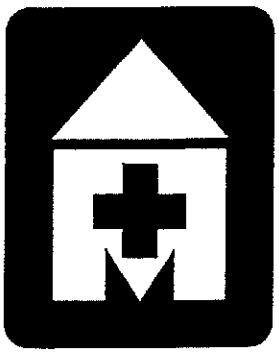
Income Protection Plan



Maine Municipal Employees Health Trust

60 Community Drive
Augusta, Maine 04330-9486
(207) 621-2645
1-800-852-8300

HT IPP (04/08)

TABLE OF CONTENTS

If you have questions about eligibility or enrollment procedures, please call a Health Trust Billing and Enrollment Representative at 1-800-452-8786 (toll-free in Maine) or 207-623-8428 (out of state). If you have questions regarding benefits or claims procedures, please call a Health Trust Service Representative at 1-800-852-8300 (toll-free in Maine) or 207-621-2645 (out of state).

You may also wish to contact the Health Trust via e-mail. Simply log on to the Health Trust's Website at www.mmeht.org and click on the button labeled "Contact Us". This will bring you to a list of links to Health Trust staff members.

CHAPTER 2 – Eligibility

Who Is Eligible for Coverage Under This Plan?

To be eligible for coverage under the Health Trust Income Protection Plan (IPP), you must meet the definition of an eligible *Employee*, as shown in Chapter 9 of this booklet. You may also have to meet certain more restrictive guidelines set by your employer. For example, even though the Health Trust's definition of an eligible employee states that the employee must work a minimum of 20 hours per week on a year-round basis, your employer may set their limit at 30 hours. In that case, your employer's guidelines will prevail. Be sure to check with your employer to find out if you are eligible for coverage under this Income Protection Plan.

If you are eligible for coverage under this Plan, you will be able to obtain coverage for (enroll) yourself only. There is no coverage under the Health Trust Income Protection Plan for any of your dependents.

The next chapter (Chapter 3) will explain how to enroll in the Health Trust's Income Protection Plan.

CHAPTER 3 – Enrollment

If you would like to be covered under the Health Trust's Income Protection Plan, you must complete an enrollment application. If you do not wish to be covered under this plan, you must sign a waiver form. Please see your *employer* to obtain either of these forms.

How Do You Enroll for Coverage?

If you are a new employee, or if you are newly eligible for IPP coverage, you should ask your employer when you will be eligible for coverage (your *eligibility date*). You must enroll within 60 days of your eligibility date. Otherwise you will be considered a Late Enrollee and you will have to provide the Health Trust with *evidence of insurability* (also known as *evidence of good health*). You must pay any and all costs required to provide this evidence of good health. If you apply for coverage as a Late Enrollee, you may be denied coverage, based upon your health status.

When Does Your Coverage Become Effective?

Once you have completed your enrollment application, your coverage will become effective on the first day of the calendar month that coincides

with or next follows the end of the *waiting period* selected by your employer, as long as we receive your application before the scheduled effective date. So, for example, if your waiting period ends on June 15, and we receive your application on or before July 1, your IPP coverage will be effective July 1. Using the same example, if we did not receive your application until after July 1, the effective date of your coverage would be delayed. Please contact a Health Trust Billing and Enrollment Representative for more information.

In order to receive coverage, you must be actively at work on the date your coverage is scheduled to become effective (or be available to work if it is not a scheduled work day). If you are not at work on your scheduled effective date, then your coverage will not become effective until the day you return to active work.

You have a 60-day "window" after your eligibility date, in order to submit your application. After that, you will be considered a late enrollee.

What Is a Late Enrollee?

If you do not enroll during the 60-day eligibility period, you will be considered a late enrollee. This means that you will be required to submit proof of good health in order to qualify for Health Trust Income Protection Plan coverage. You must pay any and all costs required to provide this evidence of good health. If you are a late enrollee, the Health Trust will determine whether or not you may participate in the Income Protection Plan, based upon your health status.

There is one exception to the rule regarding late enrollees. This occurs if your employer changes how much they contribute towards the cost of your IPP coverage. For example, if your employer changes from paying less than 100% of the cost for your coverage (*contributory coverage*) to paying 100% of the cost (*non-contributory coverage*), then an open enrollment period will follow. During this open enrollment period, you may enroll in the Health Trust's Income Protection Plan without having to provide proof of good health – as long as you enroll within 60 days after the date of the change in contribution.

Changes in Coverage

It is very important that you let us know if there are any changes to your Health Trust Income Protection Plan coverage. If you wish to change the level at which your benefits would be paid in the event of a disability, you must complete a new Application for Enrollment. You may be required to submit evidence of good health in order to change your benefit level.

Please complete an Application for Change form and submit it to the Health Trust if you change your address. In addition, your employer must complete a Notification of Salary Change form whenever the amount of your salary changes (whether there is an increase or a decrease). We must receive these forms in order to update your file, and ensure that you receive the proper benefits should you become disabled and file a claim.

What If Your Employer Offers a Cafeteria Plan?

Your employer may offer a cafeteria plan, which provides for an annual open enrollment period. Employers offering a cafeteria plan must provide you with the following information:

a. a written statement indicating that the employer offers a cafeteria plan;
b. a copy of the cafeteria Plan Document; and
c. a statement of the date for the cafeteria plan's open enrollment.

You may enroll in this Plan during the cafeteria plan's open enrollment, provided you meet the eligibility requirements set out in the cafeteria Plan Document, as well as the eligibility requirements of this Plan.

CHAPTER 4 – Schedule of Benefits

What Are Your Benefit Options Under this Plan?

The Health Trust offers three different benefit options under the Income Protection Plan. When you enroll for benefits under this Plan, you must choose one of these options.

The three different benefit options available under the Income Protection Plan are:

- 40% of your *base annual salary*; or
- 55% of your base annual salary; or
- 70% of your base annual salary.

The benefit option that you choose will determine your benefit in the event of a *total disability*; that is, if you become totally disabled and eligible to receive benefits under this Plan. It will also help to determine your benefit in the event of a *partial disability* following a period of total disability.

Your benefit amount will not change during a period of disability, even if your salary changes. Any change in benefit amount will only become effective once you have returned to your normal (that is, pre-disability) level of employment.

When Will You Be Eligible to Receive Income Protection Benefits Under this Plan?

Before you can receive any benefits under this Plan, you must complete the appropriate *elimination period*. No benefits will be payable to you during the elimination period.

If you are filing a claim for Income Protection Plan benefits as the result of an *accident* or an *injury*, then there is no elimination period. Benefits will be payable as of the first day that you are certified as totally disabled. This certification must be made by your *medical provider*.

If you are filing a claim for Income Protection Plan benefits as the result of an *illness*, there is a 7-day *elimination period*. Benefits will be payable as of the eighth day that you are certified as totally disabled. This certification must be made by your medical provider.

How Long Will You Be Eligible to Receive Income Protection Benefits?

You will be eligible to receive Income Protection Plan benefits throughout the period of your total disability, as long as you are under the ongoing care of a medical provider. Unum, Claims Administrator for this Plan, will work with you, your employer, and your medical provider, in order to obtain the most accurate and current status of your disability. Your medical provider must certify that you are disabled, in order for you to be eligible to receive benefits under this Plan.

Payment of benefits under this Plan will end when your medical provider certifies that you are able to return to your occupation, at your pre-disability level of employment, even if you are no longer employed by your former employer.

The maximum benefit period for any one period of disability under this Plan is 52 weeks. This means that, even if you are disabled for longer than 52 weeks, we will stop paying benefits for that particular claim after 52 weeks.

If your employment is terminated while you are receiving disability benefits under this Plan, your benefits may continue, up to the 52-week maximum period, as long as your medical provider continues to certify that you are totally or partially disabled.

What Is the Maximum Benefit Under this Plan?

The maximum benefit payable under this Plan is $1,000 per week. This applies no matter which of the three benefit options (40%, 55%, or 70%) you have chosen.

How Often Are Benefits Paid Under this Plan?

Once you have completed the appropriate elimination period, benefits will be paid to you on a weekly basis throughout the period of your disability, provided all required forms and ongoing verifications of your disability are received in time. Benefits will only be paid for up to 52 weeks per period of disability.

Will this Plan Pay Benefits for *Partial Disability*?

If you are partially disabled, you may be eligible to receive partial benefits under this Plan. Partial disability means that, as the result of a non-job-related accident, illness or injury, you are unable to perform the material and substantial duties of your regular occupation for a portion of your regularly scheduled work week. You must be under the regular care and attendance of a medical provider (as defined by this Plan), who certifies your partial disability.

Partial disability benefits will be paid only if you first meet the definition of *total disability*. You must be totally and continuously disabled, and under the care of a medical provider, for at least eight consecutive days (if the disability is the result of an illness), or for at least one full day (if the disability is the result of an accident or injury). You must collect at least one full day of your full Income Protection Plan benefits.

If your medical provider then certifies that you are able to return to work on a part-time basis, you will continue to be eligible to receive Income Protection Plan benefits while you are partially disabled. We will reduce the amount of the Income Protection benefits that we pay you, by the percentage of your normal week that you are working. For example, if you normally work 40 hours per week and you are able to return to work for only 10 hours per week (25% of your regularly scheduled hours), we will reduce your benefits by 25%.

Benefits will only be paid for up to 52 weeks per period of disability.

Will You Have to Continue Paying Premium While You Are Out on Disability?

During the first six consecutive months that you are totally and continuously disabled, you (or someone on your behalf) must continue to pay all required premiums for your Income Protection Plan coverage, in order for you to remain enrolled in this Plan.

If you are totally disabled for a period longer than six consecutive months, the Health Trust will waive any premium due for your Income Protection Plan coverage, starting on the first day of the seventh month of your total and continuous disability. This waiver of premium will end on the day that you return to work, on either a full-time or part-time basis.

What Happens If You Return to Work, But Then Become Disabled Again?

Successive periods of disability (that is, one right after the other, resulting from the same illness or injury) will be considered as one period of disability for the purposes of paying benefits under this Plan. However, if you return to work at your pre-disability level of employment for a continuous period of at least two (2) weeks, the second period of disability will be treated as a new period of disability.

A new period of disability will also be established if the new disability is unrelated to the previous one, and if you have worked at least one full day of your regularly scheduled hours between disabilities.

Benefits will only be paid for up to 52 weeks per period of disability.

What Are Benefit Offsets?

In some cases, if you are disabled, you may be eligible to receive disability income benefits from more than one source. For example, if you are totally disabled, you may be eligible to receive Social Security disability benefits.

If you are disabled and receiving Income Protection benefits under this Plan, and you also receive disability income benefits from certain other sources, those other disability income payments will be considered as deductible sources of income, or offsets. As offsets, the amount payable to you from those other sources will be subtracted from your Income Protection benefits under this Plan.

The following payments will be considered as benefit offsets, and the amount of the payment will be subtracted from the benefits payable to you under this Income Protection Plan:

1. any payments paid pursuant to or under the Maine State Retirement System, if such payment is being made as a result of the same disability for which we are paying you Income Protection benefits under this Plan; and
2. any payments paid pursuant to or under the United States Social Security Act, if such payment is being made as a result of the same disability for which we are paying you Income Protection benefits under this Plan.

CHAPTER 5 – Claims Filing Procedures

How Do You File an Income Protection Plan Claim?

It's a fairly simple procedure to file a claim for benefits under the Health Trust Income Protection Plan. Just follow these steps:

1. Obtain a Disability Claim form from your employer or the Health Trust.
2. You, or someone on your behalf, should complete and sign the "Claimant's Statement" section of the form (Part B). Be sure to read the fraud warning and authorization sections and sign where indicated at the bottom of page 2. Failure to do so will cause a delay in the processing of the claim.
3. Have your employer complete the "Employer's Statement" section of the form (Part C). Your employer must sign and date the form where indicated, and should provide a telephone number in case of questions.
4. Give the form to your medical provider. Your medical provider will complete the "Physician's Statement" section of the form (Part A).
5. Once the form has been completed by all parties (you, your employer, and your medical provider), the form should be submitted to Unum, The Benefits Center, P.O. Box 100158, Columbia, SC 29202-3158. The form may also be faxed to Unum, at 1-800-447-2498.

In order to receive any benefits under the Health Trust's Income Protection Plan, you must file your claim within 90 days from the date that your total disability began (that is, from the date you were first certified as totally disabled by your medical provider). No benefits will be paid for claims submitted more than 90 days from the first date of total disability.

Once we have received your claim, the Health Trust (through its Claims Administrator, Unum) will pay weekly benefits to you for the duration of your period of disability, subject to the maximum benefit period established by the Plan. You must continue to be under the care of a medical provider, in order for Income Protection Plan benefits to be paid.

In order to obtain the most accurate and current status of an employee's disability, Unum will work with you, your employer, and the attending medical provider. As part of this process, Unum may obtain (but is not limited to) the following: office notes, copies of results from diagnostic testing ordered by the employee's medical provider, and copies of detailed job descriptions.

What Happens If Your Claim is Denied?

There may be times when a claim for Income Protection Plan benefits is denied, either in whole or in part. If this happens, Unum will notify you in writing within 90 days after your claim form is filed. There may be special circumstances in which an extension is required. If that happens, Unum will send you a written notice explaining the reason for the delay, and letting you know when you can expect a final decision. The final decision must be made within 180 days after your original claim form is filed.

If your claim is denied, Unum will send you a written notice of denial. That notice must include:

1. the specific reason or reasons for the denial, including references to the policy provisions on which the denial is based;
2. a description of any additional material or information which is needed to complete the claim, and an explanation of why the additional material is needed; and
3. a list of the steps you must take if you wish to have the decision reviewed.

How Do You File an Appeal?

If your claim is denied, either in whole or in part, you have the right to file an appeal with Unum. You, or an authorized representative, may appeal a denied claim within 180 days after you receive the Health Trust's notice of denial. This 180 day limit may be extended, but only if there are extenuating circumstances. You have the right to:

1. submit a written request for review to Unum, Portland Customer Care Center, Quality Performance Support / Appeals Unit, P.O. Box 9548, Portland, ME 04122-5058, stating the reason(s) that you disagree with the way the claim has been handled;
2. request a review of the eligibility status for any claim which has been denied, in whole or in part;
3. ask to review all documents relating to your claim, including a review of any claim payments. Such request must include your name and Social Security number; and
4. submit issues and comments in writing to Unum. These comments may include any additional information that you would like Unum to consider with regard to your claim.

Once Unum has received your appeal, the claim will be reviewed by a Unum employee (or group of employees) with expertise in the appropriate clinical specialization for your claim. The reviewer(s) will not have been involved in the original decision to deny your claim.

Voluntary Appeal to MMEHT Board

If you disagree with the results of your appeal, you (or your authorized representative) may wish to file an appeal to the Maine Municipal Employees Health Trust Board of Trustees. This is a voluntary appeal, which would give you one more opportunity to have your claim reviewed by the Plan.

Information regarding your claim may be submitted for independent review, by a professional who has not been involved with the first appeal through Unum.

It is important for you to know that this voluntary appeal to the Board of Trustees is what is called an "appellate" review. The Board of Trustees will only reverse any prior decision that was clearly erroneous or incorrect. The voluntary appeal to the Board of Trustees will **not** provide you with the opportunity to appear in person before the Board.

You may file this appeal by submitting your request in writing to: Board of Trustees, Maine Municipal Employees Health Trust, 60 Community Drive, Augusta, ME 04330. An appeal to the Board must be filed within 180 calendar days after the date the benefits denial was issued from Unum, unless there are extenuating circumstances. A decision will be made on your appeal to the MMEHT Board of Trustees at the next regularly scheduled meeting of the Board, and you will be notified in writing of the Board's decision within 10 working days after the meeting.

CHAPTER 6 –Benefit Offsets and Subrogation

The Health Trust has the right to exchange *confidential information* with an insurance company or other party, if it is necessary to properly pay claims under the conditions outlined in this chapter.

What Are Benefit Offsets?

In some cases, if you are disabled, you may be eligible to receive disability income benefits from more than one source. For example, if you are totally disabled, you may be eligible to receive Social Security disability benefits.

If you are disabled and receiving income protection benefits under this Plan, and you also receive disability income benefits from certain other sources, those other disability income payments will be considered as deductible sources of income, or offsets. As offsets, the amount payable to you from those other sources will be subtracted from your Income Protection benefits under this Plan.

The following payments will be considered as benefit offsets, and the amount of the payment will be subtracted from the benefits payable to you under this Income Protection Plan:

1. any payments paid pursuant to or under the Maine State Retirement System, if such payment is being made as a result of the same disability for which we are paying you Income Protection benefits under this Plan; and
2. any payments paid pursuant to or under the United States Social Security Act, if such payment is being made as a result of the same disability for which we are paying you Income Protection benefits under this Plan.

What is the Right of *Subrogation* and Reimbursement?

All income protection benefits provided under the Health Trust Income Protection Plan are subject to subrogation. Subrogation means that the Health Trust will be reimbursed, on a just and equitable basis, by a third party, if we pay a claim for which that third party is legally responsible. This may happen, for example, if you are involved in a lawsuit, automobile accident, or Workers Compensation or personal injury claim. In the same way, if a third party pays benefits for which the Health Trust is responsible, we have the right to directly reimburse that third party. This ensures that claims are paid quickly, but protects against duplicate payments of a single claim.

For purposes of subrogation, the term "third party" includes any person, organization, corporation or insurance company who may be responsible for payment of income protection benefits for lost wages, if those lost wages are the result of any injury, illness, or impairment, such as those which may arise from an automobile accident, personal injury or Workers Compensation claim, or other similar situation.

What Are Your Responsibilities with Regard to Subrogation?

If you have a claim for which a third party is responsible, you have three major responsibilities:

1. you are responsible for notifying the Health Trust of any action which you (or someone acting for you) may take, either now or in the future, to recover a settlement or payment for your expenses with regard to this illness, injury or impairment;
2. you must provide the Health Trust with information and assistance regarding the illness, injury or impairment, so that we might better exercise our right to reimbursement; and
3. you will notify the Plan if you receive any financial settlement or recovery as the result of any action with regard to the claim, and reach an agreement with us as to the amount to be paid for reimbursement.

What Are the Plan's Rights and Responsibilities with Regard to Subrogation?

If you have a claim for which a third party is responsible, the Plan has the following rights and responsibilities with regard to that claim:

1. we must notify you of our intention to seek reimbursement from the third party that is responsible for your injury, illness or impairment;
2. we may recover an amount equal to, but not more than, the amount that we have paid for lost wages in connection with the claim for which the third party is responsible; or, we may recover the amount of any cash settlement which you have received, if that amount is less than the actual income protection benefit which we have paid for such lost wages. Any such reimbursement will be made on a just and equitable basis, as allowed by law; and
3. we may recover any reasonable amount that the Plan has paid for attorney's fees and expenses, if we are required to take legal action (either through a lawsuit or arbitration) in order to recover the amount of reimbursement that is due.

CHAPTER 7 – Limitations and Exclusions

Losses resulting from any of the following situations are not covered under the Health Trust Income Protection Plan:

1. Any period of disability during which you are not under the regular care of a qualified medical provider (as defined by this Plan).
2. Any accident, illness, or injury for which you are entitled to benefits under any Workers' Compensation Act or any similar local, state, or federal law, even if you have not filed a Workers' Compensation claim. You are required to notify the Health Trust if any illness or injury for which you are filing a claim is work-related. You must also work with the Health Trust to recover any money paid by this Plan for any work-related claim.

3. Any accident, illness, or injury which you received while on full-time active duty in the armed forces of any country, combination of countries, or international authority.
4. Any accident, illness, or injury which is related to injuries or illnesses resulting from war or any act of war, whether or not war is actually declared.
5. Any accident, illness, or injury which is related to illegal conduct. This includes any illness or injury which results from your commission of (or attempt to commit) an assault or a felony, or from your engagement in an illegal activity.
6. Any accident, illness or injury which results from your participation in a civil insurrection or riot.
7. Any accident, injury, or illness resulting from or sustained as the result of commission of, or attempt to commit, any crime for which you have been convicted under state or federal law.
8. Any period of disability during which you are incarcerated (in prison).
9. Any loss of income incurred as the result of your loss of a professional license, occupational license, or certification.
10. Any vague or indefinable condition (such as "tiredness" or "pain"), for which your medical provider cannot provide a medical diagnosis.
11. Any accident, illness, or injury resulting from or sustained as the result of cosmetic surgery, unless such surgery is made necessary by an accidental injury which you incur while covered under this Plan.
12. Any period of disability which begins after the date your employment is terminated. If your employment terminates, your coverage will terminate on the last day that you are actively at work.

In addition, no benefits are payable under this Plan for any claim which is submitted by you (or someone on your behalf) more than 90 days after the date on which your total disability began.

CHAPTER 8 – Termination of Coverage

When Will Your Coverage Under this Plan End?

Your coverage under the Health Trust Income Protection Plan will end on the earliest of the following dates:

1. the date your employer (including a specific bargaining unit or department of employment) stops participating in the Health Trust Income Protection Plan;
2. the date required premium payments are not made when due (but see Note, below);
3. the date you become a full-time member on full-time active duty in the armed forces of any country; or
4. the last day that you are actively at work, unless:
   a. you are absent from work because of a disability caused by a non-job-related illness or injury. In this case, your coverage may be continued until it is terminated by your employer according to their written policy; or
   b. you are temporarily laid-off or on a leave of absence. In this case, your coverage may be continued until it is terminated by your employer in accordance with their written policy, but no longer than the end of the third month after the month in which the lay-off or leave of absence began.

Note: During the first six consecutive months of a period of disability, either you or your employer must continue to pay premiums for your coverage, in order for you to remain enrolled once you return to work. But, if you are totally disabled and receiving benefits under this Plan for at least six consecutive months, the Health Trust will waive premiums for your IPP coverage (that is, no further premiums will need to be paid) until you return to work on either a full-time or part-time basis.

What Happens If You Are Disabled on the Date Your Coverage Would Otherwise End?

If you are disabled on the date your coverage under this Plan would otherwise end, and if you are eligible for Income Protection benefits under this Plan on that date, then you may be eligible to continue receiving Income Protection benefits for the duration of the maximum benefit period (as stated in Chapter 4). In order to be eligible for this extension, you must remain disabled and under the care of a *medical provider* (as defined in Chapter 9), throughout the entire time that benefits are paid.

What If You Are on A Family Medical Leave?

If you are covered under this Plan, you are entitled to protection under the Federal Family and Medical Leave Act of 1993 (FMLA). This Act provides that, if you are on a family or medical leave, you may continue your health insurance benefits for up to 12 weeks during any 12 consecutive month period. The Health Trust extends this coverage to include Income Protection Plan benefits. Your coverage will be continued at the same level as that for all active employees of your employer (taking into account the benefit level that you elected when you enrolled in the IPP program). You and your employer will be responsible for determining who will pay for your coverage (and how) during this leave. This determination should be made before your leave begins.

If you decide not to continue your coverage during your FMLA leave, your coverage will go back into effect as of the date you return to active work. You will not be considered a late enrollee when you return to work.

CHAPTER 9 – Terms and Definitions

The words and phrases in this chapter are defined to help you understand your benefits under this Plan. Just because a word or phrase is defined in this chapter, it does not necessarily mean that the Plan will cover services related to that word or phrase. Please refer to Chapter 4, Schedule of Benefits, for information on whether and how this Plan will provide Income Protection benefits.

Accident – An accident is an immediate, unforeseen event which is caused by external trauma to the body.

Accidental Injury Care – Treatment of a non-job related traumatic bodily injury resulting from an accident, including abrasions, concussions, sprains, strains, self-inflicted injuries and drug overdoses and/or suicide attempts.

Active Full-Time – An active full-time employee is someone who is regularly employed by a participating employer, and who works at least the number of hours set by that employer as the normal work week. That number cannot be less than the 20 hour per week minimum set by the Health Trust.

Application for Change Form – An Application for Change is the form that you must complete in order to make any changes; for example, if you wish to change your address.

Annual Salary / Base Annual Salary – An employee's base annual salary is the amount (as indicated in the Health Trust's records and provided by the employer) that a covered employee earns in one calendar year. The amount of an employee's base annual salary includes normal salaries and wages paid, up to a maximum of 40 hours per week. An employee's base annual salary does not include overtime, unless the overtime is worked as a normally scheduled part of the employee's work week.

Calendar Year – A calendar year is a period of one year beginning with January 1 and ending with December 31.

Claims Administrator – The Claims Administrator for this Plan is Unum, P.O. Box 9500, Portland, ME 04104.

Confidential Information – Confidential information is information about the participants covered under this Plan. It includes (but is not limited to) medical, dental, mental health, substance abuse, and eligibility related information, which is provided to the Plan (as allowed by state and federal law) for the purpose of administering the participants' benefits.

Contributory Coverage – Contributory coverage is group Income Protection Plan coverage which the employee enrolls in, and for which the employee agrees to make regular contributions to help pay for the cost of the coverage.

Covered Person / Participant – A covered person or participant is an employee who is enrolled and eligible for benefits under the Health Trust Income Protection Plan.

Disability – A disability is defined under this Plan as any non-job-related accident, injury, or illness, which results in the employee being unable to perform the material and substantial duties of his regular occupation. The employee must be under the regular care and attendance of a medical provider (as defined by this Plan), who certifies the employee's disability.

In order to obtain the most accurate and current status of an employee's disability, Unum (the Plan's Claims Administrator) will work with the employee, the employer, and the attending medical provider. As part of this process, Unum may obtain (but is not limited to) the following: office notes, copies of results from diagnostic testing ordered by the employee's medical provider, and copies of detailed job descriptions.

Eligibility Date – Your eligibility date is the date on which you have met all the requirements set forth by both the Health Trust and your employer, and are able to apply for coverage under the Health Trust Income Protection Plan (i.e., you are able to enroll for coverage under this Plan).

Elimination Period – The elimination period is the period of time during which you must be totally disabled, as certified by the attending medical provider. No benefits will be paid under the Health Trust Income Protection Plan until after satisfaction of the elimination period.

Employee – An employee is an individual who is enrolled for benefits under the Health Trust Income Protection Plan, provided that individual is a permanent employee who averages 20 or more hours of work each week on a year-round basis. Note: your employer may have set a higher minimum number of hours for eligibility. Please check with your employer to determine your eligibility under the Plan.

Employee Coverage – Employee coverage refers to the Health Trust Income Protection Plan benefits with respect to a covered employee.

Employer / Participating Employer – The employer is any individual municipality or other eligible employer which has chosen to participate in, and has been accepted by, the Maine Municipal Employees Health Trust. The term "employer" also

includes a municipality or other eligible employer for which the Plan covers a distinct and definable sub-group. An example of this would be an entire, discrete bargaining unit subject to a collective bargaining agreement; or a municipal department or division.

Enrollment Application – An enrollment application is the form which you must complete in order to enroll under this Plan.

Evidence of Insurability – Also called **Evidence of Good Health**. Evidence of good health is proof that is required by the Health Trust that an eligible employee meets certain underwriting standards in order to be eligible for coverage. Evidence of good health would be required if an individual did not enroll when first eligible, and would thus be considered a late enrollee (as described in chapter 2).

He/His – He or She. His or Her.

Health Trust – The Health Trust is the Maine Municipal Employees Health Trust.

Illness – An illness is defined as a non-job-related sickness or disease, which has treatable symptoms and which requires treatment by a medical provider (as defined by this Plan). Pregnancy, childbirth, and related medical conditions are also treated as illnesses under this Plan.

Injury – An injury is a non-job-related bodily trauma which requires treatment by a medical provider (as defined by this Plan). Injuries include accidental traumas, self-inflicted injuries, drug overdoses, and/or suicide attempts.

Medical Necessity or Medically Necessary – A service is considered to be medically necessary if it meets all of the following criteria:

1. it is consistent with generally accepted standards of medical practice;
2. it is clinically appropriate in terms of type, frequency, extent, site, and duration;
3. it is demonstrated through scientific evidence to be effective in improving health outcomes;
4. it is representative of "best practices" in the medical profession; and
5. it is not primarily for the convenience of the enrollee or physician or other health care practitioner.

It is important to note that simply because a provider prescribes, orders, recommends, or approves a service or supply, that service or supply is not necessarily considered to be medically necessary.

Medical Provider – A medical provider is a person who is licensed to practice medicine, to prescribe and administer drugs or to perform surgery. A medical provider must be operating within the scope of his license, in order to be covered under this Plan. A covered medical provider under this Plan may be (but is not limited to) a Medical Doctor (M.D.), Osteopathic Doctor (D.O.), Podiatrist, Physician's Assistant, Chiropractor, Nurse Practitioner, and Certified Nurse Midwife.

Non-Contributory Coverage – Non-contributory coverage is group Income Protection Plan coverage which the employee enrolls in, and for which the employer makes all contributions for the cost of coverage.

Open Enrollment Period – An open enrollment period refers to the period of time which begins at the anniversary date of a documented cafeteria or flexible benefits plan offered by your employer. During the annual open enrollment period, eligible employees can elect to enroll in the employer's Income Protection Plan without being required to provide evidence of insurability.

Partial Disability – Partial disability means that, as the result of a non-job-related accident, illness or injury, the employee is unable to perform the material and substantial duties of his regular occupation for a portion of his regularly scheduled work week. The employee must be under the regular care and attendance of a medical provider (as defined by this Plan), who certifies the employee's partial disability.

In order to obtain the most accurate and current status of an employee's disability, Unum (the Plan's Claims Administrator) will work with the employee, the employer, and the attending medical provider. As part of this process, Unum may obtain (but is not limited to) the following: office notes, copies of results from diagnostic testing ordered by the employee's medical provider, and copies of detailed job descriptions.

Participant/Covered Person – A covered person or participant is an employee who is enrolled and eligible for benefits under the Health Trust Income Protection Plan.

Period of Disability – A period of disability begins on the first day that the employee begins receiving care from a medical provider for a disability (as defined by this Plan). A period of disability ends on the date of the employee's complete recovery, as certified by the attending medical provider, or as shown by the employee's return to his pre-disability level of employment.

Successive periods of disability (that is, one right after the other, resulting from the same illness or injury) will be considered as one period of disability for the purposes of paying benefits under this Plan. However, if the employee returns to work at his pre-disability level of employment for a continuous period of at least two (2) weeks, the second period of disability will be treated as a new period of disability.

A new period of disability will also be established if the new disability is unrelated to the previous one, and if the employee has worked at least one full day of his regularly scheduled hours between disabilities.

Physician – A physician is a person who is operating within the scope of his/her license to practice medicine, prescribe and administer drugs or perform surgery.

Plan Administrator – The Plan Administrator is the Maine Municipal Association.

Plan Name – The name of the Plan is the Maine Municipal Employees Health Trust.

Plan Sponsor – The Plan Sponsor is the Employees of Municipal and Other Public Employers of Maine Health Insurance Trust (Maine Municipal Employees Health Trust).

Plan Year – The Plan Year is the same as the calendar year. A calendar year is a period of one year beginning with January 1 and ending with December 31.

Subrogation – Subrogation refers to the practice of substituting one person or entity in the place of another with regard to a legal claim, demand, or right. When a claim is subrogated, the person or entity who is substituted takes the place of the original party with regard to the claim, as well as any rights or remedies that might arise from that claim.

Total Disability – Total disability means that, as the result of a non-job-related accident, illness or injury, the employee is unable to perform any and every one of the material and substantial duties of his regular occupation. The employee must be under the regular care and attendance of a medical provider (as defined by this Plan), who certifies the employee's total disability.

In order to obtain the most accurate and current status of an employee's disability, Unum (the Plan's Claims Administrator) will work with the employee, the employer, and the attending medical provider. As part of this process, Unum may obtain (but is not limited to) the following: office notes, copies of results from diagnostic testing ordered by the employee's medical provider, and copies of detailed job descriptions.

Waiting Period – The waiting period is the period of time between your date of hire and the date that you become eligible for benefits under this Plan. The waiting period is set by each individual employer.

Your benefits under this plan will become effective on the first day of the calendar month that coincides with or next follows the completion of the waiting period set by the employer, as long as you complete and submit an application to the Health Trust and any required contributions toward the cost of the coverage are made.

If your application for coverage is received at the Health Trust within the first 60 days immediately following the end of your waiting period, then your coverage will become effective on the first day of the calendar month that coincides with or next follows the date your application is received, as long as any required contributions are made.

CHAPTER 10 – Plan Information

Name and Type of Administration of the Plan:

The Plan name is the Employees of Municipal and Other Public Employers of Maine Health Insurance Trust (Maine Municipal Employees Health Trust). The Maine Municipal Employees Health Trust provides non-occupational income protection benefits through contract administration by a third-party Claims Administrator (Claims Service Company).

Name, Business Address and Telephone Number of the Person Designated as Agent for the Service of Legal Process:

Chairman, Board of Trustees; or
Any Trustee named by the Plan
Maine Municipal Employees Health Trust
60 Community Drive
Augusta, ME 04330
Telephone: 207-623-8428

Name and Address of Plan Administrator:

Maine Municipal Association
60 Community Drive
Augusta, ME 04330

Name and Address of Claims Service Company (Claims Administrator):

Unum
P.O. Box 9500
Portland, ME 04104

Names, Titles and Addresses of the Plan Fiduciary / Fiduciaries:

Chairman, Board of Trustees; or
Any Trustee named by the Plan
Maine Municipal Employees Health Trust
60 Community Drive
Augusta, ME 04330

Names, Titles, and Addresses of any Trustee or Trustees (as of April 1, 2008):

John McNaughton, Chairman (Falmouth, Maine)
Thomas Stevens, Vice Chairman (Presque Isle, Maine)
Diane Barnes, Secretary (Calais, Maine)
Ellen Blair, Trustee (Augusta, Maine)
Osmond Bonsey, Trustee (Surry, Maine)
Jonathan Carter, Trustee (Kittery, Maine)
James Doar, Trustee (Rumford, Maine)
Donald Gerrish, Trustee (Brunswick, Maine)
Kelly Karter, Trustee (Winslow, Maine)
Richard Metivier, Trustee (Lewiston, Maine)
Dale Olmstead, Trustee (Freeport, Maine)

And their successors as appointed from time to time
c/o Maine Municipal Employees Health Trust
60 Community Drive
Augusta, ME 04330

Description of Relevant Provisions of any Applicable Collective Bargaining Agreement:

None

Source of Financing of the Plan and Identity of any Organization through which Benefits are Provided:

Contributions are made to the plan by Employers and Employees. The Employer's contributions shall be made as specified by the Plan's funding policy. An Employee's contributions shall be made as soon as practicable after such contributions have been received from the Employee or withheld from the Employee's pay. All contributions must be received by the Plan Trust by the first day of the month for which they are due. Benefits are provided directly from the Plan Trust through the Plan Administrator.

Date of the End of the Plan Year:

December 31

Internal Revenue Service Plan Identification Number and Tax Identification Number:

Plan Identification Number: 501
Tax Identification Number: 01-0382676

The Plan's Requirements Regarding Eligibility for Participation and Benefits:

See Chapter 2, Eligibility, and Chapter 3, Enrollment.

Description of Circumstances Which May Result in Disqualification, Ineligibility, or Denial or Loss of Benefits:

See Chapter 7, Limitations and Exclusions, and Chapter 8, Termination of Coverage.

Procedure to be Followed in Presenting Claims for Benefits under the Plan:

See Chapter 5, Claims Filing Procedures.

The Process for Appealing Claims which Have Been Denied:

See Chapter 5, Claims Filing Procedures.

Certain Rights and Protections:

As a participant in this Plan, you are entitled to certain rights and protections under applicable state and/or federal law. All Plan participants shall be entitled to:

1. examine, without charge, at the Plan Administrator (Maine Municipal Association)'s office, all Plan Documents and copies of all documents filed by the Plan with the U.S. Department of Labor such as detailed annual reports and Plan descriptions;
2. obtain written copies of all Plan Documents and other Plan information upon written request of the Plan Administrator. The Plan Administrator

may make a reasonable charge for the copies; and

3. receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

The individuals who are responsible for the operation of your employee benefit Plan have certain obligations. The individuals who operate this Plan, called "fiduciaries" of the Plan, have a duty to operate the plan prudently and in the interest of you and all of the Plan's participants and beneficiaries. No one, including an employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under this plan or from exercising your rights under any applicable laws.

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You also have the right to have the Plan review and reconsider your claim. If the denial is upheld, you must be notified of the specific Plan provision(s) upon which the denial is based.

Your Privacy Rights Under HIPAA

You have been guaranteed certain privacy rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These rights govern the way that the Health Trust and Unum can use your Protected Health Information, or PHI, under the terms of this Plan. The Plan can use and disclose your PHI for purposes that are related to health care treatment, payment for health care, and health care operations. These terms are described in more detail below.

Payment for health care includes any activities undertaken by the Plan to obtain premiums from you or your employer. It also includes activities undertaken by the Plan to fulfill its responsibility for providing coverage to you, and for providing plan benefits to you when you receive health care services. These activities related to payment include, but are not limited to, the following:

1. determination of eligibility, coverage and cost sharing amounts (for example, the cost of a benefit, and any plan maximums and copays that will apply to your claim);
2. coordination of benefits, as described in Chapter 6 of this booklet;
3. adjudication of health benefit claims (that is, determining if and how benefits will be paid), including appeals and other payment disputes;
4. subrogation of health benefit claims, as described in Chapter 6 of this booklet;
5. establishing of employee contributions, that is, how much you pay towards the cost of your health insurance and claims;
6. risk adjusting amounts due based on enrollee health status and demographic characteristics (your annual premium adjustment);
7. billing, collection activities, and related health care data processing;
8. claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to participant inquiries about payments;
9. obtaining payment under a contract for stop loss insurance (including stop-loss and excess of loss insurance);
10. medical necessity reviews or reviews of appropriateness of care or justification of charges;
11. utilization review, including precertification, preauthorization, concurrent review, and retrospective review;
12. disclosure to consumer reporting agencies related to the collection of premiums or reimbursement. The following PHI may be disclosed for payment purposes: your name and address, date of birth, Social Security number, payment history, account number, and the name and address of your provider and/or health plan; and
13. reimbursement to the plan.

Health Care Operations include, but are not limited to, the following activities:

1. quality assessment;
2. population-based activities related to improving health or reducing health care costs (for example, wellness and disease management programs), protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
3. rating provider and plan performance, including accreditation, certification, licensing, or credentialing activities;
4. underwriting, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for stop loss insurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
5. conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
6. business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
7. business management and general administrative activities of the Plan, including, but not limited to:
   a. management activities related to the implementation of and compliance with HIPAA's administrative simplification requirements;
   b. customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers;
   c. resolution of internal grievances; and
   d. due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA, or following completion of the sale or transfer, will become a covered entity.

With your authorization, the Plan will disclose PHI to a workers' compensation plan, a long term or short term disability plan, or to any other employee benefit plan sponsored by the Maine Municipal Employees Health Trust, for purposes related to administration of these plans. As part of this agreement, the Maine Municipal Employees Health Trust agrees to the following conditions:

1. it will not use or further disclose PHI other than as permitted or required by the Plan Document or as required by law;
2. it will reasonably and appropriately safeguard electronic PHI ("ePHI") that is created, received, maintained, or transmitted to or by the Health Trust on behalf of the group health plan;
3. it will ensure that any agents, including any subcontractors, to whom the Health Trust provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Health Trust with respect to such PHI;
4. it will ensure that any agents, including any subcontractors, to whom the Health Trust provides PHI will implement administrative, physical, and technical safeguards that reasonably and appropriately safeguard the confidentiality, integrity, and availability of the ePHI that the business associate creates, maintains or transmits on behalf of the Plan;
5. it will not use or disclose PHI for employment-related actions and decisions unless authorized by the covered individual;
6. it will not use or disclose PHI in connection with any other Health Trust benefit or Health Trust employee benefit plan unless authorized by the covered individual;
7. it will report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
8. it will make PHI available to the covered individual in accordance with HIPAA's access requirements;

9. it will make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
10. it will make available the information required to provide an accounting of disclosures;
11. it will make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and
12. if feasible, it will return or destroy all PHI received from the Plan that the Health Trust still maintains in any form, and shall retain no copies of such PHI when no longer needed for the purpose for which disclosure was made; or, if return or destruction is not feasible, it shall limit further uses and disclosures to those purposes that make the return or destruction infeasible.

In accordance with HIPAA, there are only a limited number of employees or classes of employees of the Maine Municipal Association that may be given access to PHI. These persons may only have access to and use and disclose PHI for those Plan administrative functions that the Health Trust performs for the Plan:

1. the Health Trust Director;
2. the Health Trust Assistant Director;
3. the Health Trust Member Services Manager;
4. the Health Trust Service Representatives;
5. the Health Trust Enrollment and Data Services Manager;
6. the Health Trust Billing and Enrollment Representatives;
7. the Health Trust Assistants;
8. Maine Municipal Association staff designated by the Health Trust Assistant Director, including certain members of the Maine Municipal Association Finance, Management Information Systems, and Central Services Departments; and
9. the Health Trust Field Service Representatives.

If the persons listed above do not comply with this Plan Document, the Plan Sponsor (i.e., the Health Trust) shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

If you have any questions about your Plan, you should contact the Maine Municipal Employees Health Trust. The provisions of the Plan are legally enforceable.

Addendum to the "Additional Summary Plan Description Information" included with your certificate of coverage or policy and effective for claims filed on or after April 1, 2018.

The regulations governing ERISA disability claims and appeals have been amended. The amended regulations apply to disability claims filed on or after April 1, 2018. To the extent the Additional Summary Plan Description Information included with your certificate of coverage or policy conflicts with these new requirements, these new rights and procedures will apply.

These new rights and procedures include:

Any cancellation or discontinuance of your disability coverage that has a retroactive effect will be treated as an adverse benefit determination, except in the case of failure to timely pay required premiums or contributions toward the cost of coverage.

If you live in a county with a significant population of non-English speaking persons, the plan will provide, in the non-English language(s), a statement of how to access oral and written language services in those languages.

For any adverse benefit determination, you will be provided with an explanation of the basis for disagreeing or not following the views of: (1) health care professionals who have treated you or vocational professionals who have evaluated you; (2) the advice of medical or vocational professionals obtained on behalf of the plan; and (3) any disability determination made by the Social Security Administration regarding you and presented to the plan by you.

For any adverse benefit determination, you will be given either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making that decision, or a statement that such rules, etc. do not exist.

Prior to a final decision being made on an appeal, you will have the opportunity to review and respond to any new or additional rationale or evidence considered, relied upon, or generated by the plan in connection with your claim.

If an adverse benefit determination is upheld on appeal, you will be given notice of any applicable contractual limitations period that applies to your right to bring legal proceedings and the calendar date on which that period expires.

Should the plan fail to establish or follow ERISA required disability claims procedures, you may be entitled to pursue legal remedies under section 502(a) of the Act without exhausting your administrative remedies, as more completely set forth in section 503-1(l).