MASSACHUSETTS/MOSES HEALTH AND WELFARE TRUST FUND
CLOSED REIMBURSEMENT REQUEST FOR CALENDAR YEAR 2020

PLEASE PRINT

Official Use Only

Log: _____

Optical: _____

Total: _____

MR. ☐
MS. ☐

Employee Name: _____
First Name MI Last Name

Address: _____
Street PO Box/Apt # City State Zip

Check box if you changed addresses in the past year ☐ E-mail Address_____

Phone: Home ( ) _____ Work: ( ) _____ Ext. _____

Name of Dept./ Agency/ Authority_____

Name of Employee's Health Insurance_____

Please respond to the following questions:

YES ☐ NO ☐ Did you start in your MOSES represented title in Calendar Year 2020? If yes provide the date_____.

YES ☐ NO ☐ Did you leave your MOSES represented title or retire during Calendar year 2020? IF yes provide the date_____.

YES ☐ NO ☐ Did you work less than 18.75 hours/ week in a MOSES-represented title at some time during Calendar Year 2020?

YES ☐ NO ☐ Are you enrolled under COBRA?

YES ☐ NO ☐ Were you on Worker's Compensation or unpaid leave of absence from your MOSES represented title at any time during Calendar Year 2020? If YES, please show dates_____

YES ☐ NO ☐ Are you or any recipients entitled to dental or optical benefits under a health plan other that the one named above? If YES, what is the name of the other plan? Plan name_____

YES ☐ NO ☐ Were you or any recipients injured by a Third Party's wrongful act of negligence?

If you answer YES to any question above, provide dates if applicable and attach additional details.

Attach original statements from Doctor/Vendors showing: the name, address, and telephone number of the service provider; the service recipient; date of service; and proof of payment for each entry listed below. **These services must have been rendered during Calendar Year 2020, but payment may be made in Calendar Year 2021**.

Recipient of Optical Service	Relationship	Date of Birth	Service Provided	Date of Service	Cost of Service	Amount Paid
	Employee/Spouse ☐ Dependent ☐		Exam ☐ Glasses ☐ Contact Lenses ☐ Other ☐			
	Employee/Spouse ☐ Dependent ☐		Exam ☐ Glasses ☐ Contact Lenses ☐ Other ☐			
	Employee/Spouse ☐ Dependent ☐		Exam ☐ Glasses ☐ Contact Lenses ☐ Other ☐			
HEARING AID Co-payment only of a GIC authorized hearing aid up to $600.00. You must show initial payment, proof of GIC reimbursement and the unreimbursed amount.	Employee/Spouse ☐ Dependent ☐		Hearing aid ☐			

Total: $ _____

You must answer all questions and provide all required information and attachments, or your claim may be reduced or suspended until such problems are remedied or resolved. In the event that your claim is suspended prior to final processing, a $10 reprocessing fee will be assessed.

I hereby certify under the penalties of perjury that I have read the Plan printed on the back of this form, have provided all requested information, and that all information provided meets the requirements of the Massachusetts /MOSES Health and Welfare Trust Dental/Optical/Audio Aid Plan; that I have not requested reimbursement for payment for these same services from any other plan, except as allowed by this Plan; and that information submitted is true and accurate to the best of my knowledge. I understand that if I make a material misrepresentation, I may lose all rights to participate in this program and be liable for recovery costs of reimbursements improperly made

Note: Send the completed reimbursement request and all necessary attachments to:

ADMINISTRATOR
MASSACHUSETTS / MOSES HEALTH & WELFARE TRUST
P O BOX 582
MANOMET, MA 02345

SIGNATURE _____

EMPLOYEE ID NUMBER _____
(From your timesheet or check stub)

DATE _____

The full Calendar Year 2020 Plan is detailed on the back of this form.

Reimbursement requests for Calendar Year 2020 must be postmarked no later than June 30, 2021. Requests postmarked in July will be penalized 20%. Any request postmarked after July 31, 2021 will not be honored.

MASSACHUSETTS/MOSES HEALTH AND WELFARE TRUST FUND
CLOSED REIMBURSEMENT REQUEST FOR CALENDAR YEAR 2020

This Plan reimburses an eligible employee for covered expenses incurred by the employee and his/her eligible dependent(s) when such expenses are not provided by another source. This Plan may cover former employees and ineligible dependent(s) under COBRA (See Termination of Coverage).

REIMBURSEMENT FORMULA
The maximum family reimbursement for optical services provided during Calendar Year 2020 is **$450.00.**
Reimbursement for GIC co-payments on hearing aids is separate from the optical formula and shall not exceed $600 per year. Reimbursement for employees new to the Unit will be prorated based upon the length of service in the benefit year.

COVERED EXPENSES

TYPE OF SERVICE	COVERED SERVICES	AMOUNT COVERED	AMOUNT SUBJECT TO FORMULA
Optical Exam	Any vision examination provided by a legally qualified optometrist or ophthalmologist.	Actual out of pocket receipted expenses, not to exceed $60 per visit.	60%, Up to $36.00 per visit
Glasses (Single lens, Bi/Tri Focal)	Products or services provided by a legally qualified optometrist, ophthalmologist, or optician, except as noted below.	Up to $ 375.00 maximum per pair	60%, Up to $225.00 max/pair
Contact Lenses		Up to $ 375.00 maximum per person/per year including fitting charges	60%, Up to $225.00 maximum per person/per year
Laser Treatment		Up to $450.00 maximum per person/ per year	60%, Up to $ 270.00 maximum per person/per year
Intra-ocular Lenses	Lens inserted via GIC approved cataract surgery to correct vision problem(s)	Up to $450.00 maximum per person/ per year	60%, Up to $270.00 maximum per person/per year

The following optical services and items are NOT covered: Non-Prescription Glasses; Prescription Sports Goggles; Medicines; Vision Therapy; Eye Training; and Surgery such as Radial Keratotomy.

HEARING AID **Maximum GIC Hearing Aid co-payment subject to reimbursement is $600.00**

EMPLOYEE ELIGIBILITY: As used in this Plan, the term "employee" means a full-time or regular part-time person employed in a MOSES represented title. A full-time employee is defined as an employee who normally works a full week and whose employment is expected to continue for twelve months or more, or an employee who normally works a full week and who has been employed for twelve consecutive months or more. A regular part-time employee is defined as an employee who is expected to work 50% or more of the hours in a work year of a regular full-time employee in the same title. An employee is eligible for benefits after contributions have been paid on his/her behalf to the trust fund for two consecutive months. If an employee has worked for two previous months in another Unit, which waives the eligibility waiting period for Unit Nine employees, he/she shall be immediately eligible for benefits under this Plan. In no case will reimbursement be made for services provided before the first day of eligibility.

DEPENDENT ELIGIBILITY: An employee's eligible dependents include his/her spouse and unmarried children to their 19th birthday. Unmarried children are eligible to their 24th birthday if they are wholly dependent upon an employee for support and maintenance while a full-time student in school or college. **Proof of dependent status must be provided upon request**. **Proof of student status from the school must be provided with your application.** Coverage for an unmarried child, more than half of whose support and maintenance is provided by the employee, and who is incapable of self-sustaining employment because of mental disability or physical handicap and whose incapacity began prior to their 19th birthday shall continue as long as the employee's coverage remains in force and said incapacity continues.

TERMINATION OF COVERAGE: This Plan terminates when the employee leaves Unit Nine/E except that a former employee may be entitled to retroactive reimbursement for expenses incurred while in Unit Nine/Unit E on a ratio of the employee's service to a full calendar year of service. COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1986) provides a procedure by which a former employee and/or an ineligible dependent of a present employee may continue coverage, for a limited time, upon payment of the appropriate fee. To receive benefits under COBRA you must apply in writing to the Administrator, Massachusetts Unit Nine Health and Welfare Trust Fund within 60 days of your eligibility for extended coverage, or the eligibility of your dependent(s), as detailed above.

COORDINATION OF BENEFITS: If an employee or his/her dependent is entitled to benefits under any other plan which provides part or all of the benefits paid under this Plan, the employee is required to submit the name of the other plan and any amounts received so that the benefits payable under this Plan added to amounts from other plans will not exceed 100% of the expenses incurred.

The term "other plan" means any plan providing benefits or services covered under this Plan, that is: (A) group or blanket insurance coverage; (B) group Blue Cross/Blue Shield, Indemnity Plan or health maintenance organizations (HMO) and other pre-payment coverage provided on a group basis; (C) any coverage under labor-management plans, union welfare plans, employer organization plans, employee organization benefit plans or any arrangement of benefits for individuals or group; (D) any coverage under government program; (E) any coverage required or provided by any statute; and (F) any non-group plan.

SUBROGATION: If an employee or his/her dependent(s) is injured because of a third party's negligence: A. Benefits will be payable under the Plan for that injury, subject to the condition that the employee and his/her dependent (if applicable):

1. Agrees to the Massachusetts / Moses Health and Welfare Trust Fund (herein known as the Fund) being subrogated to any recovery or right to recover against the third party;
2. Will not take any action which would prejudice the Fund's subrogation rights; and
3. Will cooperate in doing what is reasonably necessary to assist the Fund in any recovery.

The Fund will be subrogated to the extent Plan benefits were paid because of that injury.

BOARD OF TRUSTEES' STATEMENT

The Board of Trustees reserves the right to amend, modify, or discontinue all or part of this Plan whenever, in its judgment, conditions so warrant. Only the Board of Trustees, or a designee acting on its behalf, has the authority to determine eligibility for benefits and the right to participate in this Plan. Correspondence to the Board of Trustees, should be addressed to Massachusetts / MOSES Health and Welfare Board of Trustees, 90 North Washington Street, Boston, MA 02114.

Attach original itemized statements from Doctor/Vendor showing in detail the name, address, and telephone number of the service provider, the recipient, the services provided, dates of service, and proof of payment. Please keep copies of all submitted materials.

EFFECTIVE DATES: No reimbursement for services provided before January 1, 2020 or after December 31, 2020.
All claims must be submitted on this form. Send completed forms to:

ADMINISTRATOR
MASSACHUSETTS / MOSES HEALTH & WELFARE TRUST
P O BOX 582
MANOMET, MA 02345

Please allow up to ten weeks for processing. If you desire a confirmation of receipt of your request form, address and apply postage to the enclosed card and include it with your application. Requests for additional forms or questions should be referred to the Fund Administrator by mail at the address listed above, by telephone (voicemail) @ 617-367-2727 ext. 326 (leave message) or by e-mail at MAclaimsprocessing@hotmail.com.