MAINE MUNICIPAL
EMPLOYEES HEALTH TRUST

EMPLOYERS REFERENCE GUIDE TO BILLING AND ENROLLMENT

"The Difference is Trust."

This is a guide to billing and enrollment provisions for employee benefits options offered by a participating employer with the Maine Municipal Employees Health Trust. The purpose of the guide is to offer assistance to employers administering the benefits selected by each employer. In the case of any inadvertent discrepancies, actual Plan Document provisions will govern.

HEALTH TRUST CONTACT LIST

PROGRAM INFORMATION **1-800-452-8786 (In Maine) or 207-623-8428**
Information about the Health Trust plan offerings, benefits presentations, or proposals.

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Lisa Rigoulot	**Ext 2222**	**lrigoulot@memun.org**	**Asst. Director, Health Trust Services**
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BENEFIT QUESTIONS **1-800-852-8300 (In Maine) or 207-621-2645 or htservice@memun.org**
Medical, Life, Dental or Disability claims submitted by Insured, Doctor, Dentist, Hospital or Medical Facility.

Jennifer Lachance	**Ext 2227**	**jlachance@memun.org**	**Member Services Manager**
Michelle York	**Ext 2225**	**myork@memun.org**	**Senior Service Representative**
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IDENTIFICATION CARDS **1-800-852-8300 (In Maine) or 207-623-8428 or htservice@memun.org**
Status of identification cards or to request additional cards

Lisa Dumont	**Ext 2288**	**ldumont@memun.org**	**Member Services Administrative Assistant**

BILLING AND ENROLLMENT **1-800-452-8786 ext. 2585 (In Maine) or 207-623-8428 or htbilling@memun.org**
Eligibility, enrollment, effective dates, monthly premiums, adjustments on monthly billing.

Nicole Ouellette	**Ext 2261**	**nouellette@memun.org**	**Billing & Enrollment Services Manager**
April Miles	**Ext 2285**	**amiles@memun.org**	**Billing & Enrollment Representative**
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Sherri Nelson	**Ext 2224**	**snelson@memun.org**	**Health Trust Administrative Assistant**
Marek Widerynski	**Ext 2323**	**mwiderysnski@memun.org**	**Billing & Enrollment Staff Assistant**

SUPPLIES **1-800-452-8786 ext. 2585 (In Maine) or 207-623-8428 or htbilling@memun.org**

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**	**d.yale@memun.org**	**Health Promotion Coordinator**
Amanda Nile	**Ext. 2283**	**anile@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 (Anthem)
www.deltadental.com (Delta Dental)
www.vsp.com (Vision Care)

Health Trust Fax Number: 207-624-0166

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Appendix – Includes All Examples Referred to in "The Guide"

Please note: if you need new forms, please download or print them from the Health Trust Web site www.mmeht.org under Employer Resources / Forms. Please do not use examples in place of actual forms

JOINING A HEALTH TRUST PROGRAM

Employers must work with their Field Representatives if they wish to offer a new Health Trust program or change an existing program offered to their employees. The employer will be required to provide a letter of intent that states the intended effective date for each plan which the employer wishes to join, and the letter must be sent to the Health Trust with completed Applications for Enrollment. Employers must provide 60 days' notice of intent to offer a new plan.

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 average of 20 hours a week on a year-round basis are eligible for this coverage. Employers may determine how many hours a part-time employee must work to be eligible for this coverage, but it cannot be less than the Health Trust's minimum average of 20 hours.

C. Elected and/or appointed officials may be eligible to participate in this coverage, per the employer's policy (see Eligibility, page 4.)

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

Have enrollment forms ready for new employees, ensuring that 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** 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 full legal names, social security numbers and dates of birth for the employee and all 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
Fax – (207) 624-0166
htbilling@memun.org

After applications are received and processed, a Welcome Packet will be mailed to the employee by the Health Trust. The packet will contain a 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, a Summary of Benefits and Coverage (SBC) as required by Health Care Reform 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 (example, page 51).

IDENTIFICATION CARDS

Cards typically take about two weeks to be printed and will be sent directly to the participant.

All medical 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.

Active members who have enrolled in Dental will receive up to two Delta Dental ID cards in the member's name only. Additional cards for dependents may be requested. All retirees who continue their Dental coverage will also be issued a Delta Dental ID card.

Retirees on Medicare will receive one card for their health insurance: Retiree Group Companion Plan Cards that are printed by Anthem Blue Cross Blue Shield and will serve as combined Group Companion Plan card and prescription drugcard. The identification cards will have the Anthem and a prescription drug logo printed on the front.

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 & Child(ren)	Coverage for Employee & Dependent Child(ren) *(Same premium as family coverage under Dental)*
Family	Coverage for Employee, Spouse & Dependent Child(ren) *(Same premium as Employee Spouse under Medical; same premium as Employee & Child(ren) coverage under Dental)*

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 9)
3. During the annual open enrollment period (see section on annual open enrollment - page 10)
4. Within 60 days after the loss of other coverage (see section on portability - page 25)

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 22 for details) shall become covered for benefits as a retiree on the first day of the calendar month coinciding with or 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. Once the employer-mandated waiting period has been completed, coverage begins the first day of the following month, following the date the applications have been received by the Health Trust.

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, IPP and LTD; and wait until the annual open enrollment period for Health, Dental and Vision coverage.

As required by the Affordable Care Act, the waiting period for medical benefits cannot exceed 90 calendar days. This means that an employer will not be allowed to establish a waiting period for health insurance coverage that lasts beyond the first day of the calendar month following 60 days of employment.

CHANGING OR WAIVING THE WAITING PERIOD

If necessary, 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 and describing the circumstances that necessitate waiving the waiting period. 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.

If the employer waives the waiting period, coverage will begin the first day of the following month.

Waiving to the Waiting Period will be permitted only in rare circumstances. If an employer group requests to waive the waiting period more than three (3) times in a calendar year, the Trust will require the group to submit a change reducing or eliminating the 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.

DEFINITION OF ELIGIBILITY

An individual must meet certain requirements in order to be eligible for coverage under the Health Trust. 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 at least 20 hours per week** on a year-round basis are eligible for coverage. The employer may impose a higher minimum if so desired. However, as required by Health Care Reform, to avoid paying a penalty, Large Employers – those with 50 or more employees - must offer coverage to all employees who work 30 or more hours per week. For more information regarding these regulations, please refer to the Healthcare Reform section of our website at www.mmeht.org.

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 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. Health, Dental and Vision 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 workday 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 (Eligible Domestic Partners may be covered if the employer authorizes such coverage. Please call the Health Trust for more information.)

2. Children who are between the ages of birth and 26 years, including natural children, adopted children, stepchildren, and other children under the **legal** guardianship of the employee.

3. Newborn care is provided for dependents of covered dependent children (i.e., grandchildren), but only for the first 31 days from the date of birth; a newborn dependent of a covered dependent child is not eligible for continued coverage beyond 31 days from the date of birth.

4. An unmarried covered dependent child who is incapable of self-sustaining employment by reason of a physical, mental, intellectual or developmental disability, 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 26th birthday. The Health Trust may require, at reasonable intervals during the two years following the dependent's 26th 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. (Example, page 57)

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: Eligible Domestic Partners may be covered if the employer authorizes such coverage. Please call the Health Trust for more information.)

EVIDENCE OF INSURABILITY / LATE ENROLLEES

IPP, LTD, and Life Insurance:

When an application for the Life, Income Protection, or Long Term Disability plans 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 Underwriting Department at Unum (for IPP or LTD coverage) or Standard Insurance Company (for Life coverage) 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 an employee is applying for an increase in the Income Protection Plan benefit, they must also satisfy Evidence of Insurability. Should their request for an increase be denied, they will keep the level of Income Protection coverage currently in force.

If an employee is applying for Life insurance coverage in conjunction with health insurance 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 to complete an Evidence of Insurability form 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 Insurability is not required for the child.

Health, Dental and Vision Insurance:

When the Health Trust does not receive an application for **Health, Dental or Vision 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 then wait until the Plan's annual open enrollment period to enroll, unless there is a qualifying event or portability applies. Please refer to page 10 (annual open enrollment and qualifying events) and to page 25 (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 is available on the Health Trust website at https://www.mmeht.org/employer-resources/forms/. This Excel form must be completed to change salaries (Example, page 36). The following information is necessary:

a. Employee ID# as it appears on the Health Trust bill.

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 is reported to the Health Trust.

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 Change Form must be sent to the Health Trust **electronically** in the Excel format, as it will be uploaded into the Trust's administration system. Handwritten, faxed or scanned Salary Change Forms will not be accepted.

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 effective dates are **based on the billing cycle**. All salary changes must be received no later than the 1st of each month to be reflected on your next invoice. For example, salaries received on August 1st bill be effective September 1st. Salary changes received on August 2nd 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, even if it is 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.

REVIEWING AND PAYING THE MONTHLY BILLING

It is the responsibility of the employer to review each monthly billing statement 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. Payment is due on the first of each month; 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) may be suspended until premium payments have been received.

An example of a Health Trust Invoice (bill) is included, as well as a sample Member Group Remittance Form. Please return the Member Group Remittance Form, along with the Employer Contributions Report to the Health Trust with your payment. (Example,pages 33-34). The detailed Invoice is to be retained for your records.

Please review your bill carefully and check to ensure that all eligible employees are covered. If there are any questions about your billing, please do not hesitate to call the Billing and Enrollment department at 1-800-452-8786, ext. 2585.

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 a Termination Form or Application for Change has been submitted for an employee and the change is not reflected on the billing, **DO NOT** adjust the premium. All credits or arrears will appear on the next month's bill.

It is **VERY IMPORTANT** that you also complete the Employer Contributions Report and submit it with your payment. (Example, page 33). 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.

Please return the Member Group Remittance Sheet and Employer Contributions report, along with your check as soon as possible or by the due date of the first of the month. **Bills and payments received by the 1st 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, ME 04330-9486

PAYMENT OF HEALTH TRUST BILLS VIA ACH

As a convenience to our employer groups, the Maine Municipal Employees Health Trust accepts payment for premiums due to the Trust by Direct Deposit via ACH electronic payment.

If you would like to take advantage of this option, please email the MMA Finance Department at finance@memun.org for account information and further instructions. Please do not send any banking information to this address.

Additionally, if you send funds via ACH, you will also be required to mail or email to the Health Trust your Member Group Remittance Sheet, along with the Employer Contributions Report completed in full, as this information is required to update eligibility and reconcile billing.

HOW TO ENROLL

The employer must complete the employer section of all applications, stating the full employer name as it appears on your Health Trust monthly bill. Fill in the employee's 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 medical 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 Medical Application for Enrollment/Change (Example, page 39), along with a Life Plan Employee Enrollment Form (Example, pages 40-41) designating his/her desired beneficiary. Completing and returning these forms as soon as possible assures the employeeof coverage, provided all eligibility requirements have been met.

An employee who has health insurance through another source (for example, through a spouse's employer) 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 (Example, pages 40-41). Please be sure to fill in the employee's annual salary. Check the "Life-No Medical" box located under Type of Coverage.

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 4).

If an employee is enrolling in a Point of Service (POS) medical plan, a Primary Care Physician (PCP) 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.** Members who participate in a Preferred Provider Organization (PPO) medical plan are not required to submit a PCP.

To enroll in Supplemental or Dependent Life insurance coverage, if this option is available to employees; complete an MMEHT Life Plan Employee Enrollment Form (Example, pages 40-41) and check the box corresponding to the type of life coverage requested. If enrolling in Supplemental Life coverage please indicate the level of coverage requested, either 1X, 2X, or 3X the basic life amount. Employees must be enrolled in Basic Life coverage or Life No-Medical 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 Income Protection Plan Application for Enrollment (Example, page 46). 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 **employer**, including the annual salary and the number of hours the employee is scheduled to work each week. The employer must also indicate if the employee is actively working as of the effective date of coverage, or available to work if it is not a regularly scheduled workday. The bottom of the application must be fully completed by the **employee.**

To enroll in the Long-Term Disability program, if this option is available to employees; complete the appropriate Long Term Disability Insurance Enrollment Form (Example, pages 47-48). 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 exact annual salary.

Do not add a new employee to your billing statement. This will be done automatically when the applications are received. Adjustments, if any, will appear on the following month's bill.

To enroll in the Dental program, if this option is available to employees; complete a Dental Plan Application for Enrollment/Change (Example, page 44).

To enroll in the Vision Plan, if this option is available to employees; complete a Vision Plan Application for Enrollment/Change form. (Example, page 45).

By not returning the Life, Long Term Disability or Income Protection Plan enrollment forms in a timely manner, the employee risks the process of Evidence of Insurability, possible rejection, or a delay of up to a month before coverage becomes effective. If the Health, Dental or Vision enrollment form are not returned in a timely manner, the employee may have to wait until the Health Trust's annual Open Enrollment period 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. Full legal names and social security numbers are required for all members and dependents.

Do not add a new employee to your billing statement. This will be done automatically when the applications are received. Adjustments, if any, will appear 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, dental or vision plan without being considered late enrollees. Dependents may not enroll in the Health Trust health, dental or vision 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 will request copies of legal documents for adoptions and legal guardianships as proof of qualifying event within 60 days of event.

ANNUAL OPEN ENROLLMENT PERIOD

Once each year, the Health Trust provides an Annual Open Enrollment period for anyone who did not enroll in the **Health, Dental or Vision** plan when he/she was originally eligible. No Evidence of Insurability is required for enrollment in Health, Dental or Vision insurance during this open enrollment period. In addition, employees enrolling in the Health insurance plan during Open Enrollment period 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.

The Open Enrollment Period is **November 15 through December 15** annually. Applications must be received by December 15. If an application is completed and **received** by the Health Trust during the Open Enrollment period, health, dental and vision insurance coverage for the employee and his/her eligible dependents will be effective January 1 of the following year.

Please note: The Health Trust annual open enrollment period applies only to the Health, Dental and Vision 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 IPP or LTD coverage.

ELECTION NOT TO ENROLL

In the event that a new hire declines health, dental, vision, income protection or life insurance coverage under the Health Trust, please have him/her fill out the specific Group Election for Enrollment/Change form, signing and dating the **Election Not to Enroll** section at the bottom of the form. (Example, page 39). This section notes 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 20, Termination.)

FLEXIBLE CHOICE OPTIONS

The Health Trust's Flexible Choice Option allows participating employers to offer up to three (3) different medical plans to their eligible employees. Eligible employees may choose between the selected health plans during Annual Open Enrollment, as long as the employer offers this Flexible Choice Option.

Eligible employees who wish to make change their health insurance plan must complete the Medical Plan Application for Enrollment/Change Form (Example, page 39) and list all eligible dependents to be covered on their plan. A Primary Care Physician must be listed for each covered member, if enrolling in a Point of Service (POS) plan.

The Health Trust must receive the completed Medical Plan Application for Enrollment/Change Form (Example, page 39) no later than December 15, for an effective date of January 1st.

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

No action is required by the Health Trust for any employee who chooses to remain with the plan in which he/she is currently participating.

CHANGE OF ADDRESS

Any member who needs to change their address ONLY may do so by completing a Change of Address form (Example, page 61). Please submit the signed and dated form to the Health Trust for processing. The submission of one Change of Address form will change the address for all plans in which the member is enrolled.

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

CHANGES IN STATUS

A Medical /Dental/Vision Application for Enrollment/Change form (Example, pages 39, 44, 45) must be completed for any of the reasons listed below. These changes will be reflected in the health, dental, and vision 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 legal name (Only one form required to change records for all programs)

b) Marriage (see page 12)

c) Newborn and Adopted Children – legal documentation is needed for adoption (see page 13)

d) Divorce/Legal separation (see page 14)

e) Legal Guardianship (submit a copy of legal documents – page 13)

f) Death of a covered dependent (note date of death)

g) Enter military service (see page 24)

h) Obtain Medicaid or State assistance

i) Loss of other insurance (certificate of coverage from former insurer will be required, including reason for loss of other coverage)

j) Acquire other insurance (include company name and effective date of coverage)

k) Other (any reason not listed with an explanation)

To add or drop a dependent from an employee's Health, Dental or Vision coverage, complete a Medical, Dental, and/or Vision Application for Enrollment/Change form (Example, pages 39, 44, 45) listing the dependent's name, reason code, date of the event and checking the appropriate coverage box(es).

When adding a dependent, make sure all information is complete and accurate. A Primary Care Physician must be listed for all dependent(s) being added to a Point-of-Service (POS) health plan.

Providing the appropriate reason code on the change form will help determine the effective date of the change, and whether it is an addition or a drop.

The Health Trust is responsible for administering COBRA (Consolidated Omnibus Budget Reconciliation Act) which is a federally required continuation of group health, dental and vision coverage. Though many small Trust groups (under 20 employees) do not qualify for COBRA under federal rules, theTrust offers COBRA to all members who would be eligible under federal regulations on a voluntary basis. It is important that notice of Terminations be made immediately, so that the Trust can send time sensitive COBRA notices. 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 employees and their dependents.

Submit all change applications to the Health Trust Billing & Enrollment Department as soon as they are completed.
NO CHANGE CAN BE MADE TO THE EMPLOYEE'S CONTRACT WITHOUT THE EMPLOYEE'S SIGNATURE

DEPENDENT CHILDREN

Children may be covered under the employee's health, dental, vision, and life insurance coverage until they reach, the age of 26, regardless of the child's marital status, and regardless of whether the child is still dependent upon the employee for support and maintenance.

Once the child reaches his/her 26th birthday, coverage may only be continued under the employee's health, dental, and vision policies if the child is mentally or physically disabled and incapable of self- support. The disability must have begun before the child's 26th birthday and the child must have been covered under the insured's contract on that birthday. A child over the age of 26 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 child, at his/her own expense, for a period of up to 36 months.

Approximately two (2) months prior to the child's 26th birthday, the employee will be notified that, as of the first of the month following the child's 26th birthday, the child's coverage will be terminated and COBRA will be offered, unless the insured has provided proof of incapacity, showing that the child cannot 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, Dental, or Vision 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, Dental or Vision Plan may enroll (either alone or with dependents) in the Health, Dental or Vision Plan, within 60 days of his/her marriage. A separate application is needed to enroll in each Plan.

To add a spouse and/or dependent children to an employee's existing Health, Dental, or Vision Plan, the employee must complete a Group (Medical, Dental, Vision) Application for Enrollment/Change form (Example, pages , pages 39, 44, 45). To enroll him or herself, either with or without dependents, the employee must complete a Medical Application for Enrollment/Change (Example, page 39), a Life Plan Employee Enrollment form (Example, pages 40-41) where applicable, a Dental Application for Enrollment/Change (Example, page 44) and/or a Vision Enrollment/Change form (Example, page 45).

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 the application 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, Dental or Vision 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 Medical Plan Application for Enrollment/Change form (Example, page 39) 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 Medical Application for Enrollment/Change (Example, page 39) 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 day 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. Please be sure to include the name of the Primary Care Physician for all dependents being added to a Point of Service (POS) policy.

If the Medical Application for Enrollment/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 and vision plans.

To enroll a dependent child in the Dental and/or Vision programs, a Dental Application for Enrollment/Change form (Example, page 44) and/or a Vision Plan Application for Enrollment/Change (Example, page 45) 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 and/or Vision programs, a Dental Application for Enrollment/Change form (Example, page 44) and/or a Vision Plan Application for Enrollment/Change (Example, page 45) 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.

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 Medical Plan Application for Enrollment/Change form (Example, page 39) 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 Dental Application for Enrollment/Change form (Example, page 44).

To remove the spouse from the employee's Vision contract, the insured must complete a Vision Enrollment/Change form (Example, page 45).

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 (Example, pages 42-43) 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 notifies 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 in excess of three (3) months, 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 Medical Plan Application for Enrollment/Change form (Example, page 39) 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 employees must complete a Dental Application for Enrolment/Change form (Example, page 44).

To remove the spouse from the employee's Vision policy, the employee must complete a Vision Application for Enrollment/Change form (Example, page 45).

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.

DOMESTIC PARTNERSHIPS

Employers are able to choose when (and if) to offer coverage to domestic partners. The Trust requires a formal vote of the municipal officers or governing board (as evidenced by a copy of the meeting minutes), and written notification, in order to add domestic partner coverage. If a group is interested in offering domestic partner coverage, they should work with their Field Service representative, who will provide the required language and advise as to the process.

The Health Trust will require the employees and their domestic partners to complete an affidavit (example pages 58-60) certifying their relationship. There are possible tax consequences to the employee seeking to provide coverage for his or her domestic partner. (Information on pages 29-30).

The Domestic Partner of an Employee shall be:

a. a "life partner" of either the same sex as or opposite sex from the Employee;
b. not married, either to the Employee or to anyone else; and
c. at least 18 years of age and mentally competent to consent to contract.

In order for the Domestic Partner to obtain coverage under the Trust's Health and/or Dental Plans, the Employee and his/her Domestic Partner must both sign an Affidavit of Domestic Partnership asserting that they:

a. are each other's Domestic Partners and intend to remain so indefinitely;
b. have been each other's Domestic Partners for at least 12 months prior to the date of the Affidavit;
c. are jointly responsible for each other's common welfare;
d. share financial obligations; and
e. share their primary residence.

They must also be able to provide evidence of joint responsibility as may be requested by the Plan to verify such Domestic Partnership. (Example Affidavit, pages 58-60).

When an employee and his/her Domestic Partner dissolve their relationship, the employee must submit a Medical Plan Application for Enrollment/Change form (Example, page 39) to remove the domestic partner from his/her Health policy within thirty (30) days of the termination of the domestic partnership.

To remove the domestic partner from the employee's Dental policy, the employee must complete a Dental Application for Enrollment/Change form (Example, page 44)

To remove the domestic partner from the employee's Vision policy, the employee must complete a Vision Application for Enrollment/Change form (Example, page 45)

Once the applications(s) have been received by the Health Trust, the change will be effective the first of the month following the dissolution of the domestic partnership. A letter will be mailed to the ex- domestic partner, offering them continuation of benefits through COBRA-like coverage for 18 months.

LIFE INSURANCE PLAN

Basic Coverage equal to one times an active employee's annual salary (rounded up to the next $1,000; to a maximum of $100,000) is provided to all employees participating in a Health Trust Medical Plan, at no additional cost to the 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 Medical Plan but does not elect coverage because he/she is covered under another medical plan, may participate in the Basic Life (Life No Med) Plan for a nominal premium amount. 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.

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 Standard Insurance Company.

Accelerated Benefit – The Health Trust's life insurance carrier (Standard Insurance Company) will pay up to 75% of the employee's Life benefit if they receive proof that the employee is terminally ill and has been certified by a physician to have 12 months or less to live. Any benefit amount paid under the Accelerated Benefit will be paid to the covered employee in a single lump sum.

Supplemental Coverage (including AD & D) is available as an employee or employer paid benefit for all active employees, provided the employer elects to make supplemental coverage available. 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 Standard Insurance Company.

Dependent Coverage - Two options are available for dependent coverage as either employee or employer paid benefits, provided the employer elects to make dependent coverage available.

	OPTION A:	**OPTION B**
Spouse	½ employee's Basic coverage amount ($5,000 maximum)	½ employee's Basic coverage amount ($50,000 maximum)
Children	Birth until 26 years ½ employee's Basic coverage amount ($5,000 maximum)	Birth until 26 years ½ employee's Basic coverage amount ($5,000 maximum)
Rates	$1.50 per month	$3.20 per month

Retirees or Surviving Spouses who continue with the MMEHT Medical 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 180 days 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 (Example, pages 42-43), and indicate the type of change 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 Standard Insurance Company underwriters. Note: If the employee is a new employee or if the employer is offering Supplemental Lifecoverage to employees for the first time, then simply use the Life Plan Employee Enrollment Form (Example, pages 40-41).

To Drop Supplemental Coverage: Check the "Benefit Change" box at the top of the MMEHT Life Plan Employee Change Form (Example, pages 42-43), and indicate the type of change 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. You will also need to complete a Termination Notification Form (Example, page 37), check the box for "Employee Still Working-Chooses to Cancel Coverage", and indicate which coverage is to be terminated.

To Change Supplemental Coverage: Check the "Benefit Change" box at the top of the MMEHT Life Plan Employee Change Form (Example, pages 42-43) and indicate the type of change 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 thedate of approval by Standard Insurance Company. 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 (Example, pages 42-43), and indicate the type of change on the form. Dependent coverage for a spouse 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 approvalby the underwriters. No Evidence of Insurability is required for Dependent Life coverage for children.

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 (Example, pages 40-41).

To Drop Dependent Coverage: Check the "Benefit Change" box at the top of the MMEHT Life Plan Employee Change Form (Example, pages 42-43), and indicate the type of change 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. You will also need to complete a Termination Notification Form (Example, page 37), check box for "Employee Still Working-Chooses to Cancel Coverage", and indicate which coverage is to be terminated.

To Change Dependent Coverage: Check the "Benefit Change" box at the top of the MMEHT Life Plan Employee Change Form (Example, pages 42-43), and indicate the type of change 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 Standard Insurance Company.

To Change Beneficiary: Check the "Beneficiary Change" box at the top of the MMEHT Life Plan Employee Change Form (Example, pages 42-43), and list new beneficiaries 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 6, 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 (Example, page 36) are available on the Health Trust's website (www.mmeht.org).

Any time an employee wishes to increase or decrease IPP benefits, he/she must complete a new Income Protection Plan Application for Enrollment (Example, page 46). Check the level the employee wishes to change to and check the Increase/Decrease Coverage box in the Enrollment Reason section of the form. The change will become effective the first of the month following receipt by the Health Trust. 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 UNUM underwriters.

Employees currently receiving benefits under the Health Trust's Income Protection Plan will not experience a change in those benefits as a result of a salary change during the disability period. 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 6, Salary Changes) on a timely basis to ensure that correct benefits are paid in the event an employee needs to submit a claim.

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 ID number and name along with a credit for the applicable month at the end of thebill 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, or if employment terminates 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.

WAIVER OF PREMIUM FOR LIFE INSURANCE

Premiums for all life insurance under the Group Policy, except AD&D insurance, will be waived once the employee becomes Totally Disabled, provided he or she is under the age of 60, and has completed the 180-day Elimination Period. Satisfactory Proof of Loss will be required by Standard Insurance Company. Premium payments must be continued until the later of:

1. the date the employee completes his or her Elimination Period; and:
2. the date Standard Insurance Company approves his or her claim for Waiver of Premium.

DENTAL ENROLLMENT AND CHANGES

In order to be eligible to participate in the Health Trust's Dental plan, employees 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 and completed employee applications.

To enroll in the Dental program, an employee must complete a Dental Plan Application for Enrollment/Change (Example, page 44), including all eligible dependents to be covered, and submit 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.

If an employee wishes to add or drop a dependent to dental coverage after his/her initial enrollment, complete the appropriate Enrollment/Change form 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 will be required to wait for the Annual Open Enrollment period.

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

VISION ENROLLMENT AND CHANGES

In order to be eligible to participate in the Health Trust's Vision plan, employees 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 Vision Plan, the Health Trust must receive a letter of intent including the requested effective date of coverage and completed employee applications.

To enroll in the Vision Plan, an employee must complete a Vision Plan Application for Enrollment/Change (Example, page 45), 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 Vision 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.

If an employee wishes to add or drop a dependent to vision coverage after his/her initial enrollment, complete the appropriate Enrollment/Change form 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 will be required to wait for the Annual Open Enrollment period.

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, Dental and Vision coverage end the first ofthe 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 plans end 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).

Please submit Termination Forms promptly. Credits for terminated employees will be automatically applied to the next month's bill and cannot be manually adjusted on the invoice or Member Group Remittance Form. For example, if an employee terminates employment after the bill has been generated, we will terminate them in the system once the form is received, and a credit will appear on the next bill for the previous month.

To avoid being charged for a month when an employee no longer has coverage, please submit your termination, and change forms to the Trust as quickly as possible.

Reason for Coverage Termination:

- Termination of Employment
- Terminated Employment during Leave of Absence
- Retired Collecting MainePERS through **this** employer
- Retired No MainePERS
- Cancelled by Employer for nonpayment of premiums during a leave of absence
- Reduction of Hours-no longer eligible for coverage
- Military Leave
- Death of Employee
- Employee Still Working-Chooses to Cancel Coverage

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 review their bill each month and submit required termination or Enrollment/Change forms in a timely manner.

Please note: If, as part of an employment severance package, an employer offers to pay health, dental and/or vision 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.

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 current 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 anactive participant in the Maine Municipal Employees Health Trust immediately prior to his/her retirement.

Complete a Termination Notification Form (Example, page 37), listing the employee's name, current mailing address, and last day worked. Also indicate if the retiree will be collecting MainePERS benefits.

When you notify the Health Trust that an employee is retiring by submitting the termination form, coverage for the employee and all of his/her dependents is temporarily cancelled. If the employee is not participating in an employer-sponsored retirement plan, fill out and return an "Employer Statement Regarding Retiree Eligibility for Continued Health Insurance" form (example, page 38) and return it with the 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 will mail 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" (example, pages 49). If the Retiree and/or spouse are over 65 and eligible for Medicare, he/she/they must also list their Medicare Claim Numbers and Effective Dates in the appropriate section of the form. The application must be returned to the Health Trust, along with a signed 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 participating in MainePERS and he/she wishes to have the monthly premium deducted from his/her Maine Public Employees Retirement System (MainePERS) check, a "MainePERS Deduction Authorization" (Example, page 50) 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.

Retirees who continue coverage through the Health Trust remain attached to their former employer group and will appear on their former employer's monthly billing invoice. If the employer pays for the premiums, they will be included in the total on the invoice and on the Member Group Remittance Form. However, if they employer does not pay towards the premiums, the premiums amounts will **NOT** be included in the total on their Member Group Remittance Form.

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 PartB at this time. The employee should, however, notify Medicare that he/she is not enrolling in Part B, because he/she is stillactively working and enrolled in an employer-sponsored group medical plan.

- Part A - is automatic and is free of cost, provided the person qualifies for the coverage.
- Part B - has a monthly cost that will typically be automatically deducted from an individual's Social Security check.

When a covered employee retires, the Health Trust will mail 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.

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 contain an application 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 and the Health Trust Group Companion Plan.

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 Group Companion Plan Application directly to the retiree. 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 enrolled in Medicare** (due to not paying into the Medicare system) he/she may be able to remain on the same coverage he/she had in force prior to age 65. However, the retiree must indicate as such on the application included in the retiree packet, attach a copy of the letter or statement of ineligibility from Social Security and return it to the HealthTrust.

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;
- Health Trust Retiree Group Companion Plan - coordinates with Medicare as a supplement; and
- Health Trust prescription drug coverage.

Dental Coverage: If a retiree was participating in the dental program at the time of his/her retirement, he/she may elect to continue this coverage as a retiree.The premium for retiree dental coverage 102% of the active rate.

Vision Coverage: If a retiree was participating in the vision program at the time of his/her retirement, he/she may continue the vision coverage under COBRA for up to 18 months.

SPLIT COVERAGES FOR RETIREES

When an employee retires and will continue to cover his or her spouse, it is possible that one person will be eligible for Medicare and the other may not be. In this case the employee and spouse are set up with what is known as a "split contract" for billing purposes.

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 combination Group Companion Plan/prescription card from Anthem Blue Cross Blue Shield.

The individual without the Medicare coverage will receive a different medical/prescription drug 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 Group Companion Plan/prescription cards from Anthem Blue Cross Blue Shield in the retiree's name, one for the retiree and one for his/her spouse.

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 occurs 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.)

For municipal employers employing between 25 and 49 employees, employees may be eligible for leave under the Maine FMLA. For municipal employers with more than 50 employees, employees are potentially eligible for leave under either or both the state and federal FMLA laws. The Maine Municipal Association Legal Services department offers a toolkit and more information regarding the state and federal FMLA laws. For more specific information on eligibility and administration of FMLA leaves, we suggest that you contact your legal counsel.

If an employee is on an approved Federal or State Family Medical (FMLA) Leave, the employer must maintain the employee's health coverage under any "group medical plan" for the duration of the leave.

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.

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, Long Term Disability, and Income Protection Plan coverage; and having to wait until the December annual open enrollment period for Health, Dental and Vision coverage.

MILITARY DUTY

When an employee receives Activation Orders, his/her coverage must be terminated, and the Health Trust must be notified by using the Termination Notification Form (Example, page 37).

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. 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 **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 provides only voluntary 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 three (3) months after activation. After the three- 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, Dental or Vision programs offered by the Health Trust because they are covered elsewhere. The employee (and his/her eligible dependents) may still enter the Health, Dental and/or Vision programs offered through the Health Trust if the other health, dental and/or vision coverage end for any of the following reasons:

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 (Example, page 54-55). 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 the processingof the application until the Certificate of Coverage is received.

a) Loss of other coverage because such other coverage is no longer available.

b) A change in the percentage of premium contribution required by the other plan (a copy of the notice of the intended change must be sent with the application).

c) Divorce or legal separation.

d) Death of the spouse.

e) Loss of Medicaid benefits (a copy of the letter from the Department of Human Services must be provided).

Portability is not available for voluntary cancellation for any reason, other than as listed above.

If an employee and/or dependent(s) meets the requirements of portability, he/she must complete a Group Medical Plan Enrollment/Change form (Example, page 39), a Life Insurance Enrollment form (Example, pages 40-41) where applicable, a Dental Enrollment/Change form (Example, page 44), and/or a Vision Enrollment/Change form (Example, page 45), listingall 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 Evidenceof Insurability for Life Coverage; and will have to wait until the annual open enrollment period for Health, Dental and Vision coverage.

COBRA

Federal law requires that most employer sponsored group medical 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 continued at group rates plus a small charge for administrative costs. Though many small Trust participating groups (under 20 employees) do not qualify for COBRA under federal rules, the Trust offers COBRA to all members who would be eligible under federal regulations on a voluntary basis.

When an employee is no longer eligible for health, dental and/or vision coverage, COBRA continuation of coverage willbe offered to the employee and his/her dependents, as long as they are covered at the time eligibility changes. The employer should submit a Termination Notification Form noting the last day actively worked, the reason for the termination, and the employee's current mailing address.

A letter, along with a "COBRA Election Form" (Example, page 53), a "Certificate of Group Medical Plan Coverage" (Example, page 54-55) and either a Life Insurance Portability / Conversion Contact Information sheet (Example, page 56), will be mailed to the employee within 14 days following receipt of the termination notification form by the Health Trust. Employer is responsible for notifying the Health Trust within **30 days** of the employee termination.

A copy of page 1 of the letter to the employee will be mailed to the employer for their personnel records (Example, page 52).

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

If COBRA is accepted the employee will be mailed a COBRA Acceptance letter stating that the completed and signed COBRA Acceptance form has been received by the Health Trust and that the employee now has 45 days to make the firstpremium payment. When the first payment has been received by the Health Trust, the employee's coverage will be reinstated back to the date of the loss of group coverage. The employee will then be mailed a monthly billing statement for making his/her future premium payments.

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 health, dental and vision coverage, the employee and/or his/her eligible dependents may chooseto accept any or all coverage plans offered.

Coverage may be continued for up to 18 months for employees, spouses, and dependents in case of loss of coverage as aresult 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 employee
- Children of current employee who no longer meet the Health Trust's definition of a dependent
- Spouses and children of current employee who would lose coverage due to the employee are becoming entitled to Medicare benefits.

Note: Please see the section entitled Military Duty (page 24) 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 within60 days of receiving such notice from Social Security, and before the end of the first 18 months of coverage. This extension will end before the 29 months if there is a final determination that the person is no longer disabled.

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 tothat 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 months COBRA period under the following circumstances:

- The group/bargaining unit no longer provides health/dental/vision insurance to any of its employees.
- The group/bargaining unit no longer offers the Health Trust health/dental/vision insurance to any of its employees.
- The Health Trust does not receive premium payments in a timely manner.
- The participant becomes covered under another group medical 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 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 giventhe opportunity for conversion or portability of 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 in an amount that is less 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 Life Insurance Portability / Conversion Contact Information sheet (Example, page 56) to theemployee upon receipt of notification of the termination or cancellation of the employee's life coverage. It will be up to the employee to contact Standard Insurance Company to request the appropriate Portability of Conversion form. The carrier will notify the employee of the premium and give him/her the opportunity to accept the converted policy.

Standard must receive the application for conversion within 60 days following the participant's termination of group coverage. Otherwise, he/she will be asked to provide Evidence of Insurability. In no event will the carrier allow for conversion extended beyond 90 days.

Income Protection Plan Information for Employers

Employer Contact with Unum:

A Unum Disability Benefit Specialist may need to speak directly with the employer if additional information is required. For example, Unum may need to ask the employer if the employee has returned to work, to explore light duty job functions as recommended by the physician, or to explore ways the employee's job function can be temporarily modified so the employee can return to work.

Claim Filing Procedures:

If the employer pays any portion of the IPP premium, or if the employee pays his/her IPP premium on a pre-tax basis, acopy of the employee's current State and Federal W-4 form must be included with the claim form.

Please send your portion of the completed claim form directly to Unum to the address or fax number on the claim form. The employer should notify Unum when the disabled employee returns to work by calling 1-800-858-6843 or by faxing a notice to 1-800-447-2498.

Tax Withholding and Reporting:
(Please note: This section applies only to those employers who pay any portion of the premium for the IPP coverage, orwho allow employees to pay their IPP premiums on a pre-tax basis.)

- Unum will withhold all employee and employer taxes (Social Security and Medicare taxes), if applicable. Unumwill submit the taxes directly to the IRS on behalf of the Trust and the employer using the Unum Employer Identification Number (EIN). **Social Security and Medicare taxes will be withheld if the employer pays any portion of the employee's premium, or if the employee pays his/her premium on a pre-tax basis.**

- The Health Trust will bill the employer on a monthly basis for any applicable Employer share of taxes paid by Unum with Health Trust funds.

- Unum will generate a W-2 for the employee in January for all taxes withheld in the previous calendar year, and will mail the W-2 directly to the employee to file with his/her federal and state tax returns. As a result, you will be relieved of the administrative burden of tracking and reporting taxes that have been withheld from Income Protection Plan benefits. If no taxes are withheld, the employee will not receive a W-2.

- An employer will continue to be responsible for payment of Social Security and Medicare taxes, **even if the employee has terminated employment**, as long as the employee continues to receive payments under the Health Trust IPP benefit. The maximum period of responsibility for payment of Social Security and Medicare taxes is sixmonths per period of disability. After six months of disability payments (i.e., during one consecutive period of disability), the employer is no longer responsible for payment of Social Security or Medicare taxes.

If you have questions regarding any of these items, please contact a Health Trust Service Representative at 1-800- 852-8300 or a Unum Customer Care Representative at 1-800-858-6843.

POTENTIAL TAX IMPLICATIONS
OF PROVIDING DOMESTIC PARTNER BENEFITS

There are certain potential tax implications to both the employee and the employer, of which all parties should be aware before domestic partner benefits are offered. Most of these implications are discussed in Section 152 of the Internal Revenue Code. Some of the major points shall be summarized here.

Internal Revenue Code Section 152(a) defines a "dependent" for federal tax purposes. This definition generally requires a blood relationship (including adoption) or a marital relationship, as well as a support test. In most situations, a domestic partner will not meet the Code requirements for the definition of a "dependent". In fact, a domestic partner will only meetthe Code definition of a "dependent" if all of the following requirements are met:

1. The taxpayer (in this case, the employee) provides over 50% of the domestic partner's support;
2. The domestic partner's principal place of abode is that of the taxpayer/employee, and the domestic partner is a member of the taxpayer/employee's "household"; and
3. The relationship of the taxpayer/employee and the domestic partner does not violate state or local law. Under theInternal Revenue Code Section 152 (b)(5), if the relationship violates state or local law, the domestic partner cannot be considered to be a member of the employee's household, and therefore cannot be considered to be a dependent.

If a domestic partner does not meet the above requirements, and therefore does not meet the IRS requirements to be considered a tax-qualified dependent, then any domestic partner benefits provided by the employer will be considered taxable benefits to the employee. If the employer pays any portion of the premium (for health and/or dental insurance) forthe domestic partner's coverage, the amount which the employer pays for that coverage is includible in the employee's income under Internal Revenue Code Section 61. So, for example, if the employer pays 50% of the cost of dependent coverage for an employee's domestic partner, that amount paid by the employer must be included in the employee's income.

In addition, any such amounts includible in the employee's income due to coverage of a domestic partner constitute wagesunder Section 3401(a) of the Internal Revenue Code, and are subject to income tax withholding, as well as FICA and FUTA taxes. This means that any employer that provides domestic partner benefits must put in place a procedural arrangement to ensure that W-2 tax forms are prepared for those employees who elect domestic partner coverage. These W-2 tax forms must include the value of the imputed income arising out of the domestic partner benefits. The employer must also be sure to make the necessary withholding and payroll tax payments.

Another issue which must be addressed by employers offering domestic partner coverage concerns payment of premiumsby employees under a cafeteria plan or other pre-tax arrangement. If the employee pays all or any portion of the cost for domestic partner coverage, that portion of the premium must be paid on an after-tax basis, unless the domestic partner meets the dependent definition in Code Section 152. In a Private Letter Ruling issued by the IRS in 1995 (IRS Private Letter Ruling 9603011, October 18, 1995), the IRS ruled that, if a domestic partner is neither a spouse nor dependent (as defined earlier in this memo), then:

1. Premiums paid by the employer for domestic partner coverage must be included in the employee's income, as already described; and
2. The employee cannot pay any part of the premium for the domestic partner's coverage on a pre-tax basis. Thus, even if the employer has a plan in place for employees to pay their portion of health and/or dental insurance premiums on a pre-tax basis, employees would not be able to pay for domestic partner premiums pre-tax. Any contribution which the employee makes toward the cost of coverage for his/her domestic partner must be made on an after-tax basis.

Because of all the potential tax implications and complications arising from the offering of domestic partner coverage, theHealth Trust strongly recommends that any employer group offering such coverage consult with its payroll administrator, tax consultant and/or attorney, and (if applicable) cafeteria plan administrator.

THIS DISCLOSURE IS NOT INTENDED TO CONSTITUTE TAX ADVICE, BUT RATHER IS INTENDED TO HIGHLIGHT SOME OF THE COMPLEX TAX AND ADMINISTRATIVE ISSUES ARISING OUT OF DOMESTIC PARTNER BENEFIT COVERAGE. EMPLOYERS ARE ENCOURAGED TO CONSULT THEIR OWN ACCOUNTANTS FOR SPECIFIC TAX ADVICE.

Date: October 2022

To: Health Trust Employers - Please forward a copy to your Finance/Payroll Department

From: Lisa Wilson, Controller

Re: Life Insurance Tax Information

In 1996, the Health Trust received a "private letter ruling" from the IRS in regard to the taxable aspects of the Basic and Supplemental Life Insurance plans. This ruling was requested by the Health Trust and two of its members. Technically, the ruling applies to these two members only, but the information is the same for all Trust members.

The ruling essentially states that the purchase of Supplemental Life insurance by an employee will result in no taxable income, irrespective of the amount, because the Basic Life and Supplemental Life plans offered by the Trust are two separate plans.

Listed below is a summary of the year-end tax reporting requirements for employers who provide life insurance to their employees:

A. **Employees (including retirees): The cost of any employer-paid group term life insurance in excess of $50,000 must be reported as part of an employee's income. (This includes the life coverage under the Health Plan and any other employer-paid life insurance coverage.) The calculation of taxable amount is explained below along with the IRS Rate Table.**

B. Dependents: The cost of an employer-paid group term dependent life insurance of $2,000 or less is not includible in the employee's income. If the amount provided is more than $2,000, the cost of the coverage is includible in the employee's taxable income based on Table 1.

C. Tax Withholding & Reporting: To the extent that the cost of group term life insurance is included in an employee's taxable income both Social Security and Medicare FICA taxes must be withheld. Includible amounts are not subject to federal or state income tax withholding, but must be reported on Form W-2. *(consult with your payroll service or software provider to see if this calculation can be done as part of your regular payroll processing.)*

D. Table 1 below is published by the IRS and gives you uniform premiums for $1,000 of group term life insurance. The "age" refers to the employee's age on the last day of the taxable year.

To compute the cost of excess coverage:

(1) Total the life coverage in force for each month of the year. From this total, deduct $50,000 for the same number of months (up to $600,000). This is the "Life Excess" for consideration of possible taxable income;

(2) Determine the employee's age at year-end and apply the appropriate rate to the "Life Excess" computed in Step 1;

(3) Determine the employee's contributions for the year, only if contributions are made as an after tax deduction. If contribution is before taxes, no credit is allowed.

(4) If the amount in Step 3 is more than the amount in Step 2, there is NO taxable income. If the amount in Step 3 is less than the amount in Step 2, then the difference represents the amount to be added to the W-2 taxable income.

(5) The amount should included in all boxes related to taxable income on the W-2, such as in Boxes 1, 3, 5, 16 and also entered in box 12 with code C.

2022

Table 1

Cost per $1,000 of Protection for 1 Month

Age	eff 7/1/99
under 25	0.05
25 to 29	0.06
30 to 34	0.08
35 to 39	0.09
40 to 44	0.10
45 to 49	0.15
50 to 54	0.23
55 to 59	0.43
60 to 64	0.66
65 to 69	1.27
70 and above	2.06

EXAMPLES OF CALCULATIONS ARE SHOWN ON THE BACK SIDE OF THIS PAGE

If you should have any questions, please don't hesitate to call me at 1-800-452-8786

2022 GRP TERM LIFE TAX LTR - letter

MMEHT Letter re: Life Insurance Tax Information

EXAMPLE ONE
NO EMPLOYEE CONTRIBUTION TO HEALTH COVERAGE

	JANUARY TO JUNE	JULY TO DECEMBER	
Employee Age at **End-Of-Year**	*46*		
Enter amount of life coverage included in Health Premium	$67,000	$69,000	
Less: $50,000 per month	50,000	50,000	
Excess amount of insurance	$17,000	$19,000	
Number of months at this coverage	6	6	
Total coverage in excess of $50,000 for the year	102,000	114,000	216,000
Divide this amount by $1,000			216.00
Multiply by cost per $1,000 per Table 1			0.15
Cost of excess life insurance for entire tax year - Total Included in Income			$32.40

THIS AMOUNT IS LISTED ON EACH OF THE HEALTH TRUST'S MONTHLY BILLINGS

EXAMPLE TWO
EMPLOYEE CONTRIBUTES PERCENTAGE TO HEALTH COVERAGE

	HEALTH CONTRIBUTION IS AN "AFTER TAX" DEDUCTION			HEALTH CONTRIBUTION IS A "BEFORE TAX" DEDUCTION		
	JANUARY TO JUNE	JULY TO DECEMBER		JANUARY TO JUNE	JULY TO DECEMBER	
Employee Age at End-Of-Year	*46*			*46*		
Basic Coverage (included with Health Premium)	$67,000	$69,000		$67,000	$69,000	
percentage employee pays for Single Coverage	10%	10%				
amount of insurance paid by employee	$6,700	$6,900		NO CREDIT ALLOWED		
Coverage Provided By Employer	$60,300	$62,100		$0	$0	
Less: $50,000 per month	50,000	50,000		$67,000	$69,000	
Excess amount of insurance	$10,300	$12,100		50,000	50,000	
Number of months at this coverage	6	6		$17,000	$19,000	
Cost of excess life insurance for entire tax year	61,800	72,600	134,400	6	6	
Divide this amount by $1,000			134.40	102,000	114,000	216,000
Multiply by cost per $1,000 per Table 1			0.15			216.00
Total Included in Income			$20.16			0.15

EXAMPLE THREE
EMPLOYEE CONTRIBUTES FIXED AMOUNT TO HEALTH COVERAG

	JANUARY TO JUNE	JULY TO DECEMBER		JANUARY TO JUNE	JULY TO DECEMBER	
Employee Age at **End-Of-Year**	*46*			*46*		
Enter amount of life coverage included in Health Premium	$67,000	$69,000		$67,000	$69,000	
Less: $50,000 per month	50,000	50,000		50,000	50,000	
Excess amount of insurance	$17,000	$19,000		$17,000	$19,000	
Number of months at this coverage	6	6		6	6	
	102,000	114,000	216,000	102,000	114,000	216,000
Divide this amount by $1,000			216.00			216.00
Multiply by cost per $1,000 per Table 1			0.15			0.15
Cost of excess life insurance for entire tax year			$32.40			$32.40
	Amount	# of Paydays		Amount	# of Paydays	
Less: Amount paid by employee toward Single Coverage	$5.00	26	130.00	NO CREDIT ALLOWED		
Total Included in Income (if contribution exceeds cost of excess amount = 0)			$0.00			$32.40

EXAMPLE ONE
NO EMPLOYEE CONTRIBUTION TO DEPENDENT COVERAGE

	JANUARY TO JUNE	JULY TO DECEMBER	
Dependent Age at End-Of-Year	*63*		
Enter amount of life coverage included in Health Premium	$50,000	$50,000	
Less: $2,000 per month	2,000	2,000	
Excess amount of insurance	$48,000	$48,000	
Number of months at this coverage	6	6	
Total coverage in excess of $2,000 for the year	288,000	288,000	576,000
Divide this amount by $1,000			576.00
Multiply by cost per $1,000 per Table 1			0.66
Cost of excess life insurance for entire tax year - Total Included in Income			$380.16

$106.44

EMPLOYER pays full cost of $3.20 per mth

Annual Cost	$38.40
	$137.14

MAINE MUNICIPAL
EMPLOYEES HEALTH TRUST
60 Community Drive I Augusta, ME 04330-9486
(207) 621-2645 or 1-800-852-8300 I www.mmeht.org

INFORMATION REQUIRED

Please complete the Contribution Report below and return to the Maine Municipal Employees Health Trust with your Member Group Remittance sheet and payment. If paying via ACH or Check, please, indicate below and returnthis completed form with your Member Group Remittance sheet.

☐ **ACH** ☐ **CHECK**

EMPLOYER GROUP	ACCOUNT ID	INSURANCE MONTH	STATEMENT DATE	DUE DATE

	HEALTH	DENTAL	LIFE
EMPLOYEE SHARE:	$_____	$_____	$_____
EMPLOYER SHARE:	$_____	$_____	$_____

	IPP	LTD	VISION
EMPLOYEE SHARE:	$_____	$_____	$_____
EMPLOYER SHARE:	$_____	$_____	$_____

REMIT TO: MAINE MUNICIPAL EMPLOYEES HEALTH TRUST
60 COMMUNITY DRIVE
AUGUSTA, ME O4330

https://www.mmeht.org/wp-content/uploads/employer-resources/Employer-Contributions-Form.pdf

Member Group Remittance (August 2021 Final Invoice)

Previous Total Due	Total Payments Received	Unpaid Balance	Current Premium	Payment Due Date
$4,432.61	**$4,432.61**	**$0.00**	**$4,432.61**	08/01/2021

Location	Policy Number	Prepared	Billing Period	Remit Payment to:
00000-APPLE COVE TOWN OF 41 APPLE LANE APLLE COVE, ME 02167	APPLE COVE TOWN OF	07/09/2021	August 2021 Final Invoice	Maine Municipal Employees Health Trust 60 Community Drive Augusta, ME 04330

PLEASE PAY THIS AMOUNT	$4,432.61

Coverage	Enrolled	Volume	Current Premium	Credit Premium	Debit Premium	Total Premium
Dental	3	$0.00	$161.57	$0.00	$0.00	$161.57
Basic Life	4	$145,000.00	$0.00	$0.00	$0.00	$0.00
Basic Life - No Medical	1	$38,000.00	$11.40	$0.00	$0.00	$11.40
Basic ADD	4	$145,000.00	$0.00	$0.00	$0.00	$0.00
Basic ADD - No Medical	1	$38,000.00	$0.00	$0.00	$0.00	$0.00
Medical	4	$0.00	$4,259.64	$0.00	$0.00	$4,259.64
Total Premium			$4,432.61	$0.00	$0.00	$4,432.61

Totals with Adjustments

Previous Total Due	**$4,432.61**
Total Payments Received	**$4,432.61**
Unpaid Balance	**$0.00**
Current Premium	**$4,432.61**
Credit Premium	**$0.00**
Debit Premium	**$0.00**
Location Fees/Deductions	**$0.00**
Location Adjustments	**$0.00**
Current Total Due	**$4,432.61**

Location Detail for 00000- APPLE COVE TOWN OF

Location	Prepared	Billing Period	Remit Payment to:
00000 - APPLE COVE TOWN OF 41 APPLE LANE APPLE COVE ME 02167	07/09/2021	August 2021 Final Invoice	Maine Municipal Employees Health Trust 60 Community Drive Augusta, ME 04330
PLEASE PAY THIS AMOUNT		**$4,432.61**	

CURRENT

SSN/ID	Employee	Plan	Tier	Coverage	Employee Premium	Company Premium	Total Premium
A0001234	**AGUILERA, CHRISTINA**						
		Basic Life - No Med	Life Rate	$38,000.00	$0.00	$11.40	$11.40
			Employee Totals	**$38,000.00**	**$0.00**	**$11.40**	**$11.40**
A00042869	**BON JOVI, JOHN**						
		Basic ADD - Class 1 Active 20Hrs Plus	Life Rate	$30,000.00	$0.00	$0.00	$0.00
		Basic Life - Class 1 Active 20Hrs Plus	Life Rate	$30,000.00	$0.00	$0.00	$0.00
		Dental	ESP	$0.00	$74.85	$0.00	$74.85
		POS 200	EMP	$0.00	$1,064.91	$0.00	$1,064.91
			Employee Totals	**$60,000.00**	**$1,139.76**	**$0.00**	**$1,139.76**
A00099326	**HAGAR, SAMMY**						
		Basic ADD - Class 1 Active 20Hrs Plus	Life Rate	$43,000.00	$0.00	$0.00	$0.00
		Basic Life - Class 1 Active 20Hrs Plus	Life Rate	$43,000.00	$0.00	$0.00	$0.00
		POS 200	EMP	$0.00	$1,064.91	$0.00	$1,064.91
			Employee Totals	**$86,000.00**	**$1,064.91**	**$0.00**	**$1,064.91**
A00075192	**SWIFT, TAYLOR**						
		Basic ADD - Class 1 Active 20Hrs Plus	Life Rate	$34,000.00	$0.00	$0.00	$0.00
		Basic Life - Class 1 Active 20Hrs Plus	Life Rate	$34,000.00	$0.00	$0.00	$0.00
		Dental	EMP	$0.00	$43.36	$0.00	$43.36
		POS 200	EMP	$0.00	$1,064.91	$0.00	$1,064.91
			Employee Totals	**$68,000.00**	**$1,108.27**	**$0.00**	**$1,108.27**
518675309	**WILSON, CARLY**						
		Basic ADD - Class 1 Active 20Hrs Plus	Life Rate	$38,000.00	$0.00	$0.00	$0.00
		Basic Life - Class 1 Active 20Hrs Plus	Life Rate	$38,000.00	$0.00	$0.00	$0.00
		Dental	EMP	$0.00	$43.36	$0.00	$43.36
		POS 200	EMP	$0.00	$1,064.91	$0.00	$1,064.91
	Employee Totals			**$76,000.00**	**$1,108.27**	**$0.00**	**$1,108.27**
	Location Current Totals			**$328,000.00**	**$4,421.21**	**$11.40**	**$4,432.61**

ADJUSTMENTS

ADJUSTED TOTALS

Location Adjusted Totals	**$328,000.00**	**$4,421.21**	**$11.40**	**$4,432.61**

Maine Municipal Employees Health Trust

NOTIFICATION OF SALARY CHANGE

All salary changes must be reported to the Health Trust immediately upon approval by the employer, to update coverage for Life Insurance and/or Income Protection Plan coverage. All changes will be effective the 1st of the month of the current billing cycle, following receipt of notification by the Health Trust.

This form must be submitted electronically via Excel format, as information will be imported. (Handwritten forms and faxes will not be accepted.)
Send to the Health Trust at htbilling@memun.org. Thank you.

Employer Group: _____

Employee ID# Number *(From your bill)*	**Employee First Name**	**Employee Last Name**	**New Base Annual Salary** *(Do not round)*	**Employer's Effective Date**	**Is Employee Actively Working as of Date HT Notified?** *(Enter Y or N)*

https://www.mmeht.org/employer-resources/forms/

MAINE MUNICIPAL
EMPLOYEES HEALTH TRUST
60 Community Drive | Augusta, ME 04330-9486
(207) 621-2645 or 1-800-852-8300 | www.mmeht.org

TERMINATION NOTIFICATION FORM

☐ PLEASE CONTINUE TO BILL EMPLOYER FOR RETIREE PREMIUMS

Email completed form to htbilling@memun.org or Fax: (207) 624-0166

EMPLOYEE'S INFORMATION (To Be Completed By Employer)	
Employer:	**Employee Participated in LD1021:** ☐ **YES** ☐ **NO**
Employee's Legal Name:	
Alternate ID# (from the bill):	
Current Mailing Address:	
City/State/Zip:	

REASON FOR COVERAGE TERMINATION (Please Check Appropriate Box) & Specify Date Requested		
	Retired Collecting MEPERS Thru This Employer (No Additional Forms Req'd)	**Last Date Worked:**
	Retired No MEPERS (Please include Retiree Eligibility Form from mmeht.org)	**Last Date Worked:**
	Terminated Employment: Voluntary Involuntary ☐	**Last Date Worked:**
	Terminated Employment During a Leave of Absence	**Last Date Considered Employee:**
	Cancelled by Employer for nonpayment of premiums during a leave of absence	**Coverage Term Date:**
	Reduction of Hours- no longer eligible for coverage	**Last Date as Full Time Employee:**
	Military Leave	**Last Date Worked:**
	Death of Employee	**Date of Death:**
	Employee Still Working-Chooses to Cancel Coverage (Check all that apply below)	**Cov. Term Date:**

☐ *Health* ☐ *Life* ☐ *Dental* ☐ *Vision* ☐ *IPP* ☐ *LTD*

If cancelling health, life coverage may continue at a cost of .30 per $1,000 of life volume per month

Printed Name of Person completing form

Signature of Person Completing (cannot be employee above)

FOR MMEHT USE ONLY					
IPP/LTD Coverage Term Date:		**Term Date for All Other Plans:**			
Subgroup:	**Health Plan:**	**Status:**	**Status:**	**Status:**	
Name		**Health Eff Date**	**Dental Eff Date**	**Vision Eff Date**	**Life Vol.**
Member:					**Basic:**
Spouse:					
Dep1:					**Supp:**
Dep2:					
Dep3:					**Spouse:**
Dep4:					
Dep5:					**Dep:**
Dep6:					

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MAINE MUNICIPAL EMPLOYEES HEALTH TRUST EMPLOYER STATEMENT REGARDING RETIREE ELIGIBILITY FOR CONTINUED HEALTH INSURANCE

To be completed by employer and sent with termination form when employee qualifies for retiree benefits but is not collecting MainePERS

Employee Name:_____ Date of Birth:_____

Employee ID #:_____ Date of Retirement:_____

YES _____ NO _____ 1. Has the employee been employed by, or been an elected or appointed official with this employer for the last five (5) consecutive years?

YES _____ NO _____ 2. On the date of retirement was the employee at least 55 years old?

YES _____ NO _____ 3. Is the employee receiving benefits from a retirement plan established by **this** employer such as ICMA?

Your employee qualifies for our retiree benefit if questions 1 and 2 are yes or if question 3 is yes.

_____
Name of Employer

_____ _____
Signature of Employer Representative Date

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(207) 621-2645 or 1-800-852-8300 | www.mmeht.org

MMEHT OFFICE USE ONLY
Subgroup No.
Effective Date
Status
Entered by:

MEDICAL PLAN APPLICATION ENROLLMENT/CHANGE FORM

PLEASE PRINT

1. EMPLOYER SECTION

Employer	
Date of Employment	Elected Official (Yes or No)
Annual wages or salary	Hours worked per week

Enrollment Reason:

- ☐ New Hire
- ☐ Newly Eligible on (date & reason) _____
- ☐ New Group (initial enrollment)
- ☐ Open Enrollment
- ☐ Portability or Qualifying Event
- ☐ Employer Change-Dept/Union Change (not previously eligible)

2. PLAN CHOICE

☐ PPO_____(indicate plan) Point of Service_____(indicate plan)

If you are enrolling in a medical plan, please also complete the MMEHT life enrollment form for submission.

3. EMPLOYEE NAME ADDRESS & TELEPHONE

Employee Legal Name	Social Security Number
Mailing Address	Home Phone: Cell Phone:
Town State Zip	Work Phone:

4. CHANGE STATUS

Type of change: ☐ Address Change ☐ Name Change – provide previous name: _____

☐ Add dependent(s) listed below in section 5 ☐ Drop dependent(s) listed below in section 5

Reason for change: **Date of change or event:** _____

- ☐ Adoption
- ☐ Covered by other insurance
- ☐ Divorce
- ☐ Involuntary loss of coverage
- ☐ Birth (if grandchild see below*)
- ☐ Death
- ☐ Dissolution of Domestic Partnership
- ☐ Marriage
- ☐ Court order
- ☐ Discharge from the Military
- ☐ Entrance to the Military
- ☐ Other _____

☐ * Grandchild - Coverage for 31 days from birth only. Please contact the Health Trust with questions.

5. MEMBER AND FAMILY INFORMATION

You may apply to cover your legal spouse, domestic partner (DP) (IF your employer offers this benefit and the Trust receives a completed MMEHT Domestic Partner Affidavit form verifying qualification) and children between birth and 26 years of age.

Legal Name (Last, First, MI)	Date of Birth MM/DD/YR	Gender M	F	Non-Binary	Social Security Number	Primary Care Physician-PCP (www.anthem.com) POS Pans ONLY	Current Patient?
Self					Provided Above	PCP Name/Address(city/town)	Y☐ N☐
☐Spouse or ☐Domestic Partner						PCP Name/Address(city/town)	Y☐ N☐
Child						PCP Name/Address(city/town)	Y☐ N☐
Child						PCP Name/Address(city/town)	Y☐ N☐
Child						PCP Name/Address(city/town)	Y☐ N☐

6. SIGNATURE

I am requesting coverage for myself, and all dependents listed, including any type of change selected in the Change Status section as indicated above. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete, or misleading information to obtain insurance or benefit coverage for the purpose of defrauding the plan or insurance carrier. Penalties may include imprisonment, fines, or denial of insurance benefits. I understand all benefits are subject to conditions stated in the Plan Document. I understand that, under a POS plan, each family member's care must be provided or arranged by his/her Primary Care Physician (PCP) except as described in my Summary Plan Description.

Employee Signature: _____ Date: _____

7. ELECTION NOT TO ENROLL

☐ I elect not to enroll in health coverage during my new hire enrollment period. I understand I may choose to elect coverage later during open enrollment or with a qualifying event.

NAME (PRINT): _____ EMPLOYER: _____

SIGNATURE: _____ DATE: _____

Email completed form to htbilling@memun.org or via fax to (207) 624-0166
For questions, please call the Billing & Enrollment Department at (207) 621-2645 or (within Maine (800) 452-8786 EXT. 2585
PLEASE RETAIN A COPY FOR YOUR RECORDS

MAINE MUNICIPAL
EMPLOYEES HEALTH TRUST
60 Community Drive | Augusta, ME 04330-9486
(207) 621-2645 or 1-800-852-8300 | www.mmeht.org

Standard Insurance Co.
Group Policy NO. 648982

MMEHT LIFE INSURANCE PLAN
ENROLLMENT FORM
PLEASE PRINT

Employer	Date of Hire	Annual Salary

Employee Legal Name _____ Soc. Sec. # _____

Employee Address: _____

Phone (H)_____ (W)_____ Gender ___ Marital Status ___ Date of Birth _____

I would like to enroll in the following Life Insurance coverage(s):

Type of Coverage – Check coverage and level option(s) desired only if offered by your employer

Basic Life ☐
Life No Medical ☐
Supplemental Life ☐ Please enroll me for: ☐ 1x ☐ 2x ☐ 3x salary.
Dependent Life ☐ Please enroll me in: ☐ Option A ☐ Option B

Dependent Information: Complete only if enrolling in Dependent Life

Name	Date of Birth	Relationship

Beneficiary Designation: Please designate each name as Primary (P) or Contingent (C) in last column

Name	Relationship	Address	Percentage	P or C

I hereby apply for life insurance to which I am entitled or to which I may become entitled under the terms of the group policy or policies issued to the Maine Municipal Employees Health Trust. If I do not elect the health coverage, I understand that I have the option to enroll in Life No Medical for a monthly premium.

Enrolling in Life Insurance: Signature_____ Date: _____

I understand by not electing to enroll in life insurance during my new hire period, I can elect to enroll at any time, but will be subject to the evidence of insurability process and coverage may be denied.

Not Enrolling in Life: Signature _____ Date: _____

PLEASE READ IMPORTANT INFORMATION ON THE NEXT PAGE
Email completed form to htbilling@memun.org or Fax (207) 624-0166
PLEASE RETAIN A COPY FOR YOUR RECORDS

DEFINITIONS: **Primary Beneficiary** – The person or persons you want to receive the life insurance benefits if you die.
Contingent Beneficiary –The person or persons you want to receive the life insurance benefit if no Primary Beneficiary is alive on the date of your death.

Note:

If more than one primary beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries who are then still living, unless their shares are specified. If there is no named beneficiary or if no beneficiary survives, settlement will be made in the following order: surviving spouse; equal shares to surviving children; equal shares to surviving parents; equal shares to surviving siblings; your Estate.

A member cannot be covered as both an employee/retiree under Basic or Supplemental coverage and also as a dependent under Dependent Life coverage.

IMPORTANT NOTICE:

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is guilty of a crime, and may be prosecuted and punished under state law. Penalties may include fines, civil damages, and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

General Disclosure:

Group Life Insurance coverage is issued by Standard Insurance Company. The phone number for Life Claims is: 1-800-628-8600. Please refer to the Booklet-Certificate, which is made a part of the Group Contract, for all plan details, including any exclusions, limitations and restrictions which may apply. If there is a discrepancy between this document and the Booklet-Certificate/Group Contract issued by Standard Insurance Company, the terms of the Group Contract will govern.

Please Return Completed Form to:

htbilling@memun.org or fax (207) 624-0166
or mail to:
Maine Municipal Employees Health Trust 60
Community Drive
Augusta, Maine 04330

For questions, please call the Billing & Enrollment Dept. at 207-621-2645 or (within Maine) 800-452-8786 EXT. 2585

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60 Community Drive | Augusta, ME 04330-9486
(207) 621-2645 or 1-800-852-8300 | www.mmeht.org

MMEHT LIFE INSURANCE PLAN
EMPLOYEE CHANGE FORM
Please Print

Standard Insurance Company
Group Policy No. 648982

1. TYPE OF CHANGE	**Beneficiary Change** ☐	**Name Change** ☐ ***Previous Name***: _____	**Address Change** ☐	**Benefit Change** ☐

2. EMPLOYER SECTION	Employer:	Date of Hire:	Annual Salary: $

3. EMPLOYEE SECTION

Employee Legal Name: _____ Soc. Sec. #: _____

Employee Address: _____

Phone (H): _____(W):_____Gender: _____Marital Status: _____ Date of Birth: _____

4. PLAN OPTIONS

I would like to change my Life Insurance coverage(s) as specified below (you may only select coverage options offered by your employer): * May Require Evidence of Insurability

Type of Coverage	Add *	Drop	Level			*May Require Evidence of Insurability
Basic Life	☐	☐	N/A			
Supplemental Life	☐	☐	☐ 1x salary	☐ 2x salary	☐ 3x salary	
Dependent Life	☐	☐	☐ Option A	☐ Option B		

Specify Change: _____

Dependent Information: *Note: Complete only if enrolling in or updating Dependent Life

5. DEPENDENT INFORMATION

Name	Date of Birth	Relationship

Beneficiary Designation: *Note: Please designate each name as Primary (P) or Contingent (C) in last column

6. BENEFICIARY DESIGNATION

Name	Relationship	Address	Percentage	P or C

7. AUTHORIZED SIGNATURE

I hereby apply for life insurance to which I am entitled or to which I may become entitled under the terms of the group policy or policies issued to the Maine Municipal Employees Health Trust. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance.

SIGNATURE: _____ DATE: _____

PLEASE READ IMPORTANT INFORMATION ON THE NEXT PAGE

EMAIL COMPLETED FORM TO HTBILLING@MEMUN.ORG OR FAX (207) 624-0166
PLEASE MAKE A COPY TO RETAIN FOR YOUR RECORDS

DEFINITIONS: **Primary Beneficiary** – The person or persons you want to receive the life insurance benefits if you die.
Contingent Beneficiary –The person or persons you want to receive the life insurance benefit if no Primary Beneficiary is alive on the date of your death.

Note:

If more than one primary beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries who are then still living, unless their shares are specified. If there is no named beneficiary or if no beneficiary survives, settlement will be made in the following order: surviving spouse; equal shares to surviving children; equal shares to surviving parents; equal shares to surviving siblings; your Estate.

IMPORTANT NOTICE:

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is guilty of a crime, and may be prosecuted and punished under state law. Penalties may include fines, civil damages, and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

General Disclosure:

Group Life Insurance coverage is issued by Standard Insurance Company. The telephone number for Life Claims is: 1-800-628-8600. Please refer to the Booklet-Certificate, which is made a part of the Group Contract, for all plan details, including any exclusions, limitations and restrictions which may apply. If there is a discrepancy between this document and the Booklet-Certificate/Group Contract issued by Standard Insurance Company, the terms of the Group Contract will govern.

htbilling@memun.org or fax (207) 624 0166
or Mail to
Maine Municipal Employees Health Trust
60 Community Drive
Augusta, Maine 04330

For questions, please call the Billing & Enrollment Dept. at 207-621-2645 or (within Maine) 800-452-8786 EXT. 2585

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EMPLOYEES HEALTH TRUST
60 Community Drive | Augusta, ME 04330-9486
(207) 621-2645 or 1-800-852-8300 | www.mmeht.org

MMEHT OFFICE USE ONLY
Subgroup No.
Effective Date
Status
Entered by:

DENTAL PLAN APPLICATION ENROLLMENT/CHANGE FORM PLEASE PRINT

1. EMPLOYER SECTION

Employer

Date of Employment | Hours worked per week

Enrollment Reason:
- ☐ New Hire
- ☐ Newly Eligible on (date & reason) _____
- ☐ New Group (initial enrollment)
- ☐ Open Enrollment
- ☐ Portability/Qualifying Event

2. PLAN CHOICE

I elect to be insured at the ☐ **Employee Only** ☐ **Employee/Spouse** ☐ **Employee/Child** ☐ **Family** level of coverage and hereby authorize my employer to withhold from payroll the amount necessary to make coverage effective.

3. NAME, ADDRESS & TELEPHONE

Employee Legal Name | Gender ☐ Male ☐ Female ☐ Non-Binary | Social Security Number

Mailing Address | Home Phone: / Cell Phone:

Town | State | Zip | Work Phone:

4. CHANGE STATUS

Type of change: ☐ Address change ☐ Name change – provide previous name:
☐ Add dependent(s) listed below in section 5 ☐ Drop dependent(s) listed below in section 5

Reason for change: **Date of change or event**

☐ Adoption	☐ Birth	☐ Court order
☐ Covered by other insurance	☐ Death	☐ Discharge from the Military
☐ Divorce	☐ Dissolution of Domestic Partnership	☐ Entrance to the Military
☐ Involuntary loss of coverage	☐ Marriage	☐ Other _____

You may apply to cover your legal spouse, domestic partner (DP) (IF your employer offers this benefit and the Trust receives a completed MMEHT domestic partner affidavit, verifying qualification) and children between birth and 26 years of age.

5. FAMILY INFORMATION (IF ELECTING FAMILY COVERAGE)

Name (Last, First, MI)	Date of Birth Mo/Day/Yr	Social Security Number	Gender		
			Male	Female	Non-Binary
☐ Spouse or ☐ Domestic Partner					
Child					
Child					
Child					

6. SIGNATURE

I am requesting coverage for myself, and all dependents listed. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete, or misleading information to obtain insurance or benefits coverage for the purpose of defrauding the plan or insurance carrier. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject to conditions stated in the Plan Document.

Employee Signature: _____ Date: _____

7. ELECTION NOT TO ENROLL

☐ I elect **not** to enroll in dental coverage during my new hire enrollment period. I understand I may choose to elect coverage later during open enrollment or with a qualifying event.

NAME (print) _____ EMPLOYER _____

SIGNATURE _____ DATE _____

Email completed form to htbilling@memun.org or fax (207) 624-0166
For questions, please call the Billing & Enrollment Dept. at 207-621-2645 or (within Maine) 800-452-8786 EXT. 2585

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(207) 621-2645 or 1-800-852-8300 | www.mmeht.org

VSP Vision care for life

MMEHT OFFICE USE ONLY
Subgroup No.
Effective Date
Status
Entered by:

VISION PLAN APPLICATION ENROLLMENT/CHANGE FORM PLEASE PRINT

1. EMPLOYER SECTION

Employer

Date of Employment | Hours worked per week

Enrollment Reason:
- ☐ New Hire
- ☐ Newly Eligible on (date & reason) _____
- ☐ New Group (initial enrollment)
- ☐ Open Enrollment
- ☐ Portability/Qualifying Event

2. PLAN CHOICE

I elect to be insured at the ☐ **Employee Only** ☐ **Employee/Spouse** ☐ **Employee/Child** ☐ **Family** level of coverage and hereby authorize my employer to withhold from payroll the amount necessary to make coverage effective.

3. NAME, ADDRESS & TELEPHONE

Employee Legal Name	Date of Birth	Gender	Social Security Number
		☐ Male ☐ Female ☐ Non-Binary	

Mailing Address | Home Phone: / Cell Phone:

Town | State | Zip | Work Phone:

4. CHANGE STATUS

Type of change: ☐ Address change ☐ Name change – provide previous name: _____
☐ Add dependent(s) listed below in section 5 ☐ Drop dependent(s) listed below in section 5

Reason for change: **Date of change or event** _____

☐ Adoption	☐ Birth	☐ Court order
☐ Covered by other insurance	☐ Death	☐ Discharge from the Military
☐ Divorce	☐ Dissolution of Domestic Partnership	☐ Entrance to the Military
☐ Involuntary loss of coverage	☐ Marriage	☐ Other _____

You may apply to cover your legal spouse, domestic partner (DP) (IF your employer offers this benefit and the Trust receives a completed MMEHT domestic partner affidavit, verifying qualification) and children between birth and 26 years of age.

5. FAMILY INFORMATION (IF ELECTING FAMILY COVERAGE)

Name (Last, First, MI)	Date of Birth Month/Day/Year	Gender		
		Male	Female	Non-Binary
☐Spouse or ☐Domestic Partner				
Child				
Child				
Child				

6. SIGNATURE

I am requesting coverage for myself, and all dependents listed. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete, or misleading information to obtain insurance or benefits coverage for the purpose of defrauding the plan or insurance carrier. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject to conditions stated in the Plan Document.

Employee Signature: _____ Date: _____

7. ELECTION NOT TO ENROLL

☐ I elect **not** to enroll in VSP Vision coverage during my new hire enrollment period. I understand I may choose to elect coverage later during open enrollment or with a qualifying event.

NAME (print) _____ EMPLOYER _____

SIGNATURE _____ DATE _____

Email completed form to htbilling@memun.org or fax (207) 624-0166
For questions, please call the Billing & Enrollment Dept. at 207-621-2645 or (within Maine) 800-452-8786 EXT. 2585

HT016 07-2023

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Entered by:

INCOME PROTECTION PLAN ENROLLMENT/CHANGE FORM PLEASE PRINT

1. EMPLOYER SECTION

NOT TO BE COMPLETED BY EMPLOYEE

Employer		**Enrollment Reason:** ☐ New Hire ☐ Newly Eligible on (date & reason) _____ ☐ New Group (initial enrollment) ☐ Increase/Decrease Coverage ☐ Late Enrollee ☐ Employer Change-Dept/Union Change - not previously eligible to enroll in plan or at the same premium
Date of Employment	Hours worked per week	
Annual wages or salary	Department	
Is employee actively working as of the effective date of coverage, or available to work if it is not a regularly scheduled workday?		☐ Yes ☐ No
***Employer Signature**: _____ ***Title**: _____ **CANNOT BE SIGNED BY THE EMPLOYEE ENROLLING IN COVERAGE**		

Employee: Complete section below only if you are enrolling in the Income Protection Plan coverage.
If you do not wish to enroll, please complete the "Election Not to Enroll" section below.

2. PLAN CHOICE

I elect to be insured at ☐ 40% ☐ 55% ☐ 70% of salary as a weekly benefit

3. NAME, ADDRESS & TELEPHONE

Employee Legal Name	Date of Birth	Gender ☐ Male ☐ Female ☐ Non-Binary	Social Security Number
Mailing Address			Home Phone: Cell Phone:
Town	State	Zip	Work Phone:

4. SIGNATURE

I am requesting coverage, or a change in coverage, for myself. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete, or misleading information to obtain insurance or benefits coverage for the purpose of defrauding the plan or insurance carrier. Penalties may include imprisonment, fines, or denial of insurance benefits. I understand that the benefits I am applying for are subject to the terms and conditions stated in the applicable Health Trust Plan Document and that benefits will be coordinated with other insurance programs. I understand that I am subject to the Plan's subrogation rights and responsibilities, as defined by the Plan in the applicable Health Trust Plan Document and/or Summary Plan Description. Any dispute of claim will be resolved by the grievance procedures established in the applicable Health Trust Plan Document.

Employee Signature: _____ Date: _____

5. ELECTION NOT TO ENROLL

☐ I elect not to enroll in the Income Protection Plan during my new hire enrollment period. I understand I can elect to enroll at any time but will be subject to the evidence of insurability process and coverage may be denied.

NAME (print)_____ EMPLOYER _____

SIGNATURE _____ DATE _____

Email completed form to htbilling@memun.org or fax (207) 624-0166
For questions, please call the Billing & Enrollment Dept. at 207-621-2645 or (within Maine) 800-452-8786 EXT. 2585

Underwritten by:
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

MAINE MUNICIPAL EMPLOYEES HEALTH TRUST
Long Term Disability Insurance Enrollment Form
Policy #588982

Employee Name:	Occupation:
Address:	Date of Birth:
Social Security Number:	Gender:
Hours Worked / Week:	Location:
Date of Hire:	Annual Salary:

Rates * per $100 of Covered Salary			
Age	**Rate**	**Age**	**Rate**
< 25	$0.25	50 - 54	$1.03
25 - 29	$0.30	55 - 59	$1.20
30 - 34	$0.34	60 - 64	$1.65
35 - 39	$0.43	65 - 69	$1.80
40 - 44	$0.57	70+	$2.05
45 - 49	$0.77		
* LTD rates are based on five-year increments. Rates increase as you age.			

To calculate the per-paycheck cost for this coverage, complete the calculations below.

Note: *If your annual salary exceeds $120,000.00, use $120,000.00 as your annual salary in the calculation.*

÷ 100 =		X	=	÷		=
Annual Salary		Your Rate	Your Annual Cost		# of Paychecks per Year	**Cost per Paycheck***

* Final cost may vary slightly due to rounding.

❒ **Yes,** I would like to participate. I authorize my employer to deduct from my salary or wages the necessary premium for this coverage. My signature verifies the accuracy of information contained on this form.

I understand the effective date of my coverage will be delayed if I am not in active employment because of an injury, sickness, temporary lay-off or leave of absence on the date this insurance would otherwise become effective. **I have also read and understand the information in the Plan Highlights, including all statements regarding exclusions and benefit amounts and offsets.**

❒ **No,** I do not wish to participate. I understand that evidence of insurability will be required, at my own expense, if I decide to elect this cover in the future.

Employee Signature: _____ Date: _____

Return Forms To Plan Administrator

This section to be completed by your employer:
Coverage Effective Date:

Underwritten by:
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

MAINE MUNICIPAL EMPLOYEES HEALTH TRUST
Long Term Disability Insurance Enrollment Form
Policy #588982

Employee Name:	Employer:	
Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ _	Date of Birth: ___ ___ / __ __ / __ __ __ __	
Hours Worked / Week:	Gender:	Location:
Date of Hire: ___ ___ / __ __ / __ __ __ __	Annual Salary:	
Address:		

I understand the effective date of my coverage will be delayed if I am not in active employment because of an injury, sickness, temporary lay-off or leave of absence on the date this insurance would otherwise become effective. **I have also read and understand the information in the Plan Highlights, including all statements regarding exclusions and benefit amounts and offsets.** My signature verifies the accuracy of information contained on this form.

Employee Signature: _____ Date: _____

Return Forms To: YOUR PLAN ADMINISTRATOR

This section to be completed by your employer:

Coverage Effective Date: __ ___ / __ ___ / ___ ___ ___ ___

MAINE MUNICIPAL
EMPLOYEES HEALTH TRUST
60 Community Drive | Augusta, ME 04330-9486
(207) 621-2645 or 1-800-852-8300 | www.mmeht.org

MMEHT OFFICE USE ONLY	
Structure	Subgroup Number
Effective Date	Plan

Health Plan Application for Continued Enrollment as a Retiree

YOU MAY EMAIL COMPLETED FORM TO HTBILLING@MEMUN.ORG OR FAX (207) 624-0166

1. FAMILY INFORMATION

You may apply to cover your legal spouse and children between the ages of birth and 26.

Legal Name (Last, First, MI)	Date of Birth MO/DA/YR	Gender M	F	Non-Binary	Social Security Number	Primary Care Physician (PCP) (www.anthem.com or see Anthem Directory)	Current Patient?
Retiree						PCP Name:	Y ☐ N ☐
Spouse						PCP Name:	Y ☐ N ☐
Dependent						PCP Name:	Y ☐ N ☐
Dependent						PCP Name:	Y ☐ N ☐

2. ADDRESS & TELEPHONE

Mailing Address			Home Telephone
City/Town	State	Zip	Mobile Telephone

3. MEDICARE INFORMATION

Refer to your Medicare Health Insurance card for Claim Number and Effective Dates.

Is anyone listed on this application currently eligible for Medicare?

☐ **Yes** Please complete the following for each person to be covered who has Medicare A&B. ☐ **No** Please disregard this section.

Retiree				Spouse			
Medicare Claim Number				Medicare Claim Number			
EFFECTIVE DATES	**Month**	**Year**		**EFFECTIVE DATES**	**Month**	**Year**	
HOSPITAL (PART A)				**HOSPITAL (PART A)**			
MEDICAL (PART B)				**MEDICAL (PART B)**			
REASON(S) FOR MEDICARE CHECK ALL THAT APPLY	**Age 65**	**Disability**	**ESRD***	**REASON(S) FOR MEDICARE CHECK ALL THAT APPLY**	**Age 65**	**Disability**	**ESRD***
	***End Stage Renal Failure**				***End Stage Renal Failure**		

4. SIGNATURE

I am requesting coverage, or a change in coverage, for myself and dependents listed. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete, or misleading information to obtain insurance or benefit coverage for the purpose of defrauding the plan or insurance carrier. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject of conditions stated in the Plan Document.

Retiree Signature:	Date:

FOR QUESTIONS, PLEASE CALL THE BILLING & ENROLLMENT DEPT.
207-621-2645 OR (WITHIN MAINE) 800-452-8786 EXT. 2585

HT001-08-2023

MAINE MUNICIPAL
EMPLOYEES HEALTH TRUST
60 Community Drive | Augusta, ME 04330-9486
(207) 621-2645 or 1-800-852-8300 | www.mmeht.org

MainePERS Deduction Authorization

PLEASE PRINT

Subscriber Name:	Date of Birth			Social Security Number:
	Month	Day	Year	
Spouse Name:	Date of Birth			Social Security Number:
	Month	Day	Year	
Address: Street		City	State	Zip Code
I hereby authorize the Maine Public Employees Retirement System to deduct the proper amount to cover the costs of my healthcare coverage. Subscriber Signature:				Date:

HT002-06-2023

MAINE MUNICIPAL
EMPLOYEES HEALTH TRUST
60 Community Drive | Augusta, ME 04330-9486
(207) 621-2645 or 1-800-852-8300 | www.mmeht.org

TO: Jon Bon Jovi
Dorothea Hurley
123 Sesame St.
Apple Cove, ME 02176

FROM: Maine Municipal Employees Health Trust Billing and Enrollment Department

DATE: September 22, 2023

ID #:	739542612					
EMPLOYER:	Town of Apple Cove					
PLAN:	**Health:**	POS 200	**Status:**	Single	**Effective:**	**August 1, 2023**
	Dental:	Dental	**Status:**	Employee-Spouse	**Effective:**	**August 1, 2023**
IPP PERCENTAGE:		**Effective:**				
VISION:		**Effective:**				
LTD:		**Effective:**				
BASIC LIFE:	30,000		**Effective:**	**August 1, 2023**		
LIFE-NO MEDICAL:			**Effective:**			
SUPPLEMENTAL LIFE:			**Effective:**			
DEPENDENT LIFE:			**Effective:**			

Welcome to the Maine Municipal Employees Health Trust!

Under Federal Law, the Health Trust is required to inform you, as a new participant, of your rights under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) regarding health, vision, and dental insurance. The enclosed material will explain your rights under the COBRA law, should your coverage with the Maine Municipal Employees Health Trust terminate.

The Health Trust is also required by Federal Law to notify all new participants of benefits available for mastectomies and reconstructive breast surgeries. Please see page 7 of the enclosed Annual Notice.

Included in this packet is a Summary Plan Description benefit booklet for coverage(s) listed above. If you have questions regarding benefit coverage, please call a Health Trust Service Representative at 1-800-852-8300 or 207-621-2645. **Please note: Medical and Dental identification cards are mailed separately and should be received within 7-10 business days. Identification cards are not issued for Vision coverage.**

Please read this information carefully. If you have any questions pertaining to the effective date or level of coverage, please call the Health Trust Billing and Enrollment Department at 1-800-452-8786.

Enclosure

MAINE MUNICIPAL
EMPLOYEES HEALTH TRUST
60 Community Drive | Augusta, ME 04330-9486
(207) 621-2645 or 1-800-852-8300 | www.mmeht.org

TO: Bill S.Preston
69 No Way Way
San Demos, ME 04492

FROM: Billing and Enrollment Department
Maine Municipal Association
Plan Administrator for
Maine Municipal Employees
Health Trust

SUBJECT: COBRA Election Notice
Certification of Health Coverage
Conversion Privileges

GROUP: Town of Maple Grove

DATE: September 22, 2023

This notice has important information about your right to continue your health care coverage with the Maine Municipal Employees Health Trust (the Plan), as well as other health coverage options that may be available to you. For example, you may be able to get coverage through the Health Insurance Marketplace (www.healthcare.gov) that costs less than COBRA continuation coverage. Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should use the election form provided later in this notice.

Why am I getting this notice?

You're getting this notice because your coverage under the Plan will end on October 1, 2023 due to:

X	End of employment		Reduction in hours of employment
	Death of employee		Divorce or legal separation
	Entitlement to Medicare		Loss of dependent child status
			Other: _____

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a "qualifying event" that would result in a loss of coverage under an employer's plan.

What's COBRA continuation coverage?

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan

COBRA Continuation Coverage Election Form

To elect COBRA continuation of group health coverage, complete this Election Form and return it to:

Maine Municipal Employees Health Trust Attn:
Billing and Enrollment Department
60 Community Drive, Augusta, ME 04330-9486.

You have the later of 60 days from the date of this notice or 60 days from the loss of coverage to decide to elect COBRA continuation coverage under the Plan. The last date you are able to elect COBRA coverage is November 29, 2023. This form must be returned by mail and postmarked no later than November 29, 2023.

If you do not return the completed Election Form by the date shown above, you will lose your right to elect COBRA coverage. If you reject COBRA coverage before the due date shown above, you may change your mind as long as you furnish a completed Election form before the due date. However, if you change your mind after first rejecting COBRA coverage, your COBRA coverage will begin on the date the Health Trust receives the completed form. In this case, there may be a lapse of coverage.

Insured:	Bill S. Preston		**Division No.**	12506
Insured ID:	792567890		Dependent of:	
COBRA Effective Date:	October 1, 2023		COBRA Termination Date:	April 1, 2025

Plan Type	Plan Name	Rate Category	Monthly Premium
Medical	POS C	Single	$1,216.11
Dental	Dental	Single	$44.67
Vision	Vision	Single	$5.69

1. For Insured:

I certify, as the subscriber, that I am aware of the continuation of benefits available under my current health plan and the extent to which those benefits can be continued at my expense. (Check one.)

Yes ____, I elect to continue Health ___ Dental ___ Vision coverage ___. No ____, I do not wish to continue coverage.

INSURED'S SIGNATURE: _____ Date: _____ Phone: _____

2. For Insured's Spouse:

I certify, as the subscriber's covered spouse, that I am aware of the continuation of benefits available under my current health plan and the extent to which those benefits can be continued at my expense. (Check one.)

Yes ____, I elect to continue Health ___ Dental ___ Vision coverage ___. No ____, I do not wish to continue coverage.

SPOUSE'S SIGNATURE: _____ Date: _____ Phone: _____

3. For Insured's Dependents:

I certify, as the parent or legal guardian for my covered dependents, that they are aware of the continuation of benefits available under their current health plan and the extent to which those benefits can be continued at my expense. (Check one.)

Yes ____, I elect to continue Health ___ Dental ___ Vision coverage ___. No ____, I do not wish to continue coverage.

PARENT OR LEGAL GUARDIAN'S SIGNATURE: _____ Date: _____

IS ANY OF THE FOLLOWING ENROLLED IN: (Please answer for each group)

ANOTHER GROUP HEALTH COVERAGE			**MEDICARE BENEFITS**		
Employee	Yes ____	No ____	Employee	Yes ____	No ____
Spouse	Yes ____	No ____	Spouse	Yes ____	No ____
Dependents	Yes ____	No ____	Dependents	Yes ____	No ____

Current Address: _____

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EMPLOYEES HEALTH TRUST
60 Community Drive | Augusta, ME 04330-9486
(207) 621-2645 or 1-800-852-8300 | www.mmeht.org

Certificate of Coverage

IMPORTANT – KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this health plan. Under a federal law known as HIPAA, you may need evidence of your coverage if you are enrolling in another health plan.

1. Date of this certificate: September 22, 2023

2. Name of group health plan: Maine Municipal Employees Health Trust

3. Name of participant: Bill S. Preston

4. Identification number of participant: 792567890

5. Name and start date of any dependents to whom this certificate applies:

6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate:

   Maine Municipal Employees Health Trust (MMEHT) 60
   Community Drive
   Augusta, ME 04330
   1-800-452-8786 in Maine or (207) 623-8428

7. For further information, call: MMEHT Billing and Enrollment Department

8. Date coverage began: February 1, 2000

9. Date coverage ended: October 1, 2023 (or check if coverage is continuing as of the date of this certificate ☐).

Note: Separate certificates will be furnished if information is not identical for the participant and each beneficiary.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. *Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool). To be an eligible individual, you must meet the following requirements:*

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage. The

right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

Special information for people on FMLA leave. If you are taking leave under the Family and Medical Leave Act (FMLA) and you drop health coverage during your leave, any days without health coverage while on FMLA leave will not count towards a 63-day break in coverage. In addition, if you do not return from leave, the 30-day period to request special enrollment in another plan will not start before your FMLA leave ends.

- Therefore, when you apply for other health coverage, you should tell your plan administrator or health insurer about any prior FMLA leave.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: http://www.dol.gov/ebsa, the DOL's interactive web pages – Health *E*laws, or http://www.cms.hhs.gov/hipaa1.

Portability / Conversion Contact Information
Policy No. 648982

As an employee of Maine Municipal Employees Health Trust, you had Life insurance with The Standard. As your employment terminates we want you to be aware that you have the option to continue this coverage.

You have a **portability** and/or **conversion** option with Life insurance coverages.

Portability offers you pure term insurance. The rates are competitive term rates in five year age bands. Employees that are terminating employment due to retirement or a serious illness or injury cannot port their coverage; they may only convert their coverage. You must also be under age 65 upon termination to be eligible for this option.

Portability Application:
https://www.standard.com/eforms/305_8199_648982pkt.pdf

Conversion offers you a whole life individual plan. The rates are based on your attained age once you have applied for the coverage.

Conversion Application:
https://www.standard.com/eforms/9563_648982.pdf

Both of these plans require that you apply for the coverage within 60 days of your termination from Maine Municipal Employees Health Trust. Applications must be sent directly to The Standard along with the first payment. If you have additional questions please feel free to contact The Standard at 800-378-4668 extension 6785.

This information is intended solely to provide you with a brief description of your life portability and/or conversion options. Full details will be included in certificate booklets. Any and all applications will be governed by the specific provisions of your contract.

MAINE MUNICIPAL
EMPLOYEES HEALTH TRUST
60 Community Drive | Augusta, ME 04330-9486
(207) 621-2645 or 1-800-852-8300 | www.mmeht.org

September 22, 2023
"25" Dependent
Application for Continued Coverage
Health, Dental and/or Vision

Insured Name: Nicholas Sparks Insured Acct#: 755446698 Address: 36 Readers Way Sanctuary, ME 59210 If address has changed, please print changes above.	**For Office Use Only** ☐ 25 Dependent ☐ Deleted date:_____
Name of 25 Dependent	
Helena Sparks	Town of Sanctuary

Please answer ALL questions below and sign your name. **YES** **NO**

1. I wish to keep the dependent listed above on my health dental vision plan until the 1st of the month following his/her 26th birthday. ☐ ☐

If you have checked NO, your dependent will be removed from your policy the first of the month following their 25th birthday or the 1st of the month following receipt of this form; whichever is latest.

2. Is he/she totally and permanently disabled due to physical or mental condition(s)? If yes, we will send you a Medical Certification form to be completed by you and your child's physician. ☐ ☐

3. Does he/she have other health, dental or vision insurance coverage? ☐ ☐
If yes: Name of Insured: _____ Policy #: _____
Effective Date: _____ Insurance Co. Name: _____.

PARTICIPANT CERTIFICATION

As a participant in the Maine Municipal Employees Health Trust, I hereby certify, under penalty of perjury, that the information provided above is true, accurate and complete as of the date hereof, and I agree to advise the Trust if any of the facts specified above change. I further understand that the Trust will rely on this information in providing coverage to my dependent and that any material falsehood or inaccuracy may result in the disallowance and non-payment of dependent claims.

_____ _____
Date Signature of Participant

MAINE MUNICIPAL
EMPLOYEES HEALTH TRUST
60 Community Drive | Augusta, ME 04330-9486
(207) 621-2645 or 1-800-852-8300 | www.mmeht.org

AFFIDAVIT OF DOMESTIC PARTNERSHIP

We, _____ and _____ (domestic partners), after being first duly sworn depose and attest to the following:

- We are at least 18 years of age and we are mentally competent to contract.
- Neither of us is legally married to or separated from another person.
- We are sole domestic partners, we have been sole domestic partners since _____ (month/day/year), and we intend to remain sole partners.
- We have been legally domiciled together for at least [12] months.
- We are not related by blood to a degree of closeness that would prohibit marriage in the State of Maine.
- Neither of us has covered another individual or has been covered by another individual as a domestic partner or a legal spouse in a [health] or [dental] or [vision] insurance policy in the preceding [12] months. We understand that domestic partners cannot enroll together for [12] months following the termination of coverage of a prior domestic partner or legal spouse.
- We are jointly responsible for each other's common welfare as evidenced through a joint deed, joint mortgage, joint lease, joint credit card, joint bank account, and/or powers of attorney authorizing each of us to act on behalf of the other. Maine Municipal Employees Health Trust reserves the right to request, at a future time, one of the previously mentioned documents.
- We understand that a domestic partner enrolled as a dependent ceases to be an eligible member on the first of the month following the termination of a domestic partnership and that we are required to submit an Application of Change within 31 days of the termination of a domestic partnership.

_____	_____	_____
Date	Subscriber Signature	Print Name
_____	_____	_____
Date	Domestic Partner Signature	Print Name

STATE OF _____ _____ , ss

On this _____ day of _____ , 20 _____ , personally appeared the above named _____ and _____ , and swore to the truth of the foregoing. Before me,

_____
Notary Public/Attorney at Law

My Commission Expires: _____

We understand that domestic partners are subject to the other eligibility provisions of the Health Trust benefit plans.

We agree to notify the Maine Municipal Employees Health Trust and the employee's employer within thirty (30) days of the termination of our domestic partnership. A written termination statement shall be provided and shall affirm that the partnership is terminated and that a copy of the termination statement has been mailed to the other partner.

We certify, under penalty of perjury, that the foregoing is true and correct. We, the undersigned employee and the Domestic Partner, understand that falsification of information contained in this Affidavit may cause immediate termination of Health Trust health and/or dental plan coverage, and may subject us to civil action to recover any losses, including reasonable attorney's fees incurred by the Maine Municipal Employees Health Trust for benefits provided under its health and/or dental plans. We also understand that falsification of information contained in this Affidavit may lead to disciplinary action, up to and including immediate termination of the employee's employment.

_____ _____

Signature of Employee Date

_____ _____

Signature of Domestic Partner Date

A. Dependent Child Certification

I, _____ certify that my Partner's child(ren) named below meet the following requirement:
Subscriber Name

1. I, the subscriber, have a court-appointed legal relationship with the child(ren) (i.e., adoption, guardianship), and my Partner is the biological parent, or legal guardian of the child(ren).

Partner's Dependent Child(ren)

Last Name	First Name	M.I.
Last Name	First Name	M.I.
Last Name	First Name	M.I.
Last Name	First Name	M.I.

I understand that falsely certifying as to dependent's eligibility or failure to inform the Health Trust when a dependent no longer meets applicable eligibility requirements may cause immediate termination of Health Trust health and/or dental plan coverage, and may subject me to civil action to recover any losses, including reasonable attorney's fees incurred by the Maine Municipal Employees Health Trust for benefits paid on behalf of the dependent child(ren) named above under its health and/or dental plans. I also understand that falsely certifying as to a dependent's eligibility or failure to inform my employer when a dependent no longer meets applicable eligibility requirements may result in disciplinary action, up to and including immediate termination of employment.

_____ _____

Signature of Employee Date

Approved by the Maine Municipal Employees Health Trust

By: _____ _____

Signature Date

_____

Title

The following section is for certification to an employer of the legal tax dependent status of a domestic partner.

B. Partner Certification as a Tax-Qualified Dependent

Based on consultation with a tax advisor, I certify that the previously named person whom I am enrolling for coverage is my legal tax dependent as defined in the IRS Code Section 152. I understand that falsification of this certification of dependency status may result in disciplinary action, up to and including immediate termination of employment, as well as potential charges of tax fraud. I agree to notify my employer immediately of any change in this tax status.

By: _____ _____

Signature of Employee Date

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EMPLOYEES HEALTH TRUST
60 Community Drive | Augusta, ME 04330-9486
(207) 621-2645 or 1-800-852-8300 | www.mmeht.org

MMEHT OFFICE USE ONLY
Subgroup No.
Effective Date
Entered by:

ADDRESS CHANGE FORM
PLEASE PRINT

Completion of this form will change the address on ALL policies in which the member is enrolled.

EMPLOYER SECTION	Employer	Date of Employment	Hours worked per week
EMPLOYEE INFO	Employee Legal Name	SSN – Last four digits	
OLD ADDRESS & TELEPHONE	Mailing Address	Home Phone Cell Phone	
	Town Zip	Work Phone	
NEW ADDRESS & TELEPHONE	Mailing Address	Home Phone Cell Phone	
	Town State Zip	Work Phone	
EFFECTIVE DATE OF CHANGE			
SIGNATURE	I am requesting that the Health Trust change my address as shown above. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to obtain insurance or benefits coverage for the purpose of defrauding the plan or insurance carrier. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject to conditions stated in the Plan Document. Employee's Signature: _____ Date: _____		

Email completed form to htbilling@memun.org or fax (207) 624-0166
For questions, please call the Billing & Enrollment Dept. at 207-621-2645 or (within Maine) 800-452-8786 EXT. 2585

or Mail to:
MMEHT
ATTN: Billing and Enrollment 60
Community Drive
Augusta, ME 04330

PLEASE RETAIN A COPY FOR YOUR RECORDS

HT 07-2023