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Optical
Total $

MASSACHUSETTS/MOSES HEALTH AND WELFARE TRUST FUND

OPEN PLAN REIMBURSEMENT REQUEST FOR CALENDAR YEAR 2023

PLEASE PRINT

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_____

YES ☐ **NO** ☐ Did you start in your MOSES represented title in Calendar Year 2023? If yes provide the date_____

YES ☐ **NO** ☐ Did you leave your MOSES represented title or retire during Calendar year 2023? IF yes provide the date_____

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 2023, but payment may be made in Calendar Year 2024.**

Recipient of Service	Relationship	Date of Birth	Service Provided	Date of Service	Cost of Service	Amount Paid Attach Receipts
	Proof of dependent status must be provided upon request. **You must provide verification from school for dependent students age 19 to 24th birthday.**					
DENTAL						
	Employee/Spouse ☐ Dependent ☐					
	Employee/Spouse ☐ Dependent ☐					
	Employee/Spouse ☐ Dependent ☐					
	Employee/Spouse ☐ Dependent ☐					
	Employee/Spouse ☐ Dependent ☐					
OPTICAL						
	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 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.

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: _____

Date: _____

To avoid a 20% penalty, reimbursement requests for Calendar Year 2023 must be **postmarked** no later than June 30, 2024. Requests postmarked in July will be penalized 20%. Any request **postmarked** after July 31, 2024 will **not be paid**.

MASSACHUSETTS/MOSES HEALTH AND WELFARE TRUST FUND
OPEN PLAN REIMBURSEMENT REQUEST FOR CALENDAR YEAR 2023

This Plan reimburses an eligible employee for covered expenses incurred by the employee and their 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 dental/optical services provided during Calendar Year 2023 is $2,820. The reimbursement formula is 90% of the first $2,300 plus 50% of the next $1,500 in covered expenses. However, not more than $800 in optical services including exams is reimbursable. Reimbursement for GIC co-payments on hearing aids shall not exceed $600. 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
DENTAL SERVICES			
Dental and Orthodontic Services	Any work provided by a legally qualified Dentist or Orthodontist, except bleaching or similar services. This plan does not cover work provided by Smile Direct Club or other offsite service providers.	Actual out of pocket receipted expenses.	100%
OPTICAL SERVICES (including exam) (Maximum Optical Reimbursement Amount is $800.)			
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.	100%
Glasses (Single lens, Bi/Tri Focal)	Products provided by a legally qualified optometrist, ophthalmologist, or optician except as noted below.	Up to $400.00 maximum per pair.	100% Up to $400.00 max/pair
Contact Lenses	Products provided by a legally qualified optometrist, ophthalmologist, or optician except as noted below.	Up to $375.00 maximum per person/per year including any fitting charges.	100% Up to $375.00 max/per year
Laser Treatment		Up to $450.00 maximum per person/per year.	Up to $450.00 max/per person/per year
Intra-ocular Lenses	Lens inserted via GIC approved cataract surgery to correct vision problems.	Up to $450.00 maximum per person/per year.	Up to $450.00 max/per person/per year
The following optical services and items are NOT covered: Non-Prescription Glasses; Prescription Sports Goggles; Medicines; Vision Therapy; Eye Training; Surgery such as Radial Keratotomy			
HEARING AIDS (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 their 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/E employees, they 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 their spouse and unmarried children till their 19th birthday. Unmarried children are eligible till 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:

Coverage under 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/E on a ratio of the employee's service to a full calendar year of service. COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1985) 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/MOSES 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 their dependent is entitled to benefits under any other plan which will provide 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 their 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 their 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.

B. 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, Suite 3, Boston, MA 02114

EFFECTIVE DATES: No reimbursement for services provided before January 1, 2023 or after December 31, 2023.

All claims must be submitted on this form to:

Administrator
Massachusetts/MOSES Health and Welfare Trust Fund
P.O. Box 582, Manomet, MA 02345

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. **To avoid 20% penalty, reimbursement requests for Calendar Year 2023 must be postmarked no later than June 30, 2024. Requests postmarked in July 2024 will be penalized 20%. Any request postmarked after July 31, 2024 will not be paid.** 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 email to: maclaimsprocessing@hotmail.com