Benefits Handbook

2024-2025

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CAPE COD COLLABORATIVE
EMPLOYEE BENEFITS SUMMARY

418 Bumps River Road • Osterville, MA 02655
www.capecodcollaborative.org

BENEFIT ELIGIBILITY
Employees who regularly work 20+ hours per week are considered to be benefit-eligible.

EMPLOYER CONTRIBUTION
The Collaborative contributes 60% of the cost for health, dental, and group life coverage. Employees are responsible for 40% of the cost. **The Collaborative will contribute 75% of the cost of individual health coverage for employees electing the Harvard Pilgrim Best Buy HSA HMO.**

SECTION 125 CAFETERIA PLAN
Through the Collaborative's **Premium Only Plan**, payroll deductions for health, dental, and group life insurance premiums are paid with *pre-tax dollars*. These pre-tax premiums are exempt from Federal, State, and Medicare taxes.

HEALTH AND DENTAL INSURANCE
The Collaborative offers health and dental coverage as a member of the **Cape Cod Municipal Health Group** (https://ccmhg.com/). Their website contains a wealth of information for employees, including plan information, Rx formularies, the Diabetes Care Rewards program, My Telemedicine, and Wellness programs.

HEALTH INSURANCE OPTIONS (Individual, Single Parent/Single Child, Family)

HMO Plans	HSA Qualified* High-Deductible HMO Plans
Blue Cross Blue Shield Network Blue HMO	Blue Cross Blue Shield Access Blue New England Saver
Harvard Pilgrim HMO	Harvard Pilgrim Best Buy HSA HMO

DENTAL INSURANCE (Individual, Single Parent/Single Child, Family):
Delta Dental PPO Plus Premier
EYEMED VISION PLAN – Employee Contribution only (Individual, Individual + 1, Family)

FLEXIBLE SPENDING ACCOUNT (FSA)
A Flexible Spending Account allows employees to set aside money through pre-tax payroll deductions which can be used for eligible health care costs and dependent care expenses. These accounts run on a calendar year, with open enrollment occurring in November. New hires have thirty (30) days from date of hire to enroll.

***HEALTH SAVINGS ACCOUNT (HSA)**
Eligible employees who elect HSA Qualified HMO health plans will have an HSA account established upon enrollment. The Collaborative will contribute one-half of the plan deductible to this account each year ($1,000 for individual coverage, $2,000 for single parent/single child or family coverage). The contributions are made in monthly increments of $100 or $200 over ten (10) months. Employees may elect to contribute through pre-tax payroll deductions.

GROUP LIFE, VOLUNTARY LIFE AND VOLUNTARY LONG-TERM DISABILITY
Offered through **Boston Mutual Life Insurance Company**

Group Life	Voluntary Life	Voluntary LTD
Basic Term Life, AD&D	Additional Term Life, AD&D	Long-term Disability Benefit
Employer pays 55% of premium	Employee pays full premium	Employee pays full premium
Paid through pre-tax payroll deductions	Paid through after-tax payroll deductions	Paid through after-tax payroll deductions

RETIREMENT PLANS

The Cape Cod Collaborative is a municipal employer. Collaborative employees **are not covered by Social Security**. Employees hired after March 31, 1986 have Medicare protection. Collaborative payroll deductions include Medicare, but not Social Security. Some Collaborative employees may be impacted by the *Windfall Elimination Provision*. For further information, please visit Social Security's website: https://www.ssa.gov/benefits/retirement/planner/wep.html.

In lieu of Social Security, Collaborative employees enroll in the following:

Cape Cod Collaborative OBRA 457(b) Plan

An OBRA account is appropriate for part-time employees who work less than 20 hours per week. The employee contributes 7.5% of gross income, pre-tax, to an individual account established in their name.

Massachusetts State Employees' Retirement System (MSERS)

(https://www.mass.gov/orgs/massachusetts-state-retirement-board)
Employees who regularly work 20+ hours per week are enrolled in the MSERS. The MSERS is a contributory defined benefit retirement system, or pension plan. Retirement payouts are based on a set formula which considers age, salary, and years of service. You are vested (eligible to receive a retirement allowance) if you have at least 10 years of service.

Generally, the employee contribution is 9% of gross income with an additional 2% calculated on income over $30,000. Payroll deductions are pre-tax for federal taxation, but post-tax for Massachusetts taxation.

Massachusetts Teachers Retirement System (MTRS)

(https://mtrs.state.ma.us/)
Certified educators and administrators are enrolled in the MTRS. The required payroll deduction is dependent upon the date when the employee is first entered into the system. Payroll deductions are pre-tax for federal taxation, but post-tax for Massachusetts taxation.

ADDITIONAL RETIREMENT SAVINGS OPTIONS: Deferred Compensation Plans

Cape Cod Collaborative 403(b) Plan

403(b) Plans provide a valuable retirement savings option. Employees who wish to enroll first select an authorized investment provider and an investment product. Upon establishment of an account, a "salary reduction notice" is submitted to Human Resources and pre-tax payroll deductions are established. The Collaborative's 403(b) Plan is administered by TSA Consulting Group. Additional information, including the list of Authorized Investment Providers and forms, can be found on their website: https://www.tsacg.com/individual/plan-sponsor/massachusetts/cape-cod-collaborative/.

Cape Cod Collaborative 457(b) Deferred Compensation Plan

Employees may set aside retirement savings through pre-tax contributions to the Collaborative's voluntary 457(b) plan. Unlike the mandatory OBRA plan offered to part-time employees, employees who contribute to the voluntary plan may elect to have their retirement funds managed or may select their own investment options.

WORKERS COMPENSATION INSURANCE

Workers' Compensation insurance provides coverage to employees who get injured or sick from a work-related cause. There is no cost to employees. This coverage covers medical costs and can help pay for lost wages. Any injury occurring on the job must be reported to the supervisor immediately.

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SECTION 125 PRE-TAX PREMIUM PROGRAM

MAKE THE MOST OF YOUR PAYCHECK

"It's not what you earn, It's what you keep that counts"

The Section 125 program is a tremendous opportunity for you to enhance your benefits package. Your employer knows that this is a highly beneficial program and wants you to have the opportunity to participate in a Section 125 program.

The **Premium Only Plan** is the building block of the Section 125 Plan. It allows for certain employee paid group insurance premiums (such as Health, Dental, Vision, Cancer, or Accident insurance premiums) if offered by your employer to be paid with ***pre-tax dollars***.

When you use pre-tax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck as these pre-taxed premiums are exempt from Federal, State, and Medicare & FICA Taxes. Under a Section 125 program, you can actually have more spendable income.

Your employer wants you to fully understand the advantages of your Section 125 program. Following are the most frequently asked questions about Section 125. This information will help you better understand how you can make better use of your paycheck.

What is Section 125?
Section 125 is part of the Internal Revenue Code that allows employees to convert a taxable cash benefit (salary) into non-taxable benefits. Under a Section 125 program, you may choose to pay qualified benefit premiums before any taxes are deducted from your paycheck.

Is Section 125 legal?
Yes. Even though Section 125 may sound "too good to be true", the program is legal and beneficial. The United States Congress created Code Section 125 in an effort to make benefit programs more affordable for employees. Code Section 125 was established in the Revenue Act of 1978.

What are pre-tax dollars?
Pre-tax dollars are the premiums you pay for qualified benefits under your Section 125 program. These premiums are deducted from your gross earnings – before taxes are taken out.

How can Section 125 work for me?
Your Section 125 program can make your benefits plan more affordable. You can pay for your qualified benefits with pre-tax dollars. By paying for qualified benefits before you pay taxes, you actually lower your taxable income, which means you pay less taxes. Paying less taxes usually results in more spendable income. When you take advantage of your Section 125 program, you will actually get "more for your money".

Can I enroll in a Section 125 program whenever I want to?
Your employers Section 125 plan is an annual plan. You enroll <u>initially</u> in the Section 125 plan during the eligible enrollment period or during the plan year if you experience a qualifying event or change in family status. Participation can continue each plan year unless you opt out at the open enrollment period.

What do I do to participate?
If you decide to enroll in the plan, you will simply need to sign the election form to indicate your participation and approval to have your premiums deducted on a pre-taxed basis.

Do I have to participate?
No. You are under no obligation to participate in a Section 125 program. However, you are required to sign an election form to indicate your choice.

Who is offering me this plan?
Your employer is offering this Section 125 program and has endorsed it to provide you with an enhanced employee benefits package.

Who can I call if I have a question about this plan?
Cafeteria Plan Advisors, Inc specializes in pre-tax plans and can be reached at 781-848-9848. Additional information is located on the web at: **www.cpa125.com**

The Section 125 Program is a positive step toward making your benefits package more affordable. Your employer offers this program and recommends that you take advantage of this opportunity to make the most of your paycheck.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____

.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
Cape Cod Collaborative		04-2566040
5. Employer address		6. Employer phone number
418 Bumps River Road		508-420-6950
7. City	8. State	9. ZIP code
Osterville	MA	02655
10. Who can we contact about employee health coverage at this job?		
Human Resources		
11. Phone number (if different from above)	12. Email address	
508-420-6950 x 1122	l.t.thompson@capecodcollaborative.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☒ All employees. Eligible employees are:

  Employees who regularly work 20+ hours per week

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:

  Spouse and dependent children up to age 26.

  ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____(mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation program, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $ 180.00
b. How often? ☐ Weekly ☐

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Notice of Patient Protections

Choice of Healthcare Professional
HMO Health Insurance Plans offered by the Cape Cod Municipal Health Group to employees of the Cape Cod Collaborative generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members.

For Children you may designate a pediatrician as the primary care provider.

You do not need prior authorization in order to obtain access to obstetrical or gynecological care form a health care professional within the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For information on providers within your chosen network, please visit:
https://www.bluecrossma.org/ or
https://www.harvardpilgrim.org/public/home

Women's Health and Cancer Rights Act (WHCRA) Notice
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the elected plan.

*2024-2025 Employee Portion of Benefits***

Affordable Coverage Option

	Pay Options -		*21 Bi-Weekly*	*26 Bi-Weekly*	*21 Bi-Weekly + Lump Sum*		*38 Weeks*	ADMIN *26 Bi-Weekly*	ADMIN *52 Weeks*
Single	Total Premium	40% EE Share	Coverage through August 31st*	Coverage through August 31st*	Coverage through August 31st*	Lump sum check Deduction	Coverage through August 31st*	coverage to June 30th	
Network Blue HMO	1,023.00	409.20	236.95	191.38	191.38	956.90	130.94	188.86	94.43
HPHC HMO	1,005.00	402.00	232.78	188.01	188.01	940.06	128.64	185.54	92.77
HMO New England Saver (BCBS)	839.00	335.60	194.33	156.96	156.96	784.79	107.39	154.89	77.45
HPHC Best Buy HMO***	778.00	194.50	112.62	90.97	90.97	454.83	62.24	89.77	44.88
Dental Contributory	40.00	16.00	9.26	7.48	7.48	37.42	5.12	7.38	3.69
Boston Mutual (Employee Only)	1.70	0.77	0.44	0.35	0.35	1.77	0.24	0.35	0.18
Parent & One Child	Total Premium	EE Share	Deduction	Deduction	Deduction	Deduction	Deduction	Deduction	Deduction
Network Blue HMO	2,062.00	824.80	477.60	385.75	385.75	1,928.76	263.94	380.68	190.34
HPHC HMO	2,011.00	804.40	465.79	376.21	376.21	1,881.06	257.41	371.26	185.63
HMO New England Saver (BCBS)	1,696.00	678.40	392.83	317.28	317.28	1,586.41	217.09	313.11	156.55
HPHC Best Buy HMO	1,578.00	631.20	365.49	295.21	295.21	1,476.04	201.98	291.32	145.66
Dental Contributory	79.00	31.60	18.30	14.78	14.78	73.90	10.11	14.58	7.29
Boston Mutual (Employee Only)	1.70	0.77	0.44	0.35	0.35	1.77	0.24	0.35	0.18
Family	Total Premium	EE Share	Deduction	Deduction	Deduction	Deduction	Deduction	Deduction	Deduction
Network Blue HMO	2,744.00	1,097.60	635.56	513.34	513.34	2,566.70	351.23	506.58	253.29
HPHC HMO	2,690.00	1,076.00	623.06	503.24	503.24	2,516.18	344.32	496.62	248.31
HMO New England Saver (BCBS)	2,253.00	901.20	521.84	421.48	421.48	2,107.42	288.38	415.94	207.97
HPHC Best Buy HMO	2,094.00	837.60	485.01	391.74	391.74	1,958.70	268.03	386.58	193.29
Dental Contributory	103.00	41.20	23.86	19.27	19.27	96.34	13.18	19.02	9.51
Boston Mutual (Employee Only)	1.70	0.77	0.44	0.35	0.35	1.77	0.24	0.35	0.18
EyeMed Vision Voluntary * **	**7/1/2024 - 6/30/2025**								
Individual Plan									
EyeMed Vision Voluntary	**7.53**	**7.53**	**4.30**	**3.48**			**2.38**	**3.48**	**1.74**
Individual + One Plan									
EyeMed Vision Voluntary**	**14.31**	**14.31**	**8.18**	**6.60**		**-**	**4.52**	**6.60**	**3.30**
Family Plan									
EyeMed Vision Voluntary	**21.02**	**21.02**	**12.01**	**9.70**		**-**	**6.64**	**9.70**	**4.85**

* Rates reflect a 8% estimated increase for July and August. The new plan year begins July 1st.

** All changes must be made during the open enrollment period; thereafter, changes can be made only for a qualifying event.

EyeMed Vision is a Voluntary Plan. Employee contribution only -FISCIAL year coverage 7/1/2024 - 6/30/2025.

*** In order to provide an affordable health option to employees, the Collaborative will pay 75% of the cost for this plan. The employee is responsible for 25%.

These pages summarize benefits of the plan(s). The Subscriber Certificate(s) & applicable riders define the terms and conditions of these benefits in greater detail. Should any questions arise, the certificate(s) & riders will govern.

Effective 7/1/2023

CIF = Covered in Full	Blue Cross Blue Shield		Harvard Pilgrim Health Care	
Benefit	**Network Blue HMO**	**HMO New England Saver**	**Harvard Pilgrim HMO**	**Harvard Pilgrim Best Buy HSA HMO**
Deductible	**$300 per member** **$900 per family** Applies to: In-patient admission, Out-patient surgery, ER, High Tech imaging (MRI, CT & PET) and diagnostic tests & procedures. Does not apply to routine office visits or pharmacy. Per plan year (July 1 - June 30) - **See plan document for full details.**	**$2,000 per Individual Plan** **$4,000 per Family Plan** Deductible to be satisfied, then Covered in Full except prescription co-pays and out-of-network services. Per plan year (July 1 - June 30) - Single Parent/Single Child plan design is the same as Family Plan. NOTE-The Family Plan deductible must be satisfied before the plan begins to pay. **See plan document for full details.**	**$300 per member** **$900 per family** Applies to: In-patient admission, Out-patient surgery, ER, High Tech imaging (MRI, CT & PET) and diagnostic tests & procedures. Does not apply to routine office visits or pharmacy. Per plan year (July 1 - June 30) - **See plan document for full details.**	**$2,000 per Individual Plan** **$4,000 per Family Plan** Deductible to be satisfied, then Covered in Full except prescription co-pays and out-of-network services. Per plan year (July 1 - June 30) - Single Parent/Single Child plan design is the same as Family Plan. Note-The Family Plan deductible must be satisfied before the plan begins to pay. **See plan document for full details.**
Out-of-Pocket (OOP) Maximum	**Medical:** **$2,000 per member** **$4,000 per family** **Prescription:** **$3,000 per member** **$6,000 per family** OOP Maximum: Once your out-of-pocket expenses for applicable services reaches this amount, you pay $0 for remainder of plan year.	**Medical & Rx Combined:** **$5,000 per member** **$10,000 per family** OOP Maximum: Once your out-of-pocket expenses for applicable services reaches this amount, you pay $0 for the remainder of the plan year.	**Medical:** **$2,000 per member** **$4,000 per family** **Prescription:** **$3,000 per member** **$6,000 per family** OOP Maximum: Once your out-of-pocket expenses for applicable services reaches this amount, you pay $0 for remainder of plan year.	**Medical & Rx Combined:** **$5,000 per member** **$10,000 per family** OOP Maximum: Once your out-of-pocket expenses for applicable services reaches this amount, you pay $0 for the remainder of the plan year.
Lifetime Benefit Maximum	None	None	None	None
In-Patient	You Pay	You Pay	You Pay	You Pay
General Hospital / Mental Hospital / Substance Abuse Facility (semi-private room & board, and special services) Deductible Applies	$500 co-pay per admission	Deductible, then Covered in Full (CIF)	$500 co-pay per admission	Deductible, then Covered in Full (CIF)
Physician Services	Nothing	Deductible, then Covered in Full (CIF)	Nothing	Deductible, then Covered in Full (CIF)
Skilled Nursing Facility	Nothing to 100 days per calendar year benefit maximum. **Deductible applies.**	Deductible, then Covered in Full (CIF) - 100 days per calendar year benefit maximum	Limit to 100 days per Plan Year - $500 copay per admission. **Deductible applies.**	Deductible, then Covered in Full (CIF) - 100 days per calendar year benefit maximum
Rehabilitation Hospital	Nothing to 60 days per calendar year benefit maximum. **Deductible applies.**	Deductible, then Covered in Full (CIF) - 60 days per calendar year benefit maximum	Limit to 60 days per calendar year benefit maximum - $500 co-pay per admission. **Deductible applies.**	Deductible, then Covered in Full (CIF) - 60 days per calendar year benefit maximum

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Effective 7/1/2023

CIF = Covered in Full

	Blue Cross Blue Shield		Harvard Pilgrim Health Care	
Benefit	**Network Blue HMO**	**HMO New England Saver**	**Harvard Pilgrim HMO**	**Harvard Pilgrim Best Buy HSA HMO**
Out-Patient Hospital	You Pay	You Pay	You Pay	You Pay
Emergency Room visits for Emergency or Accident Care	$100 co-pay (waived if admitted or for observation stay) **Deductible applies.**	Deductible, then Covered in Full (CIF)	$100 co-pay (waived if admitted) **Deductible applies.**	Deductible, then Covered in Full (CIF)
Emergency Room Visits for Medical Care	$100 co-pay (waived if admitted or for observation stay) **Deductible applies.**	Deductible, then Covered in Full (CIF)	$100 co-pay (waived if admitted) **Deductible applies.**	Deductible, then Covered in Full (CIF)
Surgery	$250 co-pay **Deductible applies.**	Deductible, then Covered in Full (CIF)	$250 co-pay **Deductible applies.**	Deductible, then Covered in Full (CIF)
Radiation and Chemotherapy	Deductible applies	Deductible, then Covered in Full (CIF)	Nothing	Deductible, then Covered in Full (CIF)
Diagnostic X-ray and Lab	Nothing **Deductible applies.**	Deductible, then Covered in Full (CIF)	Nothing **Deductible applies.**	Deductible, then Covered in Full (CIF)
Routine Colonoscopy (without surgery)	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
High Cost Radiology (MRI, CT, PET)	$100 co-pay **Deductible applies.**	Deductible, then Covered in Full (CIF)	$100 co-pay **Deductible applies.**	Deductible, then Covered in Full (CIF)
Hemodialysis	$0 co-pay **Deductible applies.**	Deductible, then Covered in Full (CIF)	$0 co-pay **Deductible applies.**	Deductible, then Covered in Full (CIF)
Physical Therapy	$20 co-pay to 60 visits per calendar year	Deductible, then Covered in Full (CIF) - up to 60 visits per calendar year	Co-pay level 1: $20 co-pay per visit, 30 visits per Plan Year	Deductible, then Covered in Full (CIF) - up to 30 visits per Plan Year
Physicians Office	You Pay	You Pay	You Pay	You Pay
Surgery	$20/$45 co-pay No deductible.	Deductible, then Covered in Full (CIF)	Co-pay Level I provider: $20 co-pay per visit co-pay Level 2 provider: $45 per visit No deductible.	Deductible, then Covered in Full (CIF)
Adult Preventative Exam As defined by the ACA	$0 co-pay	CIF	$0 co-pay	CIF
PCP Medical Care / Mental Health Care / Substance Abuse Care	$20 co-pay	Deductible, then Covered in Full (CIF)	Co-pay Leve I: $20 co-pay	Deductible, then Covered in Full (CIF)
Well Child Care As defined by the ACA	$0 co-pay	CIF	$0 co-pay (including routine physical exams, immunizations, school, camp, sports)	CIF

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Effective 7/1/2023

CIF = Covered in Full	Blue Cross Blue Shield		Harvard Pilgrim Health Care	
Benefit	**Network Blue HMO**	**HMO New England Saver**	**Harvard Pilgrim HMO**	**Harvard Pilgrim Best Buy HSA HMO**
Routine GYN Exam (As defined by the ACA, one per calendar year, includes preventative lab tests)	$0 co-pay	CIF	$0 co-pay	CIF
Routine Mammogram As defined by the ACA	$0 co-pay	CIF	$0 co-pay	CIF
Routine Vision Exam	$0 co-pay (once every 12 months)	CIF (once every 12 months)	Limited 1 visit per Plan Year - No charge	CIF (one visit per Plan Year)
Specialist Office Visit	$45 co-pay	Deductible, then Covered in Full (CIF)	Co-pay Level 2: $45 co-pay	Deductible, then Covered in Full (CIF)
Other Outpatient	You Pay	You Pay	You Pay	You Pay
Visiting Nurse Home Health Care Deductible Applies	Nothing	Deductible then Covered in Full (CIF)	Nothing	Deductible then Covered in Full (CIF)
Durable Medical Equipment	After deductible, member pays 20%, plan pays 80% with no limit. Wigs are covered in full when needed as a result of any form of cancer, leukemia, alopecia areata, alopecia totalis, or permanent hair loss due to injury. **Deductible applies.**	Deductible then Covered in Full (CIF)	After deductible, member pays 20% until member has paid $1,000 out of pocket, then plan pays in full. Wigs are covered in full when needed as a result of any form of cancer, leukemia, alopecia areata, alopecia totals, or permanent hair loss due to injury. **Deductible applies.**	Deductible then Covered in Full (CIF)
Ambulence	Deductible applies Nothing	Deductible then Covered in Full (CIF)	Deductible applies Nothing	Deductible then Covered in Full (CIF)
Routine Pedicatric Dental	Nothing	Nothing	Covered in full: Preventative care for children up to age 13. 2 visits per member per **plan** year including exam, cleaning, x-rays, & fluoride treatment.	Deductible then Covered in Full (CIF): Preventative care for children up to age 13. 2 visits per member per Plan Year including exam, cleaning, x-rays, & fluoride treatment
Chiropractor Visits	All charges	Deductible then Covered in Full (CIF)	All charges	Deductible then Covered in Full (CIF)

These pages summarize benefits of the plan(s). The Subscriber Certificate(s) & applicable riders define the terms and conditions of these benefits in greater detail. Should any questions arise, the certificate(s) & riders will govern.

Effective 7/1/2023

CIF = Covered in Full

	Blue Cross Blue Shield		Harvard Pilgrim Health Care	
Benefit	**Network Blue HMO**	**HMO New England Saver**	**Harvard Pilgrim HMO**	**Harvard Pilgrim Best Buy HSA HMO**
Prescription Drugs	**Retail:** (30-day supply) Tier 1: $10 co-pay Tier 2: $30 co-pay Tier 3: $65 co-pay **Mail Order:** (90-day supply) Tier 1: $25 co-pay Tier 2: $75 co-pay Tier 3: $165 co-pay	**Retail:** (30-day supply) Tier 1: $10 co-pay Tier 2: $30 co-pay Tier 3: $65 co-pay **Mail Order:** (90-day supply) Tier 1: $25 co-pay Tier 2: $75 co-pay Tier 3: $165 co-pay IMPORTANT NOTICE: **Deductible applies, once deductible is met, copays will apply.** Drugs on preventative list are not subject to the deductible. The lists are available at: https://ccmhg.com/high-deductible-hsa-qualified-health-plans/	**Retail:** (30-day supply) Tier 1: $10 co-pay Tier 2: $30 co-pay Tier 3: $65 co-pay **Mail Order:** (90-day supply) Tier 1: $25 co-pay Tier 2: $75 co-pay Tier 3: $165 co-pay	**Retail:** (30-day supply) Tier 1: $10 co-pay Tier 2: $30 co-pay Tier 3: $65 co-pay **Mail Order:** (90-day supply) Tier 1: $25 co-pay Tier 2: $75 co-pay Tier 3: $165 co-pay IMPORTANT NOTICE: **Deductible applies, once deductible is met, copays will apply.** Drugs on preventative list are not subject to the deductible. The lists are available at: https://ccmhg.com/high-deductible-hsa-qualified-health-plans/
Fitness Benefit	Up to $150 reimbursement toward membership or exercise classes at a health club; and virtual fitness. See plan details. Enroll in a qualified Weight Watchers or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	Up to $150 reimbursement toward membership or exercise classes at a health club; and virtual fitness. See plan details. Enroll in a qualified Weight Watchers or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	Up to $150 reimbursement per **calendar** year on fees for health & fitness memberships, classes, or virtual subscriptions. Must be currently enrolled in HPHC at the time of reimbursement and an active fitness club and HPHC member for at least four months within a calendar year.	Up to $150 reimbursement per **calendar** year on fees for health & fitness club memberships, classes, or virtual subscriptions. Must be currently enrolled in HPHC at the time of reimbursement and active fitness club membership and HPHC member for at least four months within a calendar year.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see www.ccmhg.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at bluecrossma.org/sbcglossary or call **1-800-782-3675** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300 member / $900 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, prenatal care, prescription drugs, most office visits, mental health visits, therapy visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For medical benefits, $2,000 member / $4,000 family; and for prescription drug benefits, $3,000 member / $6,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You Mav Need	What You Will Pay In-Network (You will pay the least)	Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 / visit	Not covered	A telehealth cost share may be applicable
	Specialist visit	$45 / visit; Not covered / chiropractor visit; $45 / Acupuncture visit	Not covered	Limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable
	Preventive care/screening/immunization	No charge	Not covered	GYN exam limited to one exam per calendar year; a telehealth cost share may be applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
	Imaging (CT/PET scans, MRIs)	$100	Not covered	Deductible applies first; copayment applies per category of test / day; pre-authorization required for certain services

Common Medical Event	Services You Mav Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bluecrossma.org/medication	Generic drugs	$10 / retail supply or $25 / designated retail or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$30 / retail supply or $75 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	$65 / retail supply or $165 / designated retail or mail service supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; cost share may be waived or reduced for certain covered drugs and supplies; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 / admission	Not covered	Deductible applies first; pre-authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	$100 / visit	$100 / visit	Deductible applies first; copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	Deductible applies first
	Urgent care	$45 / visit	$45 / visit	Out-of-network coverage limited to out of service area; a telehealth cost share may be applicable

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 / admission	Not covered	Deductible applies first; pre-authorization / authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / visit	Not covered	A telehealth cost share may be applicable; pre-authorization required for certain services
	Inpatient services	$500 / admission	Not covered	Deductible applies first; pre-authorization / authorization required for certain services
If you are pregnant	Office visits	No charge	Not covered	Deductible applies first except for prenatal care; cost sharing does not apply for preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth cost share may be applicable
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$500 / admission	Not covered	

Common Medical Event	Services You Mav Need	What You Will Pay In-Network (You will pay the least)	Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Deductible applies first; pre-authorization required
	Rehabilitation services	$20 / visit for outpatient services; No charge for inpatient services	Not covered	Deductible applies first except for outpatient services; limited to 60 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; pre-authorization required for certain services
	Habilitation services	$20 / visit	Not covered	Outpatient rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; a telehealth cost share may be applicable; pre-authorization required for certain services
	Skilled nursing care	No charge	Not covered	Deductible applies first; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	20% coinsurance	Not covered	Deductible applies first; cost share waived for one breast pump per birth, including supplies
	Hospice services	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam every 12 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge	Not covered	Limited to children under age 12 (every 6 months) and under age 18 with a cleft palate / cleft lip condition

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's glasses
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Routine eye care - adult (one exam every 12 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs ($150 per calendar year per policy)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 1-800-782-3675 or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Disclaimer: This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

■ The plan's overall deductible	$300
■ Delivery fee copay	$0
■ Facility fee copay	$500
■ Diagnostic tests copay	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost sharing	
Deductibles	$300
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$860**

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$300
■ Specialist visit copay	$45
■ Primary care visit copay	$20
■ Diagnostic tests copay	$0

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost sharing	
Deductibles	$100
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

Mia's Simple Fracture
(in-network emergency room visit and follow-up care)

■ The plan's overall deductible	$300
■ Specialist visit copay	$45
■ Emergency room copay	$100
■ Ambulance services copay	$0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost sharing	
Deductibles	$300
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,000 individual contract / $4,000 family contract.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and prenatal care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$5,000 member / $10,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

⚠ All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You Mav Need	What You Will Pay In-Network (You will pay the least)	Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	Deductible applies first; a telehealth cost share may be applicable
	Specialist visit	No charge; No charge / chiropractor visit; No charge / acupuncture visit	Not covered	Deductible applies first; limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable
	Preventive care/screening/immunization	No charge	Not covered	GYN exam limited to one exam per calendar year; a telehealth cost share may be applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Deductible applies first; pre-authorization required for certain services

Common Medical Event	Services You Mav Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bluecrossma.org/medication	Generic drugs	$10 / retail supply or $25 / designated retail or mail service supply	Not covered	Deductible applies first; up to 30-day retail (90-day designated retail or mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$30 / retail supply or $75 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	$65 / retail supply or $165 / designated retail or mail service supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	Deductible applies first; when obtained from a designated specialty pharmacy; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	No charge	No charge	Deductible applies first
	Emergency medical transportation	No charge	No charge	Deductible applies first
	Urgent care	No charge	No charge	Deductible applies first; out-of-network coverage limited to out of service area; a telehealth cost share may be applicable

Common Medical Event	Services You Mav Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Deductible applies first; pre-authorization / authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	Deductible applies first; a telehealth cost share may be applicable; pre-authorization required for certain services
	Inpatient services	No charge	Not covered	Deductible applies first; pre-authorization / authorization required for certain services
If you are pregnant	Office visits	No charge	Not covered	Deductible applies first except for prenatal care; cost sharing does not apply for preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth cost share may be applicable
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	

Common Medical Event	Services You Mav Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Deductible applies first; pre-authorization required
	Rehabilitation services	No charge for outpatient services; No charge for inpatient services	Not covered	Deductible applies first; limited to 60 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; pre- authorization required for certain services
	Habilitation services	No charge	Not covered	Deductible applies first; outpatient rehabilitation therapy coverage limits apply; coverage limits waived for early intervention services for eligible children; a telehealth cost share may be applicable; pre-authorization required for certain services
	Skilled nursing care	No charge	Not covered	Deductible applies first; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	No charge	Not covered	Deductible applies first; cost share waived for one breast pump per birth, including supplies
	Hospice services	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam per calendar year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge	Not covered	Limited to children under age 12 (every 6 months) and under age 18 with a cleft palate / cleft lip condition

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Routine eye care - adult (one exam per calendar year)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs ($150 per calendar year per policy)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 1-800-782-3675 or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Disclaimer: This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

■ The plan's overall deductible	$2,000
■ Delivery fee copay	$0
■ Facility fee copay	$0
■ Diagnostic tests copay	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$2,000
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,070**

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$2,000
■ Specialist visit copay	$0
■ Primary care visit copay	$0
■ Diagnostic tests copay	$0

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost sharing	
Deductibles	$2,000
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,720**

Mia's Simple Fracture
(in-network emergency room visit and follow-up care)

■ The plan's overall deductible	$2,000
■ Specialist visit copay	$0
■ Emergency room copay	$0
■ Ambulance services copay	$0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

⚠	**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, **www.harvardpilgrim.org/LGsampleEOC**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other **underlined** terms, see the Glossary. You can view the Glossary at **www.healthcare.gov/sbc-glossary** or call **1-888-333-4742** to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$300 member/ $900 family Benefits are administered on a Plan Year basis.	Generally you must pay all the costs up to the deductible amount before this plan begins to pay. If you have other family members on the policy, they have to meet their own individual deductible until the overall family deductible amount has been met.
Are there services covered before you meet your deductible?	Yes: prescription drugs, outpatient mental health services, preventive care, provider office visits, rehabilitation services, habilitation services, routine eye exams, are covered before you meet your deductibles.	This plan covers some items and services even if you haven't yet met the deductible amount. But, a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at **https://www.healthcare.gov/coverage/preventive-care-benefits/**
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services
What is the out–of–pocket limit for this plan?	$2,000 member/ $4,000 family Separate out-of-pocket limit applies to Pharmacy, see "If you need drugs to treat your illness or condition".	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.

Important Questions	Answers	Why This Matters
What is not included in the out-of-pocket limit?	Prescription drugs, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See **https://www.harvardpilgrim.org/public/find-a-provider** or call **1-888-333-4742** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance-billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

⚠	All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Level 1: $20 copay/visit; deductible does not apply	Not covered	None
	Specialist visit	Level 1: $20 copay/visit; deductible does not apply Level 2: $45 copay/visit; deductible does not apply	Not covered	None
	Preventive care/ screening/ immunization	No charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	X-rays: No charge Laboratory: No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	$100 copay/procedure	Not covered	Cost sharing may vary for certain imaging services.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **www.harvardpilgrim.org/2023Premium3T.**	Generic drugs	30-Day Retail Tier 1: $10 copay/prescription; deductible does not apply 90-Day Mail Tier 1: $25 copay/prescription; deductible does not apply	Not covered	You pay retail price for Out of Network pharmacy drugs and are reimbursed minus applicable cost sharing. Covered only outside of service area. Prescription drug Out-of-Pocket Maximum: $3,000 member/ $6,000 family
	Preferred brand drugs	30-Day Retail Tier 2: $30 copay/prescription; deductible does not apply 90-Day Mail Tier 2: $75 copay/prescription; deductible does not apply	Not covered	
	Non-preferred brand drugs	30-Day Retail Tier 3: $65 copay/prescription; deductible does not apply 90-Day Mail Tier 3: $165 copay/prescription; deductible does not apply	Not covered	
	Specialty drugs	All drugs are covered in Retail Pharmacy and Mail Order Pharmacy Tiers 1 — 3	Not covered	Some drugs must be obtained through a Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay/visit		None
	Emergency medical transportation	No charge		None
	Urgent care	Urgent care center: $20 copay/visit; deductible does not apply	Urgent care center: Not covered	Services with non-participating providers are only covered outside of the service area. Cost sharing may vary based on Urgent Care location.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/admit	Not covered	None
	Physician/surgeon fee	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit; deductible does not apply	Not covered	None
	Inpatient services	$500 copay/admit	Not covered	
If you are pregnant	Office visits	$20 copay/visit; deductible does not apply	Not covered	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$500 copay/admit	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	None
	Rehabilitation services Habilitation services	Physical Therapy: $20 copay/visit; deductible does not apply Occupational Therapy: $20 copay/visit; deductible does not apply Speech Therapy: $20 copay/visit; deductible does not apply	Not covered	Occupational therapy – 30 visits /Plan Year Physical therapy – 30 visits /Plan Year
	Skilled nursing care	$500 copay/admit	Not covered	100 days/Plan Year

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance of equipment cost to HPHC, not to exceed a Member's total expense of $1,000/Plan Year	Not covered	None
	Hospice services	No charge	Not covered	For inpatient see "If you have a hospital stay"
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	Not covered	1 exam/Plan Year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up – Up to age of 13	No charge; deductible does not apply	Not covered	2 exams/Plan Year

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Long-Term Care	• Routine foot care (except for diabetes or systemic circulatory diseases)
• Children's glasses	• Non-emergency care when traveling outside the U.S.	• Services that are not Medically Necessary
• Chiropractic Care	• Private-duty nursing	• Weight Loss Programs
• Cosmetic Surgery		

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery	• Hearing Aids - $2,000/aid every 36 months, for each impaired ear up to age 22	• Infertility Treatment
		• Routine eye care (Adult) – 1 exam/Plan Year

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**, or the Department of Health and Human Services, Centers for Consumer Information and Insurance Oversight, at **1-877-267-2323 x61565** or **www.cciio.cms.gov**, or for more information on your rights to continue coverage, you can contact the Member Service number listed on your ID card or call **1-888-333-4742**. Other coverage options may be available to you, too, including buying individual insurance coverage through the **Health Insurance Marketplace**. For more information about the **Marketplace**, visit **www.HealthCare.gov** or call **1-800-318-2596**.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

HPHC Member Appeals-Member Services Department
Harvard Pilgrim Health Care, Inc.
1 Wellness Way
Canton, MA 02021-1166
Telephone: 1-888-333-4742
Fax: 1-617-509-3085

Department of Labor's Employee Benefits Security Administration
1-866-444-3272
www.dol.gov/ebsa/healthreform

Health Care for All
30 Winter Street, Suite 1004
Boston, MA 02108
1-800-272-4232
http://www.hcfama.org/helpline

Does this plan meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Language Access Services:

Para obtener asistencia en Español, llame al **1–888–333–4742.**
如果需要中文的帮助, 请拨打这个号码 **1–888–333–4742.**
De assistência em Português, por favor ligue **1–888–333–4742.**

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About th Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the cost-sharing amounts (deductible, copayment and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	
■ **The plan's overall deductible**	$300
■ **Specialist copayment**	$45
■ **Hospital (facility) copayment**	$500
■ **Other**	$0
This EXAMPLE event includes services like:	
Specialist office visits (*prenatal care*)	
Childbirth/Delivery Professional Services	
Childbirth/Delivery Facility Services	
Diagnostic tests (*ultrasounds and blood work*)	
Specialist visit (*anesthesia*)	
Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$900**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ **The plan's overall deductible**	$300
■ **Specialist copayment**	$45
■ **Hospital (facility) copayment**	$500
■ **Other**	$0
This EXAMPLE event includes services like:	
Primary care physician office visits (*including disease education*)	
Diagnostic tests (*blood work*) Prescription drugs Durable medical equipment (*glucose meter*)	
Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,300**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	$300
■ **Specialist copayment**	$45
■ **Hospital (facility) copayment**	$500
■ **Other**	$0
This EXAMPLE event includes services like:	
Emergency room care (*including medical supplies*)	
Diagnostic test (*x-ray*) Durable medical equipment (*crutches*) Rehabilitation services (*physical therapy*)	
Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$300
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$650**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Harvard Pilgrim Health Care

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
The Harvard Pilgrim Best Buy HSA HMO

Coverage Period: 07/01/2023 — 06/30/2024
Coverage for: Individual + Family | Plan Type: HMO

⚠	**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, **www.harvardpilgrim.org/LGsampleEOC**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other **underlined** terms, see the Glossary. You can view the Glossary at **www.healthcare.gov/sbc-glossary** or call **1-888-333-4742** to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	Medical & Prescription Drug Deductible: $2,000 member/ $4,000 family Benefits are administered on a Plan Year basis.	Generally you must pay all the costs up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes: preventive care, routine eye exams, are covered before you meet your deductibles.	This plan covers some items and services even if you haven't yet met the deductible amount. But, a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at **https://www.healthcare.gov/coverage/preventive-care-benefits/**
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services
What is the out–of–pocket limit for this plan?	$5,000 member/ $10,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.

Important Questions	Answers	Why This Matters
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See **https://www.harvardpilgrim.org/public/find-a-provider** or call **1-888-333-4742** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance-billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

!	All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	None
	Specialist visit	No charge	Not covered	None
	Preventive care/ screening/ immunization	No charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-rays: No charge Laboratory: No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Cost sharing may vary for certain imaging services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **www.harvardpilgrim.org/2023Premium3T.**	Generic drugs	30-Day Retail Tier 1: $10 copay/prescription 90-Day Mail Tier 1: $25 copay/prescription	Not covered	You pay retail price for Out of Network pharmacy drugs and are reimbursed minus applicable cost sharing. Covered only outside of service area.
	Preferred brand drugs	30-Day Retail Tier 2: $30 copay/prescription 90-Day Mail Tier 2: $75 copay/prescription	Not covered	
	Non-preferred brand drugs	30-Day Retail Tier 3: $65 copay/prescription 90-Day Mail Tier 3: $165 copay/prescription	Not covered	
	Specialty drugs	All drugs are covered in Retail Pharmacy and Mail Order Pharmacy Tiers 1 — 3	Not covered	Some drugs must be obtained through a Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	No charge		None
	Emergency medical transportation	No charge		None
	Urgent care	Urgent care center: No charge	Urgent care center: Not covered	Services with non-participating providers are only covered outside of the service area. Cost sharing may vary based on Urgent Care location.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	None
	Physician/surgeon fee	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	None
	Inpatient services	No charge	Not covered	
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	None
	Rehabilitation services	Physical Therapy: No charge Occupational Therapy: No charge Speech Therapy: No charge	Not covered	Occupational therapy – 30 visits /Plan Year Physical therapy – 30 visits /Plan Year
	Habilitation services			
	Skilled nursing care	No charge	Not covered	100 days/Plan Year
	Durable medical equipment	No charge	Not covered	Wigs – $350/Plan Year
	Hospice services	No charge	Not covered	For inpatient see "If you have a hospital stay"
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	Not covered	1 exam/Plan Year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up – Up to age of 13	No charge	Not covered	2 exams/Plan Year

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Children's glasses • Cosmetic Surgery	• Long-Term Care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine foot care (except for diabetes or systemic circulatory diseases) • Services that are not Medically Necessary • Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery	• Chiropractic Care - 20 visits/Plan Year • Hearing Aids - $2,000/aid every 36 months, for each impaired ear up to age 22	• Infertility Treatment • Routine eye care (Adult) – 1 exam/Plan Year

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**, or the Department of Health and Human Services, Centers for Consumer Information and Insurance Oversight, at **1-877-267-2323 x61565** or **www.cciio.cms.gov**, or for more information on your rights to continue coverage, you can contact the Member Service number listed on your ID card or call **1-888-333-4742**. Other coverage options may be available to you, too, including buying individual insurance coverage through the **Health Insurance Marketplace**. For more information about the **Marketplace**, visit **www.HealthCare.gov** or call **1-800-318-2596**.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called a **grievance** or **appeal**. For more information about your rights, look at the explanation of benefits you will receive for that medical **claim**. Your **plan** documents also provide complete information on how to submit a **claim**, **appeal**, or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact:

HPHC Member Appeals-Member Services Department
Harvard Pilgrim Health Care, Inc.
1 Wellness Way
Canton, MA 02021-1166
Telephone: 1-888-333-4742
Fax: 1-617-509-3085

Department of Labor's Employee Benefits Security Administration
1-866-444-3272
www.dol.gov/ebsa/healthreform

Health Care for All
30 Winter Street, Suite 1004
Boston, MA 02108
1-800-272-4232
http://www.hcfama.org/helpline

Does this plan meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Language Access Services:

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如果需要中文的帮助, 请拨打这个号码 **1–888–333–4742.**

De assistência em Português, por favor ligue **1–888–333–4742.**

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the cost-sharing amounts (deductible, copayment and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	
■ The plan's overall deductible	$2,000
■ Specialist	$0
■ Hospital (facility)	$0
■ Other	$0
This EXAMPLE event includes services like:	
Specialist office visits (*prenatal care*)	
Childbirth/Delivery Professional Services	
Childbirth/Delivery Facility Services	
Diagnostic tests (*ultrasounds and blood work*)	
Specialist visit (*anesthesia*)	
Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,050**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ The plan's overall deductible	$2,000
■ Specialist	$0
■ Hospital (facility)	$0
■ Other	$0
This EXAMPLE event includes services like:	
Primary care physician office visits (*including disease education*)	
Diagnostic tests (*blood work*) Prescription drugs Durable medical equipment (*glucose meter*)	
Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,700**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	$2,000
■ Specialist	$0
■ Hospital (facility)	$0
■ Other	$0
This EXAMPLE event includes services like:	
Emergency room care (*including medical supplies*) Diagnostic test (*x-ray*) Durable medical equipment (*crutches*) Rehabilitation services (*physical therapy*)	
Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

The plan would be responsible for the other costs of these EXAMPLE covered services.

MEDICARE

Please visit https://www.ssa.gov/benefits/medicare/ for information.

What to do about Medicare

Medicare is our country's health insurance program for people age 65 or older. Certain people younger than age 65 can qualify for Medicare too, including those with disabilities and those who have permanent kidney family.

Most people age 65 or older are eligible for free Medical hospital insurance (Part A) if they have worked and paid Medicare taxes long enough. You can enroll in Medicare medical insurance (Part B) by paying a monthly premium. Eligibility for enrollment begins 3 months before your 65th birthday, includes the month you turn 65, and ends 3 months after that birthday.

If you have medical insurance under a group health plan based on you or your spouse's current employment, you may not need to apply for Medicare Part B at age 65. You may qualify for a "Special Enrollment Period" (SEP) that will let you sign up for Part B during:

- Any month you remain covered under the group health plan and you or your spouse's employment continues.
- The 8-month period that begins with the month after your group health plan coverage or the employment it is based on ends, whichever comes first.

Other Medicare resources:
https://www.medicare.gov/
https://www.medicare.gov/medicare-and-you
https://www.medicare.gov/coverage

When you have decided

Please notify the Employee Benefits office when you, *or your spouse,* have decided which plan you want as your primary insurance. You will be asked to confirm your decision by signing the form provided to you.*

- If you, *or your spouse,* decide to carry your group health plan as your primary insurance, please be sure to advise the hospital or physician (when you receive medical services) that your group health plan is your primary insurance. If you are enrolled in Medicare, you should *also* give your Medicare Health Insurance Claim Number and indicate that Medicare will be the *secondary* insurance.
- If you, *or your spouse,* decide to carry Medicare as your primary insurance, they will be removed from the group insurance plan and will need to convert to a non-group Medicare supplement plan.

*Employees who are enrolled in Medicare are not eligible to contribute to an HSA account.

Flexible Spending Benefits

Cape Cod Collaborative

One of the Few Gifts the IRS Gives!

Discover the benefit that SAVES YOU MONEY. This perk allows you to set aside a portion of your pay—*BEFORE TAXES*—to cover out-of-pocket expenses in these categories:

- **HEALTH CARE.*** Eligible expenses and services include: non-cosmetic medical, dental, and vision care services; prescription medications; over-the-counter 'medicines' (not vitamins and supplements); orthodontics, prescription eyeglasses, contact lenses, laser eye surgery; mental health services; alternative health therapies (e.g. chiropractic, acupuncture); and *MORE!*

  Max. Annual Health Care Election: $3,200

  Who's Covered? You, your legal spouse, and your dependents as defined by the Internal Revenue Service, including those claimed on your tax return and adult children under age 26.

  Benefit Cards. For employer plans that offer the benefit card, new Health Care FSA enrollees will receive **2 cards** that can be used at most medical facilities, dental offices, optical shops, and pharmacies to pay for eligible expenses. ***Keep your cards!*** They will reload each plan year that you enroll.

  Grace Period. Health Care FSA participants get an ***extra 75 days*** at the end of the plan year to spend down the prior year's available balance, if any.

  HSA Ineligibility. If you or your spouse have a Health Savings Account ('HSA'), you are NOT ELIGIBLE to participate in the Health Care FSA plan.

- **DEPENDENT CARE.**** For qualified childcare expenses for dependent children under age 13, elderly dependents, and dependents with special needs. Eligible expenses include day care, pre-school, before/after school care, day camp, elder day care.

  Max. Annual Dep. Care Election: $5,000. per family

Enroll by 11/30/2024
for the
1/1/2025 – 12/31/2025
Plan Year

Already in the FSA Plan?

Re-enrollment is NOT automatic!

▶**Re-enroll** via your online account portal—*not the mobile app!* Go to ***cpaemployee.lh1ondemand.com*** and log-in on the LEFT side of the sign-in screen. Once on your account homepage, click the blue *Enroll/Re-enroll* button and follow the steps to enroll for the new plan year; click *Submit* at the end. We recommend printing or saving your enrollment confirmation.

▶***New to the FSA Plan?*** Complete the *"Authorization for Pre-Tax Payroll Reduction"* form and send it to **Lena Troye Thompson, Human Resources.**

Track Your Account and File Claims 24/7!

Log in to your **employee portal** via our website (www.CPA125.com), or use our app: ***CPA Flex Mobile.***

The annual FSA administrative fee is paid by your employer so you save even more!

* Not all Health Care expenses are FSA-eligible, such as: cosmetic procedures or products (e.g. Botox, teeth whitening, veneers, etc.), couples/family counseling, general health/wellness expenses (i.e., toothbrushes, toothpastes, non-prescription sunglasses, gym dues, etc.), and federally non-permissible products. Some healthcare-related expenses, such as medical equipment and some services, may require a physician's Letter of Medical Necessity in order to be FSA-eligible. Visit *https://fsastore.com/CPAEligibility* for more info. on specific products and services.

* Overnight camp and school tuition for kindergarten and above are not FSA-eligible; day camp is eligible when utilized as a form of childcare in order for the parent(s)/guardian(s) to be able to work; curricular and enrichment programs/activities that aren't daycare/childcare-based are not eligible; money paid to a childcare provider who doesn't report it as income on their taxes is not FSA-eligible.

Flexible Spending Plans administered by...

CAFETERIA PLAN ADVISORS • *An ALERA GROUP Company* | 120 LONGWATER DR., STE. 102, NORWELL, MA 02061 | CPA125.COM
TEL.: 781.848.9848 | E-MAIL: INFO@CPA125.COM

HealthEquity HSA

Save on premiums

When it comes to choosing a healthcare plan, you really have one decision to make: High premium or low premium?

Health Savings Account (HSA)-qualified health plans (sometimes called high-deductible or consumer choice health plans) offer the lowest premiums, enabling you to unlock immediate savings. The difference could be thousands of dollars every year.

Keep your premium savings

Healthcare premium payments disappear forever. But you can use your HealthEquity HSA to keep that money instead.

Choose a low premium health plan. Then just put the extra money you would have paid toward traditional premiums into your HSA. Voila! Long-term health savings.

Want to go bigger? Don't forget IRS annual contribution limits.

	Individual Plan	Family Plan
2024	**$4,150**	**$8,300**
2025	**$4,300**	**$8,550**
Members 55+ can contribute an **extra $1,000**		

You have until the annual tax-filing deadline to max your contributions for the previous tax year.

Maximize tax savings

Every dollar you contribute pre-tax to your HSA reduces your annual taxable income.

Plus, you automatically earn tax-free interest on your money. Anytime healthcare expenses come up just pay from your HSA and you're good to go. You never pay taxes or penalties when you use HSA dollars for qualified medical expenses.

See the savings for yourself

Try our plan comparison tool to see how much an HSA-qualified health plan will save you this year.

Visit CompareMyHSA.com

HSA dollars are yours to keep

Unlike flexible spending accounts (FSA), you never lose your HSA dollars. Money in your account rolls over year after year, even if you change health plans or employers.

Spend smarter

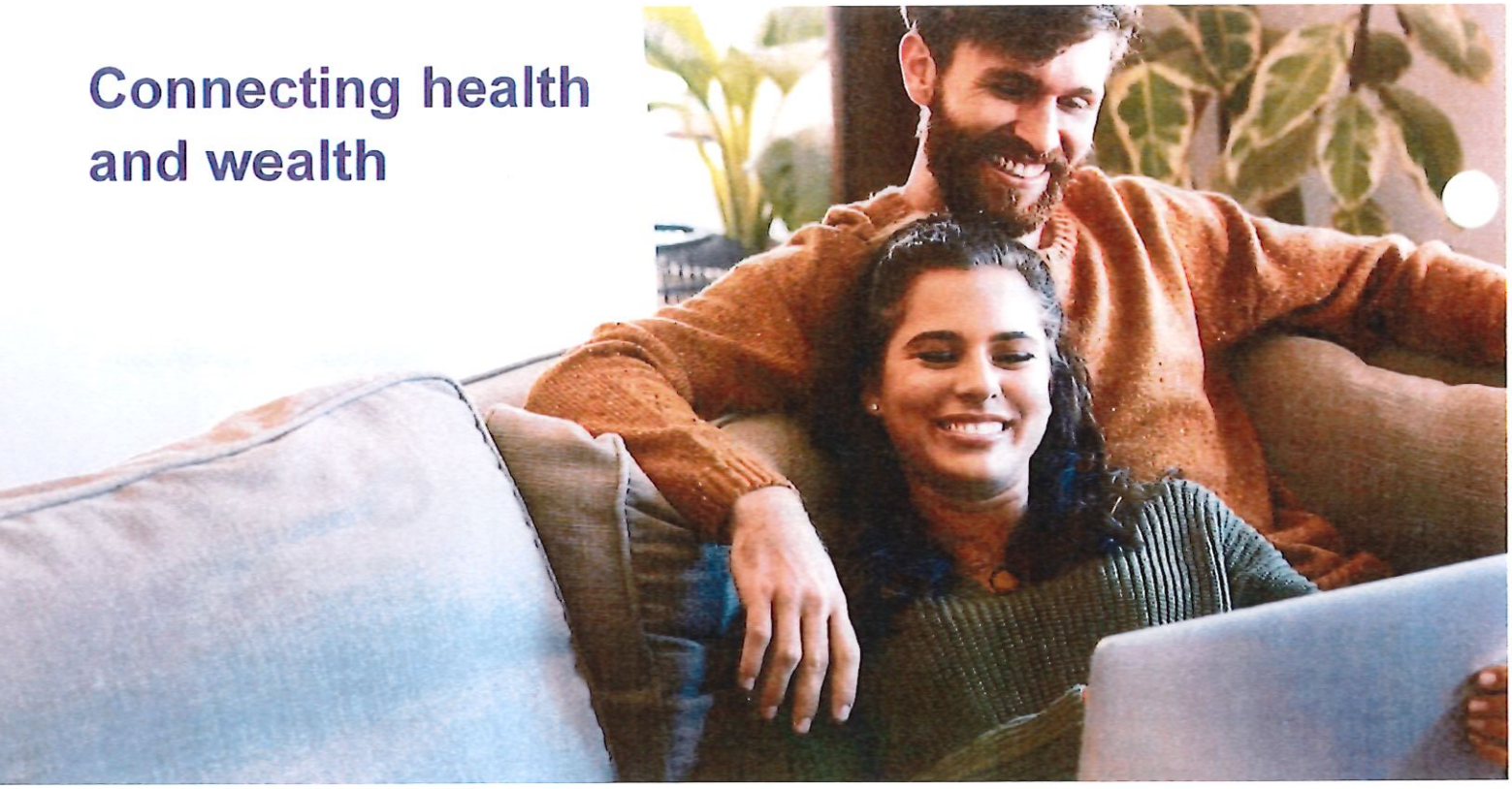
HSAs cover thousands of qualified medical expenses, including doctor visits and over-the-counter medications. See a full list of eligible expenses.

Visit HealthEquity.com/QME

HSA triple-tax advantage[1]

1. Make pre-tax contributions
2. Grow tax-free earnings
3. Enjoy tax-free distribution[2]

Connecting health and wealth



Maybe you've had an HSA before, but you've never had an HSA like this.

Get support 24/7
Call us day or night. Our US-based service team measures success by problems solved. We'll do whatever it takes.

Say goodbye to hassle
Log in and manage everything via our simple mobile app.[5] Want to submit a claim? Easy. Just snap a photo and you're on your way.

Be inspired
Check out our vast library of webinars, tutorials, videos, calculators, and more. You'll find tips and tricks to make the most of your HSA.

Join five million+ health savers
For more than two decades we've empowered some of the biggest companies in the world—and the smartest savers on the block.

Enroll today. Talk to your benefits team
866.735.8195 | HealthEquity.com/Learn

[1]HSAs are never taxed at a federal income tax level when used appropriately for qualified medical expenses. Also, most states recognize HSA funds as tax deductible with very few exceptions. Please consult a tax advisor regarding your state's specific rules.

[2]For qualified medical expenses

[3]Investments are subject to risk, including the possible loss of the principal invested and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. HSA holders may select mutual funds for investment through the HealthEquity investment platform but HealthEquity, Inc. does not provide investment advice. HealthEquity Advisors, LLC, a wholly owned subsidiary of HealthEquity, Inc. and an SEC-registered invest-ment adviser, provides web-based investment advice to HSA holders that subscribe for its services (minimum thresholds and additional fees apply). Registration does not imply endorsement by any state or agency and does not imply a level of skill, education, or training. Investing may not be suitable for everyone. You should carefully consider the investment objectives, risks, charges and expenses of any mutual fund before investing. A prospectus and, if available, a summary prospectus containing this and other important information can be obtained by visiting the fund sponsor's website. Please read the prospectus carefully before investing.

[4]After age 65, if you withdraw funds for any purpose other than qualified medical expenses, you will be subject to income taxes. Funds withdrawn for qualified medical expenses will remain tax-free

[5]Accounts must be activated via the HealthEquity website in order to use the mobile app

HealthEquity®

PINNACLECARE

Cape Cod Municipal Health Group

Your health advocacy and care navigation benefit

Dear Member,

Welcome to your new PinnacleCare benefit. PinnacleCare is here to provide you support when you are dealing with the complicated world of healthcare. Your company is providing this benefit, at no cost to you, as part of its commitment to your health and well-being.

With PinnacleCare, you receive access to a personal care advisor who will help you navigate the healthcare system so you receive the best course of treatment for your medical needs.

Our team of care advisors are supported by in-house medical directors and M.D./Ph.D. medical researchers who provide access to nationally-acclaimed specialists and medical Centers of Excellence.

Our goal is to help you obtain the answers you need to address your healthcare challenges quickly.

Contact us regarding:

- An expert medical opinion
- A new or ongoing medical diagnosis
- A recommendation for surgery
- A review of a current treatment plan
- A recommendation to top specialists
- Finding a new routine care provider
- Assistance with negotiating large medical bills over $800

Our services include:

- Facilitation of appointments with a top specialist
- Coordination of expert second medical opinion
- Comprehensive research report on your diagnosis and treatment options
- Gathering, organization, and forwarding of key medical records
- Customized referral report profiling top local, regional, or national specialists
- Virtual consultation for second medical opinion

For a confidential consultation with a care advisor, please call 888-442-7380. You may also send a secure email request or access additional details at: www.PinnacleCare.com/cape-cod

To your good health,
Your care advisory team

PCFL-EE-11023-BR-CC

SLPC 31500 04/22 (exp. 04/24)

DELTA DENTAL

Delta Dental PPO *Plus Premier*™

Visit **deltadentalma.com** for detailed benefit information

Coverage Summary for
Cape Cod Municipal Health Group
Group # 008318
Effective 7/1/2024

Deductible: $50 per individual / $100 per family. Deductible waived for Diagnostic and Preventive categories.
Calendar Year Maximum: $1,500 per person.

Category / Procedure	Qualifications	Co-insurance In Network	Co-insurance Out of Network*
Diagnostic			
Comprehensive Evaluation	Once every 60 months.	100%	100%
Periodic Oral Evaluation	Twice every 12 months.		
Panoramic or Full Mouth X- rays	Once every 36 months.		
Bitewing X-rays	Twice every 12 months.		
Single Tooth X-rays	As needed.		
Preventive			
Teeth Cleaning	Twice every 12 months.	100%	100%
Fluoride Treatments	Twice every 12 months.		
Space Maintainers	Required due to the premature loss of teeth. For members under age 14 and not for the replacement of primary or permanent anterior teeth.		
Sealants	Unrestored permanent bicuspid and permanent molars, once per 48 months per tooth for members to age 19.		
Restorative			
Fillings (Silver and White)	Once every 24 months per surface per tooth.	80%	80%
Inlays	Once every 60 months per surface per tooth, covered as an alternate benefit as silver filling and the patient is responsible for paying the difference between the silver filling and the Delta Dental negotiated fee for the inlay where permitted by state law. For non-participating providers, the patient may be responsible for paying up to the provider's full submitted charge for the inlay.		
Protective Restorations	Once per tooth.		
Stainless Steel Crowns	Once every 24 months per tooth (on primary teeth only).		
Oral Surgery		80%	80%
Extractions	Once per tooth.		
General Anesthesia	General Anesthesia and IV sedation allowed with covered surgical impacted teeth only (up to one hour).		
Periodontics (on natural teeth only)			
Periodontal Surgery	One surgical procedure per quadrant in 36 months.	80%	80%
Scaling and Root Planing	Once in 24 months, per quadrant. No more than 2 quadrants per date of service.		
Periodontal Cleaning	4 times every 12 months following active periodontal treatment. Not to be combined with preventive cleanings.	100%	100%
Bone Grafts/GTR	No more than 2 teeth per quadrant per 36 months on natural teeth.		
Endodontics			
Root Canal Treatment	Once per tooth.	80%	80%
Root Canal Retreatment	Once per tooth after 24 months have elapsed from initial treatment.		
Vital Pulpotomy	Limited to deciduous teeth.		
Prosthetic Maintenance			
Bridge or Denture Repair	Once per bridge/denture per 12 months, after 24 months of initial insertion.	80%	80%
Crown or Onlay Repair	Once per tooth per 12 months after 24 months of initial placement		
Rebase or Reline of Dentures	Once per denture within 36 months.		
Recement of Crowns, Onlays & Bridges	Once per crown, onlay or bridge.		
Emergency Dental Care			
Palliative treatment	Three occurrences in 6 months.	80%	80%
Prosthodontics			
Dentures	Once within 60 months (age 16 and older).	50%	50%
Fixed Bridges	Once within 60 months (age 16 and older).		
Implants	Once per tooth per 60 months. (Pre-estimate recommended).		
Implant Abutments	Once per 60 months.		
Major Restorative			
Crowns or Onlay	Once within 60 months per tooth (age 12 and older).	50%	50%
Cast Posts/Buildups	Once per tooth per 60 months only benefitted to retain a crown.		
Orthodontics: Covered at 50% of Maximum Plan Allowance charges up to any age. $1,000 separate LIFETIME maximum. Orthodontic treatment must be administered/supervised by a licensed dentist			
Dependent Eligibility: Eligible dependents are covered until the last day of the month of the member's 26th birthday.			

*Non-participating dentists may balance bill. Subscribers are responsible for the difference between the non-participating maximum plan allowance and the full fee charged by the dentist.

Additional Benefit Information

Deductible waived for periodontal cleanings.
Deductible met in the 4th quarter is carried over to the following calendar year.
This plan includes the Right Start 4 Kids program (only applies to dependents ages 12 and under). See RS4K flyer for additional information.
**Type 1 Preventive and Diagnostic Services do not detract from the annual calendar year maximum.
TMJ services are covered as a Type 3 major restorative service and subject to the annual plan year max and deductible.
Ask your dentist to submit a pre-treatment estimate to Delta Dental for any procedure that exceeds $300. This will help you estimate any out-of-pocket expenses you may incur and will confirm that the services are covered under your dental coverage.

This plan is eligible for Rollover Maximum

Rollover Max dollars do not apply to orthodontic services. To qualify for Rollover Max, you must receive at least one cleaning or oral exam in the plan year. You must be enrolled for dental coverage before the 4th quarter of the calendar year and your paid claims must not exceed the maximum "threshold" amount.

Your calendar year maximum benefit amount.	If your total yearly claims don't exceed this threshold amount...	Then you can roll over this amount to use next year, and beyond.	Your accumulated rollover total is capped at this amount.
$1,500	$700	$500	$1,250

Delta Dental PPO *Plus Premier*℠

DELTA DENTAL

Easy Access and Great Value – Your Delta Dental Networks

As a Delta Dental PPO *Plus Premier* subscriber, you have access to two of Delta Dental's extensive national networks—Delta Dental PPO, with more than 350,000 dentist locations and Delta Dental Premier, the largest dental network in the country with more than 450,000 dentist locations. Three out of four dentists nationwide participate in one or both of these networks.

You will enjoy great benefits when you receive your dental care from a participating dentist in either the Delta Dental PPO or Delta Dental Premier networks.

- Both networks offer discounted fees and a no balance billing policy.
- You will receive good value from Delta Dental Premier network dentists who generally accept discounted fees, but will be subject to the out-of-network co-insurance level shown on the front of this summary.
- You will enjoy the greatest savings when visiting Delta Dental PPO network dentists and will receive the in-network co-insurance level shown on the front of this summary.

If you choose to receive services from a non-participating dentist, you will have higher out-of-pocket costs as the Delta Dental contract rates and the no balance billing policy do not apply.

Delta Dental members can also take advantage of expanded discounts on many covered services, even after they have used up their benefit dollars, visit limits and other situations. Get the details at http://www.deltadentalma.com/members/discounts-on-covered-services/

Learn more at deltadentalma.com

Visit the member area of **www.deltadentalma.com** to find plan information, review eligibility status, check on claim status, or find a dentist. If you have any questions or need additional information, you can call customer service at 800-872-0500.

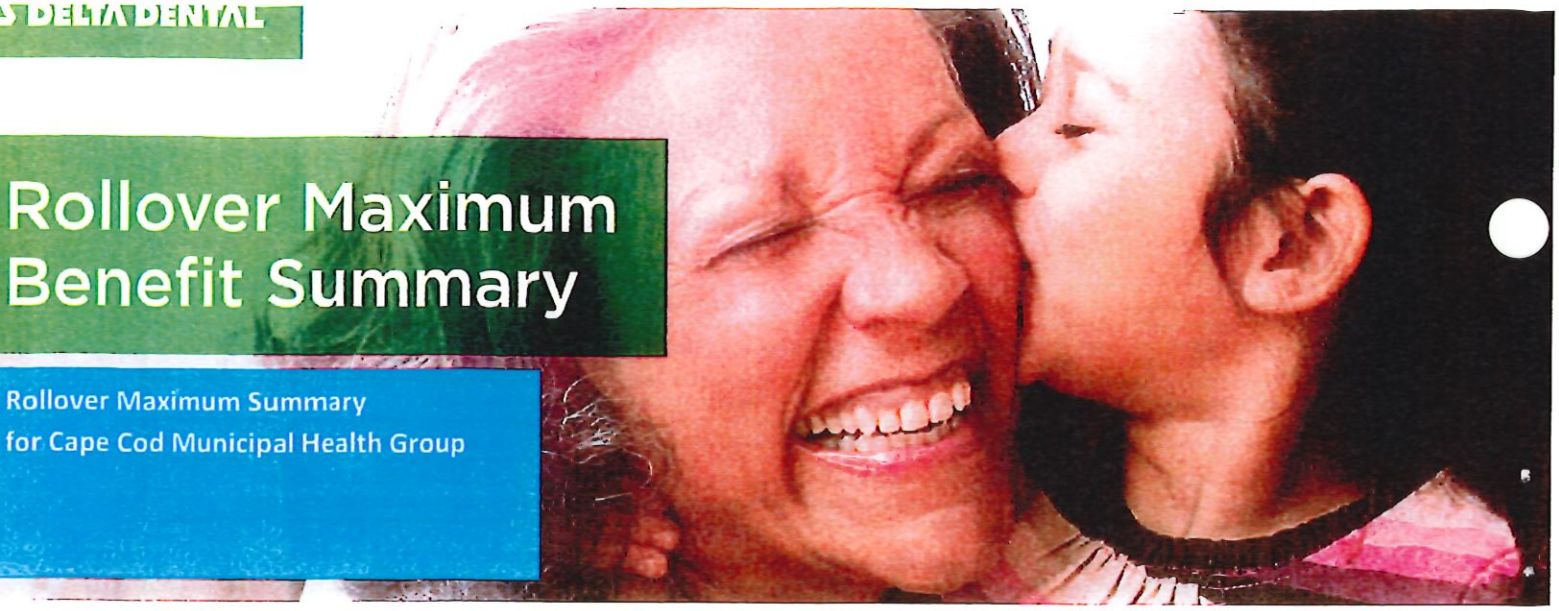
You can also find more information about your plan in the Delta Dental Member Guide, available from your benefits administrator or online at **www.deltadentalma.com**. In the guide, you can learn how to use your benefits, how to find a dentist or specialist, how to access online resources, and more about keeping a healthy mouth for life.

The information on this coverage summary should be used only as a guideline for your dental benefits plan. For detailed information on your group's plan, riders, terms and conditions, or limitations and exclusions, refer to your plan's Subscriber Certificate, which is available through your benefits administrator.

Your Plan is Administered by:
Delta Dental of Massachusetts
800-872-0500
www.deltadentalma.com

465 Medford Street, Ste. 400
Boston, MA 02129

DELTA DENTAL



Rollover Maximum Benefit Summary

Rollover Maximum Summary
for Cape Cod Municipal Health Group

With *Rollover Max* from Delta Dental, you won't lose what you don't use.

Thanks to the *Rollover Max* benefit from Delta Dental, you can save some of your unused benefit dollars to be applied to future services that would otherwise exceed your plan maximum.

Rollover Max is easy and automatic.

- To qualify for *Rollover Max,* **you must receive at least one cleaning or oral exam in the plan year.** If you don't receive a cleaning or exam, you won't be eligible to rollover any of your benefit dollars to the following year.
- In addition, your paid claims must not exceed the Plan Year Maximum "threshold" amounts outlined in the chart below.
- Once you qualify, some of your unused annual Plan Year maximum benefit dollars will automatically rollover for use in your next plan year and beyond. The amounts are outlined in the chart below.
- Annual Plan Year Maximum dollars are used first. *Rollover Max* dollars are used after the annual maximum amount for your plan has been exhausted.
- *Rollover Max* dollars cannot be applied to orthodontic treatment or other lifetime benefits.
- You must be enrolled for dental coverage before the 4th quarter of the plan (10/1-12/31) to qualify for the rollover that year.

How *Rollover Max* works.

The chart below shows how *Rollover Max* is calculated based on your plan's annual Plan Year Maximum level.

Rollover Max increases your dental benefit value.

You get more flexibility in planning and paying for your dental care, as well as the peace of mind knowing you have more benefits—if you need them, when you need them. Best of all, *Rollover Max* comes as part of your Delta Dental coverage.

	Your Plan Year Maximum benefit amount.	If your total yearly claims don't exceed this threshold amount.	Then you can roll over this amount to use next year, and beyond.	Your accumulated rollover total will not exceed this amount.
Annual Max	$1,500	$700	$500	$1,250

How to check your *Rollover Max* balance online:

- Log on to your account at **deltadentalma.com** (You'll need to register if this will be your first visit.)
- Click on Benefit Maximums.
- The rollover amount for each member will be listed under *Rollover Maximum.*

Savings plus convenience plus choice

PLUS Providers add another layer of coverage

$200
Frame allowance

$100
Additional glasses allowance

Staying in-network helps you save money on eye exams, frames and lenses. Visiting a PLUS Provider is designed to help you save even more.

And since PLUS Providers are already in our network, the additional perks are built right into your vision benefits. No promo codes, no coupons, no paperwork. The same vision benefits, plus a little more savings.

The choice is yours

Find plenty of in-network eye doctors – including PLUS Providers – on our Provider Locator. Just look for the PLUS.

Need extra assistance? Contact us at 866.723.0596 or visit eyemed.com.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION EST. 1961 OPTICAL

PDF-2303-M-1084

Cape Cod Municipal Health Group

(Access Network)

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST AT PLUS PROVIDERS	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
FRAME			
Frame	$0 copay; 20% off balance over $200 allowance	$0 copay; 20% off balance over $150 allowance	Up to $120
STANDARD PLASTIC LENSES			
Single Vision	$20 copay	$20 copay	Up to $47
Bifocal	$20 copay	$20 copay	Up to $79
Trifocal	$20 copay	$20 copay	Up to $113
Lenticular	$20 copay	$20 copay	Up to $113
Progressive - Standard	$20 copay	$20 copay	Up to $140
Progressive - Premium	$20 copay; 20% off retail price less $120 allowance	$20 copay; 20% off retail price less $120 allowance	Up to $196
LENS OPTIONS			
Anti Reflective Coating - Standard	$45	$45	Not covered
Photochromic - Non-Glass	20% off retail price	20% off retail price	Not covered
Polycarbonate - Standard	$0 copay	$0 copay	Up to $32
Scratch Coating - Standard Plastic	$0 copay	$0 copay	Up to $12
Tint - Solid and Gradient	$15	$15	Not covered
UV Treatment	$15	$15	Not covered
All Other Lens Options	20% off retail price	20% off retail price	Not covered
CONTACT LENSES			
Contacts - Conventional	$0 copay; 15% off balance over $150 allowance	$0 copay; 15% off balance over $150 allowance	Up to $120
Contacts - Disposable	$0 copay; 100% of balance over $150 allowance	$0 copay; 100% of balance over $150 allowance	Up to $120
Contacts - Medically Necessary	$0 copay; paid in full	$0 copay; paid in full	Up to $300
ADDITIONAL GLASSES ALLOWANCE			
Glasses Allowance	40% off retail price less $100 allowance	40% off retail price less $50 allowance	Up to $40
OTHER			
Hearing Care from Amplifon Network	Up to 64% off hearing aids; call 1.877.203.0675	Up to 64% off hearing aids; call 1.877.203.0675	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

FREQUENCY	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
Frame	Once every calendar year	Once every calendar year
Lenses	Once every calendar year	Once every calendar year
Contact Lenses	Once every calendar year	Once every calendar year
Glasses Allowance	Once every calendar year	Once every calendar year

(Routine benefit: Plan allows member to receive either glasses (frame, lens, lens options), or contacts. Additional Glasses Allowance: Plan allows member to receive glasses (frame and/or lens, lens options).

*Complete pair (frame & lens with or without lens options) purchase required to receive 40% discount. 20% discount applied if complete pair not purchased.
PLUS Providers not available in all states.
EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866.939.3633. No benefits will be paid for services or materials connected with or charges arising from: any Vision Examination; medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, Policy number VC-19, form number M-9083, or Policy number VC-146, form number M-9184, in New York underwritten by Fidelity Security Life Insurance Company of New York, Policy Number VCN-1, form number MN-1, or Policy Number VCN-19, form number MN-28. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891 -

FAMILY MATTERS. NO MATTER WHAT."

Basic Life and Accidental Death & Dismemberment (AD&D) Benefit Summary

Designed for the Employees of

Cape Cod Collaborative

ELIGIBILITY & BENEFIT FEATURES

Class 1: All Full Time Active Drivers & Monitors

Basic Life and AD&D: $10,000

COST OF COVERAGE

The premium for your coverage is paid by you and your employer.

GUARANTEED ISSUE

No medical questions are required for amounts up to $10,000 for first time applicants in their initial eligibility period.

REDUCTIONS IN BENEFITS

Employee coverage reduces upon the attainment of age 65 and periodically thereafter in accordance with the following schedule:

to 65 % of the original benefit at age 65

to 50 % of the original benefit at age 70

* *All insurance benefits shall terminate upon the employee's termination of employment or retirement.*

ADDITIONAL FEATURES

Accelerated Death Benefit: This provision enables an employee diagnosed and certified by a Doctor with a terminal illness, resulting in a life expectancy of twelve months or less, to receive a portion of the life insurance benefit prior to death. The remaining benefit will be paid to the beneficiary. To be eligible, the employee must have at least $10,000 in basic life coverage.

Accidental Death & Dismemberment: Dismemberment benefits are payable for loss of eyesight or limbs according to the policy provisions. An additional death benefit is paid if death is the result of a covered accident.

Portability: If you leave your employer prior to age 60 , the coverage is portable for you, your spouse under age 60 and all eligible dependent children. You may elect to exercise this option in accordance with the provisions as defined by the policy. The coverage would not include Waiver of Premium or AD&D.

Conversion: Employees have 31 days from the date of termination to *convert* their basic life insurance to an individual permanent life insurance policy without evidence of insurability. The premium will be based on Boston Mutual's usual rate for the insured's age on the date of conversion. Coverage will not include Waiver of Premium or AD&D.

EXCLUSIONS

Under the AD&D coverage, benefits are not payable for losses caused by or contributed to by: self-inflicted injuries; suicide or attempted suicide; riot or war; diseases; ptomaine or bacterial infection; drug and/or alcohol abuse; commission of an assault or felony by an employee; accident while serving on active duty; travel or flight in any aircraft or device which can fly above the earth's surface *(does not apply to commercial flights);* or injury which occurred before the employee was insured by this policy. All exclusion details are stated in the master policy and certificate which may be reviewed through your benefit administrator.

This information is a summary of benefits; this summary is not your certificate nor does it constitute coverage for claim. Any discrepancies between this summary and the master policy will be resolved by the language issued in the master policy. For complete details of coverage and availability, please refer to your certificate or contact your benefits administrator.

BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891 -

FAMILY MATTERS. NO MATTER WHAT®

Basic Life and Accidental Death & Dismemberment (AD&D) Benefit Summary

Designed for the Employees of

Cape Cod Collaborative

ELIGIBILITY & BENEFIT FEATURES

Class 1: Full Time Active Employees except Drivers & Monitors

Basic Life and AD&D: $10,000

COST OF COVERAGE

The premium for your coverage is paid by you and your employer.

GUARANTEED ISSUE

No medical questions are required for amounts up to **$10,000** for first time applicants in their initial eligiblity period.

REDUCTIONS IN BENEFITS

Employee coverage reduces upon the attainment of age **65** and periodically thereafter in accordance with the following schedule:

to 65 % of the original benefit at age 65

to 50 %of the original benefit at age 70

* *All insurance benefits shall terminate upon the employee's termination of employment or retirement.*

ADDITIONAL FEATURES

Accelerated Death Benefit: This provision enables an employee diagnosed and certified by a Doctor with a terminal illness, resulting in a life expectancy of twelve months or less, to receive a portion of the life insurance benefit prior to death. The remaining benefit will be paid to the beneficiary. To be eligible, the employee must have at least $10,000 in basic life coverage.

Accidental Death & Dismemberment: Dismemberment benefits are payable for loss of eyesight or limbs according to the policy provisions. An additional death benefit is paid if death is the result of a covered accident.

Portability: If you leave your employer prior to age **60** , the coverage is portable for you, your spouse under age **60** and all eligible dependent children. You may elect to exercise this option in accordance with the provisions as defined by the policy. The coverage would not include Waiver of Premium or AD&D.

Conversion: Employees have 31 days from the date of termination to convert their basic life insurance to an individual permanent life insurance policy without evidence of insurability. The premium will be based on Boston Mutual's usual rate for the insured's age on the date of conversion. Coverage will not include Waiver of Premium or AD&D.

EXCLUSIONS

Under the AD&D coverage, benefits are not payable for losses caused by or contributed to by: self-inflicted injuries; suicide or attempted suicide; riot or war; diseases; ptomaine or bacterial infection; drug and/or alcohol abuse; commission of an assault or felony by an employee; accident while serving on active duty; travel or flight in any aircraft or device which can fly above the earth's surface *(does not apply to commercial flights);* or injury which occurred before the employee was insured by this policy. All exclusion details are stated in the master policy and certificate which may be reviewed through your benefit administrator.

This information is a summary of benefits; this summary is not your certificate nor does it constitute coverage for claim. Any discrepancies between this summary and the master policy will be resolved by the language issued in the master policy. For complete details of coverage and availability, please refer to your certificate or contact your benefits administrator.

BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891-

FAMILY MATTERS. NO MATTER WHAT."

Voluntary Term Life and Accidental Death & Dismemberment Benefit Summary (Attained Age Pricing)

Designed for the Employees of

Cape Cod Collaborative

ELIGIBILITY & BENEFIT FEATURES

All eligible active employees working 20 or more hours per week, their spouse under age 70, unmarried children ages 14 days to 19 years *(25 if a full time student)*, and handicapped children over the age of 19 are eligible for coverage.

Dependent coverage is available only if the employee elects coverage. Dependents may not be insured if they are confined to a medical facility. If the employee is not actively at work on the effective date of coverage, the insurance will become effective on the date of the employee's return to active employment.

Employee coverage maximum of $500,000 , sold in increments of $10,000 . Coverage cannot exceed 5 times base annual salary.

Spouse coverage maximum of $100,000, sold in increments of $5,000 . Coverage cannot exceed 50 % of employee coverage amount elected.

Child coverage: Age 14 days to 1 year: $1,000

Age 1 to 19 years: $10,000 *(age 25 for full-time students)*

A spouse or child who is also an employee cannot be insured as a dependent. If both spouses are insured as employees of the same group, their children can be insured as dependents of one spouse only.

COST OF COVERAGE

The premium for your coverage is paid by you.

Attained Age means premium rates for employees are based on the employee's age at the time of enrollment and change as the employee reaches the next age band. Premium rates for spouses are based on the spouse's age at the time of enrollment and change as the spouse reaches the next age band. After the initial rate guarantee period, the group is subject to an annual review and possible rate changes.

GUARANTEED ISSUE

No medical underwriting will be required unless you apply for coverage over the Guaranteed Issue amount. apply beyond the initial 31 day eligibility period, or have been previously declined coverage by Boston Mutual.

Guaranteed Issue Amounts

AGE	EMPLOYEE	SPOUSE
Under Age 60	$100,000	$30,000
Ages 60 • 69	$50,000	$20,000
Ages 70 & Over	$10,000	NIA

All life insurance coverage for dependent children is guaranteed issue if applied for during the initial 31 day eligibility period.

REDUCTIONS IN BENEFITS

Employee coverage reduces upon the attainment of age 70 and periodically thereafter in accordance with the following schedule:

to 65 % of the original benefit at age 70	to 25% of the original benefit at age 85
to 50 % of the original benefit at age 75	to 20% of the original benefit at age 90
to 35 % of the original benefit at age 80	to 15% of the original benefit at age 95

Spouse insurance terminates upon the attainment of age 70 . Dependent children coverage terminates upon notice that all dependent children are no longer eligible. All insurance benefits shall terminate upon the employee's retirement.

see other side

ADDITIONAL FEATURES

Accidental Death & Dismemberment: The Voluntary Life Insurance benefit is doubled if death is the result of a covered accident. Dismemberment benefits are payable for loss of eyesight or limbs according to the policy provisions.

Portability: If you leave your employer prior to age 60 , the coverage is portable for you, your spouse under age 60 and all eligible dependent children. You may elect to exercise this option in accordance with the provisions as defined by the policy. The coverage would not include Waiver of Premium or Group Voluntary AD&D.

Conversion: Employees have 31 days from the date of termination to convert the voluntary life insurance to an individual permanent life insurance policy without evidence of insurability. The premium will be based on Boston Mutual's usual rate for the insured's age on the date of conversion. Coverage will not include Waiver of Premium or Voluntary AD&D.

Waiver of Premium: If you become totally disabled prior to age 60 and remain totally disabled for the period stated in the policy, Boston Mutual will continue your insurance without any further payment of premiums subject to the provisions of the contract.

Accelerated Death Benefit: This provision enables an employee diagnosed and certified by a Doctor with a terminal illness, resulting in a life expectancy of twelve months or less, to receive a portion of the life insurance benefit prior to death. The remaining benefit will be paid to the beneficiary. To be eligible, the employee must have purchased at least $10,000 in voluntary life coverage.

Also Included: Education Benefit, Seat Belt Benefit, and Repatriation of Remains Benefit.

EXCLUSIONS

Under the AD&D coverage, benefits are not payable for losses caused by or contributed to by: intentionally self-inflicted injuries; suicide or attempted suicide; riot or war; diseases; ptomaine or bacterial infection; drug and/or alcohol abuse; commission of an assault or felony by an employee; accident while serving on active duty; travel or flight in any aircraft or device which can fly above the earth's surface *(does not apply to commercial flights);* or injury which occurred before the employee was insured by this policy. All exclusion details are stated in the master policy and certificate which may be reviewed through your benefits administrator.

This information is a summary of benefits; this summary is not your certificate nor does it constitute coverage for claim. Any discrepancies between this summary and the master policy will be resolved by the language issued in the master policy. For complete details of coverage and availability, please refer to your certificate or contact your benefits administrator.

BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891 -

FAMILY MATTERS. NO MATTER WHAT!

Group Long Term Disability Benefit Summary

Designed for the Employees of

Cape Cod Collaborative

ELIGIBILITY & BENEFIT FEATURES

Class 1: Full Time Active Employees except Drivers & Monitors

Coverage: 24 Hour

Elimination Period: 90 days

Approved benefits will be paid at the end of the Elimination Period or after the date STD payments end. *(whichever is greater)*

Your disability must continue through the elimination period before payments begin.

Maximum Payment Duration: Reducing Benefit Duration

Consult your benefits administrator or certificate of coverage for complete details of your benefit duration.

Maximum Monthly Benefit: 50 % of your Basic Monthly Earnings to a maximum of $5,000 with a minimum monthly benefit of $100 or 10% (whichever is greater).

COST OF COVERAGE

The premium for your coverage: is paid by you

ADDITIONAL FEATURES

Cost of Living Freeze: If you receive cost of living increases in any income from other sources, your benefit payment will not be further reduced.

Waiver of Premium: While you are disabled and receiving benefits, you will not be required to pay the monthly premium for your plan.

Survivor Benefit: If an insured dies after having been disabled for a minimum of 90 consecutive days and was receiving payments under the plan, the eligible survivor will be paid a one-time lump sum benefit. If there is no eligible survivor, payment will be made to the insured's estate. If there is no estate, no payment will be made.

Primary and Family Social Security Integration: The LTO benefit will be reduced by primary and family social security benefits and all other income benefits related to the disability such as Worker's Compensation.

Offsets at Time of Claim: Benefits may be reduced by payment under Worker's Compensation law, occupational disease law, or similar law, group insurance, SSA, state or Federal Disability, pension, salary or wage continuance plans and Federal old age benefits.

see other side

LIMITATIONS

Pre-existing Condition Limitation: This means that any disability caused by sickness or injury for which you have received treatment in the 12 months prior to your effective date of coverage will not be covered unless the disability began more than 12 months after your effective date of coverage.

We will pay benefits for up to 24 months if your disability is due to:
Mental Illness or Substance Abuse as defined in the master policy

Own Occupation Period: 2 Years
Payment will continue for the period specified above, if due to the same sickness or injury, you are unable to perform the material and substantial duties of your regular occupation.

EXCLUSIONS

We will not cover a disability if it is due to war, declared or not or any act of war; intentionally self-inflicted injuries, active participation in a riot, attempt to commit or commission of a felony under federal/state law.

No benefits are payable while incarcerated in a penal or correctional facility for a period of 30 or more consecutive days.

This coverage is not portable. If your employment is terminated, all coverage is terminated.

This information is a summary of benefits; this summary is not your certificate nor does it constitute coverage for claim. Any discrepancies between this summary and the master policy will be resolved by the language issued in the master policy. For complete details of coverage and availability, please refer to your certificate or contact your benefits administrator.

BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891 -

FAMILY MATTERS.NO MATTER WHAT.<>

Group Long Term Disability Benefit Summary

Designed for the Employees of

Cape Cod Collaborative

ELIGIBILITY & BENEFIT FEATURES

Class 1: All Full Time Active Drivers & Monitors

Coveraee: 24 Hour

Elimination Period: 90 days

Approved benefits will be paid at the end of the Elimination Period or after the date STD payments end. *(whichever is greater)*

Your disability must continue through the elimination period before payments begin.

Maximum Payment ouratjon: Reducing Benefit Duration

Consult your benefits administrator or certificate of coverage for complete details of your benefit duration.

Maximum Monthly Benefit: 50% of your Basic Monthly Earnings to a maximum of $5,000 with a minimum monthly benefit of $100 or 10% (whichever is greater).

COST OF COVERAGE

The premium for your coverage: is paid by you

ADDITIONAL FEATURES

Cost of Living Freeze: If you receive cost of living increases in any income from other sources, your benefit payment will not be further reduced.

Waiver of Premium: While you are disabled and receiving benefits, you will not be required to pay the monthly premium for your plan.

Survivor Benefit: If an insured dies after having been disabled for a minimum of 90 consecutive days and was receiving payments under the plan, the eligible survivor will be paid a one-time lump sum benefit. If there is no eligible survivor, payment will be made to the insured's estate. If there is no estate, no payment will be made.

Primary and Family Social Security Integration: The LTD benefit will be reduced by primary and family social security benefits and all other income benefits related to the disability such as Worker's Compensation.

Offsets at Time of Claim: Benefits may be reduced by payment under Worker's Compensation law, occupational disease law, or similar law, group insurance, SSA, state or Federal Disability, pension, salary or wage continuance plans and Federal old age benefits.

see other side

LIMITATIONS

Pre-existing Condition Limitation: This means that any disability caused by sickness or injury for which you have received treatment in the 12 months prior to your effective date of coverage will not be covered unless the disability began more than 12 months after your effective date of coverage.

We will pay benefits for up to 24 months if your disability is due to:
Mental Illness or Substance Abuse as defined in the master policy

Own Occupation Period: 2 Years
Payment will continue for the period specified above, if due to the same sickness or injury, you are unable to perform the material and substantial duties of your regular occupation.

EXCLUSIONS

We will not cover a disability if it is due to war, declared or not or any act of war; intentionally self-inflicted injuries, active participation in a riot, attempt to commit or commission of a felony under federal/state law.

No benefits are payable while incarcerated in a penal or correctional facility for a period of 30 or more consecutive days.

This coverage is not portable. If your employment is terminated, all coverage is terminated.

This information is a summary of benefits; this summary is not your certificate nor does it constitute coverage for claim. Any discrepancies between this summary and the master policy will be resolved by the language issued in the master policy. For complete details of coverage and availability, please refer to your certificate or contact your benefits administrator.

MEANINGFUL NOTICE / PLAN SUMMARY INFORMATION 2024

403(b) PLAN

The 403(b) Plan is a valuable retirement savings option. This notice provides a brief explanation of the provisions, policies and rules that govern the 403(b) Plan offered.

Plan administration services for the 403(b) plan are provided by U.S. OMNI & TSACG Compliance Services. Visit the U.S. OMNI & TSACG Compliance Services' website *(https://www.tsacg.com)* for information about enrollment in the plan, investment product providers available, distributions, enrollment, exchanges or transfers, 403(b) loans, and rollovers.

ELIGIBILITY

Most employees, with the exception of private contractors, appointed/elected trustees and/or school board members are eligible to participate in the 403(b) plan immediately upon employment. Please verify if your employer allows student workers to participate in the 403(b) plan. Eligible employees may make voluntary elective deferrals to the 403(b) plan. Participants are fully vested in their contributions and earnings at all times.

EMPLOYEE CONTRIBUTIONS

Upon enrollment, participants designate a portion of their salary that they wish to contribute to their traditional 403(b) account up to their maximum annual contribution amount on a pre-tax basis, thus reducing the participant's taxable income. Salary deferral contributions to the participant's 403(b) account are made from income paid through the employer's payroll system. Taxes on contributions and any earnings are deferred until the participant withdraws their funds.

The Internal Revenue Service regulations limit the amount participants may contribute annually to tax-advantaged retirement plans and imposes substantial penalties for violating contribution limits. U.S. OMNI & TSACG Compliance Services monitors 403(b) plan contributions and notifies the employer in the event of an excess contribution.

IE BASIC CONTRIBUTION LIMIT FOR 2024 IS $23,000.

Additional provisions allowed:

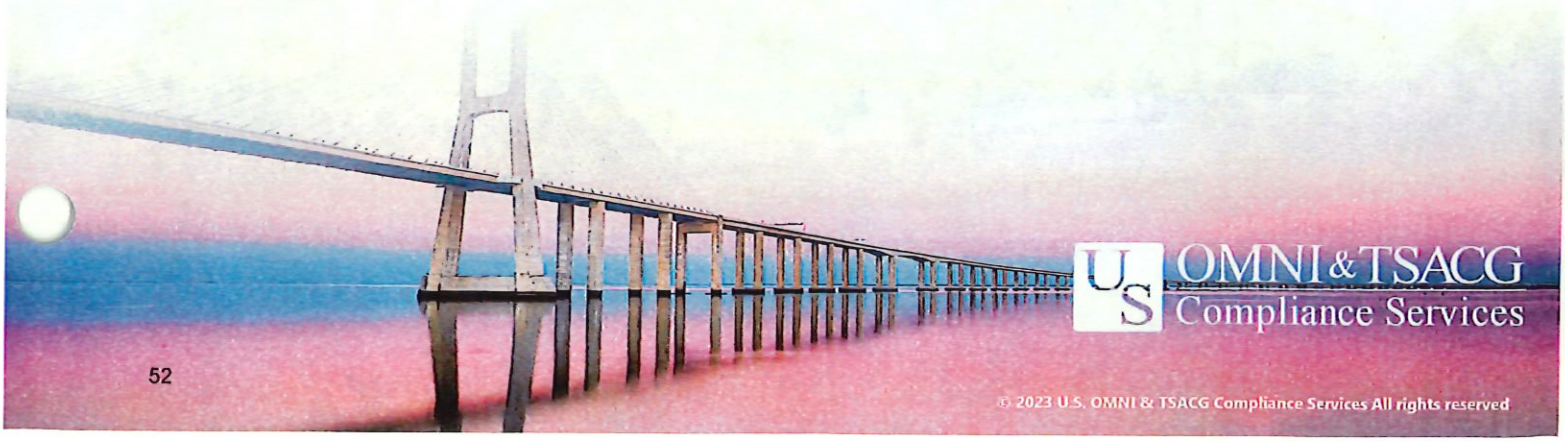
AGE-BASED ADDITIONAL AMOUNT

Participants who are age 50 or older any time during the year qualify to make an additional contribution of up to $7,500.

ENROLLMENT

Employees who wish to enroll in the employer's Supplemental 403(b) Retirement Plan must first select the provider and investment product best suited for their 403(b) account. Upon establishment of the account with the selected provider, a "Salary Reduction Agreement" (SRA) form and any disclosure forms must be completed and submitted to the employer. This form authorizes the employer to withhold 403(b) contributions from the employee's pay and send those funds to the Investment Provider on their behalf. A SRA must be completed to start, stop or modify contributions to a 403(b) account. Unless otherwise notified by your employer, you may enroll and/or make changes to your current contributions anytime throughout the year.

Please note: The total annual amount of a participant's contributions must not exceed the Maximum Allowable Contribution (MAC) calculation. For convenience, a MAC calculator is available at https://www.tsacg.com.



INVESTMENT PROVIDER INFORMATION

A current list of authorized 403(b) Investment Providers and current employer forms are available on the employer's specific Web page at *https://www.tsacg.com.*

PLAN DISTRIBUTION TRANSACTIONS

Distribution transactions may include any of the following depending on the employer's Plan Document: loans, transfers, rollovers, exchanges, hardships, unforeseen financial emergency withdrawals or distributions. Participants may request these distributions by completing the necess forms obtained from the provider and plan administrator as required. All completed forms should be submitted to the plan administrator processing.

PLAN-TO-PLAN TRANSFERS

A plan-to-plan transfer is defined as the movement of a 403(b) account from a previous plan sponsor's plan and retaining the same account with the authorized investment provider under the new plan sponsor's plan.

ROLLOVERS

Participants may move funds from one qualified plan account, i.e. 403(b) account, 401(k) account or an IRA, to another qualified plan account at age 59½ or when separated from service. Rollovers do not create a taxable event.

DISTRIBUTIONS

Retirement plan distributions are restricted by IRS regulations. A participant may not take a distribution of 403(b) plan accumulations unless they have attained age 59½ or separated from service in the year in which they turn 55 or older. In most cases, any withdrawals made from a 403(b) account are taxable in full as ordinary income.

EXCHANGES

Participants may exchange account accumulations from one 403(b) investment provider to another 403(b) investment provider that is authorized under the plan; however, there may be limitations affecting exchanges, and participants should be aware of any charges or penalties that may exist in individual investment contracts prior to exchange.

403(b) PLAN LOANS

Participants may be eligible to borrow their 403(b) plan accumulations depending on the provisions of their 403(b) account contract and provisions of the employer plan. If loans are available, they are generally granted for a term of five years or less (general-purpose loans). Loans taken to purchase a principal residence can extend the term beyond five years depending on the provisions of their 403(b) account contract and provisions of the employer. Details and terms of the loan are established by the provider. Participants must repay their loans through monthly payments as directed by the provider. Prior to taking a loan, participants should consult a tax advisor.

HARDSHIP WITHDRAWALS

Participants may be able to take a hardship withdrawal in the event of an immediate and heavy financial need. To be eligible for a hardship withdrawal according to IRS Safe Harbor regulations, you must verify and provide evidence that the distribution is being taken for specific reas These eligibility requirements to receive a Hardship withdrawal are provided on the Hardship Withdrawal Disclosure form at *https://www.tsacg.com*

EMPLOYEE INFORMATION STATEMENT

Participants in defined contribution plans are responsible for determining which, if any, investment vehicles best serve their retirement objectives. The 403(b) plan assets are invested solely in accordance with the participant's instructions. The participant should periodically review whether his/her objectives are being met, and if the objectives have changed, the participant should make the appropriate changes. Careful planning with a tax advisor or financial planner may help to ensure that the supplemental retirement savings plan meets the participant's objectives.

PLAN ADMINISTRATOR CONTACT INFORMATION

Transactions
P.O. Box 4037
Fort Walton Beach, FL 32549
Toll-free: 1-888-796-3786
https://www.tsacg.com

For overnight deliveries
73 Eglin Parkway NE, Suite 202
Fort Walton Beach, FL 32548
Toll-free: 1-888-796-3786
https://www.tsacg.com

Cape Cod Collaborative Deferred Compensation Plan Features and Highlights

Read these highlights to learn more about your Plan. If there are any discrepancies between this document and the Plan Document, the Plan Document will govern.

About the Governmental 457(b) Plan

A governmental 457(b) deferred compensation plan (457 Plan) is a retirement savings plan that allows eligible employees to supplement any existing retirement and pension benefits by saving and investing before-tax dollars through a voluntary salary contribution. Contributions and any earnings on contributions are tax-deferred until money is withdrawn. Distributions are subject to ordinary income tax.

Eligibility Requirements

To enroll in the Plan, employees must meet the following criteria:

- Age 21 or older
- No service requirement

Eligible employees may enroll immediately.

Please contact your Plan Administrator for information regarding excluded employees.

Enrollment

You may enroll by completing an Enrollment form and returning it to your Plan Administrator.

Contribution Limits

Before Tax

In 2024, the Before Tax amount is between 1% and 100% of your compensation or $23,000.00, whichever is less.

Special 457(b) catch-up contributions allow you for 3 years prior to normal retirement age to contribute the lesser of:

- Twice the annual limit, or
- The basic annual limit plus the amount of basic limit not used in prior years if not using age 50 or over catch-up contributions.

Roth

The Roth option will give you the flexibility to designate all or part of your Governmental 457(b) elective deferrals as Roth contributions.

Roth contributions are made with after-tax dollars, as opposed to the pre-tax dollars you contribute to a traditional Governmental 457(b). In other words, with the Roth option, you've already paid income taxes on money you contribute. With the traditional Governmental 457(b), your contribution is made on a pre-tax basis and you pay income taxes only when you take a distribution.

Investment Options[1]

A wide array of core investment options are available through your Plan. Each option is explained in further detail in your Plan's fund sheets. Once you have enrolled, investment option information is also available through the website at empowermyretirement.com or call the Voice Response System toll free at 1-888-672-7240. The website and the Voice Response System are available to you 24 hours a day, 7 days a week.

[1]Prospectuses, disclosure documents and investment-related options/services information are only available in English. Please have them translated prior to investing.

Transfers and Allocation Changes[1]

You can move all or a portion of your existing balances between investment options (subject to Plan rules) and change how your payroll contributions are invested.

[1]Transaction requests received in good order after the close of the New York Stock Exchange will be processed the next business day.

Rollovers[1]

Only Plan Administrator approved balances from an eligible governmental 457(b), 401(k), 403(b) or 401(a) plan or an Individual Retirement Account (IRA) may be rolled over to the Plan. Some plans may only allow rollovers from other Governmental 457(b) plans.

[1]Governmental 457 funds rolled into another type of plan or account may become subject to the 10% early withdrawal penalty if taken before age 59 1/2.

Withdrawals

Qualifying distribution events are as follows:

- Retirement
- Permanent disability
- Unforseeable emergency (as defined by the Internal Revenue Code and if allowed by your Plan's provisions)
- Severance of employment (as defined by the Internal Revenue Code provisions)
- Death (your beneficiary receives your benefits)

Ordinary income tax will apply to each distribution. Distributions received prior to age 59 1/2 from money sources other than Governmental 457(b) money sources may also be assessed a 10% early withdrawal federal tax penalty. Refer to your Summary Plan Description for more information about distributions.

Any transaction related fees will be disclosed during the withdrawal process.

Plan Fees

Distribution Fees

The benefit disbursement fee is $0.00.

Investment Option Fees

Each investment option has an investment management fee that varies by investment option. These fees are deducted by each investment option's management company before the daily price or performance is calculated. Fees pay for trading of securities within the investment option and other management expenses.

Funds may impose redemption fees on certain transfers, redemptions or exchanges.

Empower SecureFoundation® Guarantee Benefit Fee

The Empower SecureFoundation® Guarantee Benefit fee is in addition to the fees and expenses of the Plan. For more important information regarding the Empower SecureFoundation® option, including product specifics and fees, refer to the Empower SecureFoundation® Summary Disclosure Statement attached to the Enrollment form and located on your Plan's website.

Empower Advisory Services

Your Plan offers a service called Empower Advisory Services. You can have Empower Advisory Group, LLC, a registered investment adviser, manage your retirement account for you. Or, if you prefer to manage your retirement account on your own, you can use the Online Advice tool. These services help create a personalized retirement strategy for you.There is no guarantee provided by any party that participation in any of the advisory services will result in a profit.

For more detailed information about these services, including any applicable fees, visit your Plan's website at empowermyretirement.com or call the Voice Response System, toll free at 1-888-672-7240.

How do I get more information?

Visit the website at empowermyretirement.com or call the Voice Response System, toll free at 1-888-672-7240 for more information. The website provides information regarding your Plan, as well as financial education information, financial calculators and other tools to help you manage your account.