



# BENEFITS ORIENTATION

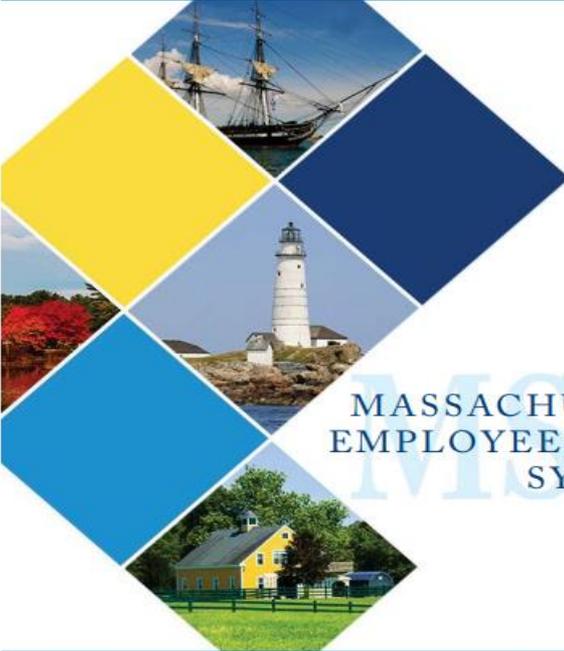
# What Benefits are available to you?

- Retirement Plans
- Group Insurance Commission
  - Health Plan
  - Long Term Disability
  - Life Insurance
- Flexible Spending Accounts (FSAs)
- Dental and Vision Discount Plans
- Employee Assistance Program (EAP)
- Leave Accruals/Paid Time Off
- Tuition Remission
- Professional Development
- Employee Discounts
- Commonwealth of MA Financial Wellness Program



# Retirement Plans - Mandatory

Plan Name	Abbreviation	Description	Eligibility
Massachusetts State Employees Retirement System	MSERS	Defined benefit plan that provides predictable & guaranteed income (benefits calculated using a formula)	Classified Employees, Faculty, Unit Professionals, and Non-Unit Professionals
Optional Retirement Plan	ORP	Defined contribution plan that provides income based on the investment performance of your individual account balance, which you decide how to invest	Faculty, Unit Professionals, and Non-Unit Professionals
Omnibus Budget Reconciliation Act	OBRA	Massachusetts Deferred Compensation SMART Plan	Part-time employees* *Exemptions: Already paying into MSERS or ORP/Full-time Student



# MASSACHUSETTS STATE EMPLOYEES' RETIREMENT SYSTEM

Retirement Benefit Guide

YOU SERVE THE COMMONWEALTH. WE SERVE YOU.



# State Board of Retirement Enrollment Form – must be completed!



THE COMMONWEALTH OF MASSACHUSETTS  
**State Board of Retirement**  
ONE WINTER STREET 8TH FLOOR, BOSTON, MA 02108

**COMMONWEALTH AGENCY  
NEW MEMBER  
ENROLLMENT FORM**

SECTION A TO BE COMPLETED BY MEMBER - SECTION B TO BE COMPLETED BY AGENCY  
PLEASE RETURN COMPLETED FORM TO THE MASSACHUSETTS STATE RETIREMENT BOARD

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SECTION A - TO BE COMPLETED BY MEMBER

1. MEMBER INFORMATION

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Name (Print)	Former Name	SSN
Street Address	Date of Birth	Gender: M <input type="checkbox"/>
City	State	Zip Code
E-Mail	Phone Number	F <input type="checkbox"/>

Marital Status:

<input type="checkbox"/> Married	<input type="checkbox"/> Single	If Divorced, are you subject to a Qualified Domestic Relations Order?		
<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced		<input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse Date of Birth

Are you a Veteran?

<input type="checkbox"/> Yes <input type="checkbox"/> No	The retirement law establishes specific periods of active service, which may qualify you for certain Veteran benefits.	Employment Position
Dates of Military Service	to	Start Date
A copy of your military discharge may be requested		Agency or Department
		Agency Phone Number

2. PAST MEMBERSHIP HISTORY WITH ANY OTHER CONTRIBUTORY RETIREMENT SYSTEM IN MASSACHUSETTS

Retirement System	Start Date	End Date	Was a Refund Taken?	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you wish to reinstate / purchase past creditable service you must make a separate request to the State Retirement Board.

3. ARE YOU CURRENTLY OR HAVE YOU EVER RECEIVED A RETIREMENT ALLOWANCE FROM ANOTHER PUBLIC RETIREMENT SYSTEM?

	<input type="checkbox"/> Yes <input type="checkbox"/> No
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4. STATEMENT AND SIGNATURE OF MEMBER

I certify the above information to be true and correct to the best of my knowledge and hereby accept membership in the Massachusetts State Employees' Retirement System. This statement is signed under penalties of perjury.

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Member Signature	Date
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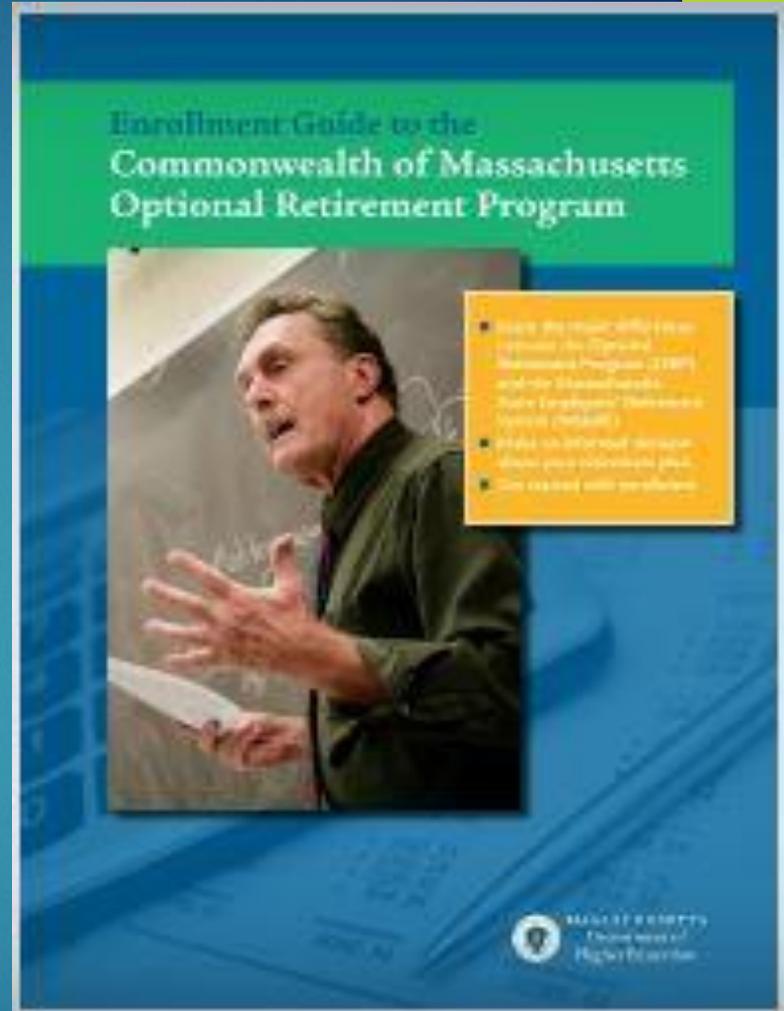
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Main Office: One Winter Street, 8th Floor, Boston, MA 02108. Phone: 617-367-7770 Fax: 617-723-1438 Toll Free (within MA): 1-800-392-6014  
Regional Office: 436 Dwight Street, Room 109A, Springfield, MA 01103. Phone: 413-730-6135 Fax: 413-730-6139  
mass.gov/retirement

3/2016

# Optional Retirement Program –

You have 180 days to determine if you would like to enroll





## Notice of ORP Eligibility

[Date]

Dear [Employee]:

Welcome!

I am pleased to tell you that as a new [Job Title], you may be eligible to choose your pension coverage from the Commonwealth's two retirement plans:

- The Optional Retirement Program (ORP), and
- The State Employees' Retirement System (SERS).

You are *not eligible* to choose your retirement coverage if you are already vested in a state pension such as the SERS, the Mass. Teachers' Retirement System; or other plan operating under Chapter 32 of the Massachusetts General Laws (*i.e.*, many county and municipal pensions).

### Election Period

If you are eligible for ORP coverage, you must select one of the two retirement plans during your 180-day Election Period, which begins [election begin date] and ends [180 days, election end date]. If you do not actively select one of the plans, you will remain in the SERS.

I strongly encourage you to utilize the Election Period to learn about the features of both plans, to determine which of them better suits your expectations and needs. If you are uncertain about your ability to make this decision alone, then consider employing an independent, experienced financial advisor to help you.

I have enclosed the "ORP Enrollment Guide" for your reference. To learn more about the ORP and the Providers offering investments and services under the Plan—and to enroll if you so choose—go to the ORP web pages at: [www.mass.edu/orpenrollment](http://www.mass.edu/orpenrollment).

The State Retirement Board can answer your questions about the SERS.

Your retirement benefits are an important part of your overall compensation package with the Commonwealth, and your choice of coverages is irrevocable. Therefore, you should exercise great care in selecting the plan that best suits your needs.

Please confirm your receipt of this notice by signing below and returning the original to me. Remember to keep a copy for yourself.

Sincerely,

Elizabeth A. Austin  
Associate Director of Human Resources

**EMPLOYEE SECTION: Please fill out and return the original signed copy to me.**

I have participated in the ORP during six of the past twelve months:  True  False

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

Enclosures

# Notice of ORP Eligibility



# Supplemental Retirement Plans (sign up any time!)

Plan Name	Abbreviation	Description	Eligibility
Tax Sheltered Annuity Plan	TSA-403(b)	Employees may contribute through various approved vendors by the Commonwealth of MA	All Employees
457 Deferred Compensation Plan – SMART Plan	457	Pre-tax employee contributions are invested in the investment options you have selected. All earnings are tax deferred	All Employees

## 403(b) Vendors

Valic – Jim Kaufmann  
[James.Kaufmann@valic.com](mailto:James.Kaufmann@valic.com)

TIAA – Heather Martin  
[Heather.martin@tiaa.org](mailto:Heather.martin@tiaa.org)

Fidelity – Matthew Toedt  
[Matthew.toedt@fmr.com](mailto:Matthew.toedt@fmr.com)

## Empower Retirement (457)

Manny Jardim  
[Manny.jardim@empower-retirement.com](mailto:Manny.jardim@empower-retirement.com)

# Smart Plan Enrollment Form



Massachusetts Deferred Compensation  
**SMART Plan**

QUICK ENROLLMENT FORM  
GOVERNMENTAL 457(b) PLAN  
98966-01

Upon completion, the following  
**SMART Plan Quick Enrollment Form**

can be either faxed to

1-781-890-2919, or mailed to:

Empower Retirement  
255 Bear Hill Road  
Waltham, MA 02451

Questions? Email [SMART@Empower-Retirement.com](mailto:SMART@Empower-Retirement.com)

or call

1-877-457-1900 (option 0)

PLEASE NOTE: DO NOT SEND THE  
**SMART PLAN QUICK ENROLLMENT FORM**  
TO THE MASSACHUSETTS RETIREMENT BOARD.  
THANK YOU

PARTICIPANT FAX TO: 1-781-890-2919 (or) MAIL TO: Empower Retirement™, 255 Bear Hill Road, Waltham, MA 02451

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98966-01

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# Smart Plan Enrollment Form



Massachusetts Deferred Compensation  
**SMART Plan**

QUICK ENROLLMENT FORM  
GOVERNMENTAL 457(b) PLAN  
89866-01

**PARTICIPANT INFORMATION PLEASE SELECT ONE OPTION**

- 1) YES, I would like to contribute 3% of my salary on a pre-tax basis to the Massachusetts Deferred Compensation SMART Plan to supplement my retirement benefit.\*
- 2) YES, I would like to contribute \_\_\_\_\_% of my salary on a pre-tax basis to the Massachusetts Deferred Compensation SMART Plan to supplement my retirement benefit.\*
- 3) NO, I do not wish to supplement my retirement benefit by contributing any portion of my salary to the Massachusetts Deferred Compensation SMART Plan at this time. I understand there is a ten year creditable service vesting period for members of the separate state retirement system and I am not contributing to Social Security as a state employee.

\*If you elect to supplement your retirement benefit you will be defaulted into a SMART Plan custom target date fund based on your date of birth and an assumed retirement age of 65. (See the chart at the end of this form.) Additional information about the SMART Plan and options available to you can be found at [www.mass-smart.com](http://www.mass-smart.com).

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address - Number & Street \_\_\_\_\_ E-Mail Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Married  Unmarried  Female  Male

Mo \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Mo \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Date of Birth \_\_\_\_\_ Date of Hire \_\_\_\_\_

Payroll Center Name & Number \_\_\_\_\_ Division Name & Number \_\_\_\_\_

Do you have a retirement account with a previous employer or an IRA?  Yes  No

Would you like help consolidating your other retirement accounts into your SMART Plan account?  Yes, I would like a representative to call me at phone # \_\_\_\_\_ to review my options and assist me with the process. The best time to call is \_\_\_\_\_ to \_\_\_\_\_ A.M./P.M. (circle one - available 8:00 A.M. to 6:00 P.M. EST). \*Callers are subject to your Plan's provisions.

**Investment Option:** I understand that this form is my election to enroll in the Plan. By signing this form, my contributions will be allocated to the Plan's default investment fund without additional action by me. If I wish to contribute to any of the investment options of the Plan other than the default fund, I understand that I must contact my Plan Administrator or local representative to obtain a Participant Enrollment Form. The Plan has selected a TARGET DATE portfolio of funds as its default investment fund. Until such time as you choose investment options for your Plan account, your contributions will be invested in the fund within this portfolio that most closely corresponds to certain factors in your profile. For more information, please contact your GWS Representative. I acknowledge that information about Plan investment options, including prospectuses, disclosure document and Fund Data sheets are available to me through my Plan Administrator or Plan Web site. I understand the risks of investing and that all payments and account values may not be guaranteed and may fluctuate in value.

I understand that funds may impose redemption fees on certain transfers, redemptions or exchanges if assets are held less than the period stated in the fund's prospectus or other disclosure documents. I understand that I have the right to direct the investment of my account and that I can change my investment allocation from the Plan's default fund at any time by logging on to my account at [www.mass-smart.com](http://www.mass-smart.com) or by calling the Voice Response System at 1-877-457-1900. A personal identification number (PIN) that gives you access to your account via the Web or phone will be mailed to you soon after your application is processed. You are responsible for keeping the assigned PIN confidential. Please contact us if you suspect unauthorized use.

My Account: I understand that it is my obligation to review all confirmations and quarterly statements for discrepancies or errors. Corrections will be made only for errors which I communicate within 90 calendar days from the last calendar quarter. After this 90 days, account information shall be deemed accurate and acceptable to me. If I notify Service Provider of an error after this 90 days, the correction will only be processed from the date of the notification forward and not on a retroactive basis.

**Beneficiary Designation:** I understand that I must choose a beneficiary of my account with this Plan by filing a separate Beneficiary Designation form with the Service Provider.

**Required Signature:** By signing this form, I acknowledge that I have previously received detailed information about this Plan from my employer and understand that my participation in the Plan must be in compliance with the Plan Document and/or the Internal Revenue Code. I understand that Service Provider is required to comply with the regulations and requirements of the Office of Foreign Assets Control, Department of the Treasury ("OFAC"). As a result, Service Provider cannot conduct business with persons in a blocked country or any person designated by OFAC as a specially designated national or blocked person. For more information, please access the OFAC Web site at: <http://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx>. Deferral agreements must be entered into prior to the first day of the month that the deferral will be made.

X  
Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

*Continued on reverse*

PARTICIPANT FAX TO: 1-781-890-2919 (or) MAIL TO: Empower Retirement™, 255 Bear Hill Road, Waltham, MA 02451

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89866-01

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QUICK ENROLLMENT FORM GOVERNMENTAL 457(B) PLAN - PAGE 2

89866-01

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Social Security Number \_\_\_\_\_ 89866-01 Number \_\_\_\_\_

Date of Birth	SMARTPath Retirement Funds	Expected Retirement Date Range
1993 or after	SMARTPath 2060 Retirement Fund	2058 or after
1988-1992	SMARTPath 2055 Retirement Fund	2053-2057
1983-1987	SMARTPath 2050 Retirement Fund	2048-2052
1978-1982	SMARTPath 2045 Retirement Fund	2043-2047
1973-1977	SMARTPath 2040 Retirement Fund	2038-2042
1968-1972	SMARTPath 2035 Retirement Fund	2033-2037
1963-1967	SMARTPath 2030 Retirement Fund	2028-2032
1958-1962	SMARTPath 2025 Retirement Fund	2023-2027
1953-1957	SMARTPath 2020 Retirement Fund	2018-2022
1948-1952	SMARTPath 2015 Retirement Fund	2013-2017
1943-1947	SMARTPath 2010 Retirement Fund	2008-2012
1938-1942	SMARTPath 2005 Retirement Fund	2003-2007
1937 or before	SMARTPath Retirement Allocation Fund	2002 or before

Please note that if a date of birth is not included on this form, or otherwise on file when your account is created, the date of birth assigned to your SMART Plan account will be the date of account creation, which will result in your allocations being set to the SMARTPath 2060 Retirement Fund. You may change your investment allocations by calling 877-457-1900 or accessing your account online through [www.mass-smart.com](http://www.mass-smart.com).

<sup>1</sup> Access to KeyTalk and/or any website may be limited or unavailable during periods of peak demand, market volatility, system upgrades/maintenance or other reasons. Transfer requests made via the website and/or KeyTalk received on business days prior to close of the New York Stock Exchange (4:00 p.m. Eastern Time or earlier on some holidays or other special circumstances) will be initiated at the close of business the same day the request was received. The actual effective date of your transaction may vary depending on the investment option selected.

Coin securities, when offered, are offered through GWS Equities, Inc. and/or other broker dealers. GWS Equities, Inc. Member FINRA/SIPC, is a wholly owned subsidiary of Great-West Life & Annuity Insurance Company. Empower Retirement™ refers to the products and services offered in the retirement markets by Great-West Life & Annuity Insurance Company (GWL&A), Corporate Headquarters: Greenwood Village, CO. Great-West Life & Annuity Insurance Company of New York, Home Office: White Plains, NY, and their subsidiaries and affiliates. All trademarks, logos, service marks, and design elements used are owned by their respective owners and are used by permission.

PARTICIPANT FAX TO: 1-781-890-2919 (or) MAIL TO: Empower Retirement™, 255 Bear Hill Road, Waltham, MA 02451

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89866-01

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For more information on the optional plans, please go to:

<https://www.mass.edu/forfacstaff/otherretirement/home.asp>



# 2021-2022 OVERVIEW

KNOW YOUR GIC BENEFITS

COMMONWEALTH  
OF MASSACHUSETTS  
**EMPLOYEES**



**ANNUAL ENROLLMENT:  
APRIL 7 - MAY 5, 2021**

Benefits and rates effective **July 1, 2021**

[mass.gov/gic](https://mass.gov/gic)

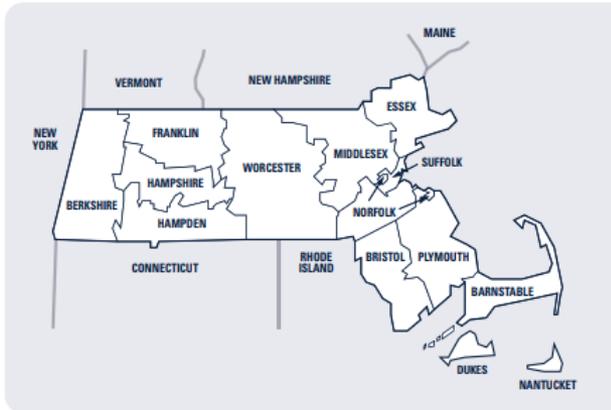


# GIC Benefit Decision Guide

## Where Do You Live?



Where you live determines which health insurance product you may enroll in.



The **bold** text is a shortened version of the full product name. These names are used to indicate which product is available in each county.

- DIRECT** - Fallon Health Direct Care
- SELECT** - Fallon Health Select Care
- INDEPENDENCE** - Harvard Pilgrim Independence
- PRIMARY CHOICE** - Harvard Pilgrim Primary Choice
- HNE** - Health New England
- ALLWAYS COMPLETE** - AllWays Health Partners Complete HMO
- NAVIGATOR** - Tufts Health Plan Navigator
- SPIRIT** - Tufts Health Plan Spirit
- BASIC** - UniCare State Indemnity Plan/Basic
- COMMUNITY CHOICE** - UniCare State Indemnity Plan/Community Choice
- PLUS** - UniCare State Indemnity Plan/PLUS

### Is the Health Product Available Where You Live?

#### BARNSTABLE

Independence, AllWays Complete, Navigator, Spirit, Basic, Community Choice, PLUS

#### BERKSHIRE

Select, Independence, Primary Choice, HNE, Navigator, Spirit\*, Basic, Community Choice, PLUS

#### BRISTOL

Direct, Select, Independence, Primary Choice, AllWays Complete, Navigator, Spirit, Basic, Community Choice, PLUS

#### DUKES

Independence, AllWays Complete, Navigator, Basic, PLUS

#### ESSEX

Direct, Select, Independence, Primary Choice, AllWays Complete, Navigator, Spirit, Basic, Community Choice, PLUS

#### FRANKLIN

Select, Independence, Primary Choice, HNE, Navigator, Spirit, Basic, Community Choice, PLUS

#### HAMPDEN

Direct\*, Select, Independence, Primary Choice, HNE, Navigator, Spirit, Basic, Community Choice, PLUS

#### HAMPSHIRE

Direct\*, Select, Independence, Primary Choice, HNE, Navigator, Spirit\*, Basic, PLUS, Community Choice

#### MIDDLESEX

Direct, Select, Independence, Primary Choice, AllWays Complete, Navigator, Spirit, Basic, Community Choice, PLUS

#### NANTUCKET

Independence, AllWays Complete, Navigator, Basic, PLUS

#### NORFOLK

Direct, Select, Independence, Primary Choice, AllWays Complete, Navigator, Spirit, Basic, Community Choice, PLUS

#### PLYMOUTH

Direct, Select, Independence, Primary Choice, AllWays Complete, Navigator, Spirit, Basic, Community Choice, PLUS

#### SUFFOLK

Direct, Select, Independence, Primary Choice, AllWays Complete, Navigator, Spirit, Basic, Community Choice, PLUS

#### WORCESTER

Direct, Select, Independence, Primary Choice, HNE, AllWays Complete, Navigator, Spirit, Basic, Community Choice, PLUS

### OUTSIDE OF MASSACHUSETTS

The UniCare State Indemnity Plan/Basic is the **only** health insurance product offered by the GIC that is available throughout the United States and outside of the country.

#### CONNECTICUT

Independence, HNE\*, Navigator\*, Basic, PLUS\*

#### MAINE

Independence, Navigator\*, Basic, PLUS

#### NEW HAMPSHIRE

Select\*, Independence, Navigator\*, Basic, PLUS

#### NEW YORK

Independence\*, Navigator\*, Basic

#### RHODE ISLAND

Independence, Navigator, Basic, PLUS

#### VERMONT

Independence\*, Navigator\*, Basic, PLUS

\*Not every city and town is covered in this county or state; contact the health insurance carrier to find out if you live in the service area. The product also has a limited network of providers in this county or state; contact the health insurance carrier to find out which doctors and hospitals participate.

# Page 4 – Where Do You Live?

# This determines which plans you are eligible for...

# Page 5 - GIC Plan Rates

## Rate Chart



		Monthly GIC Product Rates Effective July 1, 2021			
		FOR EMPLOYEES HIRED BEFORE JULY 1, 2003		FOR EMPLOYEES HIRED ON OR AFTER JULY 1, 2003	
		20%		25%	
		EMPLOYEE PAYS MONTHLY		EMPLOYEE PAYS MONTHLY	
BASIC LIFE INSURANCE ONLY - \$5,000 Coverage		\$1.27		\$1.59	
HEALTH INSURANCE PRODUCTS (Premium includes Basic Life Insurance)	PRODUCT CATEGORY	INDIVIDUAL	FAMILY	INDIVIDUAL	FAMILY
UniCare State Indemnity Plan/ Basic with CIC* (Comprehensive)	National Network	\$289.58	\$644.22	\$346.88	\$770.90
UniCare State Indemnity Plan/ Basic without CIC		\$229.19	\$506.73	\$286.49	\$633.41
UniCare State Indemnity Plan/ PLUS	Broad Network	\$157.12	\$373.31	\$196.41	\$466.64
Tufts Health Plan Navigator		\$168.02	\$409.03	\$210.02	\$511.29
Fallon Health Select Care		\$173.27	\$419.92	\$216.59	\$524.90
Harvard Pilgrim Independence Plan		\$193.45	\$470.85	\$241.82	\$588.57
Health New England	Regional Network	\$126.90	\$301.11	\$158.62	\$376.39
AllWays Health Partners Complete HMO		\$154.33	\$401.01	\$192.91	\$501.26
UniCare State Indemnity Plan/ Community Choice	Limited Network	\$119.62	\$295.41	\$149.53	\$369.26
Tufts Health Plan Spirit		\$128.57	\$308.58	\$160.71	\$385.72
Fallon Health Direct Care		\$128.33	\$322.49	\$160.42	\$403.11
Harvard Pilgrim Primary Choice Plan		\$140.37	\$356.42	\$175.47	\$445.53

\* CIC is an enrollee-pay-all benefit.



## Long Term Disability (LTD)



### What is it?

LTD insurance is an income replacement program that financially protects you and your family in the event you become disabled and are unable to perform the material and substantial duties of your job. Effective July 1, 2021, MetLife is the GIC's Long Term Disability (LTD) Carrier. If you are unable to work for 90 consecutive days due to illness or injury, this program provides income replacement. Benefits include:

- A tax-free benefit of 55% of a participant's gross monthly salary, up to a maximum benefit of \$10,000 per month, up to the age of 65. If a participant is disabled on or after age 62, benefits may continue after age 65;
- A benefit for partial disabilities;
- A 36-month benefit for behavioral health disabilities;
- A rehabilitation and return-to-work assistance benefit;
- A dependent care expense benefit; and
- Partial benefits, even if you are receiving other income benefits, with a minimum of \$100 or 10% of your gross monthly benefit amount - whichever is higher.

### Eligibility and Enrollment

Active state employees who are eligible for GIC benefits are eligible for LTD.

**Current State Employees:** All eligible employees can apply for LTD coverage during Annual Enrollment, or at any time during the year. You must provide proof of good health for MetLife's approval to enter the plan.

**New State Employees:** Eligible employees may enroll in LTD without providing evidence of good health.

MONTHLY GIC PLAN RATES EFFECTIVE JULY 1, 2021	
ACTIVE EMPLOYEE AGE	EMPLOYEE PREMIUM - Per \$100 of Monthly Earnings
Under Age 24	\$0.06
25 - 29	\$0.07
30 - 34	\$0.11
35 - 39	\$0.13
40 - 44	\$0.30
45 - 49	\$0.40
50 - 54	\$0.48
55 - 59	\$0.60
60 - 64	\$0.58
65 - 69	\$0.33
70 and over	\$0.20

### Questions?



1.877.355.6277



[metlife.com/gicbenefits](https://metlife.com/gicbenefits)

# Page 12 - Long Term Disability



## Life Insurance and Accidental Death & Dismemberment (AD&D)

Insured by MetLife, Life and AD&D insurance help provide for your beneficiary's well-being in the event of a serious accident or death. This benefit is paid to your designated beneficiary(ies).

- **Basic Life Insurance:** The Commonwealth offers \$5,000 of Basic Life Insurance.
- **Optional Life Insurance:** You may buy additional coverage of up to eight times your annual salary, to a maximum benefit of \$1.5 million. You pay the full cost of this benefit.

This is term insurance, which means that it is in effect for as long as you are eligible for coverage through your employment, and premium rates increase as you age. It has no cash value. Benefits are paid to your beneficiary(ies), so it is important to keep your beneficiary designation up to date.

### Optional Life Insurance

You must be enrolled in basic life insurance in order to be eligible for optional life insurance.

- **New State Employees:** You may enroll in optional life insurance within 10 days of employment without providing evidence of good health.
- **Current Employees During the Year:** State employees actively at work may apply for the first time or apply to increase their coverage at any time during the year. After you apply, you will receive instructions for completing a personal health application for MetLife's review and approval. The GIC will determine the effective date if MetLife approves your application.

### Current Employees with a Qualified Family Status Change

If you experience a qualified family status change during the year, you may enroll in or increase your optional life insurance amount without providing proof of good health. You must provide the GIC with proof of your status change within 60 days. Total optional life insurance coverage is limited to up to four times your salary.

### Optional Life Insurance Non-Smoker Benefit

At initial enrollment or during Annual Enrollment, if you have been tobacco-free, you are eligible for reduced non-smoker optional life insurance rates. Tobacco-free means you have not smoked cigarettes, cigars or a pipe, used snuff or chewing tobacco or any nicotine delivery system for the previous 12 months. You will be required to periodically recertify your non-smoking status in order to qualify for the lower rates. Changes in smoking status made during Annual Enrollment take effect effective July 1, 2021.

### Optional Life Insurance Rates (Including AD&D)

ACTIVE EMPLOYEE AGE	MONTHLY GIC PLAN RATES EFFECTIVE JULY 1, 2021 Per \$1,000 of Coverage	
	NON-SMOKER RATE	SMOKER RATE
Under Age 35	\$0.04	\$0.10
35 - 44	\$0.05	\$0.12
45 - 49	\$0.06	\$0.19
50 - 54	\$0.13	\$0.31
55 - 59	\$0.20	\$0.49
60 - 64	\$0.29	\$0.73
65 - 69	\$0.67	\$1.37
70 and over	\$1.13	\$2.49

Questions?



1.877.355.6277



metlife.com/gicbenefits

# Page 13 - Life Insurance and AD&D



## Flexible Spending Accounts (FSAs)



### How can an FSA save you money?

With an FSA, you set aside money every paycheck on an income tax-free basis. You use this money during the year to pay for eligible expenses — tax free.

For example:

BREAKDOWN OF PAYCHECK & DEDUCTIONS	NOT PARTICIPATING IN HCSA OR DCAP PLAN	PARTICIPATING IN HCSA OR DCAP PLAN
Gross Yearly Pay	\$30,000	\$30,000
Health Care FSA Annual Contribution (Pre-Tax)	\$0	(\$2,000)
Dependent Care FSA Annual Contribution (Pre-Tax)	\$0	(\$4,000)
Taxable Income	\$30,000	\$24,000
Sample Income Tax Withholdings of 25%	(\$7,500)	(\$6,000)
Yearly Health Care Expenses	(\$2,000 post-tax)	\$2,000 (Claims reimbursed)
Yearly Daycare Expenses	(\$4,000 post-tax)	\$4,000 (Claims reimbursed)
Net Available Income	\$16,500	\$18,000

### Who is eligible and when do I enroll?

Active state employees who are eligible for GIC benefits may enroll in a Health Care and/or Dependent Care FSA.

#### FSA Enrollment for the 2022 Plan Year: April 7 - May 5, 2021

During the GIC's spring 2021 Annual Enrollment period, you may enroll in one or both FSAs for the plan year of July 1, 2021-June 30, 2022. **You must re-enroll every year.**

- **New State Employees and Changes in Status:** New state employees and employees who experience a qualifying status change during the year may enroll for partial-year benefits. For the Health Care FSA, new hire participation begins at the same time as other GIC benefits. For the Dependent Care FSA, participation begins on the first day of employment.

### What else do I need to know?

In exchange for the tax savings these programs offer, the IRS imposes a use-it-or-lose-it rule. This means that you must use all the money in your account by the end of the plan year, or you lose that money, subject to the grace period.

- **2½-Month Grace Period:** If you still have money left in your FSA at the end of the plan year, you have an additional 2½ months to incur eligible claims and submit them for reimbursement. For the 2022 plan year, you have until September 15, 2022 to incur claims and until October 15, 2022 to submit them.
- **Administrative Fee:** You pay a \$1.00 monthly administrative fee regardless of whether you enroll in one or both FSAs.

KEY FSA DATES   Open Enrollment: April 7 - May 5, 2021	
2021 Plan Year	2022 Plan Year
<ul style="list-style-type: none"> <li>• <b>Plan Year:</b> July 1, 2020 - June 30, 2021</li> <li>• <b>2½ month Grace Period:</b> July 1, 2022 - September 15, 2022</li> <li>• <b>Claim filing deadline:</b> October 15, 2021</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Plan Year:</b> July 1, 2021 - June 30, 2022</li> <li>• <b>2½ month Grace Period:</b> July 1, 2022 - September 15, 2022</li> <li>• <b>Claim filing deadline:</b> October 15, 2022</li> </ul>

### Questions?

Toll Free: 1.877.FlexGIC (1.877.353.9442)

[benstrat.com/gic-fsa](http://benstrat.com/gic-fsa)

# Page 9 - Flexible Spending Accounts (HCSA or DCAP)

**GIC ENROLLMENT/CHANGE FORM (FORM-1)**  
 Health, Basic Life, Optional Life, and Long Term Disability Insurance



INSURED INFORMATION					
REQUIRED	Insured Information	GIC-ID (usually Soc. Sec. #)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Dept. ID # or Agency/Division #
	Address	Name - Last	First	MI	
	Contact Information	Home or Cell Phone ( )	Work Phone ( )	Email	Country (if not USA)
	Employment Information	Bargaining Unit/Union Name	HR/CMS or UMASS Employee ID #	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time Hours/week: / /	Date of Hire / /

REQUIRED	Select all that apply: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Adding Dependent(s) <input type="checkbox"/> Dropping Dependent(s) <input type="checkbox"/> Decline GIC Health Insurance <input type="checkbox"/> Decline All GIC Coverage	Qualifying Status Change <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Change in Dependent Eligibility Status <input type="checkbox"/> Gain of Other Coverage	Date of Event: / / <input type="checkbox"/> Involuntary Loss of Other Coverage <input type="checkbox"/> Return from FMLA or Military Leave <input type="checkbox"/> Death of spouse/dependent <input type="checkbox"/> Spouse's Annual Enrollment <input type="checkbox"/> Moved out of health plan's service area
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HEALTH, BASIC LIFE, OPTIONAL LIFE AND LTD		Effective Date:		
<input type="checkbox"/> Basic Life Only	(For GIC Coordinator use only) Annual Salary: \$	/ 01 /		
<input type="checkbox"/> Long Term Disability (LTD)				
<input type="checkbox"/> Basic Life and Health	Salary Effective Date: / /	Cancel Coverage <input type="checkbox"/> Long Term Disability (LTD) <input type="checkbox"/> Health Insurance <input type="checkbox"/> Optional Life Insurance		
Health Plan	<input type="checkbox"/> Fallon Direct (HMO) <input type="checkbox"/> Fallon Select (HMO) <input type="checkbox"/> Harvard Pilgrim Independence (POS) <input type="checkbox"/> Harvard Pilgrim Primary Choice (HMO)	<input type="checkbox"/> Health New England (HMO) <input type="checkbox"/> NHP Prime-Neighborhood Health Plan (HMO) <input type="checkbox"/> Tufts Health Plan Navigator (POS) <input type="checkbox"/> Tufts Health Plan Spirit (HMO-type)	<input type="checkbox"/> UniCare State Indemnity/Basic CIG: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UniCare Community Choice (PPD-type) <input type="checkbox"/> UniCare/PLUS (PPD-type)	Coverage Election <input type="checkbox"/> Individual <input type="checkbox"/> Family
Optional Life	Enrollment/Change: (check one) <input type="checkbox"/> Automatic Increase - select multiple of salary <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 4x <input type="checkbox"/> 5x <input type="checkbox"/> 6x <input type="checkbox"/> 7x <input type="checkbox"/> 8x Multiple Factor 2-8 times is allowed only with Automatic Increase. <input type="checkbox"/> Fixed Amount - Amount \$ Will not increase as your salary increases. No more than \$1,000 less than annual salary rounded down to the nearest \$1,000.	Family Status Change: (Check one and complete Qualifying Status Change box above) <input type="checkbox"/> Automatic Increase - select multiple of salary <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 4x <input type="checkbox"/> Fixed Amount - Amount \$ Will not increase as your salary increases. No more than \$1,000 less than annual salary rounded down to the nearest \$1,000.	Please Check One: <input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker Yes, I have been tobacco free for the past 12 months and choose the lower optional life insurance rates.	

SPOUSE/DEPENDENT INFORMATION (See instructions on back)							
For Changes Only	LAST NAME	FIRST NAME	MI	SSN (REQUIRED)	DATE OF BIRTH	SEX	RELATIONSHIP
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	

FORMER SPOUSE INFORMATION - If Listed Above				Date of Divorce:
Are you remarried? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of your remarriage: / /	Has your former spouse remarried? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of former spouse's remarriage: / /	/ /
Address: Street		City	State	Zip

SIGNATURE REQUIRED	AUTHORIZATION - I have read the instructions on the reverse side of this form and authorize my employer, or direct my pension authority, to deduct from my payroll or pension check the amount required for the coverage I have selected. I understand that due to IRS regulations, my health insurance coverage elections are binding for the duration of the plan year and that I may only enroll in health insurance or change my coverage elections during the plan year if I experience a qualifying status change (examples include marriage, adoption/birth of a child, death of a dependent, and involuntary loss of other coverage). I understand that the GIC must receive any required documentation for health insurance changes within 60 days of the event. Family status change documentation for optional life enrollment and changes must be received by the GIC within 31 days of the qualifying event.			
	Signature of Applicant:	Date: / /		
	Signature of Authorized Official:	Date: / /		
For GIC Use Only	Entered	Verified	Political Subdivision	

(See over for Form-1 instructions)

Insurance Enrollment/Change Form  
 Can be completed electronically!



**GIC LIFE INSURANCE BENEFICIARY FORM-319**  
For one to three beneficiaries



Insured GIC ID (Usually Soc. Sec. No.):		Agency/Division	
Insured Name: First		M.I.	Last
Street Address			
City		State	Zip Code Country (if not USA)

**YOU MUST READ INSTRUCTIONS ON BACK BEFORE COMPLETING FORM - PRINT CLEARLY IN CAPITAL LETTERS**

BENEFICIARY #1			RELATIONSHIP
First Name	M.I.	Last Name <input type="checkbox"/> Same as Insured	<input type="checkbox"/> Spouse
Street Address <input type="checkbox"/> Same as Insured			<input type="checkbox"/> Parent
City			<input type="checkbox"/> Child
State		Zip Code	<input type="checkbox"/> Brother/Sister
Country (if not U.S.A.)			<input type="checkbox"/> Other, specify:
Social Security Number	Date of Birth	Phone Number (Optional)	<b>% OF PROCEEDS</b> (Do Not Put \$ Amount)

BENEFICIARY #2			RELATIONSHIP
First Name	M.I.	Last Name <input type="checkbox"/> Same as Insured	<input type="checkbox"/> Spouse
Street Address <input type="checkbox"/> Same as Insured			<input type="checkbox"/> Parent
City			<input type="checkbox"/> Child
State		Zip Code	<input type="checkbox"/> Brother/Sister
Country (if not U.S.A.)			<input type="checkbox"/> Other, specify:
Social Security Number	Date of Birth	Phone Number (Optional)	<b>% OF PROCEEDS</b> (Do Not Put \$ Amount)

BENEFICIARY #3			RELATIONSHIP
First Name	M.I.	Last Name <input type="checkbox"/> Same as Insured	<input type="checkbox"/> Spouse
Street Address <input type="checkbox"/> Same as Insured			<input type="checkbox"/> Parent
City			<input type="checkbox"/> Child
State		Zip Code	<input type="checkbox"/> Brother/Sister
Country (if not U.S.A.)			<input type="checkbox"/> Other, specify:
Social Security Number	Date of Birth	Phone Number (Optional)	<b>% OF PROCEEDS</b> (Do Not Put \$ Amount)

I hereby make the above designation of beneficiary revoking any and all previous beneficiary nominations and make the above nomination of beneficiary with respect to all insurance provided now or at any time in the future under the group insurance policies. I still reserve the privilege of making other and future changes subject to the policy provisions.

If more than one beneficiary is designated, settlement will be made in equal shares to each of the designated beneficiary(ies) that survive me, unless otherwise provided herein. If no designated beneficiary(ies) survive me, settlement will be made as provided in the policy in the following order: to the spouse, then to the children, then to the parents, then to the siblings, then to the estate.

Signature of Insured \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE MAKE A COPY OF THIS COMPLETED FORM AND FILE WITH YOUR IMPORTANT RECORDS.**

<b>For GIC Use Only</b>	Entered	Verified
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Please return form to: Group Insurance Commission, P.O. Box 8747, Boston, MA 02114

(See over for Form-319 instructions)

# Life Insurance Beneficiary Designation Form

# Dental & Discount Vision Program

MCCC

MetLife Dental & Vision Savings

Non-Unit Professionals

MetLife Dental & Vision Savings

[www.healthplansinc.com](http://www.healthplansinc.com)

AFSCME

Delta Dental & Davis Vision

[www.mpefund.org](http://www.mpefund.org)



MetLife Dental Insurance Enrollment/Change Form  
BHE/Massachusetts Teachers Association Health and Welfare Trust

**INSTRUCTIONS**

- To be completed by members of APA, MOC, MSCA, MSP/FSU and USA Unions.
- Print your name, address, the name and social security numbers of your spouse and eligible dependents.
- Please include the name and location of your college or university.
- Sign this application and give it to your HR office.

**CHECK OFF ALL THAT APPLY**

New Hire     Change of Name    Provide former name: \_\_\_\_\_  
 New Address     Prior Service/Transfer from another institution    Provide former institution: \_\_\_\_\_

**Change in Status:**  
 Part-time to Full-time    Effective Date: \_\_\_\_\_  
 Non-Unit to Unit    Effective Date: \_\_\_\_\_

**Change in Family Status:**  
 Additional Dependents    Reason and Effective Date: \_\_\_\_\_  
 Removal of Dependents    Reason and Effective Date: \_\_\_\_\_

Coverage Requested:     Employee only     Family

**EMPLOYEE INFORMATION**

Name \_\_\_\_\_ Employee ID # \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Phone # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date of Hire \_\_\_\_\_  
 Place of Employment (specify campus): \_\_\_\_\_

**DEPENDENTS**

First Name (indicate Last Names only if different)	Date of Birth	Social Security #	M/F
Spouse			
Child			
Child			
Child			

Check here if your spouse is also employed by UMASS, the state university system or the community college system in Massachusetts and is also eligible for coverage through the BHE/Dental Care Trust Fund.

**DECLINE COVERAGE**

Check here if you are declining enrollment in the plan

**SIGNATURE**  
 Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

For more information about the plan, visit [www.HealthPlansInc.com/BHE-MTA](http://www.HealthPlansInc.com/BHE-MTA)

rev 12/18/13



MetLife Dental Insurance Enrollment/Change Form  
Non-Unit Higher Education Health and Welfare Fund

The Trustees of the Non-Unit Higher Education Health and Welfare Fund are offering the members an indemnity dental plan. In order to participate in the plan, I will have to make a payroll contribution based on the coverage I select. I may also choose not to participate in this dental plan. By completing and signing this form, I am informing the Trustees of my election.

If you do not wish to participate, you still need to submit this form.

**COVERAGE ELECTION**

I DO wish to participate in this dental plan. I authorize the appropriate payroll deduction.  
 I DO NOT wish to participate in this dental plan. I understand that I will not have dental insurance through my employer.

**CHECK OFF ALL THAT APPLY**

New Hire     Change of Name    Provide former name: \_\_\_\_\_  
 New Address     Prior Service/Transfer from another institution    Provide former institution: \_\_\_\_\_

**Change in Status/Special Handling:**  
 Waive Waiting Period    Coverage Start Date: \_\_\_\_\_  
 Reason: \_\_\_\_\_

**Change in Family Status:**  
 Addition of Dependents    Effective Date: \_\_\_\_\_  
 Reason: \_\_\_\_\_  
 Removal of Dependents    Effective Date: \_\_\_\_\_  
 Reason: \_\_\_\_\_

Coverage Requested:     Employee only     Family

**EMPLOYEE INFORMATION**

Name \_\_\_\_\_ Employee ID # \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
 Phone # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date of Hire \_\_\_\_\_

Work Email Address (required): \_\_\_\_\_

Place of Employment (specify campus): \_\_\_\_\_

**DEPENDENTS**

First Name (indicate Last Names only if different)	Date of Birth	Social Security #	M/F
Spouse			
Child			
Child			
Child			

**SIGNATURE**  
 Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

For more information about the plan, visit [HealthPlansInc.com/BHE](http://HealthPlansInc.com/BHE)

HR Administrators may send via: Fax: 508-798-1833 | Email: [BHEelig@questions@HealthPlansInc.com](mailto:BHEelig@questions@HealthPlansInc.com) | Mail: Health Plans, Inc., P.O. Box 8189 - Westborough, MA 01581

BHE\_NonUnit\_EMI\_122118

# Dental Enrollment Forms

# AllOne Health: Employee Assistance Program



- ▶ The AllOne Health EAP is available to all employees and their families.
- ▶ This free, confidential resource is available 24/7 at 800-451-1834 or [mylifeexpert.com](http://mylifeexpert.com) (company code: qccollege)
- ▶ Everyone faces challenges from time to time – financial worries, aging parents, job stress, health issues, etc – the EAP can help!

# Leave Accruals

General Guidelines	Personal	Sick	Vacation
	Granted every January 1 (must use previous year's by December 31)	Accrues biweekly Retirement – 20% payout (unless grant funded)	Accrues biweekly Retirement payout (unless grant funded)
Work Group	Accruals*	Accruals*	Accruals*
AFSCME	37.5 hours (Unit 1) 40 hours (Unit 2)	112.5 hours (15 days)	10 – 25 days (depending on length of service)
Faculty – MCCC	15 hours (2 days)	75 hours (10 days)	N/A
Unit Professionals - MCCC	37.5 hours (5 days)	112.5 hours (15 days)	20 – 25 days (depending on length of service)
Non-Unit Professionals	37.5 hours (5 days)	112.5 hours (15 days)	20 – 25 days (depending on length of service)



# Tuition Remission



- ▶ Eligible employees can access tuition benefits in accordance with their respective collective bargaining agreements or Department of Higher Education policy. To take advantage of this benefit, employees must complete the **College's Tuition Remission Form** and have all signatures obtained. You must then submit the form with your semester tuition bill to the College or University at which you, your spouse or child are enrolled.
  
- ▶ Please see the HR Office for more information.

# Professional Development



The Staff and Faculty Development Committee invites all members of the QCC staff and faculty to submit applications for funding to support professional development activities including:

1. Travel and tuition for virtual conferences, professional trainings, courses, webinars, workshops, and presentations.
2. Departmental initiatives to support professional development activities such as virtual site visits, virtual retreats, guest speakers, presenters, and curriculum consultants.
3. Mini-grants to support course and curriculum development and special projects to enhance the College's mission.
4. Best Practices to support initiatives that further the efforts of the institutional goals and priorities.

Applications and guidelines may be accessed on the college's Intranet page with this link: [Staff and Faculty Development page](#).

**We recognize that QCC's greatest asset is its human resources and we are committed to supporting on and off campus professional development opportunities to maximize the potential of each individual.**



# Employee Discounts

- Cell Phone Discounts: (Please contact your provider as percentages may vary)
- Variety Auto Sales-Ask for Chris
- Museum of Fine Arts: For the promo code please email Juliana at [jesposito@qcc.mass.edu](mailto:jesposito@qcc.mass.edu) with an image of your College ID and she will provide you with the code
- Table Talk Pies-Please visit the discount store located on Green St.
- WooSox: Provide your staff ID and use the following link for Thursday Night's and also receive an \$9.00 food voucher
  - [https://fevo.me/woosox\\_college](https://fevo.me/woosox_college)
- Worcester Railers : Please use the following link to get your discounted tickets [www.railershc.com/qcc](http://www.railershc.com/qcc)
- Coming soon:
  - BJ's Wholesale Membership
  - 2022 Worcester Pirates Tickets
  - Worcester Botanical Garden

# Commonwealth of MA Financial Wellness Program

## Your Map to Financial Wellness Resources

The Office of Economic Empowerment and the Massachusetts State Retirement Board are here to guide you on your journey to financial wellness. Learn more about the opportunities, tools, and resources to help you make sound financial decisions for you and your family.

### 1. **Financial Education:**

Visit our state-of-the-art financial wellness portal, powered by Enrich! Lessons are designed specifically for you.

Enrich



2. **Webinars:** Attend Money Talk Tuesdays on relevant and timely topics.

3. **Retirement:** Have you begun saving for retirement? Mass SMART Plan advisors can get you started.



Mass **4** YOU

### 4. **Financial Counseling:**

MA active employees have access to free financial counseling through Mass4You.

5. **Loan Forgiveness:** As state employees, you could be eligible for the Public Service Loan Forgiveness program. Find out if you qualify.

6. **Tuition Benefit:** Thinking about going back to school but unsure how to finance it? State employees receive a tuition benefit at public colleges and universities in MA.

7. **Expecting a child?** Sign up for the BabySteps Savings Plan. All children born or adopted after January 1, 2020 will receive a free \$50 deposit.

8. **Commuting to work?** Benefit Strategies can help you find ways to save on your commute to the office. Sign up now.

5



6



7



8



<https://www.mass.gov/financial-education-for-massachusetts-employees-and-retirees>



**QUINSIGAMOND**  
Community College

# Questions?

PLEASE CONTACT:

SARA SIMMS

508-854-2757

SSIMMS@QCC.MASS.EDU