COMMONWELATH OF MASSACHUSETTS
NATONAL ASSOCIATION OF GOVERNMENT EMPLOYEES

Health & Welfare

TRUST FUND

Benefit Plan Information Booklet

January 1, 2024

January 1, 2024

Dear Member:

The Board of Trustees of the Commonwealth of Massachusetts/National Association of Government Employees (NAGE) Health and Welfare Trust Fund (Fund) is pleased to provide you and your eligible dependents with the benefits described in this booklet.

- The Dental Plan, Delta Dental PPO *Plus Premier*.
- The Optical Assistance Program, a choice between the Closed Plan provided by Davis Vision, and the Open Plan through which members can receive services from any vision care provider you choose.
- The Hearing Aid Assistance Program, which provide reimbursement toward the cost of hearing aid devices.
- A Death Benefit for each eligible employee, spouse and dependent child, payable to the estate of the deceased.
- The Dependent Care Assistance Program, which provides reimbursement for eligible work-related dependent care expenses for your eligible dependents, as defined under the Dependent Care Assistance Program.

Contributions to the Fund are made in accordance with the Collective Bargaining Agreements between the National Association of Government Employees (NAGE/SEIU Local 5000), or its affiliates, and the Commonwealth of Massachusetts, or another employer who has an employment relationship with NAGE/SEIU Local 5000.

This "Information Booklet" will give you general information regarding all the available benefits. Please review this booklet carefully and keep it with your important papers.

If you have any questions about your benefits or your eligibility, please call the Commonwealth of Massachusetts/NAGE Health and Welfare Trust Fund Office at (617) 773-8947 or 1-800-641-0700 or email *fundoffice@nage.org*. You can also write to the Commonwealth of Massachusetts/NAGE Health and Welfare Trust Fund, 159 Burgin Parkway, Quincy, MA 02169-4213.

The Trustees are pleased to provide all the benefits described in this Information Booklet. We urge you to take full advantage of these important benefits.

Sincerely,

The Board of Trustees
Commonwealth of Massachusetts/NAGE
Health and Welfare Trust Fund

COMMONWEALTH OF MASSACHUSETTS/NAGE
Health and Welfare Trust Fund
159 Burgin Parkway
Quincy, MA 02169-4213
(617) 773-8947
1-800-641-0700
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fundoffice@nage.org

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COMMONWEALTH OF MASSACHUSETTS/ NAGE HEALTH AND WELFARE TRUST FUND

GENERAL INFORMATION

GENERAL INFORMATION APPLIES TO ALL COMMONWEALTH OF MASSACHUSETTS/NAGE HEALTH AND WELFARE TRUST FUND BENEFITS.

WHO IS ELIGIBLE FOR BENEFITS?

All full-time and regular part-time employees who work at least 18.75 hours of the work week are eligible, in accordance with the terms of the Collective Bargaining Agreements between the National Association of Government Employees (NAGE/SEIU Local 5000), or its affiliates, and the Commonwealth of Massachusetts, or another employer who has an employment relationship with NAGE/SEIU Local 5000.

All Commonwealth of Massachusetts/NAGE Fund Office employees are also eligible for benefits.

EMPLOYEE ELIGIBILITY

New employees are eligible for benefits immediately upon the first day of employment. This benefit, resulting from a vote by the Board of Trustees, replaces the six-month waiting period previously in effect. The Board revisits the employee eligibility period on an annual basis. Any change to the employee eligibility period will only affect new members.

If you are on an unpaid leave of absence, you will be covered for one (1) month after the end of the month during which your leave of absence begins. After the one (1) month period, you will have the option to elect COBRA Continuation Coverage as described on page 3 of this booklet. Upon your return to active employment, your benefits will be reinstated immediately.

DEPENDENT ELIGIBILITY

Your eligible dependents may include your lawful spouse. Your eligible dependent children may include your natural or adopted children, children legally placed for adoption with you, stepchildren, or a child under your legal guardianship birth to 26 years of age, none of whom are separately eligible under the Commonwealth of Massachusetts/NAGE Health and Welfare Fund as employees.

Trust Fund coverage for an unmarried child who meets the dependent eligibility requirements, below, who is incapable of self-sustaining employment because of disability and whose incapacity began prior to the limiting age shown above, may continue so long as: (a) your coverage remains in force and (b) such incapacity continues. Proof of such incapacity must be submitted to the Commonwealth of Massachusetts/NAGE

Fund Office within 31 days of the date the dependent's coverage would otherwise terminate. Proof of continuing disability may be required from time to time.

Additional Dependent Eligibility Requirements

1. For the Fund to consider a child an eligible dependent, the child must have the same principal place of abode as you for over half of the year and must be dependent on you for over half of his or her support. Proof that the child is dependent upon you for over half of his or her support must be furnished to the Fund upon request.

2. The requirement that you provide over half of the child's support and that the child has the same principal abode as you for over half of the year, will not apply if: (a) you and the child's other parent are divorced or legally separated under a decree of divorce or separate maintenance, separated under a written separation agreement, or live apart at all times during the last six (6) months of the calendar year; (b) you and the child's other parent provide over half of the child's support; and (c) the child is in the custody of one or both parents for more than half of the calendar year.

3. In order for the Fund to consider a child under your legal guardianship to be an eligible dependent, in addition to the requirements set forth in section 1 above, if the child is not related to you (in the manner described in Internal Revenue Code section 152(d)(2)(A) through (G), the child must, for the entire year, share your principal place of abode and be a member of your household.

Your dependents' coverage will become effective as soon as their eligibility information is provided to the NAGE Fund Office. You must submit a completed Enrollment Form to the Fund Office before your dependents can obtain benefits. You must provide proof of your dependents' status, which includes a marriage certificate, birth certificate, tax documents, adoption papers or guardianship documents.

TERMINATION OF COVERAGE

Your coverage and your dependents' coverage under this Plan will terminate 30 days after the end of the month when you leave the employ of your employer.

COBRA

The Federal COBRA law allows you and your family to receive dental, optical, hearing aid, dependent care and a death benefit, from the Fund under certain circumstances. Once your coverage has terminated due to: (1) Employee's termination of employment or a reduction in hours including leave of absence; (2) Employee's death; (3) Employee's dependent child reaches age 26; (4) Employee's dependent child has married; (5) Employee's divorce or legal separation; (6) Employee's entitlement to Medicare; you or your spouse or dependent have the right to continue coverage on a self-pay basis.

For the following qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator no later than 60 days after the later of: the date of the qualifying event or the date coverage would be lost under the Plan as a result of the qualifying event.

If during the initial 18 month period of COBRA continuation coverage you or anyone in your family, who was covered under the Plan at the time of the employee's qualifying event of the termination of employment or reduction in hours of employment, is determined by the Social Security Administration (SSA) to be disabled, the disabled individual may be entitled to receive up to an additional 11 months of COBRA continuation coverage for a total maximum of 29 months. You must notify the Plan Administrator of a disability determination by the Social Security Administration (SSA) within 60 days after the later of: the date of the Social Security Administration determination; the date of the qualifying event; or the date on which the qualified beneficiary would lose Plan coverage due to the qualifying event; and before the end of the 18-month period of continuation coverage, if you want to extend your COBRA coverage to a total maximum of 29 months. If the qualified beneficiary is determined to be no longer disabled, you must notify the Plan of the fact within 30 days after SSA's determination.

You must also notify the Plan Administrator within 60 days after a second qualifying event occurs if you want to extend your COBRA continuation coverage.

In order to provide these notices, you must complete and submit a notification form to the Plan Administrator. Please contact the Plan Administrator to obtain the notification form and the address where you must submit it. Additional documentation of the qualifying event may also be required (i.e. copy of the divorce decree, court order granting legal separation, birth certificate or other documentation.) The Plan

Administrator may reject an incomplete notice from you if the notice does not contain sufficient information to allow the Plan Administrator to identify and determine any of the following: (1) the name of the Plan; (2) the covered employee and qualified beneficiaries; (3) the qualifying event or disability determination; or (4) the date of the qualifying event or disability determination. If you do not notify the Plan of your qualifying event in a timely manner as in accordance with the Plan's procedures, COBRA coverage will be denied. Please contact the Commonwealth of Massachusetts/NAGE Fund Office at (617) 773-8947, 1-800-641-0700 or email fundoffice@nage.org or by writing to 159 Burgin Parkway, Quincy, MA 02169-4213.

COVERAGE WHILE ON INDUSTRIAL ACCIDENT LEAVE

If you are on Industrial Accident Leave with the Commonwealth, and your COBRA continuation coverage under the Fund terminates, you may elect to continue Fund coverage on a self-pay basis for the term of your Industrial Accident Leave. Please contact the Fund Office for details.

COORDINATION OF BENEFITS

If you or your dependent is entitled to benefits under any other plan which will pay part or all of the expenses incurred for any benefits received or services rendered under this Plan, the amount of benefits payable under this Plan and any other plans will be coordinated so that the aggregate amount paid will not exceed 100% of the expense incurred. However, in no event will the amount of benefits paid under the Plan exceed the amount, which would have been paid if there were no other plan involved.

The plan that provides benefits first is known as the primary plan. The primary plan is responsible for providing benefits to the full extent of their coverage.

The plan that provides benefits next is the secondary plan. It provides benefits towards any remaining balance of covered services as long as the payment, when added to the primary plan's payment, is not more than the total amount of the covered benefit expenses.

Depending on circumstances, this Plan may be primary plan or the secondary plan. The term "plan" refers to any plan providing benefits or services for hospital, medical or dental care or treatment; that is: (a) group or blanket insurance coverage, (b) group health insurance, and other prepayment coverage provided on a group basis, (c) any coverage under labor management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans or any other arrangement of benefits for individuals of a group and (d) any coverage under governmental programs, and any coverage required or provided by any statute.

SUBROGATION

Advance on Account of Plan Benefits

The Plan does not cover expenses for services or supplies for which a third party is required to pay because of a negligent, wrongful, or other act, but it will advance payment on account of Plan benefits (hereafter called an "Advance"), subject to its right to be reimbursed to the full extent of any Advance payment from the covered employee and/or dependent(s) if and when there is any recovery from any third party. The right of reimbursement will apply:

1. even if the recovery is not characterized in a settlement or judgment as being paid on account of the expenses for which the Advance was made; and
2. even if the recovery is not sufficient to make the ill or injured employee and/or dependent(s) whole pursuant to state law or otherwise (sometimes referred to as the "make-whole" rule); and
3. without any reduction for legal or other expenses incurred by the employee and/or dependent (s) in connection with the recovery against the third party or that third party's insurer pursuant to state law or otherwise (sometimes referred to as the "common fund" rule); and
4. regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule).

Reimbursement and/or Subrogation Agreement

The eligible employee and/or any eligible dependent(s) on whose behalf the Advance is made, must sign and deliver a reimbursement and/or subrogation agreement (hereafter called the "Agreement") in a form provided by or on behalf of the Fund. If the ill or injured dependent(s) is a minor or incompetent to execute that Agreement, that person's parent (in the case of a minor dependent child) or spouse or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Fund Administrator or designee.

If the Agreement is not executed at the Fund Administrator's request, the Fund may refuse to make any Advance, but if, at its sole discretion, the Fund makes an Advance in the absence of an Agreement, that Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Fund's rights.

Cooperation with the Fund by all Covered Individuals

By accepting an Advance, regardless of whether or not an Agreement has been executed, the eligible employee and/or eligible dependent(s) each agree to:

1. reimburse the Fund for all amounts paid or payable to the eligible employee and/or dependent(s) or that third party's insurer for the entire amount Advanced; and
2. do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Fund's reimbursement and/or subrogation rights; and
3. notify and consult with the Fund Administrator or designee before starting any legal action or administrative proceeding against a third party based on any alleged negligent or wrongful act that may have caused or contributed to the injury or illness that resulted in the Advance, or entering into any settlement Agreement with that third party or third party's insurer based on those acts; and
4. Inform the Fund Administrator or designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

Subrogation

1. By accepting an Advance, the eligible employee and/or eligible dependent(s) jointly agree that the Fund will be subrogated to the eligible employee and/or eligible dependent's right of recovery from a third party or that third party's insurer for the entire amount advanced, regardless of any state or common law rule to the contrary, including without limitation, a so-called collateral source rule (that would have the effect of prohibiting the Fund from recovering any amount). This means that, in any legal action against a third party who may have wrongfully caused the injury or illness that resulted in the Advance, the Fund may be substituted in place of the eligible employee and/or eligible dependent(s), but only to the extent of the amount of the advance.

2. Under its subrogation rights, the Fund may, at its discretion:
    - start any legal action or administrative proceeding it deems necessary to protect its right to recover its Advances, and try or settle that action or proceeding in the name of and with the full cooperation of the eligible employee and/or eligible dependent(s), but in doing so, the Fund will not represent, or provide legal representation for the eligible employee and/or eligible dependent(s) with respect to their damages that exceed any Advance; or

- intervene in any claim, legal action, or administrative proceeding started by the eligible employee or eligible dependent(s) against any third party or third party's insurer on account of any alleged negligent or wrongful action that may have caused or contributed to the injury or illness that resulted in the Advance.

Remedies Available to the Fund

1. Apply any future Fund benefits that may become payable on behalf of the eligible employee and/or eligible dependent(s) to the amount not reimbursed; or

2. Obtain a judgment against the eligible employee and/or eligible dependent(s) for the amount Advanced and not reimbursed, and garnish or attach the wages or earnings of the eligible employee and/or eligible dependent(s).

OPTIONAL SERVICES

In cases where a more expensive course of treatment may be performed than is necessary or is customarily provided, the Plan will pay for treatment only in accordance with the terms of this Plan.

ONE-YEAR LIMITATION FOR SUBMITTING CLAIMS

The Plan will not accept claims submitted later than one year after the service occurred. Contact the Commonwealth of Massachusetts/NAGE Fund Office for additional information at 1-800-641-0700. See separate rules regarding the submission of claims for the Dependent Care Assistance Program, included in this information booklet

PRIVACY NOTICE

The Commonwealth of Massachusetts/NAGE Health and Welfare Trust Fund ("The Fund") takes your privacy seriously. We want to tell you about our privacy practices to protect your personal health information. Protected personal health information is information about you, including demographic information, that may identify your present or past physical or mental health or condition. Use and disclosure of your personal health information is regulated by federal law, the Health Insurance Portability and Accountability Act ("HIPAA").

Your Privacy Rights

When it comes to your health information, you have certain rights under HIPAA. This section explains your rights and some of our responsibilities to help you.

You May Ask the Fund to Limit the Information that it Uses or Shares

- You can ask the Fund not to use or share certain health information for treatment, payment, or operations.
- The Fund is not required to agree to your request and may deny your request if it would affect your care.

You May Request Confidential Communications

- You can ask the Fund to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- The Fund will consider all reasonable requests and must agree to such a request if you would be in danger if the Fund did not.

You May Obtain a Copy of Your Health and Claims Records

- You can ask to see or get a copy of your health and claims records and other health information the Fund has about you. This request must be in writing.
- The Fund will provide a copy or a summary of your health and claims records, usually within 30 days of your request. The Fund will charge a reasonable, cost-based fee.

You May Ask the Fund to Correct its Health and Claims Records

- You can ask the Fund to correct your health and claims records if you think they are incorrect or incomplete. This request must be in writing.
- The Fund may deny your request but will tell you why in writing within 60 days.

You May Obtain a List of Those with Whom the Fund has Shared Information

- You can ask for a list (accounting) of the times the Fund has shared your health information for six years prior to the date you ask, who the Fund shared it with, and why. This request must be in writing.
- The Fund will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked the Fund to make). The Fund will provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

You May Obtain a Paper Copy of this Notice upon Request

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. The Fund will provide you with a paper copy promptly.

You May Choose Someone to Act for You

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- The Fund will make sure the person has this authority and can act for you before the Fund takes any action.

You May File a Complaint If You Feel Your Rights Are Violated

- You can complain if you feel the Fund has violated your rights by contacting the Fund using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter **to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- The Fund will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell the Fund your choices about what it shares. If you have a clear preference for how the Fund shares your information in the situations described below, tell the Fund what you want it to do, and the Fund will follow your instructions.

In these cases, you have both the right and choice to tell the Fund to:

- Share information with your family, close friends, or others involved in payment for your care.
- Share information in a disaster relief situation.

If you are not able to tell the Fund your preference, for example if you are unconscious, the Fund may go ahead and share your information if the Fund believes it is in your best interest. The Fund may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, the Fund will never share your information unless you give the Fund written permission:

- Marketing purposes.
- Sale of your information.

THE FUND'S USES AND DISCLOSURES

How Does the Fund Typically Use or Share Your Health Information?

The Fund typically uses or shares your health information in the following ways.

Help Manage the Health Care Treatment You Receive

The Fund can use your health information and share it with professionals who are treating you.

Example: A dentist sends the Fund information about your treatment plan so the Fund can arrange additional services and recommend treatment alternatives.

Run the Organization

- The Fund can use and disclose your information to run the organization and contact you when necessary.
- The Fund is not allowed to use genetic information to decide whether it will give you coverage and the price of that coverage.

Example: The Fund uses health information about you to develop better services for you.

Pay For Your Health Services

The Fund can use and disclose your health information as it pays for your dental and vision services.

Example: The Fund shares information about you with your dental plan to coordinate payment for your dental work.

Administer the Fund

The Fund may disclose your health information to the Fund's Board of Trustees for plan administration.

Example: The Board of Trustees sponsors the Fund's dental and vision plans, and the Fund provides the Board of Trustees with certain information to set the required contribution amounts.

How Else Can the Fund Use or Share Your Health Information?

The Fund is allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. The Fund must meet many conditions in the law before it can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Comply With the Law

The Fund will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that the Fund is complying with federal privacy law.

Respond to Lawsuits and Legal Actions

The Fund can share health information about you in response to a court or administrative order, or in response to a subpoena.

Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director

- The Fund can share health information about you with organ procurement organizations.
- The Fund can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Do Research

The Fund can use or share your information for health research.

Help with Public Health and Safety Issues

The Fund can share health information about you for certain situations such as:

- Preventing disease.
- Helping with product recalls.
- Reporting adverse reactions to medications.
- Reporting suspected abuse, neglect, or domestic violence.
- Preventing or reducing a serious threat to anyone's health or safety.

Address Workers' Compensation, Law Enforcement, and Other Government Requests

The Fund can use or share health information about you:

- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.
- For special government functions such as military, national security, and presidential protective services.

THE FUND'S RESPONSIBILITIES

- The Fund is required by law to maintain the privacy and security of your protected health information.
- The Fund will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- The Fund must follow the responsibilities and privacy practices described in this notice and give you a copy of it.
- The Fund will not use or share your information other than as described herein unless you tell the Fund it can in writing. If you tell the Fund it can, you may change your mind at any time. Let the Fund know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

The Fund can change the terms of this notice, and the changes will apply to all information the Fund has about you. The new notice will be available upon request, on the Fund's website, and a copy will be mailed to you.

IF YOU NEED MORE INFORMATION

If you have any questions, comments or suggestions or if you would like to exercise your rights or feel your privacy rights have been violated, please contact the Fund's Privacy Officer at:

The NAGE Fund Office
Attn: Johanna McNally, Privacy Officer
159 Burgin Parkway
Quincy, MA 02169
1-800-641-0700 or (617) 773-8947
jmcnally@nage.org

PHI use and disclosure by the Plan is regulated by the Federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Under the Executive Branch collective bargaining agreements between the Commonwealth and NAGE/SEIU Local 5000, the Family and Medical Leave Act (FMLA) provides that, you may have the right to take up to 26 weeks of unpaid leave for your serious illness, after the birth or placement of a child in your care for adoption or foster care, or to care for your seriously ill spouse, parent or child. **If you are under unpaid FMLA you must elect COBRA Continuation Coverage to continue your Trust Fund benefits. Contact the NAGE Fund Office to receive COBRA information.** FMLA leave requires certain employers to maintain health coverage during the leave period. If you think that this leave may apply to you, please contact your employer.

In accordance with Federal Law, NAGE/SEIU Local 5000 members covered under another collective bargaining agreement may take up to 12 weeks of unpaid FMLA leave.

COVERAGE WHILE ON ACTIVE MILITARY SERVICE

If you are absent from employment because of service in the United States Armed Forces, under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you may be eligible to continue coverage under this Plan for you or your dependents on a self-pay basis for the period of your military service (to a maximum of 24 months).

However, under current Plan provisions, if you are on active military duty, you and your eligible dependents will continue to receive Fund coverage during the term of your active military service, whether or not the Commonwealth, or another employer makes contributions to the Fund on your behalf. (Since this is more than what USERRA requires, the Trustees reserve the right to modify this provision.)

BOARD OF TRUSTEES' STATEMENT

Provider Selection

Plan members may select the benefit options that best serve their needs and may select the provider who alone is responsible for the delivery of quality care. The Trustees have selected Delta Dental Plan of Massachusetts and Davis Vision to provide contracted panels of dental and vision providers, respectively, throughout the area. Delta Dental Plan of Massachusetts and Davis Vision represent that they have selected these providers based on their demonstrated commitment to providing and maintaining the highest quality of care. Delta Dental Plan of Massachusetts and Davis Vision and the providers in their networks are independent and separate entities, not affiliated with or under the control of the Board of Trustees of the Fund. The Trustees cannot take responsibility for the quality of care or treatment decisions received through Delta Dental Plan of Massachusetts and Davis Vision or their providers, nor will the Trustees interfere in the professional relationship between a member and his or her provider.

Plan Amendment, Modification or Termination

The Board of Trustees, by a majority vote, may amend, modify, or terminate all or part of each plan, whenever, in their judgment, conditions so warrant, upon reasonable notice. No benefits or rules described in this booklet are guaranteed (vested) for any employee or eligible dependent.

Claim Appeals

If your claim is denied or partially denied, you will receive written notification along with the specific reason for the denial. Provided that you have exhausted all appeals available under the dental and vision plans, you may appeal any denial directly to the Board of Trustees of the Commonwealth of Massachusetts/NAGE Trust Fund, c/o the Commonwealth of Massachusetts/NAGE Fund Office, 159 Burgin Parkway, Quincy, MA 02169-4213 provided you do so within sixty (60) days of the date of the denial notice.

Trustees' Determinations

The Fund's Board of Trustees, or the Fund Administrator acting on its behalf, has the final discretionary authority to determine any outcomes arising in connection with the administration, interpretation and application of any or all these plans, including any question regarding eligibility for benefits and the right to participate in a plan. Either the Board's or the Administrator's determination concerning the administration, application and interpretation of the plans shall be conclusive and binding on all persons subject to the provisions of these plans.

Reimbursement of Benefit Expenses

If the Fund reimburses you for dental, optical, hearing aid or dependent care assistance expenses, you cannot be reimbursed for the same expenses from any other source. For example, if you participate in a Flexible Spending Plan through the Group Insurance Commission (GIC) and are reimbursed for eligible dependent care expenses by the GIC, you cannot be reimbursed for the *same* dependent care expenses by the Fund.

Misrepresentations

It is illegal for a Fund member to willfully and knowingly misrepresent any fact for the purpose of securing benefits under any of the Fund's plans. Any member found by the Board of Trustees to have committed such a misrepresentation may immediately become ineligible for benefits and will be required to reimburse the Fund for any benefits so obtained. The Trust Fund will cooperate with law enforcement agencies investigating and prosecuting criminal complaints, including fraud or larceny.

ORAL STATEMENTS CANNOT MODIFY THE BENEFITS DESCRIBED IN THIS BOOKLET.

DELTA DENTAL PLAN OF MASSACHUSETTS DELTA DENTAL PPO *PLUS PREMIER*

Delta Dental PPO *Plus Premier* is a comprehensive dental plan administered by Delta Dental Plan of Massachusetts.

How the Delta Dental PPO *Plus Premier* Program Works

The Delta Dental PPO *Plus Premier* program combines two of Delta's dental networks – the Delta Dental PPO network of participating providers, and the Delta Dental Premier network of participating providers – giving you access to dentists that participate in both.

When you need dental services, you will be able to select a dentist from either the Delta Dental Premier or the Delta Dental PPO network of dentists. Depending on which network you select, the payment for covered dental procedures may vary.

- The Delta Dental Premier network is a large network of dentists, with approximately 90% of dentists in Massachusetts. Savings are created through Delta-negotiated dentist fees.
- The Delta Dental PPO network is a smaller network of dentists who have agreed to fees that are up to 35%-45% less than what dentists normally charge. Approximately 30% of dentists who participate with Delta Premier in Massachusetts also participate with Delta Dental PPO. Most often, the Delta Dental PPO network will result in greater out-of-pocket savings for you, as compared to the Delta Dental Premier network.
- Members or eligible dependents who receive services from a dentist who does not contract with Delta Dental will still be eligible for coverage, but without the benefit of the Delta discount. You will be balance billed for the difference between the dentist's charge and the maximum payment allowed by the Fund.

To verify if your dentist is part of the Delta Dental PPO *Plus Premier* network, simply visit www.deltadentalma.com to find a participating dentist in your area. You can also call Delta Dental Customer Service department at (800) 872-0500.

When choosing a participating provider, keep in mind that the deepest discounts will be received with a Delta Dental PPO provider.

Maximum Payment

The maximum payment each calendar year is $1,052.00 for each insured person, excluding orthodontia. Reimbursement for orthodontia procedures is up to 50% of the orthodontist's charges to a lifetime maximum of $2,000.00 for each insured person. Reimbursement of dental implants is $1,000.00 per calendar year.

Pre-Treatment Estimates

If your dentist expects that dental treatment will involve a series of covered services, he or she should file a copy of the treatment plan with Delta Dental BEFORE these services are rendered to you or your dependent. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate of the charges for each service. Pre-treatment estimates are recommended for any services that are $300 or more, but are not mandatory.

Upon receipt of the treatment plan Delta Dental will notify you and your dentist about the maximum extent of your benefits for the services reported. If your dentist does not file a treatment plan for a pre-treatment estimate, Delta Dental will decide the extent of your benefit based on a review of those services using standards that are generally considered as accepted dental practices.

DO YOU PARTICIPATE IN A FLEXIBLE SPENDING PLAN?

A Flexible Spending Plan is a program that allows you to have a designated dollar amount of your paycheck put aside and held in an account until you need to use it for out-of-pocket healthcare expenses. The money is deducted before taxes are paid, allowing you to apply 100 percent of the money you earn and put aside toward eligible expenses.

Out-of-pocket dental costs that are not covered by your dental insurance are an eligible expense under a Flexible Spending Plan. Some examples are: Crowns/Bridges, Dentures, Extractions, Fillings, Gum Treatment, Oral surgery, Orthodontia. For additional information call The Group Insurance Commission Health Care Spending Account Administrator at 1 (800) 745-9202 or visit the Group Insurance Commission web site at the link below.

www.mass.gov

FOR MORE INFORMATION ABOUT YOUR DENTAL ASSISTANCE PROGRAM, PLEASE REFER TO THE BROCHURE REGARDING THE DELTA DENTAL SCHEDULE. THIS BROCHURE INCLUDES INFORMATION ON MEMBERS' RIGHTS AND RESPONSIBILITIES, HOW TO FILE A CLAIM, APPEAL INFORMATION AND EXCEPTIONS AND LIMITATIONS.

OPTICAL ASSISTANCE PROGRAM`

The Optical Assistance Program offers two optical plans. You can choose between the Optical Assistance Open Panel Plan and the Optical Assistance Closed Panel Plan.

- With the Optical Assistance Open Panel Plan you may receive services from any vision care provider you choose. Davis Vision administers the Open Plan.
- With the Optical Assistance Program Closed Panel Plan you may receive service at any Davis Vision provider. Davis Vision is the Closed Plan provider.

You must choose between the Open and Closed Plan once during each eligibility period. Please see the Benefit Information Notice below for eligibility period information. Benefits can not be divided between the Open and Closed Panel Plans.

Benefit Information Notice

Members who have been reimbursed for benefits under the Commonwealth of Massachusetts/NAGE Optical Assistance Program will not be eligible for benefits until the next eighteen (18) month eligibility period (twelve (12) months for dependents less than nineteen (19) years of age) has been completed. The eligibility period starts from the date of your last service. Contact Davis Vision directly at 1-800-999-5431 or you can go to their website at www.davisvision.com to verify your eligibility date.

If you are in need of an eye examination prior to your eighteen-month eligibility date with the Fund, contact your health insurance carrier to see if you are eligible for coverage.

General Information

- Coverage is for a routine eye examination and prescription corrective eyewear only
- Benefits for medical treatment of eye disease or injury are not provided under this program
- If you received coverage for your eye examination from your health insurance carrier, you will be reimbursed for your co-payment only up to the $50.00 maximum

With question on the Optical Assistance Program, contact the Fund Office 1-800-641-0700 or call Davis Vision at 1-800-999-5431 or visit their website at www.davisvision.com.

DO YOU PARTICIPATE IN A FLEXIBLE SPENDING PLAN?

A Flexible Spending Plan is a program that allows you to have a designated dollar amount of your paycheck put aside and held in an account until you need to use it for out-of-pocket healthcare expenses. The money is deducted before taxes are paid, allowing you to apply 100 percent of the money you earn and put aside toward eligible expenses.

Out-of-pocket costs for vision care are an eligible expense under a Flexible Spending Plan, including eyeglasses, contact lenses and their upkeep, prescription sunglasses, non-prescription reading glasses, or laser eye surgery and examination fees. For additional information call The Group Insurance Commission Health Care Spending Account Administrator at 1 (800) 745-9202 or visit the Group Insurance Commission web site at the link below.

www.mass.gov

PLEASE REFER TO THE OPTICAL ASSISTANCE PROGRAM BROCHURE FOR A DETAILED DESCRIPTION OF THE PROGRAM, INCLUDING INFORMATION ON PLAN BENEFITS, FREQUENCIES AND COSTS, PLAN EXCLUSIONS, CLAIMS AND APPEALS INFORMATION AND YOUR RIGHTS AS A PATIENT OF DAVIS VISION.

HEARING AID ASSISTANCE PROGRAM

The Hearing Aid Assistance Program provides a maximum reimbursement of $1,500.00 every three (3) years for the cost of a hearing aid device. Reimbursement is provided for a hearing aid device only. There is no coverage for hearing test.

How Do You File Claims For Reimbursement?

The Trust Fund is your secondary insurance for a hearing aid device. You must submit your claim to your health insurance carrier through the Commonwealth of Massachusetts Group Insurance Commission for coverage first. Then submit your paid receipt for your hearing aid device to the Fund Office with a completed claim form for the Hearing Aid Assistance Program.

The Commonwealth of Massachusetts/NAGE Fund Office will not process any claim until all payments have been received from your health insurance carrier. You must submit an itemized statement of services as well as the Explanation of Benefits (EOB) from your health insurance carrier.

DEATH BENEFIT

There is a $4,000.00 death benefit available for each eligible employee, spouse and dependent child. This benefit will be paid directly to the estate of the deceased, provided a copy of the death certificate is submitted.

Who Is Eligible?

A Death Benefit will only be paid for members or eligible dependents that are eligible for Trust Fund benefits at the time of death.

Filing A Claim

A completed Death Benefit Claim Form must be submitted to the Commonwealth of Massachusetts/NAGE Fund Office with a copy of the death certificate. If a copy of the death certificate is not included, the claim will not be processed.

DEPENDENT CARE ASSISTANCE PROGRAM

The Dependent Care Assistance Program provides reimbursement up to a maximum of $2,000.00 per calendar year for eligible work-related dependent care expenses for your eligible dependents as defined below.

What Are Eligible Expenses?

Eligible expenses that qualify for reimbursement include dependent care expenses incurred on behalf of the eligible dependents. The following lists some examples:

- Care at a day care center that complies with all appropriate state and local regulations, including before/after school care.
- Care by a housekeeper whose duties include dependent care.
- Care by a relative who cares for the member's dependents, so long as the relative is not another one of the member's dependents (For example, a member cannot be reimbursed for paying their 16-year old child to care for their 2-year old infant.)
- Care for an elderly or incapacitated spouse or dependent, either in the member's home or outside of the member's home. If the member is claiming reimbursement for care outside of his or her home, the dependent must spend at least eight hours each day in the member's care.
- Care at a day camp to which the member sends his or her school aged children during school vacations or after school hours for work related dependent care expenses.

What Are Non-Reimbursable Dependent Care Expenses?

The following are some examples of expenses that do not qualify for reimbursement under the Dependent Care Assistance Program:

- Dependent care that allows you and your spouse to participate in leisure time activities or take vacations
- Expenses claimed as a tax credit on your Federal income tax returns
- Expenses incurred so that you and your spouse can perform volunteer work
- Food, clothing, transportation, overnight camp, entertainment and field trips
- Kindergarten
- 24-hour nursing homes
- Amounts paid to your child under age 19 or to any person who can be claimed as a dependent on your Federal income tax return.
- Expenses for entertainment or enrichment (e.g., after school sports, dance lessons, education or enrichment programs, such as summer school, computer classes, tutoring or music classes.)

What Expenses May Qualify for Reimbursement?

The following information relates to some expenses that may qualify for reimbursement under the Dependent Care Assistance Program, as described below:

- *Parents Working at Night*
  If one parent works during the day and the other works at night and sleeps during the day, expenses for care while the second parent is sleeping may be reimbursable. Similarly, if a child's parent works at night and pays for overnight care while working, those expenses may also be reimbursable.
- *Temporary Absences*
  Dependent care expenses for a period in which the employee is absent from work are generally not employment-related expenses; however, short, temporary absences from work (such as for minor illness or vacation) are disregarded provided the care arrangement requires you to pay for care during the absence. An absence of no more than two consecutive weeks is temporary; whether a longer absence will be considered temporary will depend on the facts and circumstances.
- *Part-Time Work*
  If you work part-time, you must allocate expenses between days worked and not worked. However, if you are required to pay for dependent care on a weekly or longer basis, you are not required to allocate the expenses. Working at least one hour is considered a day of work.
- *Divorced or Separated Parents and Parents Living Apart*
  When a child's parents are divorced, separated or live apart during the last six months of the year, the child is treated as the qualifying individual of the custodial parent only. The custodial parent is the parent with whom the child lives for the greater portion of the year. As a result, the custodial parent is the only parent who can seek reimbursement from the Dependent Care Assistance Program.

What Are Work-Related Dependent Care Expenses?

To be work related, your eligible expenses must allow you to work or look for work. If you are married, generally both you and your spouse must work or look for work. Your spouse is treated as working during any month he or she is a full-time student or is physically or mentally not able to care for him or herself.

Work also includes actively looking for work. However, if you do not find a job and have no earned income for the year, these expenses do not qualify as work-related expenses.

Who Are Eligible Dependents?

Eligible dependents, for the purpose of the Dependent Care Assistance Program, include:

- Your "qualifying child" who has not attained age 13; or
- Your spouse, "qualifying child" or "qualifying relative," provided the person is physically or mentally incapable of self-care and has the same principal place of abode as you for more than one-half of the taxable year.

The terms "qualifying child" and "qualifying relative" are defined in section 152 of the Internal Revenue Code (IRC), and the applicable requirements set out in IRC section 152 must also be met. A "qualifying child" is generally a child who lives with you for more than half of the year who does not provide more than half of his or her own support. A "qualifying relative" is generally a relative who receives more than half of his or her support from you and is not the "qualifying child" of any other taxpayer. If you have questions about whether a person meets the required tests, you should contact your tax adviser.

What Is Needed To Submit A Claim?

The following information is required in order for a claim to be eligible for reimbursement. A paid receipt, an invoice marked paid or a written statement from the person or organization that provide the services on appropriate letterhead and must include all of the following:

- The name of the child or children the services have been provided for
- The type of service provided i.e. daycare, preschool, camp, before and/or after school care, etc.
- The dates of service (from/to) NOT PAYMENT DATES
- Total amount paid for services provided
- The provider's Tax ID # or Social Security #
- The provider's signature
- The provider's name and complete address

Any paid receipt missing any of the above information or required signatures will be returned to the member.

What Is Unacceptable Proof of Payment?

- A receipt or written statement created by the member and signed by the provider
- Payment history statements
- Copies of cancelled checks
- Past Dependent Care Assistance receipt forms

How Will the Benefit Work?

You may submit eligible expenses on a monthly basis, and you will be reimbursed up to a maximum of $2,000.00 per calendar year. When submitting a claim, you must include a copy of an invoice marked "paid" or a written statement from the person or organization that provided the care, including the dates of service and amount paid. Copies of cancelled checks are not accepted as proof of payment. You must also include the provider of care's name, address and taxpayer identification or Social Security number, the beginning and end dates of care was provided and for whom, and the amount of the expense, as well as any additional information that the Fund may request.

No claim will be processed without a completed claim form and a paid statement signed by the provider. ***Please Note: The claim form and the paid receipt must both be signed by the provider.***

All claims for services each calendar year must be post marked no later than the following January 31st. No reimbursement will be issued retroactively for any claim received by the Commonwealth of Massachusetts/NAGE Fund Office after that date.

In accordance with the Internal Revenue Service (IRS) guidelines, reimbursements for childcare/elder care expenses can be made only after the care has been provided and not when you are billed, charged, or pay for services.

Please note that the Commonwealth of Massachusetts/NAGE Health and Welfare Trust Fund will be required to report your reimbursement amount to both you and the IRS each year on an IRS Form W-2.

Is There A Limit on Dependent Care Benefits?

All benefits payable under this Program and any contributions you make to a dependent care spending account must be considered in determining whether you are exceeding the legal limit on tax-free dependent care benefits.

Members should be aware that benefits under all dependent care plans, including this plan, cannot exceed the lesser of:

- $5,000 if you are a single or married and file a joint income tax return
- $2,500 if you are married and file a separate income tax return
- your earned income, if single
- if you are married, the earned income of the spouse who earned the lesser amount during the calendar year.

Be sure to sign and date your claim form. Keep a copy of the completed form and attachments with your records. Claim forms are available from the Commonwealth of Massachusetts/NAGE Fund Office.