806.

2. Complies with the following provisions:

a. Such private plan shall provide family and medical leave benefits for all eligible employees throughout

the course of their employment;

b. If such private plan is in the form of self-insurance, the employer shall provide documentation to demonstrate sufficient financial capacity to meet all current and anticipated claim obligations under the program in a form, amount, and manner determined by the Commission; and

c. If such plan is in the form of a third-party provider of insurance, the forms of the policy must be issued by an insurer and approved by the Commission.

B. Employers with an approved private plan shall reapply to the Commission for approval to meet their obligations under this chapter every two years. At the time of certification and recertification, employers shall disclose any changes in the family and medical leave benefits provided through the private plan and shall pay a fee, to be determined by the Commissioner, which shall be deposited into the Fund.

C. The Commission shall withdraw approval for an employer's private plan pursuant to subsection A if such employer violates the terms or conditions of such private plan, including by:

a. Failing to pay benefits;

b. Failing to pay benefits timely and in a manner consistent with the provisions of this chapter;

c. Misusing private plan money;

d. Failing to submit reports or comply with other requirements or terms set by the Commission; or

e. Failing to comply with this chapter or regulations promulgated pursuant to this chapter.

D. An employee covered by a private plan approved under this section shall retain all applicable rights provided in §§ 60.2-808 and 60.2-809.

E. A contested determination or denial of family and medical leave insurance benefits by a private plan is subject to appeal before the Commission and any court of competent jurisdiction pursuant to § 60.2-812.

F. The Commission shall establish a fine structure for employers and entities offering private plans that violate this section. The Commission shall transfer any fines collected pursuant to this subsection to the state treasurer for deposit into the Fund. The Commission shall establish a process for the determination, assessment, and appeal of fines under this subsection.

G. The Commission shall annually determine the total amount expended by the Commission for costs arising from the administration of private plans. Each employer offering a private plan pursuant to this section shall reimburse the Commission for the costs arising out of the private plans in the amount, form, and manner determined by the Commission.

H. The Commission, in consultation with the State Corporation Commission, may establish rules, processes for data sharing, and a memorandum of understanding related to their respective roles in implementing the approval of coverage pursuant to this section, authorizing products, and requiring filings related to private family leave insurance, paid family and medical leave, group disability, and individual or group accident and sickness policies.

I. No employer shall be deemed to have fulfilled its obligations under the paid family and medical leave insurance program through a private family leave insurance policy issued pursuant to § 38.2-107.2 unless the Commission determines that such policy, in combination with a temporary disability insurance policy issued to such employer, meets the minimum requirements necessary for approval pursuant to this section.

J. Nothing in this section shall preclude an employer from providing benefits in addition to paid family and medical leave benefits as provided in this chapter.

§ 60.2-817. Federal income tax treatment.

If the Internal Revenue Service determines that family and medical leave benefits under this chapter are subject to federal income tax, the Commission shall advise any covered individual filing a new claim for family and medical leave benefits, at the time of filing such claim, that:

1. The Internal Revenue Service has determined that benefits are subject to federal income tax;

2. Requirements exist pertaining to estimated tax payments;

3. The individual may elect to have federal income tax deducted and withheld from the individual's payment of benefits in the amount specified in the federal Internal Revenue Code; and

4. The individual is permitted to change a previously elected withholding status.

§ 60.2-818. Reports; public dashboard.

By April 1, 2030, and annually thereafter, the Commission shall report to the General Assembly on projected and actual program participation by purpose listed in § 60.2-802, gender of beneficiaries, race and ethnicity of beneficiaries, age of beneficiaries, amount of benefits paid to beneficiaries per week, premium rates, fund balances, outreach efforts, and, for leaves taken under subdivision A 2 of § 60.2-802, family members for whom leave was taken to provide care.

The Commission shall develop and continually update a publicly accessible online dashboard with information including the number of claims filed and approved and the average times for claim approval, in the aggregate and divided by the purpose for which leave is requested, and additional information as the Commission deems appropriate. The dashboard shall be developed and launched no later than the date on which family and medical leave benefits are first paid pursuant to this chapter.

2. That the Virginia Employment Commission (the Commission) shall promulgate all rules and regulations necessary for implementation of this act by April 1, 2028, including (i) a process for

receiving benefits claims filed, (ii) the form of any application for family and medical leave benefits, (iii) the timeline and process for providing notice of a claim to an employer, (iv) the timeline and process for making initial claim determinations, (v) the timeline and process for requesting information prior to any decision on a claim being rendered, (vi) the process and timeline for a self-employed person to elect family and medical leave coverage, and (vii) best practices for communication and coordination between employees and employers regarding the use of leave. The Commission shall also adopt regulations to establish certification processes that promote efficiency and prevent fraud, including (a) the process and requirements for certification as described in subsection B of § 60.2-802 of the Code of Virginia, as created by this act, as well as a timeline for such certification; (b) the process by which health care providers certify documentation provided and authorized by employees directly to the Commission; (c) the process by which the Commission notifies employers of the approval of an employee's family and medical leave request; (d) the process for confirming that certification required under § 60.2-802 of the Code of Virginia, as created by this act, is accurate and appropriate; and (e) the process for certifying an employee's work authorization to the Commission. Any such rules and regulations shall be promulgated as required by the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia), except that § 2.2-4007.06 of the Code of Virginia shall not apply.

3. That by December 1, 2028, the Department of Human Resource Management (the Department) shall modify the Commonwealth's policies relating to family and medical leave pursuant to subsection C of § 60.2-801 of the Code of Virginia, as created by this act. In modifying such policies, the Department shall not reduce any existing leave or benefits available to an employee of the Commonwealth that are more generous than the leave and benefits provided under the paid family and medical leave insurance program, as created by this act. The Governor shall (i) if necessary, submit legislation to the General Assembly to codify any such modifications to the Department's policies and (ii) include any necessary funding to support such modifications to the Department's policies in the budget bill submitted for the 2026–2028 or 2028–2030 biennium pursuant to § 2.2-1509 of the Code of Virginia.

4. That the Virginia Employment Commission (the Commission) shall develop and conduct a public education campaign to inform workers and employers regarding the availability of family and medical leave benefits. Such campaign shall include multiple ways to communicate to employers and employees about the new benefits system and leave rights, contributions, timeline, and eligibility requirements. Such campaign shall be an ongoing function of the Commission for the duration of the paid family and medical leave insurance program. In conducting and planning such campaign, the Commission shall work with stakeholders, including chambers of commerce, trade associations, nonprofit organizations, and labor unions, to develop and implement a statewide communication outreach strategy. Such campaign shall also include targeted outreach and education for small businesses. Outreach information shall be available in English, Spanish, and other languages spoken by more than five percent of the Commonwealth's population.

5. That the Virginia Employment Commission (the Commission) may use state data collection and technology to the extent possible and to integrate the provisions of this act with existing state policies. To the extent permitted by law, the Commonwealth may make relevant data sources from state agencies available to the Commission for the purposes of implementing the provisions of this act to increase the efficiency of eligibility and benefit determinations under this act.