

REFERENCE GUIDE TO BILLING AND ENROLLMENT



Offered by:
**Maine Municipal
Employees
Health Trust**

“The Difference is Trust.”

HEALTH TRUST CONTACT LIST (effective August 1, 2008)

PROGRAM INFORMATION

1-800-452-8786 (In Maine) or 207-623-8428

Information about the different Health Trust plans, benefits presentations, proposals.

Karen Childs	Ext 2280	kchilds@memun.org	Asst. Director, Health Trust Services
Gail Schroeder	Ext 2230	gschroeder@memun.org	Field Service Representative
Deborah Bridges	Ext 2229	dbridges@memun.org	Field Service Representative

BENEFIT QUESTIONS

1-800-852-8300 (In Maine) or 207-621-2645

Medical, Life, Dental or Disability bills submitted by Insured, Doctor, Dentist, Hospital or Medical Facility.

Susan Smith	Ext 2222	issmith@memun.org	Member Services Manager
Michelle York	Ext 2225	myork@memun.org	Senior Service Representative
Nicole Ouellette	Ext 2226	nouvellette@memun.org	Service Representative
Jennifer Lachance	Ext 2227	jlachance@memun.org	Senior Service Representative
Lisa Rigoulot	Ext 2228	lrigoulot@memun.org	Senior Service Representative
Karen Guillemette	Ext 2308	kguillemette@memun.org	Subrogation Specialist

BILLING AND ENROLLMENT

1-800-452-8786 (In Maine) or 207-623-8428

Eligibility, effective dates, monthly premiums, adjustments on your monthly billing.

Terry LaChance	Ext 2223	tlachance@memun.org	Enrollment & Data Services Manager
Linda Mack	Ext 2261	lmack@memun.org	Sr. Billing & Enrollment Representative
Melanie Ingraham	Ext 2262	mingraham@memun.org	Billing & Enrollment Representative

IDENTIFICATION CARDS & SUPPLIES

1-800-452-8786 (In Maine) or 207-623-8428

Status of ID cards, additional cards, supplies.

Sharon Reardon	Ext 2224	sreardon@memun.org	Health Trust Assistant
Vacant	Ext 2285		Health Trust Assistant

WELLNESS WORKS

1-800-452-8786 (In Maine) or 207-623-8428

Information on health education and promotion programs, classes, grants, etc.

Anne Charles	Ext. 2292	acharles@memun.org	Health Promotion Manager
Abigail DiPasquale	Ext. 2303	adipasquale@memun.org	Health Promotion Coordinator
Danielle Yale	Ext. 2282	dyale@memun.org	Health Promotion Coordinator
Amanda Collins	Ext. 2283	acollins@memun.org	Health Promotion Assistant

It is important to us that we give you the best service possible. Please be sure to make note of the name of the Health Trust Representative you speak with, in the event there are further questions.

WEB SITES – www.mmeht.org (Health Trust); www.anthem.com; www.anthemprescription.com

HEALTH TRUST FAX NUMBER: 207-621-0165

TABLE OF CONTENTS

Joining a Health Trust Program	Page 1
Membership	Page 2
Waiting Period	Page 3
Definition of Eligibility	Page 4
Evidence of Insurability	Page 6
Salary Changes	Page 7
Reconciling the Monthly Billing	Page 8
How to Enroll	Page 10
Qualifying Events / Annual Enrollment / Election Not To Enroll	Page 11
Dual Option Annual Election	Page 12
Changes in Status and Address	Page 13
Dependents Age 19 – 25	Page 14
M arriage	Page 15
Newborns and Adopted Children	Page 16
Divorce/Legal Separation	Page 17
Life Insurance Plan	Page 18
Changes in Supplemental Life and Dependent Life	Page 19
Income Protection Plan (IPP) Changes / LTD Changes	Page 20
Waiver of Premium for IPP and LTD	Page 21
Dental Enrollment and Changes	Page 22
Termination or Cancellation Requests	Page 23
Family and Medical Leave	Page 24
Retirem ent	Page 25
Coverage for Retirees	Page 26
Split Coverages for Retirees	Page 27
Layoff or Leave of Absence	Page 28
Military Duty	Page 29
Po rtability	Page 30
COBRA	Page 31
Termination of COBRA Coverage	Page 33
Life Insurance Conversion	Page 34
Check List of Items to Give New Employees	Page 35

Important Tax Information for Employers

Income Protection Plan Tax Information	Addendum 1
Domestic Partner Tax Implications	Addendum 2
Life Insurance Tax Information	Addendum 3

Appendix – Includes All Samples Referred To In The Guide

Samples:

1	Employee Welcome Letter
2	Salary Change Notification Form
3a	Sample Health Trust Bill – First Page
3b	Sample Health Trust Bill – Final Page
4	Termination Notification Form
5	MMEHT Department Codes Listing
6	Health Application For Enrollment
7	Life Plan Employee Enrollment Form
8	Income Protection Plan (IPP) Enrollment Form
9a	LTD Enrollment Form (Employer Paid)
9b	LTD Enrollment Form (Employee Paid)
10	Dental Application Form
11	Health Plan Election Not To Enroll
12	Dual Option Annual Election Form
13	Group Application For Change
14	+19 Application
15	Life Plan Employee Change Form
16	Dental Eligibility Checklist
17	Employer Statement Re: Retiree Eligibility For Coverage
18	Health Plan Application For Continued Coverage As A Retiree
19	Anthem Blue Cross Blue Shield Companion Plan B Application For Enrollment
20	MSRS Deduction Authorization
21	Certificate of Coverage
22	Subscriber Election To Continue Group Coverage
23	Notice of Conversion Privilege
24	COBRA Letter – Page 2

Please note – if you need new forms, please call the Health Trust and order by title.

Please do not use samples in place of actual forms.

JOINING A HEALTH TRUST PROGRAM

The Health Trust must receive a letter of intent from an employer that chooses to make any Health Trust program available to their employees. The letter must state the intended effective date for each plan in which the employer wishes to join and must be sent to the Health Trust with completed applications for coverage.

Check your personnel policy to see if:

- A. All full time employees are eligible for this coverage and determine if eligibility is limited to a specific department or bargaining unit.
- B. Any part time employees who work a minimum of 20 hours a week on a year round basis are eligible for this coverage. If not, how many hours must a part time employee work to be eligible for this coverage?
- C. Any elected and/or appointed officials are eligible to participate in this coverage.

Know your employer's waiting period (see page 3). Know which coverages your employer offers.

Have enrollment forms ready for new employees, ensuring applications for all Plans offered by your employer are provided to each new employee. **(You should include applications and information for all programs in which your employer participates.)**

Employees must complete an application for **each Plan** in which he/she will be enrolling, checking to be sure that all information is correct. This includes social security numbers and dates of birth for the employee and all of his/her dependents to be covered.

ADDRESS ALL APPLICATIONS/FORMS REFERENCED IN THIS GUIDE TO:

**MMEHT
ATTN: BILLING DEPARTMENT
60 COMMUNITY DRIVE
AUGUSTA, MAINE 04330-9486**

After applications are received and processed, a packet will be issued to the employee. The packet will contain a "welcome letter" confirming each plan in which the employee is enrolled, effective dates of enrollment for each plan and dependent status for all signed applications received by the Health Trust. The packet will also contain inserts explaining COBRA rights, Mastectomy/Breast Reconstructive surgery rights and a Summary Plan Description booklet for each plan in which the employee has enrolled. The employer will receive a copy of the welcome letter for the employee's file (sample #1).

IDENTIFICATION CARDS: Cards take up to 2 weeks to be printed and will be sent directly to the participant.

All health plan cards for active employees and retirees not on Medicare are printed by Anthem and will serve as combined prescription and medical cards. The identification cards will have the Health Trust logo and the Anthem Blue Cross Blue Shield logo on the front.

Retirees on Medicare will receive two cards: Companion Plan Cards that are printed by Anthem Blue Cross Blue Shield, with a Health Trust Major Medical sticker on the back and a prescription drug card also printed by Anthem that looks different from active employee cards.

Please note: The Health Trust does not issue ID cards for Dental Plan participants.

MEMBERSHIP

Employees are able to enroll in one of the following types of contracts:

Employee coverage	for employee only
Employee & Spouse	coverage for employee & spouse only (same premium as family coverage under Medical)
Employee and Child(ren)	coverage for employee and dependent child(ren) (same premium as family coverage under Dental)
Family	coverage for employee, spouse and dependent child(ren) (same premium as employee & spouse under Medical; same premium as family coverage under Dental)
+19 Dependents	may be carried on either employee and child(ren) or family contract if between the ages of 19-25 and at least 50% dependent on the covered employee (parent)
for	support. There is no additional charge for these dependents, under either of these two coverage types.

There are four enrollment periods when an employee may join the Health Trust Health Insurance Plan.

1. When the employee is first hired (see section on waiting periods - page 3)
2. Within 60 days of a qualifying event (see section on qualifying events - page 11)
3. During the annual open enrollment period (see section on annual open enrollment - page 11)
4. Within 60 days after loss of other coverage (see section on portability - page 30)

Coverage will be effective on the first day of the calendar month that coincides with or follows the end of the waiting period selected by the employer, provided we receive the application before the effective date. If application is not made within 60 days of a new employee's eligibility date, the applicant will be considered a late enrollee unless there is either a qualifying event or loss of other coverage (portability).

A retiree (as defined by the Plan; see page 25 for details) shall become covered for benefits as a retiree on the first day of the calendar month coincident with or next following his/her date of retirement, provided proper application for coverage and any required contributions are made.

If there is any discrepancy between this booklet and the Health Trust Plan Document, the Plan Document provisions shall apply.

WAITING PERIOD

The waiting period is the length of time an employee must wait before he or she is eligible to enroll in the group plan offered by the Maine Municipal Employees Health Trust. The EMPLOYER establishes the waiting period when the group opts to participate in the program(s) offered, with the exception of the Long Term Disability (LTD) program, which has been set by Unum at three (3) months for all participating groups. Waiting periods are calculated from the first working day of the month.

The Health Trust must receive the employee's Application for Enrollment before the end of the waiting period for coverage to be effective on the earliest possible date. However, if we receive the application no more than 60 days after the end of the waiting period, coverage is effective on the first day of the calendar month after the application is received by the Health Trust. If an application is received after that, the applicant will be considered a late enrollee and must satisfy Evidence of Insurability for Life, Dental, IPP and LTD; and wait until the annual enrollment period in December for Health coverage.

WAIVER OF WAITING PERIOD

An employer may waive any existing waiting period for an employee, with the exception of the waiting period for the Long Term Disability (LTD) plan, by sending a letter along with the application stating that it is the intent of the employer to waive the waiting period for all programs, or a specific program (see samples listed below). The LTD plan is offered by the Health Trust through Unum and has a fixed waiting period of three (3) months for all eligible employees. The waiting period for the LTD plan cannot be waived.

CHANGING YOUR GROUP'S WAITING PERIOD

The Health Trust must be notified in writing of an Employer's desire to change an existing waiting period for any or all of the programs in which the employer participates.

SAMPLE WORDING TO WAIVE WAITING PERIOD

- Enclosed please find an enrollment application for John Doe. Mr. Doe was originally hired by the Town of Utopia as a part-time employee (20 hours per week) on 01-02-04 and was not at that time eligible for benefits under the policy of the town. The town council has voted to make Mr. Doe a salaried employee and also offer him health insurance benefits effective 07-01-05. Please waive the normal 90-day waiting period and begin his coverage as of 07-01-05.
- Enclosed please find an enrollment application for John Doe. Mr. Doe is a new employee with the Town of Utopia and the town would like to have the waiting period required by the town waived and make his coverage effective 07-01-05.

DEFINITION OF ELIGIBILITY

An individual must meet certain requirements in order to be eligible for coverage under the Health Trust plans. The Maine Municipal Employees Health Trust eligibility requirements are as stated below:

1. Employees who are hired on a full or part time basis and **work an average of 20 hours per week on a year round basis** are eligible for coverage. (The employer may impose a higher minimum if so desired.)
2. Elected officials, whose term is of at least one year's duration, regardless of the work schedule, may be eligible for coverage. (This is at the employer's discretion.)
3. Appointed officials, whose term is of at least one year's duration, provided they work an average of at least 20 hours per week, are eligible for coverage. (The employer may impose a higher minimum if so desired.)
4. For Dental, Income Protection Plan (IPP), Long Term Disability (LTD) and Life Plans, if the employee is not actively at work on the day coverage would become effective because of a non-job-related injury or illness, the coverage will become effective on the day he/she returns to work full time. However, Dental and Life coverage for any eligible dependents may begin as though the employee was actively at work, provided the dependents are not disabled at such time. Health insurance coverage will begin on the employee's effective date if he/she is actively at work, available to work if it is not a regularly scheduled work day, or absent from work due to a non-work related illness or injury.
5. If the employee is not actively at work on the day the coverage would become effective because of a job-related injury or illness, coverage for all other disabilities or illnesses will become effective on the normal effective date.

DEPENDENTS

Eligible dependents will be covered on the same date as the employee, provided application has been made for them within 60 days of the Employee's eligibility date. The **only** persons considered eligible dependents are:

1. The legally married spouse of an employee. (Effective January 1, 2000, Domestic Partners may be covered if the employer authorizes such coverage. Please call the Health Trust for more information.)
2. Unmarried children who are between the ages of birth and 19 years, including natural children, adopted children, stepchildren and other children under the legal guardianship of the employee.
3. An unmarried covered dependent child after his/or her 19th birthday provided the child is primarily dependent on the employee for support and maintenance and is under the age of 25. The child does **not** have to be a full-time student.
4. An unmarried covered dependent child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who is chiefly dependent upon the employee for support and maintenance, provided proof of such incapacity and dependency is furnished to the Plan by the covered person within 31 days of the child's 19th (or 25th) birthday. The Health Trust may require, at reasonable intervals during the two years following the dependent's 19th (or 25th) birthday, subsequent proof of the child's continued disability and dependency. After such two-year period, the Health Trust may require subsequent proof not more than once each year.

For Health and Dental insurance plans, employees who have dependents reaching the age of 19 will receive a questionnaire approximately two months prior to the dependent's 19th birthday and **annually** thereafter to determine the continued eligibility of the dependent child.

EXCLUDED AS DEPENDENTS

The Health Trust does **not** allow employees to cover any of the following as eligible dependents:

1. A spouse **legally** separated or divorced from the employee.
2. Any person(s) while on active duty in any military service of any country.
3. A married couple working for the same employer cannot be covered as both an insured and a dependent of the other. Any dependent children may be covered by one parent only.
4. Live in companions. (Note: Domestic Partners may be covered, if the employer authorizes such coverage. Please call the Health Trust for more information.)

EVIDENCE OF INSURABILITY

When an application for the Dental, Life, Income Protection Plan, or Long Term Disability plan is not received by the Health Trust within 60 days from the date of hire, within the waiting period or within 60 days following the end of the employer's waiting period, the applicant is considered a late enrollee and must satisfy Evidence of Insurability.

The Health Trust will mail an Evidence of Insurability form directly to the employee to complete and return to the Health Trust. Upon receipt of the completed form, it will be logged in by the Health Trust and sent to the applicable Underwriting Department for immediate review. The employee will be notified if any additional information is needed to process the application. The applicant will be notified as soon as possible after a decision has been made.

If a late enrollee is applying for **Long Term Disability coverage** or **Income Protection Plan coverage**, or for an increase in the Income Protection Plan benefit, he/she must complete the questionnaire answering all questions with regard to him/herself only, being sure to complete the sections asking for date of birth, height and weight.

If a late enrollee is applying for **Dental coverage**, a statement of dental condition will be sent to the employee for the employee and all dependents he/she wishes to cover under his/her contract. The top portion of each form is to be completed by the employee and the dentist must complete the bottom portion. Any expense incurred for completion of the form is the responsibility of the employee. If the form is not signed by both the employee and the dentist, the form will be returned for the necessary signature(s).

If a late enrollee is applying for **Life insurance coverage**, a personal health statement must be completed and returned to the Health Trust. However, if the enrollment is received during either the Health Trust's annual Open Enrollment period for health insurance, or as part of an employer's cafeteria plan open enrollment, this requirement is waived and the application for Basic Life insurance and/or one unit of Supplemental Life insurance for the employee will be accepted without evidence of good health. The application must be received in conjunction with a health enrollment application. If the late enrollee includes a dependent child on his/her application, Evidence of Good Health is not required for the child.

NOTE: When the Health Trust does not receive an application for **Health insurance** within 60 days of the date of hire or within 60 days following the end of the waiting period, the applicant will be considered a late enrollee. He/she must wait until the Plan's annual enrollment period in December to enroll, unless there is a qualifying event or portability applies. Please refer to page 11 (annual open enrollment and qualifying events) and to page 30 (portability) for further information.

SALARY CHANGES

It is **imperative** that salary changes be reported to the Health Trust **as soon as they occur**. Salaries affect life insurance as well as Income Protection Plan and Long Term Disability plan benefits.

The Salary Change Notification Form must be completed to change salaries (sample #2). The following information is necessary:

- a) Complete social security number of the employee.
- b) Name of the employee as it appears on the Health Trust bill.
- c) Actual ANNUAL salary, not rounded.
- d) Indicate if the employee was actively working on the date of the salary change.

Do not wait to send the salary changes with the bills when you send payment, as this may delay the effective date of the change.

The salary should be reported as an exact annual salary, and should not be rounded up or down. Salaries are based on a normal work week and do not include overtime unless it is part of an employee's normal work week (for example, if it is in the employee's contract).

Salary changes are effective **the next billing cycle** following receipt by the Health Trust. For example, on August 10th September bills are run. Salary changes received on August 11th will be effective October 1st. This holds true even if the employee's raise is retroactive (for example, in the case of a bargaining unit contract ratified retroactively), the salary change (for purposes of the Health Trust plans) is not.

Prompt reporting will prevent an employee from receiving an incorrect benefit if he/she files a disability claim.

Prompt reporting will also ensure that a beneficiary receives the correct benefit amount in the event of the employee's death.

Salary change forms are now available on the Trust's website!
www.mmeht.org

RECONCILING THE MONTHLY BILLING

It is the responsibility of the employer to review each monthly bill to ensure that all individuals have correct coverage.

Bills are mailed the middle of the month for coverage in the upcoming month. For example, April's bill is mailed in mid-March. Please pay your bill promptly. If payment has not been received, a "Late Notice" will be sent to the employer on approximately the twentieth day of the month in which the bill was due. If no payment is received after this notice, payment on claims for all employees (and their dependents) will be suspended until premium payments have been received.

An example of a Health Trust bill is included as sample #3 (a-b).

Check your bill carefully. If there are any questions about your billing, please do not hesitate to call.

Check to see that all eligible employees are covered.

Status codes listed in the "health status" column are: D1 = Employee-only coverage, D3 = Employee and Spouse coverage, D4 = Employee and Child(ren) coverage, D5 = Family coverage.

Employees need to be deleted from your billing effective the first day of the calendar month following their last day actively worked. (Note: This does not include employees who are absent from work and collecting benefits from Worker's Compensation.)

If an employee retires and is to remain on the employer's billing, deduct the billed premium for all coverages. Note on the Termination Notification Form (sample #4) to bill the employer, and the date the employee retired. In order for coverage to continue, the employee / retiree must complete and return the retiree acceptance forms to the Health Trust. Once the Health Trust receives these completed forms, the retiree will be added back to the bill. Coverage will be reinstated retroactive back to the date of the employee's retirement. There will be no lapse in coverage, and arrears will be billed as necessary.

For an employee who has terminated his/her employment for any reason, highlight his/her name and premium(s) billed. Deduct the premium(s) before you make your payment, complete a Termination Notification Form (sample #4) and attach it to your bill when you send the payment to the Trust.

If an employee requests cancellation for any coverage, highlight the premium for that coverage and deduct that amount from your payment. Do this even if the employee only wants to cancel coverage under one Plan and keep the rest. Complete a Termination Notification Form (sample #4) and note "C" for cancellation requested. Clearly note on the Termination Notification Form which coverage is being canceled. Send the Termination Notification Form to the Trust along with your payment.

If an application for enrollment has been submitted for an employee and the employee's name does not appear on the billing, **DO NOT** add the employee to the billing. Adjustments will appear on the next bill and will reflect a double billing if necessary.

If an application for change has been submitted for an employee and the change is not reflected on the billing, **DO NOT** change the premium. All adjustments will appear on the next month's bill.

It is **VERY IMPORTANT** that you complete the final page of the billing (sample #3b). This is **Federally required information** and must be completed **EVERY** month. The employee's share is the total dollar amount that is deducted from **all** employees for **each program**. The employer's share is the total dollar amount that is paid by the employer for each program.

Each employer will receive two copies of the monthly billing. Please reconcile your monthly bill and return one copy, along with your check and termination forms, as soon as possible. This will avoid confusion and enable us to notify terminated employees of their options for continuation of coverage through the Health Trust. **Bills and payments received by the 10th of the month will ensure that maintenance is updated prior to the next billing.** Refunds of excess premiums paid in error will be limited to three (3) months. Mail premium payments to:

**MMEHT
ATTN: FINANCE DEPARTMENT
60 COMMUNITY DRIVE
AUGUSTA, MAINE 04330-9486**

HOW TO ENROLL

The employer must complete the employer section of all applications, stating your full employer name as it appears on your HealthTrust monthly bill. Fill in the department code number if applicable (sample #5), the annual salary, the date of hire and the number of hours the Employee is scheduled to work each week. If an employee is applying for health insurance coverage, indicate which health plan the employee has chosen, making sure that this is an option offered by the employer.

The Health program and the Basic Life program go hand in hand. The employee must complete the application for Health (sample #6), along with a Life Plan Employee Enrollment Form (sample #7) designating his/her desired beneficiary. Completing and returning these forms as soon as possible assures the employee of coverage, provided all eligibility requirements have been met.

An employee who has health insurance through another source should be offered basic life insurance with the Health Trust. Life-only coverage is available at a nominal fee. To enroll in the life coverage only, the employee must complete a Life Enrollment form (sample #7). Please be sure to fill in the employee's annual salary. Write the words "Life No Med" at the top of the form.

A part time employee who is not eligible for benefits (as stated in the employer's personnel policy and as stipulated in the Health Trust guidelines) may, if his or her hours are increased or if he/she becomes full time, apply for benefits using the date of the increase in hours or full time employment as the "date of hire" (see sample wording on page 3).

If an employee is enrolling in a Point of Service Health Plan, a primary care physician must be listed for the employee as well as for each of his/her dependents to be covered. Failure to list a Primary Care Physician will delay the production of an identification card and claims processing.

To enroll in Supplemental or Dependent Life insurance coverage, if this option is available to employees, complete an MMEHT Life Plan Employee Enrollment Form (sample #7) and check the appropriate coverage boxes in the middle of the form. Employees must be enrolled in Basic Life coverage to be eligible for Supplemental or Dependent Life coverage.

To enroll in the Income Protection Plan (IPP) program, if this option is available to employees, complete an IPP application (sample #8). The employee may choose to be covered at 40%, 55%, or 70% of his/her annual base salary. The top portion of the application must be fully completed by the employee. The bottom of the application must be fully completed by the employer, including the annual salary and the number of hours the employee works each week.

To enroll in the Long Term Disability program, if this option is available to employees, complete the appropriate application (sample #9a and sample #9b). There are two different applications: one for coverage with employer-paid premiums, and one for coverage with employee-paid premiums. The application must include the employee's annual salary.

To enroll in the Dental program, if this option is available to employees, complete a dental plan application for coverage (sample #10).

By not returning the Life, Dental, Long Term Disability or Income Protection Plan enrollment forms in a timely manner, the employee risks the process of Evidence of Insurability and possible rejection or a delay of up to a month before coverage becomes effective. If the Health enrollment form is not returned in a timely manner, the employee may have to wait until the Health Trust's annual Open Enrollment period in December, in order to enroll. All applications must be returned within 60 days of the date of hire, or, if a waiting period is required by the employer, within 60 days of the date of the end of the waiting period.

Do not add a new employee to your billing. This will be done automatically when the applications are received. Any adjustments will be made on the following month's bill.

QUALIFYING EVENTS

At any time during the course of the year, if a qualifying event occurs, the employee and his/her eligible dependents may join the health plan without being considered late enrollees. Dependents may not enroll in the Health Trust health plan unless the employee is enrolled.

Qualifying events are as follows:

- a. Marriage.
- b. Birth of a child.
- c. Adoption of a child.
- d. Placement of a child for adoption within an employee's home.

The Health Trust must receive proof of the event along with the original application to enroll within 60 days of the qualifying event. **Please do not fax applications to the Health Trust.**

ANNUAL OPEN ENROLLMENT PERIOD

Once each year, during the month of December, an annual open enrollment period is allowed for anyone who did not enroll in the **Health** plan when he/she was originally eligible. No Evidence of Insurability is required for enrollment in Health insurance. In addition, employees enrolling in the Health insurance plan during open enrollment may also enroll in Basic Life insurance and one unit of Supplemental Life insurance (provided that coverage is available to employees) without having to provide Evidence of Insurability.

If an application is completed and received by the Health Trust between December 1 and December 31, health insurance coverage for the employee and his/her eligible dependents will be effective January 1 of the following year.

The Health Trust must receive the Health application form no later than December 31st.

Please note: The Health Trust annual open enrollment period applies only to the Health insurance (and to Basic Life and one unit of Supplemental life, if applied for in conjunction with the Health insurance). It does **not** apply to Dental, IPP, or LTD coverage.

ELECTION NOT TO ENROLL

In the event that a new hire declines health insurance coverage under the Health Trust, please have him/her fill out the Group Health Plan Election Not to Enroll form (sample #11). This form explains the circumstances under which an employee could enroll, should coverage with the Health Trust become desirable. This form is **not** used to cancel existing coverage. (Refer to page 23, Termination.)

DUAL OPTION ANNUAL ELECTION

Any employer who offers the Dual Option Traditional or Comprehensive Plan (i.e., both Traditional POS and Indemnity Choice, **or** both Comprehensive POS and Indemnity Choice) has an Annual Election period for all eligible participating employees to be effective January 1st each year. This does **not** apply to the Point of Service "B" Plan, which is a stand-alone plan.

All eligible employees are given the opportunity to choose to participate in the Indemnity Choice Plan or the Point of Service Plan offered by the employer, if the employer offers a Dual Option program.

Eligible employees who wish to make a change in coverage plan (Indemnity or POS) must complete the Dual Option Annual Election Form (sample #12) and list eligible dependents currently on their plan. The Primary Care Physician must be listed for each covered member if changing from the Indemnity Choice plan to a Point of Service plan.

The Health Trust must receive the completed Dual Option Annual Election Form (sample #12) no later than the date stated in the annual letter mailed to the employees, for an effective date of January 1st.

Please mail applications to the Health Trust only for employees who choose to change their Health plan.

For any employee who chooses to remain with the plan in which he/she is currently participating, file the completed application in the employee's personnel folder.

THIS IS NOT AN OPEN ENROLLMENT FOR EMPLOYEES NOT PARTICIPATING IN THE HEALTH PROGRAM. THIS OPTION IS ONLY FOR PARTICIPATING EMPLOYEES AND THEIR CURRENT DEPENDENTS. PLEASE DO NOT ADD OR DROP DEPENDENTS WITH THE DUAL OPTION FORM.

CHANGES IN STATUS AND ADDRESS

A Group Application for Change form must be completed for any and all of the reasons listed below. These changes will be reflected in the health and dental policies only, except as otherwise noted. **No changes can or will be made to an employee's contract without his/her signature.**

- a) Change of name (this will change records for all programs)
- b) Change of address (this will change records for all programs)
- c) Marriage (see page 15)
- d) Newborn and Adopted Children – legal documentation is needed for adoption (see page 16)
- e) Divorce/Legal separation (see page 17)
- f) Legal Guardianship (submit a copy of legal documents – page 16)
- g) Death of a covered dependent (note date of death)
- h) Enter military service (see page 29)
- i) Obtain Medicaid or State assistance
- j) Loss of other insurance (certificate of coverage from former insurer will be required, including reason for loss of other coverage)
- k) Acquire other insurance (include company name and effective date of coverage)
- l) Other (any reason not listed with an explanation)

To add or drop a dependent from an employee's Health or Dental coverage, complete a Group Application for Change form (sample #13), listing the dependent's name, reason code, date of the event and checking the appropriate coverage box(es).

Providing the appropriate reason code on the change form will help determine the effective date of the change.

To cancel a dependent's coverage for any reason, please complete **all** items in section 5 on the Group Application for Change form. The Health Trust is responsible for sending out COBRA (Consolidated Omnibus Budget Reconciliation Act) information, unless the employer elects to administer COBRA himself or herself. COBRA is a federally required continuation of group health and dental coverage, so this information is extremely important. The reason code indicated on the change form will help the Health Trust to determine the termination date of coverage as well as the length of COBRA coverage offered for dropped dependents.

To add a dependent, complete section 4 on the Group Application for Change form. Make sure all information is complete and accurate. If the employee is enrolled in the Point of Service program, be sure to include the name of the Primary Care Physician for the new dependent(s).

Social security numbers are very important for all applications.

Mail all change applications to the Health Trust Billing Department as soon as they are completed.

NO CHANGE CAN BE MADE TO THE EMPLOYEE'S CONTRACT WITHOUT THE EMPLOYEE'S SIGNATURE.

DEPENDENTS AGE 19 - 25

When a covered dependent reaches the age of 19, that dependent is eligible for continued coverage under the insured's contract at no additional charge (other than the regular dependent premium) if he/she is:

- Under the age of 25 and dependent on the employee for at least 50% of his/her support; or
- Mentally or physically disabled and incapable of self-support. The disability must have begun before the child's 19th (or 25th) birthday and the child must have been covered under the insured's contract on that birthday.

A dependent over the age of 19 who is not a qualified dependent is no longer eligible for coverage under the employee's contract and must be dropped from the policy. COBRA will be offered to the dependent for a period of up to 36 months if he/she chooses to accept the coverage at his/her own expense.

A dependent child must be dropped from the employee's policy when the employee is no longer the principal financial support. If and when the child again meets the definition of a dependent, prior to the age of 25, he/she may again be added to the parent's policy provided a "Group Application for Change" (sample #13) and a "+19 application" (sample #14) are completed.

Approximately two (2) months prior to the dependent's 19th birthday and on an annual basis thereafter, a questionnaire will be mailed to the insured to complete. A determination will be made as to the eligibility of the dependent under the guidelines of the Health Trust when the questionnaire is completed and returned. If the completed questionnaire is not returned within 60 days, the dependent's coverage will be terminated.

Approximately two (2) months prior to the dependent's 25th birthday, the employee will be notified that, as of the first of the month following the dependent's 25th birthday, that dependent will be terminated from the policy and COBRA will be offered, unless the insured has provided proof of incapacity, showing that the dependent can not support him/herself due to a mental health or physical medical condition. In such cases, the employer will be notified as the change in dependent status may affect the premium billed.

MARRIAGE

When an employee marries, he/she may add his/her spouse and any dependent children (see section on Definition of Eligibility, page 4) to his/her Health and/or Dental Plan provided the employee applies within 60 days of the date of marriage. In addition, an employee who is not currently enrolled in the Health and/or Dental Plan may enroll (either alone or with dependents) in the Health and/or Dental Plan, within 60 days of his/her marriage. **A separate application is needed to enroll in each Plan**; however, if the employee is simply adding dependents to his/her Health and Dental policies, then only one Change form is required.

To add a spouse and/or dependent children to an employee's existing health and/or dental Plan, the employee must complete a Group Application for Change form (sample #13). To enroll him/herself, either with or without dependents, the employee must complete a Health Application for Enrollment (sample #6), a Life Plan Employee Enrollment form (sample #7) where applicable, and/or a Dental Application (sample #10).

The effective date of coverage for the newly-married employee, his/her spouse and/or dependents, will be the first day of the calendar month following receipt of the application by the Health Trust, provided it is received within the 60-day eligibility period.

If the application is received after the 60-day eligibility period, the newly-married employee (if not previously enrolled), his/her spouse and any dependent children will be considered late enrollees and must wait for the annual open enrollment period to be enrolled in the Health insurance program, or will have to submit Evidence of Insurability for the Dental insurance program.

NO CHANGE CAN BE MADE TO AN EMPLOYEE'S CONTRACT WITHOUT THE EMPLOYEE'S SIGNATURE.

NEWBORNS AND ADOPTED CHILDREN

Newborn children are automatically covered under the employee's Health insurance for 31 days from the date of birth. However, the Health Trust must be notified of the birth and application must be made to the Health Trust, in order for any claims to be paid.

The Health Trust must receive a Group Application for Change form (sample #13) within 60 days of the date of birth, and if all required contributions (if any) are paid, coverage will be continuous from birth. Premiums will be billed retroactively to the first of the month following the date of birth.

To add an adopted child or a child under the employee's legal guardianship to an employee's Health coverage, a Group Application for Change (sample #13) must be completed and received by the Health Trust within 60 days from the date the employee becomes legally responsible for that child. Coverage will begin on the first date of legal responsibility. Premiums will be billed retroactively to the first of the month following the date of legal responsibility. **Be sure to include a copy of the legal documents to expedite processing of the application.** If the insured is enrolled in the Point of Service health plan, be sure to include the name of the child's Primary Care Physician.

If the Group Application for Change form is not received within the above stated time frames, the child will be considered a late enrollee and must wait for the annual open enrollment period to be covered under the health plan.

To enroll a dependent child in the dental program, a Group Application for Change form (sample #13) must be received by the Health Trust within 60 days of the child's second birthday. Premiums will be billed retroactively to the first of the month following the child's second birthday.

To add an adopted child or a child under the employee's legal guardianship to the dental program, a Group Application for Change form (sample #13) must be received by the Health Trust within 60 days of the date of adoption or legal guardianship or within 60 days of the child's second birthday, whichever comes later. **Be sure to include a copy of the legal documents to expedite processing of the application.**

NO CHANGE CAN BE MADE TO AN EMPLOYEE'S CONTRACT WITHOUT THE EMPLOYEE'S SIGNATURE.

DIVORCE

The law states that until a final divorce judgment or decree of judicial separation is entered, each party is enjoined from voluntarily removing the other party or any child or children of the parties from any policy of health insurance that provided coverage for the other party or the child or children of the parties.

In the event an employee divorces, the spouse is not considered to be an eligible dependent and must be removed from the employee's policy when the divorce becomes final; coverage ends the first of the month following the date of the divorce. Complete a Group Application for Change form (sample #13) to remove the spouse from the employee's Health contract and mail the form to the Health Trust.

To remove the spouse from the employee's Dental contract, the insured must complete a Group Application for Change form (sample #13).

If an employee drops a spouse because of divorce or legal separation, the employee should review his/her Life insurance beneficiary. The employee must complete a Life Plan Employee Change form (sample #15) to change beneficiaries. Check the box marked "Beneficiary Change" at the top of the form.

The following information is necessary to enable the Health Trust to offer COBRA continuation of Health and/or Dental benefits to an ex-spouse following a divorce:

- The name of the ex-spouse and any child(ren) no longer to be covered by the employee.
- The current mailing address of the ex-spouse.
- The birth date and social security number of the ex-spouse.

Once the Health Trust receives the application(s), the change will be effective the first of the month following the date the divorce is final. A letter will be mailed to the ex-spouse and/or dependents that no longer qualify as dependents according to the guidelines set by the Health Trust, offering them continuation of benefits through COBRA.

If a spouse is dropped prior to a divorce or separation, and said spouse calls to inform the Health Trust that the divorce or separation is not legalized, the spouse will be added back to the employee's policy and the employer will be billed accordingly.

If a divorced spouse is not properly dropped from the policy, the Health Trust will not reimburse premiums paid in error, unless the ex-spouse accepts COBRA and pays the premiums.

LEGAL SEPARATION

When an employee and his/her spouse obtain a legal separation from the presiding court, the employee must submit a Group Application for Change form (sample #13) to remove the spouse and any dependent child(ren) no longer eligible from his/her Health policy.

To remove the spouse from the employee's Dental policy, the insured must complete a Group Application for Change form (sample #13).

Once the application(s) have been received by the Health Trust, the change will be effective the first of the month following receipt by the Health Trust. A letter will be mailed to the spouse and /or dependents that no longer qualify as dependents according to the guidelines set by the Health Trust, offering them continuation of benefits through COBRA.

LIFE INSURANCE PLAN

Basic coverage equal to one times an active employee’s annual salary (rounded to the next higher \$1,000; to a maximum of \$100,000) is provided to all employees participating in a Health Trust Health Plan, at no additional cost to employee or employer, provided the Employee enrolls when first eligible or following a qualifying event, or during the annual Health open enrollment period (applications received during the annual open enrollment period must be accompanied by a health enrollment application). Eligible elected or appointed municipal officials receive a minimum benefit of \$5,000, and a maximum benefit of \$50,000. Any employee who is eligible to participate in the Health Trust Health Plan, but does not elect coverage because he/she is covered under another health plan, may participate in the Basic Life Plan for a nominal premium amount. Benefits for active employees are reduced by 50% at age 70. When an employee reaches age 70, the Health Trust will notify him/her of the right to convert the reduced amount of coverage to an individual life insurance policy through Prudential Life Insurance Company. The life plan provided by the Health Trust also includes Accidental Death and Dismemberment (AD&D) coverage, which means the benefit amount is doubled if the covered person dies as the result of an accident.

Accelerated Benefit – The Health Trust’s life insurance carrier (Prudential Life Insurance Company of America) will pay up to 80% of the employee’s Life benefit if they receive proof that the employee is terminally ill and is certified by a physician to have 6 months or less to live. Any benefit amount paid under the Accelerated Benefit will be paid to the covered employee either in a single lump sum, or in six (6) equal monthly installments, at the employee’s request.

Supplemental Coverage (including AD & D) is available on a contributory or non-contributory basis for all active employees, provided the employer elects to make the supplemental coverage available. If employer-paid, 100% of all active employees must enroll; if employee-paid, at least 25% of all active employees must enroll. Employees may select coverage equal to an additional one times their annual salary without having to submit Evidence of Insurability. Employees may choose additional coverage for two or three times their annual salary by submitting Evidence of Insurability. The maximum total supplemental life benefit is \$300,000. Benefits are reduced by 50% at age 70. When an employee reaches age 70, the Health Trust will notify him/her of the right to convert the reduced amount of coverage to an individual life insurance policy through Prudential Life Insurance Company.

Dependent Coverage - Two options are available on a contributory or non-contributory basis for dependent coverage, provided the employer elects to make the dependent coverage available. If employer-paid, 100% of all active employees must enroll; if employee-paid, at least 25% of all active employees must enroll.

OPTION A:

OPTION B:

Spouse.....1/2 employee’s Basic Coverage amount
(\$5,000 maximum) (\$50,000)

1/2 employee’s Basic Coverage amount
maximum)

Children1/2 employee’s Basic Coverage amount
(6 mo.-19yrs) (\$5,000 maximum)
(25 if full-time student)

1/2 employee’s Basic Coverage amount
(\$5,000 maximum)

Infantsbirth - 6 mos.
\$1,000 \$2,500

birth - 6 mos.

Retirees or Surviving Spouses, who continue with the MMEHT Health Plan, receive Basic Life coverage at a flat amount of \$2,000. Accidental Death & Dismemberment coverage for retirees and surviving spouses will terminate at age 70.

Note: The life insurance premium will be waived for the employee’s Basic and Supplemental Life insurance coverage if the employee is totally disabled for six months or more while covered; and the employee is age 60 or less when the disability begins. Please call the Health Trust for details.

CHANGES IN SUPPLEMENTAL & DEPENDENT LIFE COVERAGE

To Add Supplemental coverage: Check the “Benefit Change” box at the top of the MMEHT Life Plan Employee Change Form (sample #15), and indicate the type of change where requested on the form. This coverage is subject to Evidence of Insurability. The effective date of coverage, if approved, will be the first of the month following the date of approval by the underwriters. Note: If the employee is a new employee, or if the employer is offering Supplemental Life coverage to employees for the first time, then simply use the Life Plan Employee Enrollment Form (sample #7).

To Drop Supplemental coverage: Check the “Benefit Change” box at the top of the MMEHT Life Plan Employee Change Form (sample #15), and indicate the type of change where requested on the form. The effective date of the cancellation will be the first of the month following receipt of the Life Form by the Health Trust.

To Change Supplemental coverage: Check the “Benefit Change” box at the top of the MMEHT Life Plan Employee Change Form (sample #15), and indicate the type of change where requested on the form. Any increase in Supplemental coverage is subject to Evidence of Insurability. The effective date of coverage, if approved, will be the first of the month following the date of approval by the underwriters. The effective date of any decrease will be the first of the month following receipt of the Life form by the Health Trust.

To Add Dependent coverage: Check the “Benefit Change” box at the top of the MMEHT Life Plan Employee Change Form (sample #15), and indicate the type of change where requested on the form. This coverage is subject to Evidence of Insurability unless there has been a status change within the previous 60-day period (i.e., marriage, birth or adoption of a child). The effective date of coverage, if approved, will be the first of the month following the date of approval by the underwriters. Note: If the employee is a new employee, or if the employer is offering Dependent Life coverage for the first time, then simply use the Life Plan Employee Enrollment Form (sample #7).

To Drop Dependent coverage: Check the “Benefit Change” box at the top of the MMEHT Life Plan Employee Change Form (sample #15), and indicate the type of change where requested on the form. The effective date of the cancellation will be the first of the month following receipt of the Life form by the Health Trust.

To Change Dependent coverage: Check the “Benefit Change” box at the top of the MMEHT Life Plan Employee Change Form (sample #15), and indicate the type of change where requested on the form. An increase in dependent coverage is subject to Evidence of Insurability unless the increase is made as a result of the employee’s marriage. Application for the increase due to marriage must be made within 60 days of the date of marriage. The effective date of coverage, if approved, would be the first of the month following the date of approval by the underwriters.

To Change Beneficiary: Check the “Beneficiary Change” box at the top of the MMEHT Life Plan Employee Change Form (sample #15), and list new beneficiaries where requested on the form.

NO CHANGE CAN BE MADE TO AN EMPLOYEE’S CONTRACT WITHOUT THE EMPLOYEE’S SIGNATURE.

INCOME PROTECTION PLAN (IPP) CHANGES

It is extremely important that employers update salaries (see page 7, salary changes) on a timely basis to ensure that correct benefits are paid in the event an employee needs to submit a claim. Salary Change Forms are available on the Health Trust's website (www.mmeht.org).

CHANGES IN COVERAGE

Any time an employee wishes to **decrease** IPP benefits, he/she must complete a new application (sample #8). Check the level the employee wishes to change to and write **DECREASE** at the top of the form. The change will become effective the first of the month following receipt by the Health Trust.

Any time an employee wishes to **increase** IPP benefits to a higher percentage, he/she must complete a new application (sample #8). Check the level the employee wishes to change to and write **INCREASE** at the top of the form. Increases in benefit levels are subject to Evidence of Insurability. Coverage will become effective the first of the calendar month following the date of approval by the underwriters.

BENEFIT CHANGES

Any benefit increase for an Employee not actively at work as the result of a disability (i.e., currently receiving benefits under the Health Trust's Income Protection Plan) on the effective date of a salary change will not affect benefits paid for that period of disability. The employee will not be eligible to receive the new benefit until he/she qualifies for a new disability period.

Any salary increase reported for an employee not actively at work will not be billed. The Health Trust will contact you and ask you to report the salary increase again when the employee returns to work.

LONG TERM DISABILITY PLAN CHANGES

It is extremely important that employers update salaries (see page 7, Salary Changes) on a timely basis to ensure that correct benefits are paid in the event an employee needs to submit a claim.

NO CHANGE CAN BE MADE TO AN EMPLOYEE'S CONTRACT WITHOUT THE EMPLOYEE'S SIGNATURE.

WAIVER OF PREMIUM FOR INCOME PROTECTION PLAN

During the first six (6) consecutive months that an employee is continuously and totally disabled, any required premium must be paid in order for the employee to remain enrolled in the Income Protection Plan (IPP).

If the employee is disabled for a period longer than six consecutive months, starting on the first day of the seventh month of disability, the Health Trust will waive any IPP premiums due until the employee returns to work on either a full-time or part-time basis.

The monthly bill will list the employee's social security number and name along with a credit for the current month at the end of the bill for any employee who has been disabled for more than six months.

It is the responsibility of the employer to notify the Health Trust's Billing Department when the employee has returned to work on either a full-time or part-time basis, so the credit can be discontinued.

WAIVER OF PREMIUM FOR LONG TERM DISABILITY

Premiums must be paid for the Long Term Disability (LTD) plan, even while the employee is out on an Income Protection Plan (short term disability) claim. Premiums for the employee's Long Term Disability coverage will be waived as of the date the employee first begins collecting LTD benefits, and throughout the period of the LTD claim. Premium billing for the LTD coverage will resume once the employee returns to work on a full-time basis.

DENTAL ENROLLMENT AND CHANGES

For an employer to participate in the Dental Program offered by the Health Trust, 50% of all eligible employees (see Definition of Eligibility, page 4) must participate in the program. An eligible employee must work a minimum of 20 hours per week on a year round basis. (Note: the employer may set a higher minimum if so desired.)

When an employer first chooses to offer the Dental Plan, the Health Trust must receive a letter of intent including the requested effective date of coverage, a Dental Eligibility Checklist (sample #16) and completed employee applications.

Know your waiting period. Your employer may have established a waiting period when first offering the Dental plan. If the employer wishes to change this at any time, please send the Health Trust a letter stating the change and the requested effective date for the change.

To enroll in the Dental program, an employee must complete a Dental application (sample #10) including all eligible dependents to be covered, and mail it to the Health Trust. Employees do **not** have to be enrolled in the Health insurance plan in order to be eligible to enroll in the Dental Plan.

Coverage will become effective the first of the month following receipt of the application by the Health Trust provided all eligibility requirements have been met.

CHANGES IN AN EMPLOYEE'S COVERAGE

If an employee wishes to add or drop a dependent after his/her initial enrollment, complete a Group Application for Change form (sample #13) listing the dependent's name, birthday and social security number and the reason why the dependent is being added to or cancelled from the policy. Any additions received after the eligibility period are subject to Evidence of Insurability and possible denial of coverage.

NO CHANGE CAN BE MADE TO AN EMPLOYEE'S CONTRACT WITHOUT THE EMPLOYEE'S SIGNATURE.

TERMINATION OR CANCELLATION REQUESTS

When an employee terminates employment for any reason, his/her Health, Life, and Dental coverage end the first of the month following the last day the employee actually works, or the first of the month following the request for cancellation. Coverage under both the Income Protection Plan and Long Term Disability plan ends at midnight on the last day that the employee is actively at work (i.e., coverage is terminated effective the day after the employee's employment terminates – these coverages do NOT continue until the end of the month).

On the monthly bill, the employer must highlight the coverage(s) to be cancelled, deduct the appropriate premiums from the payment and attach the Termination Notification Form (sample #4) to the bill prior to submitting it to the Health Trust. Be sure to note the employee's last day at work.

If an insured requests cancellation of one or more coverages, premiums for his/her coverage should be highlighted and deleted the first of the month following the date of the request. A Termination Notification Form (sample #4) should be attached to the bill with the code "C" for cancellation requested.

For any employee who will no longer be covered for one or all benefit coverages, highlight the current month's premium(s) on your bill, for the coverage(s) involved. Deduct the current premium(s) from the total due **before** you submit your bill.

In the event your bill is paid prior to the due date and an unanticipated termination occurs after payment but within the month following the payment, please call Linda Mack or Melanie Ingraham at 1-800-452-8786 **immediately** to receive proper credit.

Attach the completed Termination Notification Form (sample #4) to the bill when you deduct the payment. Complete the employer section only with name of the employee, current mailing address, social security number, last day actively at work and appropriate code, as follows:

1. Resignation or Termination - Code A
2. Temporary Layoff or Leave of Absence - Code B
3. Cancellation Requested - Code C
4. Death of the Employee - Code D (Please note date of death)
5. Disability - Code E
6. Military - Code F
7. Reduction of Hours making the employee ineligible for coverage - Code H
8. Retirement - Contributes to MSRS - Code M
9. Retirement - Does not contribute to MSRS - Code R
10. Work Related Injury or Occupational Disease - Code W
11. Active Employee Chooses Medicare and Cancels Health Trust Coverage - Code X

In the event of an employee's (or dependent's) death, a certified copy of the death certificate must be sent to the Health Trust if the employee (or dependent) had life insurance coverage.

Retroactive credits will not be given for more than three (3) months of back premiums. It is up to the group to check their bill each month and make necessary adjustment(s) for any employee who has terminated employment.

Please note: If, as part of an employment severance package, an employer offers to pay health and/or dental premiums for a period of time following the termination, the employee must be terminated as stated above.

COBRA information will be sent to the employee, and the employer can pay premiums for the extended coverage under COBRA.

FAMILY AND MEDICAL LEAVE (FMLA)

The Family and Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to “eligible” employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if the employer employs at least 50 employees within a 75-mile radius.

Reasons For Taking Leave Under FMLA

Unpaid leave must be granted for any of the following reasons:

1. to care for the employee’s child after birth, or placement for adoption or foster care;
2. to care for the employee’s spouse, son or daughter, or parent, who has a serious health condition;
3. for a serious health condition that makes the employee unable to perform his/her job; or
4. to deal with “any qualifying exigency” that arises from a spouse’s, child’s or parent’s active duty in the armed forces, including an order or call to duty.

Extended FMLA leave to care for injured service member. Employees may take up to 26 weeks of leave to care for spouses, children, parents or next of kin with serious illnesses or injuries incurred during active duty in the armed forces. This leave is available in only one 12-month period, and any other FMLA leaves in the same period count against the 26-week limit. As with all FMLA leaves, the time is unpaid, though employers may require employees (and employees may elect) to use any accrued paid time off.

At the employee’s or employer’s option certain types of paid leave may be substituted for unpaid leave.

Advance Notice And Medical Certification

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- ◆ The employee ordinarily must provide 30 days advance notice when the leave is “foreseeable.”
- ◆ An employer may require medical certification to support a request for leave because of a serious health condition and may require second or third opinions (at the employer’s expense) and a fitness for duty report to return to work.

Job Benefits And Protection

- ◆ For the duration of the FMLA leave, the employer must maintain the employee’s health coverage under any “group health plan.” The employer is not required to pay the employee’s insurance premiums, however, and may require the employee to contribute up to 100% of premium cost.
- ◆ Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- ◆ The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

Unlawful Acts By Employers

FMLA makes it unlawful for any employer to:

- ◆ interfere with, restrain, or deny the exercise of any right provided under FMLA; or
- ◆ discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

- ◆ The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- ◆ An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

RETIREMENT

When an employee retires from active employment, there are two ways he/she may qualify as a retiree and continue his/her health coverage through the Health Trust.

To qualify as a retiree under the Health Trust, the former employee must:

1. Be receiving (or have received) retirement benefits, other than Social Security benefits, from his/her employer's retirement plan, and the employer must be participating in the Maine Municipal Employees Health Trust on the date of retirement; or
2. If the employer has no sponsored retirement plan or the employee has waived his/her rights to participate in the employer sponsored retirement plan, the employee must have been employed by, or have been an elected or appointed official of, the participating employer for at least five (5) consecutive years immediately prior to retirement **and** be at least 55 years of age on the date of retirement.

In both of the above cases, with the exception of a new group transferring into the plan, the "retiree" must have been an active participant in the Maine Municipal Employees Health Trust immediately prior to his/her retirement.

The employer should take the following steps when reconciling their Health Trust billing:

1. Highlight the employee's name and any premiums to be cancelled.
 2. Deduct the premiums before making your payment.
 3. Complete a Termination Notification Form (sample #4), listing the employee's name, current mailing address, last day worked and the appropriate code, as listed below:
- Code M - Retiring and has been making contributions to the Maine State Retirement System (MSRS).
 - Code R - Retiring and has not been making contributions to the Maine State Retirement System.

When you notify the Health Trust that an employee is retiring by deducting his/her premium and coding the termination form, coverage for the employee and all of his/her dependents is temporarily cancelled. If the termination form is coded with an "R," fill out and return an "Employer Statement Regarding Retiree Eligibility for Continued Health Insurance" form (sample #17) and return it with your bill and Termination Notification Form so that the Health Trust can determine if the person retiring meets the qualifications of a retiree under the guidelines of the Health Trust. Once the person's eligibility is determined, the Health Trust mails a letter and an informational packet to the retiree. Not all retirees choose to remain with the Health Trust so it is very important that any retiree who wishes to remain insured through the Health Trust complete the "Health Plan Application for Continued Enrollment as a Retiree" (sample #18). If the Retiree and/or spouse are over 65 and eligible for Medicare, he/she/they must also fill out an "Anthem Blue Cross Blue Shield Companion Plan Application for Enrollment" (sample #19). Both applications should be returned to the Health Trust, along with page 2 or page 3 of the letter, within 60 days of the date of the letter. At that time the retiree's coverage will be reinstated with no lapse in coverage. The retiree will be required to pay any premiums due during the interim period. All claims that are incurred during this interim period will be denied and it will be up to the insured to call and have the claims reprocessed once premium payments are made.

If the retiree is coded with an "M" and he/she wishes to have the monthly premium deducted from his/her Maine State Retirement System (MSRS) check, an "MSRS Deduction Authorization" (sample #20) will be included in the informational packet and must be completed and returned to the Health Trust. Once the completed application is received and processed by the Health Trust, the retiree will receive a bill from the Health Trust for any premiums due during this process.

COVERAGE FOR RETIREES

When an individual reaches the age of 65, he/she is notified by Social Security if he/she is eligible for Medicare Parts A & B. If the employee or his/her spouse is actively working and has group health insurance, they do not need to sign up for Part B at this time. The employee should, however, notify Medicare that he/she is not enrolling in Part B, because he/she is still actively working.

- Part A - is automatic and is free of cost.
- Part B - has a monthly cost that will be automatically deducted from an individual's Social Security check.

When a covered employee retires, the Health Trust mails a letter and an informational packet explaining the employee's options. If he/she wishes to continue health coverage through the Health Trust, the enrollment form, and page 2 or page 3 of the retirement letter, must be completed and returned within 60 days of the date of the letter. If the employee is 65 years old or older, he/she needs to complete the section of the application listing his/her claim number along with the effective dates of Medicare Part A & Part B.

In addition, if a retired employee becomes eligible for Medicare as the result of a disability, he/she should contact the Health Trust in order to be enrolled in the appropriate health insurance plan(s).

If an employee retires prior to his/her 65th birthday, the Health Trust will send an informational packet approximately two months prior to the individual's 65th birthday. This packet will have two applications that must be completed with the Medicare claim number and the effective dates of Medicare Part A & Part B from the employee's Medicare card.

If an employee works past his/her 65th birthday and later retires, he/she needs to notify Social Security approximately three months prior to retirement and sign up for Medicare Part B. Failure to do so may result in the individual being penalized by Social Security.

Retiree coverage can be confusing. We will try to simplify things for you here. **1. If a retiree is under age 65** and not eligible for Medicare, he/she will remain on the same coverage he/she had with the Health Trust prior to retirement, until the retiree reaches age 65 and/or becomes eligible for Medicare benefits. **2. If a retiree is age 65 or older and is eligible for Medicare upon retirement**, he/she must enroll in both Medicare Parts A and B, the Anthem Blue Cross Blue Shield Companion Plan coverage, and the Health Trust Major Medical coverage. In order for a retiree to have Companion Plan coverage the retiree must have Medicare Part A and Part B. The Health Trust will send the Companion Plan Application directly to the retiree. This will also serve to enroll the retiree in the Health Trust Major Medical coverage. The retiree will have received a notice in the mail from Social Security three months prior to his/her 65th birthday to enroll in Medicare. **3. If a retiree is age 65 or older, but is not eligible for Medicare**, he/she will be able to remain on the same coverage he/she had in force prior to age 65. However, the retiree must indicate on the application included in the retiree packet that he/she is not eligible for Medicare, attach a copy of a statement of ineligibility from Social Security and return it to the Health Trust.

The retiree who is "Medicare eligible" and has enrolled in both Medicare Parts A & B will have the following coverage:

- Medicare Parts A & B - as the primary coverage.
- Companion Plan - coordinates with Medicare as a supplement.
- Major Medical - covers some of the expenses that Medicare and Companion Plan do not. The Health Trust Major Medical coverage includes a prescription drug card.

Prescription Drugs: The retiree will retain the same prescription drug coverage as he/she had as an active employee.

Dental Coverage: If a retiree was participating in the dental program at the time of his/her retirement, he/she may continue the dental coverage under COBRA for up to 18 months. If COBRA is accepted for the dental coverage, all claims should be submitted under the retiree's social security number, changing the first digit to an "8".

SPLIT COVERAGES FOR RETIREES

When an employee retires with his/her spouse covered under the health insurance contract, and one person is eligible for Medicare and one person is ineligible for any reason, the employee and spouse are set up as a “split contract” for billing purposes, with no change in coverage.

The retiree and spouse will be provided with separate identification numbers.

In the event of a split contract, the individual with Medicare coverage will receive a Companion Plan card from Anthem Blue Cross Blue Shield and a separate prescription card from the Health Trust in his/her name. The Companion Plan card will have a Health Trust Major Medical coverage sticker on the back.

The individual without the Medicare coverage will receive a medical card from Anthem Blue Cross Blue Shield in his/her name.

All claims and any prescriptions filled should be processed under the number on the individual’s card.

When both the retiree and his/her spouse are eligible for Medicare, they will both be set up under one identification number. At this time they will receive two Companion Plan cards from Anthem Blue Cross Blue Shield in the retiree’s name, one for the retiree and one for his/her spouse. These cards will both have Health Trust Major Medical stickers on the back. They will also receive two prescription drug cards from the Health Trust, both in the retiree’s name.

LAYOFF OR LEAVE OF ABSENCE

If an employee is absent from active work due to disability caused by a non-job-related injury or illness, coverage may continue until it is terminated by the employer according to the employer's written policy.

If an employee is temporarily laid-off or on a non-medical leave of absence, coverage may continue until it is terminated by the employer according to the employer's written policy, or the end of the third month after the month in which the layoff or leave of absence began, whichever comes first. (Note: Under the Long Term Disability plan, coverage may only continue until the end of the month following the month in which the layoff or leave of absence began.)

If coverage was terminated during a layoff or leave of absence, an employee may enroll in any or all plans being offered by the employer upon his/her return to work, noting the date that he/she returned to work as the date of hire. Coverage will become effective the first of the month following receipt of the application by the Health Trust, provided the application is made within 60 days of the date of return to work. The employer's waiting period will apply unless the Health Trust receives a written request from the employer to waive the waiting period (see page 3).

By not completing and returning the necessary applications in a timely manner, an employee risks the process of Evidence of Insurability for Life, Dental, Long Term Disability and Income Protection Plan coverage; and having to wait until the December annual open enrollment period for Health coverage.

MILITARY DUTY

When an employee receives Activation Orders, the Health Trust must be notified by using the Termination Notification Form (sample #4).

Coverage will be continued to the end of the month in which the employee enters temporary military service.

Under USERRA (the federal Uniformed Services Employment and Reemployment Rights Act), the employee and his/her family members (if applicable) will be offered COBRA continuation of coverage for up to 24 months. The premium charged for the first 31 days will be the same amount he/she would have paid as an active employee. After that, the premium will be billed at 102% of the active employee premium.

If the employee and/or family members accept the COBRA option, the Health Trust will be secondary to any other coverages the employee may have (including Federal military medical programs, such as TriCare). The Health Trust will not provide benefits for expenses incurred while an individual is on full-time active duty in the armed forces of a country.

If the employee has dependents, they should also sign up for TriCare (formerly CHAMPUS) health insurance coverage offered by the military service. This is available to the employee at no cost. If TriCare coverage is selected for dependents, the Health Trust will be primary coverage and the TriCare benefits for dependents will be secondary.

If the employee has **Health** insurance coverage, as stated above, he/she has the choice of COBRA or TriCare while on active military duty. Once the employee returns from military duty and returns to active employment, his/her Health insurance coverage will be reinstated effective the first day he/she returns to work following military service.

If the employee has **Dental** coverage, COBRA continuation coverage will be offered. The military service does not provide any Dental coverage. Once the employee returns from military duty and returns to active employment, his/her Dental coverage will be reinstated effective the first day he/she returns to work following military service.

Coverage for **Life** Insurance can continue for up to 3 months after activation. After the 3-month period, the employee will have 31 days in which to convert to an individual policy. Dependent Life Insurance can be continued for up to 60 days after the employee is released from active duty. Life insurance coverage will be reinstated effective the first day the employee returns to work following active military duty.

The employee's **Income Protection Plan** and **Long Term Disability plan** coverage stop on the last day of work and will be reinstated effective the first day the employee returns to full-time employment following active military duty.

Following discharge from military service and upon the employee's return to work, he/she must complete applications for all programs that he/she had prior to termination, noting the date that he/she was discharged from the military and the date he/she returned to work. Coverage will become effective on the first day the employee returns to work after military service. Please include a copy of the employee's DD214 as proof of active military duty.

If the employee is reinstated by the employer on or before the 15th of the month, the Health Trust will charge a full month's premium; if the employee is reinstated after the 15th of the month, the Health Trust will not charge a premium for the remainder of that month.

Please contact the Health Trust if you have any questions regarding the Health Trust's Extended Military Leave Policy.

PORTABILITY

The employee, his/her spouse, or any eligible dependents may choose not to enroll in the Health and/or Dental programs offered by the Health Trust because they are covered elsewhere. If the other health and/or dental coverage ends for any of the following reasons, the employee (and his/her eligible dependents) may still enter the Health and/or Dental programs offered through the Health Trust.

- a) Loss of the other insurance coverage due to termination of employment, or a reduction in the number of hours worked. The application to join the Health Trust must be accompanied by a certificate of coverage (if immediately available) from the former insurance company, showing start date, end date and full name of each person covered (sample #21). Application for coverage should be sent to the Health Trust as soon as possible after learning of the loss of other coverage. This will allow the Health Trust to apply the appropriate coverage effective date, however the Trust will hold processing of the application until the Certificate of Coverage is received.
- b) Loss of other coverage because such other coverage is no longer available.
- c) A change in the percentage of premium contribution required by the other plan (a copy of the intended change must be sent with the application).
- d) Divorce or legal separation.
- e) Death of the spouse.
- f) Loss of Medicaid benefits (a copy of the letter from the Department of Human Services must be provided).

EXCLUDED UNDER PORTABILITY

- ◆ Voluntary cancellation for any reason other than listed above.

If an employee and/or dependent(s) meets the requirements of portability, he/she must complete a Group Health Plan Application for Enrollment (Sample #6), a Life Insurance Enrollment form (sample #7) where applicable, and/or a Dental application (sample #10), listing all eligible dependents to be covered. **The Health Trust must receive the application within 60 days of the date of the event.** Coverage will be made effective the first of the month following the later of the date of loss of other coverage, or receipt of the application by the Health Trust.

By not completing and returning the necessary applications in a timely manner, the employee risks the process of Evidence of Insurability for Life and Dental Coverage; and having to wait until the December annual enrollment period for Health coverage.

COBRA

Federal law requires that most employer sponsored group health plans offer employees and their dependents a temporary extension of health coverage at the employee's expense in instances when coverage would otherwise end. This coverage, which is mandated under the Consolidated Omnibus Budget Reconciliation Act, is known as COBRA. COBRA coverage is continued at group rates plus a small charge for administrative costs.

When an employee is no longer eligible for health and/or dental coverage, COBRA continuation of coverage will be offered to the employee and his/her dependents who are covered at the time eligibility changes. The employer should terminate the employee from the monthly billing, cross out the employee's name, deduct the premium and attach a "Termination Notification Form" (sample #4) to the bill, noting the last day actively worked, the reason for the termination and the employee's current mailing address.

A letter, along with a "Subscriber Election Form To Continue Group Coverage" (sample #22), a "Certification of Health Coverage" (sample #21) and a "Notice of Conversion Privilege" (sample #23) to convert life coverage, will be mailed to the employee within seven working days following receipt of the notification to the Health Trust accompanying the monthly billing.

A copy of page 2 of the letter to the employee will be mailed to the employer for their personnel records (sample #24).

The employee's coverage will be terminated on a "pending basis" until COBRA is accepted.

If COBRA is accepted, the employee's coverage must be reinstated back to the date of the loss of group coverage. The employee will be issued a coupon booklet to use for making his/her monthly premium payments, once the first month's premium is received.

Payments are due on the first day of each month. To avoid cancellation, it is necessary to make payments in a timely manner. No benefits, including prescription drugs, will be processed beyond the "paid through" date.

COBRA may be accepted for the employee and/or all eligible dependents that were covered at the time of the loss of group coverage (or any one or more eligible dependents of the employee).

If COBRA is offered for both health and dental coverage, the employee and/or his/her eligible dependents may choose to accept both coverages, or just the health or dental.

Coverage may be continued for up to 18 months for employees, spouses, and dependents in case of loss of coverage as a result of the employee's:

- Termination of employment.
- Reduction in work hours (less than 20 hours per week).
- Layoff.

Coverage may be continued for up to 36 months for:

- Legally separated or divorced spouses and children of current employees.
- Children of current employees who no longer meet the Health Trust's definition of a dependent.
- Spouses and children of current employees who would lose coverage due to the employee's becoming entitled to Medicare benefits.

Note: Please see the section entitled Military Duty (page 29) for special continuation provisions for employees on active military duty, and their family members.

Coverage may be extended from 18 to 29 months for an individual who is disabled at the time of termination of employment, or who is disabled at the time of a reduction in hours of employment, or who becomes disabled within the first 60 days of COBRA coverage, provided the employee has provided notice of the disability to the Health Trust within 60 days of receiving such notice from Social Security, and before the end of the first 18 months of coverage.

COBRA is not available to anyone who becomes eligible for Medicare or other group coverage after he/she becomes effective on COBRA (unless that other group coverage contains a pre-existing condition limitation which would apply to that individual). Participants covered by Medicare on the date that active coverage terminates may also elect COBRA coverage. COBRA will be secondary to Medicare in this case.

In addition, it is important to note that COBRA continuation coverage is not available to Domestic Partners of covered employees. However, the Health Trust does offer a COBRA-like coverage, similar in many respects to COBRA, in the event that coverage for a Domestic Partner is terminated. Please contact the Health Trust for further details.

TERMINATION OF COBRA COVERAGE

The Health Trust may terminate coverage prior to the expiration of the 18 or 36 month COBRA period under the following circumstances:

- The group/bargaining unit no longer provides health/dental insurance to any of its employees.
- The group/bargaining unit no longer offers the Health Trust health/dental insurance to any of its employees.
- The Health Trust does not receive premium payments in a timely manner.
- The participant becomes a covered employee under another group health plan, unless that other group plan contains a pre-existing condition limitation that would apply to the participant. In this case, the employee will need to send a written cancellation notice to the Health Trust to end COBRA coverage.
- The participant remarries and becomes covered under another group health plan, unless that other group plan contains a pre-existing condition limitation that would apply to the participant.
- The participant becomes entitled to benefits under Medicare subsequent to the COBRA effective date.

LIFE INSURANCE CONVERSION

When an employee loses his/her Life Insurance coverage due to termination of employment or retirement, he/she is given the opportunity to convert his/her Life Insurance to a personal policy through the Health Trust Life Insurance carrier at his/her own expense. The employee is eligible to apply for coverage lesser than or equal to the current coverage he/she has through the Health Trust, as well as any dependent coverage. Premiums are based on the employee's age and the amount of coverage that is chosen.

The Health Trust will mail a Notice of Conversion Privilege for Life Insurance (sample #23) to the employee upon receipt of notification of the termination or cancellation of the employee's life coverage. It will be up to the employee to complete the form and mail it to the Health Trust's life insurance carrier (currently Prudential Life Insurance Company of America) if he/she is interested in continuing this coverage. The carrier will notify the employee of the premium and give him/her the opportunity to accept the converted policy.

Prudential must receive the application for conversion within 31 days following the participant's termination of group coverage or, if later, 15 days after his/her notification of conversion rights. Otherwise, he/she will be asked to provide Evidence of Insurability. In no event will the carrier allow for conversion extended beyond 91 days.

To receive an approximate quote on conversion of life insurance, please call Prudential toll-free at 1-877-889-2070.

CHECK LIST OF ITEMS TO GIVE NEW EMPLOYEES

All new **eligible** employees should be given the following:

- Informational material to assist them in choosing which program(s) they wish to enroll in.

Depending on the plans offered by the employer ... applicable enrollment forms:

- Health* (Eligible employees must either complete a health enrollment form or the election not to enroll form)
- Basic Life (Complete Supplemental/Dependent if applicable)
- Dental*
- Income Protection Plan
- Long Term Disability

If for any reason an eligible employee chooses not to enroll in any of the programs offered by the employer, he/she must sign the form(s) indicating he/she has been given the option and elects not to enroll.

NOTE: ALL EMPLOYEES ELIGIBLE FOR HEALTH INSURANCE ARE ELIGIBLE FOR BASIC LIFE INSURANCE. If the employee elects to enroll in the health insurance, the basic life insurance is included at no additional premium. If the employee elects not to enroll in the health insurance, HE/SHE MUST STILL BE OFFERED THE BASIC LIFE COVERAGE. The basic life insurance is available for a nominal charge.

Remember: If your employer has a waiting period for benefits, newly eligible employees must sign up within 60 days from the end of that waiting period. If there is no waiting period, newly eligible employees must sign up for benefits within 60 days of hire date.

*If your group offers Domestic Partner Coverage your enrollment form will indicate this, i.e. Application for Enrollment (DP).