



2026-2027

Benefits Handbook

Table of Contents

Employee Benefits Summary	1
Section 12 5 Pre-Tax Premium Program	4
2025-2026 Employee Portion of Benefits (Payroll Deduction Calculations)	5
Blue Cross Blue Shield Network Blue Plan Summary	6
Blue Cross Blue Shield Access Blue New England Saver Plan Summary	10
Harvard Pilgrim HMO Plan Summary	14
Harvard Pilgrim Best Buy HSA HMO Plan Summary	22
Delta Dental PPO Plus Premier Plan Summary	30
EyeMed Vision Plan	32
Flexible Spending Account (FSA)	36
Health Savings Account (HSA)	38
Boston Mutual Basic Group Life Insurance Summary	40
Boston Mutual Voluntary Life Benefit Summary	42
Boston Mutual Voluntary Long Term Disability Benefit Summary	43
Boston Mutual Portal Whole Life Insurance	44
Boston Mutual Portal Critical Illness (Cancer Benefit)	45
Boston Mutual Portal Group Accident Coverage	48
Employee Assistance Program (EAP)	50
CANARX Program	52
Diabetes Care Rewards Program	55
Pinnacle Care - health advocacy and care navigation	57
COBRA Notice	5
Retirement Savings Options 403(b) Retirement Plan Cape Cod Collaborative Deferred Compensation Plan	62
School Calendar 2025-2026	66



BENEFIT ELIGIBILITY

Employees who regularly work 20+ hours per week are benefit eligible.

EMPLOYER CONTRIBUTION

The Collaborative contributes 65% of the cost for health, dental, and group life coverage. Employees are responsible for 35% 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 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 INSURANCE

The Collaborative offers health, dental, and vision 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, and Wellness programs.

HEALTH INSURANCE OPTIONS

HMO PLANS	HSA 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

Coverage is provided by **Delta Dental PPO Plus Premier**. Delta Dental members can take advantage of expended discounts on many services covered. Get the details here:

<https://www.deltadentalma.com/Members/Discounts-on-Covered-Services>

EYEMED INSURANCE

Coverage is provided by **EyeMed Vision Plan**. EyeMed Vision Plan is a **100% employee contribution**. Get more information here:

<https://www.eyesiteonwellness.com/eyemed/en/post/understanding-your-benefits>

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

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 pay 65% of premium	Employees pay full premium	Employees pay full premium
Paid through pre-tax payroll deduction	Paid through after-tax payroll deductions	Paid through after-tax payroll deductions

PORTAL INSURANCE PLANS

Boston Mutual Life Insurance Company

ECIP	ELOP	GAC
Employee Critical Illness Plan	Whole Life Insurance	Group Accident Coverage
Employees pay full premium	Employees pay full premium	Employees pay full premium
Paid through after-tax payroll deductions	Paid through after-tax payroll deductions	Paid through after-tax payroll deductions

COBRA

Coverage that allows employees and their families to continue their group health insurance coverage after a qualifying event such as: *Job Loss, Reduction in work hours, Divorce or legal separation*. Coverage can last 18 to 36 months, depending on the situation. Additional information can be found here:

<https://www.dol.gov/general/topic/health-plans/cobra>

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. 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.

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. The employee contribution is n% of gross income. 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 have to 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.



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 employer's Section 125 plan is an annual plan. You enroll initially 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.

2026-2027 Health Insurance Rates**

	Pay Options -			Per Pay Period		ADMIN
	21 Pay Periods			26 Weeks	19 Pay Periods	26 Weeks
Single	Total Premium	35% EE Share	21 coverage to June 30 th	Coverage through August 31 st	Weekly Rate coverage to June 30 th	coverage to June 30 th
Network Blue HMO	1,176.00	411.60	196.00	192.50	216.63	189.97
HPHC HMO	1,156.00	404.60	192.67	189.23	212.95	186.74
HMO New England Saver (BCBS)	966.00	338.10	161.00	158.13	177.95	156.05
HPHC Best Buy HMO***	895.00	223.75	106.55	104.65	117.76	103.27
Dental Contributory	40.00	14.00	6.67	6.55	7.37	6.46
Boston Mutual (Employee Only)	1.70	0.60	0.28	0.27	0.31	0.27
Parent & One Child	Total Premium	EE Share		Deduction		Deduction
Network Blue HMO	2,372.00	830.20	395.33	388.28	436.95	383.17
HPHC HMO	2,313.00	809.55	385.50	378.62	426.08	373.64
HMO New England Saver (BCBS)	1,950.00	682.50	325.00	319.20	359.21	315.00
HPHC Best Buy HMO	1,815.00	635.25	302.50	297.10	334.34	293.19
Dental Contributory	79.00	27.65	13.17	12.93	14.55	12.76
Boston Mutual (Employee Only)	1.70	0.60	0.28	0.27	0.31	0.27
Family	Total Premium	EE Share		Deduction		Deduction
Network Blue HMO	3,156.00	1,104.60	526.00	516.61	581.37	509.82
HPHC HMO	3,094.00	1,082.90	515.67	506.46	569.95	499.80
HMO New England Saver (BCBS)	2,591.00	906.85	431.83	424.13	477.29	418.55
HPHC Best Buy HMO	2,408.00	842.80	401.33	394.17	443.58	388.98
Dental Contributory	103.00	36.05	17.17	16.86	18.97	16.64
Boston Mutual (Employee Only)	1.70	0.60	0.28	0.27	0.31	0.27

EyeMed Vision Plan

Individual Voluntary

EyeMed Vision Voluntary**

Individual + One Voluntary

EyeMed Vision Voluntary**

Family Voluntary

EyeMed Vision Voluntary**

* Rates reflect a 8% increase effective July. 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 fiscal year coverage 7/1/26 -6/30/27

*** 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 the remaining 25%.

NETWORK BLUE[®] NEW ENGLAND \$300 DEDUCTIBLE

Cape Cod Municipal
Health Group

Plan-Year Deductible: \$300/\$900

TAP INTO YOUR HEALTH PLAN

MyBlue is your online member account that makes understanding and using your health plan simple.



Track claims
and benefits



Find personalized
care options



View your
member ID card

Get started

Sign in or create an account today. Download the app or visit bluecrossma.org.



This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

YOUR CARE

Your Primary Care Provider (PCP)

When you enroll in this health plan, you must choose a primary care provider. Be sure to choose a PCP who can accept you and your family members and who participates in the network of providers in New England. For children, you may choose a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYN physicians, visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.org; consult Find a Doctor at bluecrossma.com/findadoctor; or call the Member Service number on your ID card.

If you have trouble choosing a doctor, Member Service can help. They can give you the doctor's gender, the medical school the doctor attended, and whether there are languages other than English spoken in the office.

Referrals

Your PCP is the first person you call when you need routine or sick care. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is likely affiliated with your PCP's hospital or medical group.

You will not need prior authorization or referral to see an HMO Blue New England network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield of Massachusetts regarding referrals and Utilization Review Requirements, including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see your benefit description.

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for certain benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **\$300** per member (or **\$900** per family).

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is **\$2,000** per member (or **\$4,000** per family). Your out-of-pocket maximum for prescription drug benefits is **\$3,000** per member (or **\$6,000** per family).

Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). After meeting your deductible, you pay a copayment per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services

Telehealth services are covered when the same in-person service would be covered by the health plan and the use of telehealth is appropriate. Your health care provider will work with you to determine if a telehealth visit is medically appropriate for your health care needs or if an in-person visit is required. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.org, consult Find a Doctor, or call the Member Service number on your ID card.

Your Virtual Care Team

Your health plan includes an option for a tech-enabled primary care delivery model where virtual care team covered providers furnish certain covered services. See your benefit description (and riders, if any) for exact coverage details.

Service Area

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine.

When Outside the Service Area

If you are traveling outside the service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. See your benefit description for more information.

Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your benefit description (and riders, if any) for exact coverage details.

Covered Services	Your Cost
Preventive Care	
Well-child care exams	Nothing, no deductible
Preventive dental care for children under age 12 (one visit each six months)	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Mental health wellness exams (at least one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to \$2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum, no deductible
Routine vision exams (one every 12 months)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
Outpatient Care	
Emergency room visits	\$100 per visit after deductible (copayment waived if admitted or for an observation stay)
Office or health center visits, when performed by:	
• Your PCP, OB/GYN physician, nurse midwife, limited services clinic, or by a physician assistant or nurse practitioner designated as primary care	\$20 per visit, no deductible
• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	\$45 per visit, no deductible
Mental health or substance use treatment	\$20 per visit, no deductible
Outpatient telehealth services	
• With a covered provider	Same as in-person visit
• With the designated telehealth vendor	\$20 per visit, no deductible
Acupuncture visits (up to 12 visits per calendar year)	\$45 per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$20 per visit, no deductible
Speech, hearing, and language disorder treatment—speech therapy	\$20 per visit, no deductible
Diagnostic x-rays and lab tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	\$100 per category per service date after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance after deductible**
Prosthetic devices	20% coinsurance after deductible
Surgery and related anesthesia in an office or health center, when performed by:	
• Your PCP, OB/GYN physician, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care	\$20 per visit***, no deductible
• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	\$45 per visit***, no deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$250 per admission after deductible
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	\$500 per admission after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	\$500 per admission after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders or Down syndrome.

** Cost share waived for one breast pump per birth, including supplies.

*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

Covered Services	Your Cost
Prescription Drug Benefits*	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	No deductible \$10 for Tier 1 \$30 for Tier 2 \$65 for Tier 3
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	No deductible \$25 for Tier 1 \$75 for Tier 2 \$165 for Tier 3
<p>* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.</p> <p>** Cost share may be waived, reduced, or increased for certain covered drugs and supplies.</p>	
<p>Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.</p>	
Wellness Participation Program	
Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.)	\$200 per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.)	\$200 per calendar year per policy
<p> 24/7 Nurse Line: Speak to a registered nurse, day or night, to get immediate guidance and advice. Call 1-888-247-BLUE (2583). No additional charge.</p>	

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at bluecrossma.org.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: chiropractors' office visits cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders. Note: Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

BLUE CARE ELECT SAVER

Cape Cod Municipal
Health Group

Plan-Year Deductible: \$2,000/\$4,000

TAP INTO YOUR HEALTH PLAN

MyBlue is your online member account that makes understanding and using your health plan simple.



Track claims
and benefits



Find personalized
care options



View your
member ID card

Get started

Sign in or create an account today. Download the app or visit bluecrossma.org.



This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

YOUR CHOICE

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for certain benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductibles are **\$2,000** per individual membership (or **\$4,000** per family membership) for in-network services and **\$2,000** per individual membership (or **\$4,000** per family membership) for out-of-network services. **The entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership.** Any amount applied toward the in-network deductible will also be applied toward the out-of-network deductible (and vice versa).

When You Choose Preferred Providers

You receive the highest level of benefits under your health care plan when you obtain covered services from preferred providers. These are called your “in-network” benefits. See the charts for your cost share.

Note: If a preferred provider refers you to another provider for covered services (such as a lab or specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you use is not a preferred provider, you are still covered, but your benefits, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you.

How to Find a Preferred Provider

To find a preferred provider:

- Look up a provider on Find a Doctor at bluecrossma.com/findadoctor. If you need a copy of your directory or help choosing a provider, call the Member Service number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.org

When You Choose Non-Preferred Providers

You can also obtain covered services from non-preferred providers, but your out-of-pocket costs are higher. These are called your “out-of-network” benefits. See the charts for your cost share.

Payments for out-of-network benefits are based on the Blue Cross Blue Shield allowed charge as defined in your benefit description. You may be responsible for any difference between the allowed charge and the provider's actual billed charge (this is in addition to your deductible and/or your coinsurance).

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical and prescription drug benefits is **\$5,000** per member (or **\$10,000** per family) for in-network and out-of-network services combined.

Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). After meeting your in-network deductible, you pay nothing for in-network or out-of-network emergency room services.

Telehealth Services

Telehealth services are covered when the same in-person service would be covered by the health plan and the use of telehealth is appropriate. Your health care provider will work with you to determine if a telehealth visit is medically appropriate for your health care needs or if an in-person visit is required. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.org, consult Find a Doctor, or call the Member Service number on your ID card.

Your Virtual Care Team

Your health plan includes an option for a tech-enabled primary care delivery model where virtual care team covered providers furnish certain covered services. See your benefit description (and riders, if any) for exact coverage details.

Utilization Review Requirements

Certain services require **pre-approval/prior authorization** through Blue Cross Blue Shield of Massachusetts for you to have benefit coverage; this includes non-emergency and non-maternity hospitalization and may include certain outpatient services, therapies, procedures, and drugs. You should work with your health care provider to determine if pre-approval is required for any service your provider is suggesting. If your provider, or you, don't get pre-approval when it's required, your benefits will be denied, and you may be fully responsible for payment to the provider of the service. Refer to your benefit description for requirements and the process you should follow for Utilization Review, including Pre-Admission Review, Pre-Service Approval, Concurrent Review and Discharge Planning, and Individual Case Management.

Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your benefit description (and riders, if any) for exact coverage details.

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Preventive Care		
Well-child care exams, including routine tests, according to age-based schedule as follows: <ul style="list-style-type: none"> • Ten visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year for age 3 and older 	Nothing, no deductible	20% coinsurance, no deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing, no deductible	20% coinsurance, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance, no deductible
Mental health wellness exams (at least one per calendar year)	Nothing, no deductible	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance, no deductible
Hearing aids (up to \$2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum after deductible	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one per calendar year)	Nothing, no deductible	20% coinsurance, no deductible
Family planning services—office visits	Nothing, no deductible	20% coinsurance, no deductible
Outpatient Care		
Emergency room visits	Nothing after deductible	Nothing after in-network deductible
Office or health center visits	Nothing after deductible	20% coinsurance after deductible
Mental health or substance use treatment	Nothing after deductible	20% coinsurance after deductible
Outpatient telehealth services <ul style="list-style-type: none"> • With a covered provider • With the in-network designated telehealth vendor 	Same as in-person visit Nothing after deductible	Same as in-person visit Only applicable in-network
Chiropractors' office visits	Nothing after deductible	20% coinsurance after deductible
Acupuncture visits (up to 12 visits per calendar year)	Nothing after deductible	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	Nothing after deductible	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	Nothing after deductible	20% coinsurance after deductible
Diagnostic x-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing after deductible	20% coinsurance after deductible
Home health care and hospice services	Nothing after deductible	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	Nothing after deductible**	20% coinsurance after deductible
Prosthetic devices	Nothing after deductible	20% coinsurance after deductible
Surgery and related anesthesia	Nothing after deductible	20% coinsurance after deductible
Inpatient Care (including maternity care)		
General or chronic disease hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible	20% coinsurance after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders or Down syndrome.

** Cost share waived for one breast pump per birth, including supplies.

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Prescription Drug Benefits*		
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	After deductible \$10 for Tier 1 \$30 for Tier 2 \$65 for Tier 3	After deductible \$20 for Tier 1 \$60 for Tier 2 \$130 for Tier 3
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	After deductible \$25 for Tier 1 \$75 for Tier 2 \$165 for Tier 3	Not covered

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.
 ** Cost share may be waived, reduced, or increased for certain covered drugs and supplies.

Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

Wellness Participation Program	
Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.)	\$200 per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.)	\$200 per calendar year per policy

 **24/7 Nurse Line:** Speak to a registered nurse, day or night, to get immediate guidance and advice. Call 1-888-247-BLUE (2583). No additional charge.

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at bluecrossma.org.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders. **Note:** Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

Schedule of Benefits

THE HARVARD PILGRIM HMO MASSACHUSETTS

This Schedule of Benefits states any Benefit Limits and the Member Cost Sharing amounts you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook for details. Your Member Cost Sharing may include a Deductible, Coinsurance, and Copayments. Please see the tables below for details.

In a Medical Emergency you should go to the nearest emergency facility or call 911 or other local emergency access number. A Referral from your PCP is not needed. Your emergency room Member Cost Sharing is listed in the tables below.

Medical Necessity Guidelines

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our Medical Necessity Guidelines on our website at www.harvardpilgrim.org or by calling the Member Services Department at 1-888-333-4742.

Office Visit Cost Sharing Levels

Office visit cost sharing may include Copayments, Coinsurance, or Deductible amounts, as described throughout this Schedule of Benefits. There are two types of office visit cost sharing that apply to your Plan: a lower cost sharing, known as "Level 1," and a higher cost sharing known as "Level 2."

Level 1 applies to covered outpatient professional services received from the following types of providers: all Primary Care Providers (PCPs); obstetricians and gynecologists; Licensed Mental Health Professionals; certified nurse midwives; and nurse practitioners who bill independently.

Level 2 applies to covered outpatient professional services received from specialty care providers.

Your Plan may have other cost sharing amounts. Please see the benefit table below for specific cost sharing requirements.

Covered Benefits

Your Covered Benefits are administered on a Plan Year basis. Your Plan Year begins on your Employer's Anniversary Date. Please see your Benefit Handbook for more details. If you do not know your Employer's Anniversary Date, please contact your Employer's benefits office or call the Member Services Department at 1-888-333-4742.

Your Member Cost Sharing will depend upon the type of service provided and the location the service is provided in, as listed in this Schedule of Benefits. For example, for services provided in a physician's office, see "Physician and Other Professional Office Visits." For services provided in a hospital emergency room, see "Emergency Room Care." For inpatient hospital care, see "Hospital – Inpatient Services," and for outpatient surgical procedures, please see "Surgery - Outpatient."

When you receive a service at your home (other than home health care), your Member Cost Sharing will be the same as when the service is provided in an office or facility. For example, if you have a physician visit in your home, see "Physician and Other Professional Office Visits." If you have blood drawn at home, see "Laboratory, Radiology and Other Diagnostic Services."

EFFECTIVE DATE: 01/01/2025

THE HARVARD PILGRIM HMO - MASSACHUSETTS

General Cost Sharing Features:		Member Cost Sharing:
Coinsurance and Copayments		
		See the benefits table below
Deductible		
The following Deductibles apply to all services except where specifically noted below.		\$300 per Member per Plan Year \$900 per family per Plan Year
Deductible Rollover		
		None
Out-of-Pocket Maximum		
Includes all Member Cost Sharing except Member Cost Sharing for prescription drugs, which has a separate Out-of-Pocket Maximum		\$2,000 per Member per Plan Year \$4,000 per family per Plan Year

Benefit	Member Cost Sharing:
Acupuncture Treatment	
	Not covered
Ambulance and Medical Transport	
Emergency ambulance transport	Deductible, then no charge
Non-emergency medical transport	Deductible, then no charge
Autism Spectrum Disorders Treatment	
Applied behavior analysis	\$20 Copayment per visit
Chemotherapy and Radiation Therapy	
Chemotherapy	No charge
Radiation therapy	No charge
COVID-19 Services	
COVID-19 Testing	No charge
COVID-19 testing is covered without the use of Prior Approval processes when Medically Necessary and provided by either Plan or Non-Plan Providers.	
COVID-19 Treatment	No charge
COVID-19 treatment is covered without the use of Prior Approval processes when Medically Necessary and provided by either Plan or Non-Plan Providers.	
COVID-19 Vaccines	No charge

THE HARVARD PILGRIM HMO - MASSACHUSETTS

Benefit		Member Cost Sharing:
Dental Services		
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.		
Extraction of teeth impacted in bone (performed in a physician's office)		\$45 Copayment per visit
Pediatric Dental Care for children (up to the age of 13) – limited to 2 preventive dental exams per Plan Year		No charge
Dialysis		
		Deductible, then no charge
Installation of home equipment is covered up to \$300 in a Member's lifetime.		No charge
Durable Medical Equipment		
Durable medical equipment		Deductible, then 20% Coinsurance in equipment cost to HPHC, not to exceed a Member's total expense of \$1,000
Blood glucose monitors, infusion devices and insulin pumps (including supplies)		No charge
Oxygen and respiratory equipment		No charge
Early Intervention Services		
		No charge
The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.		
Emergency Room Care		
		Deductible, then \$100 Copayment per visit
This Copayment is waived if you are (1) transferred to either Observation Services or Outpatient Surgery or (2) admitted to the hospital directly from the emergency room. Please see "Hospital - Inpatient Services," "Observation Services," or "Surgery – Outpatient" for the Member Cost Sharing that applies to these benefits.		
Fertility Services (see the Benefit Handbook for details)		
		\$20 Copayment per visit
Gender Affirming Services		
		Your Member Cost Sharing will depend upon the type of service provided and the location the service is provided in, as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery – Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."
Hearing Aids (for Members up to the age of 22)		
– Limited to \$2,000 per hearing aid every 36 months, for each hearing impaired ear		No charge
Home Health Care		
		Deductible, then no charge
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.		

THE HARVARD PILGRIM HMO - MASSACHUSETTS

Benefit		Member Cost Sharing:
Hospice – Outpatient		
		Deductible, then no charge
Hospital – Inpatient Services		
Acute hospital care		Deductible, then \$500 Copayment per admission
Inpatient maternity care		Deductible, then \$500 Copayment per admission
Inpatient routine nursery care		No charge
Inpatient rehabilitation – limited to 60 days per Plan Year		Deductible, then \$500 Copayment per admission
Skilled nursing facility – limited to 100 days per Plan Year		Deductible, then \$500 Copayment per admission
Infertility Treatment (see the Benefit Handbook for details)		
		\$20 Copayment per visit
Laboratory, Radiology and Other Diagnostic Services		
Laboratory		Deductible, then no charge
Genetic testing		Deductible, then no charge
Radiology		Deductible, then no charge
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services		Deductible, then \$100 Copayment per procedure
Other diagnostic services		Deductible, then no charge
Low Protein Foods		
– Limited to \$5,000 per Plan Year		Deductible, then no charge
Maternity Care - Outpatient		
Routine outpatient prenatal and postpartum care		No charge The Deductible does not apply to prenatal and postpartum care provided in a physician's office. All other care is covered as stated in this Schedule of Benefits.
Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, Member Cost Sharing for services provided by a specialist is listed under "Physician and Other Professional Office Visits" and when not specifically listed above, Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under "Laboratory, Radiology and Other Diagnostic Services."		
Medical Drugs (drugs that cannot be self-administered)		
Medical drugs received in a physician's office or other outpatient facility		No charge
Medical drugs received in the home		No charge
Some Medical Drugs may be supplied by a specialty pharmacy. When Medical Drugs are supplied by a specialty pharmacy, the Member Cost Sharing listed above will apply.		
Medical Formulas		
		Deductible, then no charge

Benefit		Member Cost Sharing:
Mental Health and Substance Use Disorder Treatment		
Inpatient services	Deductible, then \$500 Copayment per admission	
Intermediate care services – Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs	Deductible, then no charge	
Annual mental health wellness examination performed by a licensed mental health professional. Please Note: Your annual mental health wellness examination may also be provided by a PCP as part of your annual routine examination for preventive care.	No charge	
Outpatient group therapy	\$10 Copayment per visit	
Outpatient individual therapy	\$20 Copayment per visit	
Outpatient treatment, including outpatient detoxification and medication management	\$20 Copayment per visit	
Outpatient methadone maintenance	No charge	
Outpatient psychological testing and neuropsychological assessment	Deductible, then no charge	
Outpatient telemedicine virtual visit – group therapy	\$10 Copayment per visit	
Outpatient telemedicine virtual visit services – including individual therapy, detoxification, and medication management	\$20 Copayment per visit	
Observation Services		
	No charge	
Ostomy Supplies		
	Same as Durable medical equipment	
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits)		
Routine examinations for preventive care, including immunizations	No charge	
Not all services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services Notice on our		

(Continued on next page)

Benefit		Member Cost Sharing:	
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits) (Continued)			
website at www.harvardpilgrim.org . Please see "Laboratory, Radiology and Other Diagnostic Services" for the Member Cost Sharing that applies to diagnostic services not included on this list.			
Consultations, evaluations, sickness and injury care		Level 1: \$20 Copayment per visit Level 2: \$45 Copayment per visit	
Cost sharing level varies depending on the type of provider. Please refer to the beginning of this Schedule of Benefits to determine which cost sharing level applies.			
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you need sutures, please refer to office based treatments and procedures below. If you need an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."			
Office based treatments and procedures, including, but not limited to administration of injections, casting, suturing and the application of dressings, genetic counseling, non-routine foot care, and surgical procedures		No charge	
Administration of allergy injections		No charge	
Preventive Services and Tests			
		No charge	
Under federal and state law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies, certain labs and x-rays, voluntary sterilization for women, and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services Notice on our website at www.harvardpilgrim.org . You may also get a copy of the Preventive Services Notice by calling the Member Services Department at 1-888-333-4742. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with federal and state guidance.			
Prosthetic Devices			
		Same as Durable medical equipment	
Rehabilitation and Habilitation Services - Outpatient			
Cardiac rehabilitation		Deductible, then no charge	
Pulmonary rehabilitation therapy		\$20 Copayment per visit	
Speech-language and hearing services		\$20 Copayment per visit	
Occupational therapy – limited to 30 visits per Plan Year Physical therapy – limited to 30 visits per Plan Year		\$20 Copayment per visit	
Outpatient physical and occupational therapy is not subject to the limit listed above and is covered to the extent Medically Necessary for: (1) children under the age of three and (2) the treatment of Autism Spectrum Disorders.			
Scopic Procedures - Outpatient Diagnostic and Therapeutic			
Colonoscopy, endoscopy and sigmoidoscopy		Deductible, then \$250 Copayment per visit	
Spinal Manipulative Therapy (including care by a chiropractor)			
		Not covered	
Surgery – Outpatient			
		Deductible, then \$250 Copayment per visit	

THE HARVARD PILGRIM HMO - MASSACHUSETTS

Benefit	Member Cost Sharing:
Telemedicine Virtual Visit Services - Outpatient	
	Level 1: \$20 Copayment per visit Level 2: \$45 Copayment per visit
For inpatient hospital care, see "Hospital — Inpatient Services" for cost sharing details.	
Travel Reimbursement Benefit	
See the Benefit Handbook for details	Not covered
Urgent Care Services	
Doctor On Demand	\$20 Copayment per visit
Important Note: Doctor On Demand is a specific network of providers contracted to provide virtual Urgent Care services. For more information on Doctor On Demand, including how to access them, please visit our website at www.harvardpilgrim.org .	
Convenience care clinic	\$20 Copayment per visit
Urgent care center	\$45 Copayment per visit
Hospital urgent care center	\$45 Copayment per visit
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefit. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."	
Vision Services	
Routine eye examinations – limited to 1 exam per Plan Year	No charge
Vision hardware for special conditions	Deductible, then no charge
Voluntary Sterilization in a Physician's Office	
	\$20 Copayment per visit
Voluntary Termination of Pregnancy	
	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery – Outpatient." For services provided in a physician's office, see "Office based treatments and procedures." For inpatient hospital care, see "Hospital –Inpatient Services." No charge
Wigs and Scalp Hair Protheses as required by law	
	No charge

Schedule of Benefits

THE HARVARD PILGRIM BEST BUY HSA HMO MASSACHUSETTS

This Schedule of Benefits states any Benefit Limits and Member Cost Sharing amounts you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook for details. Your Member Cost Sharing may include a Deductible, Coinsurance, and Copayments. Please see the tables below for details.

In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency access number. A Referral from your PCP is not needed. Your emergency room Member Cost Sharing is listed in the tables below.

Medical Necessity Guidelines

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our Medical Necessity Guidelines on our website at www.harvardpilgrim.org or by calling the Member Services Department at 1-888-333-4742.

Covered Benefits

Your Covered Benefits are administered on a Plan Year basis. Your Plan Year begins on your Employer's Anniversary Date. Please see your Benefit Handbook for more details. If you do not know your Employer's Anniversary Date, please contact your Employer's benefits office or call the Member Services Department at 1-888-333-4742.

Your Member Cost Sharing will depend upon the type of service provided and the location the service is provided in, as listed in this Schedule of Benefits. For example, for services provided in a physician's office, see "Physician and Other Professional Office Visits." For services provided in a hospital emergency room, see "Emergency Room Care." For inpatient hospital care, see "Hospital – Inpatient Services," and for outpatient surgical procedures, please see "Surgery - Outpatient."

When you receive a service at your home (other than home health care), your Member Cost Sharing will be the same as when the service is provided in an office or facility. For example, if you have a physician visit in your home, see "Physician and Other Professional Office Visits." If you have blood drawn at home, see "Laboratory, Radiology and Other Diagnostic Services."

General Cost Sharing Features:		Member Cost Sharing:	
Coinsurance and Copayments		See the benefits table below	
Deductible			
The following Deductibles apply to all services except where specifically noted below.		\$2,000 for Individual Coverage per Plan Year \$4,000 for Family Coverage per Plan Year	

EFFECTIVE DATE: 01/01/2025

General Cost Sharing Features:		Member Cost Sharing:
Deductible (Continued)		
<p>Important Notice: If you have Individual Coverage, the Individual Coverage Deductible applies (the Family Coverage Deductible will never apply). If you have Family Coverage, the Family Coverage Deductible may be met by any combination of covered family Members (the Individual Coverage Deductible will never apply).</p> <p>Once a Deductible is met, coverage by the Plan is subject to any other Member Cost sharing that may apply.</p>		
Out-of-Pocket Maximum		
Includes all Member Cost Sharing	<p>\$5,000 for Individual Coverage per Plan Year \$10,000 for Family Coverage per Plan Year – with a \$5,000 embedded individual Out-of-Pocket Maximum per Plan Year</p>	
<p>Important Notice: If you have Individual Coverage, the Individual Coverage Out-of-Pocket Maximum applies (the Family Coverage Out-of-Pocket Maximum will never apply). If you have Family Coverage, the Family Coverage Out-of-Pocket Maximum can be satisfied in one of two ways:</p> <p>a. If a Member of a covered family meets the embedded individual Out-of-Pocket Maximum, then that Member has no additional Member Cost Sharing for the remainder of the Plan Year.</p> <p>b. If any number of Members in a covered family collectively meet the Family Coverage Out-of-Pocket Maximum, then all Members of the covered family have no additional Member Cost Sharing for the remainder of the Plan Year. No one family member may contribute more than the embedded individual Out-of-Pocket Maximum amount toward the Family Coverage Out-of-Pocket Maximum.</p>		

Benefit	Your Cost Sharing
Acupuncture Treatment	
	Not covered
Ambulance and Medical Transport	
Emergency ambulance transport	Deductible, then no charge
Non-emergency medical transport	Deductible, then no charge
Autism Spectrum Disorders Treatment	
Applied behavior analysis	Deductible, then no charge
Chemotherapy and Radiation Therapy	
Chemotherapy	Deductible, then no charge
Radiation therapy	Deductible, then no charge
COVID-19 Services	
COVID-19 Testing	Deductible, then no charge
COVID-19 Treatment	Deductible, then no charge
COVID-19 Vaccines	No charge
Dental Services	
<p>Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.</p>	
Extraction of teeth impacted in bone (performed in a physician's office)	Deductible, then no charge
Pediatric Dental Care for children (up to the age of 13) – limited to 2 preventive dental exams per Plan Year	Deductible, then no charge

THE HARVARD PILGRIM BEST BUY HSA HMO - MASSACHUSETTS

Benefit	Your Cost Sharing
Dialysis	
	Deductible, then no charge
Installation of home equipment	Deductible, then no charge
Durable Medical Equipment	
Durable medical equipment	Deductible, then no charge
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	Deductible, then no charge
Oxygen and respiratory equipment	Deductible, then no charge
Early Intervention Services	
	Deductible, then no charge
The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.	
Emergency Room Care	
	Deductible, then no charge
Fertility Services (see the Benefit Handbook for details)	
	Deductible, then no charge
Gender Affirming Services	
	Your Member Cost Sharing will depend upon the type of service provided and the location the service is provided in, as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery – Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."
Hearing Aids (for Members up to the age of 22)	
– Limited to \$2,000 per hearing aid every 36 months, for each hearing impaired ear	Deductible, then no charge
Home Health Care	
	Deductible, then no charge
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.	
Hospice – Outpatient	
	Deductible, then no charge
Hospital – Inpatient Services	
Acute hospital care	Deductible, then no charge
Inpatient maternity care	Deductible, then no charge
Inpatient routine nursery care	No charge
Inpatient rehabilitation – limited to 60 days per Plan Year	Deductible, then no charge
Skilled nursing facility – limited to 100 days per Plan Year	Deductible, then no charge
Infertility Treatment (see the Benefit Handbook for details)	
	Deductible, then no charge

Benefit		Your Cost Sharing
Laboratory, Radiology and Other Diagnostic Services		
Laboratory		Deductible, then no charge
Genetic testing		Deductible, then no charge
Radiology		Deductible, then no charge
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services		Deductible, then no charge
Other diagnostic services		Deductible, then no charge
Low Protein Foods		
– Limited to \$5,000 per Plan Year		Deductible, then no charge
Maternity Care - Outpatient		
Routine outpatient prenatal and postpartum care		No charge
Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, Member Cost Sharing for services provided by a specialist is listed under "Physician and Other Professional Office Visits" and when not specifically listed above, Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under "Laboratory, Radiology and Other Diagnostic Services."		
Medical Drugs (drugs that cannot be self-administered)		
Medical drugs received in a physician's office or other outpatient facility		Deductible, then no charge
Medical drugs received in the home		Deductible, then no charge
Some Medical Drugs may be supplied by a specialty pharmacy. When Medical Drugs are supplied by a specialty pharmacy, the Member Cost Sharing listed above will apply.		
Medical Formulas		
		Deductible, then no charge
Mental Health and Substance Use Disorder Treatment		
Inpatient services		Deductible, then no charge
Intermediate care services – Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs		Deductible, then no charge
Annual mental health wellness examination performed by a licensed mental health professional. Please Note: Your annual mental health wellness examination may also be		No charge

Benefit	Your Cost Sharing
Mental Health and Substance Use Disorder Treatment (Continued)	
provided by a PCP as part of your annual routine examination for preventive care.	
Outpatient group therapy	Deductible, then no charge
Outpatient individual therapy	Deductible, then no charge
Outpatient treatment, including outpatient detoxification and medication management	Deductible, then no charge
Outpatient methadone maintenance	Deductible, then no charge
Outpatient psychological testing and neuropsychological assessment	Deductible, then no charge
Outpatient telemedicine virtual visit – group therapy	Deductible, then no charge
Outpatient telemedicine virtual visit services – including individual therapy, detoxification, and medication management	Deductible, then no charge
Observation Services	
	Deductible, then no charge
Ostomy Supplies	
	Deductible, then no charge
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits)	
Routine examinations for preventive care, including immunizations	No charge
Not all services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services Notice on our website at www.harvardpilgrim.org . Please see "Laboratory, Radiology and Other Diagnostic Services" for the Member Cost Sharing that applies to diagnostic services not included on this list.	
Consultations, evaluations, sickness and injury care	Deductible, then no charge
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you need sutures, please refer to office based treatments and procedures below. If you need an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."	
Office based treatments and procedures, including, but not limited to administration of injections, casting, suturing and the application of dressings, genetic counseling, non-routine foot care, and surgical procedures	Deductible, then no charge
Administration of allergy injections	Deductible, then no charge
Preventive Services and Tests	
	No charge

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Benefit	Your Cost Sharing
Preventive Services and Tests (Continued)	
Under federal and state law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies, certain labs and x-rays, voluntary sterilization for women, and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services Notice on our website at www.harvardpilgrim.org . You may also get a copy of the Preventive Services Notice by calling the Member Services Department at 1-888-333-4742. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with federal and state guidance.	
The following additional preventive services, tests and devices: alpha-fetoprotein (AFP), fetal ultrasound, hepatitis C testing, lead level testing, prostate-specific antigen (PSA) screening, routine hemoglobin tests, group B streptococcus (GBS), routine urinalysis, blood pressure monitor, retinopathy screening, and international normalized ratio (INR) testing.	No charge
Prosthetic Devices	
	Deductible, then no charge
Rehabilitation and Habilitation Services - Outpatient	
Cardiac rehabilitation	Deductible, then no charge
Pulmonary rehabilitation therapy	Deductible, then no charge
Speech-language and hearing services	Deductible, then no charge
Occupational therapy	Deductible, then no charge
– limited to 30 visits per Plan Year	
Physical therapy	Deductible, then no charge
– limited to 30 visits per Plan Year	
Outpatient physical and occupational therapy is not subject to the limit listed above and is covered to the extent Medically Necessary for: (1) children up to the age of three and (2) the treatment of Autism Spectrum Disorders.	
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Colonoscopy, endoscopy and sigmoidoscopy	Deductible, then no charge
Spinal Manipulative Therapy (including care by a chiropractor)	
– Limited to 20 visits per Plan Year	Deductible, then no charge
Surgery – Outpatient	
	Deductible, then no charge
Telemedicine Virtual Visit Services - Outpatient	
	Deductible, then no charge
For inpatient hospital care, see “Hospital — Inpatient Services” for cost sharing details.	
Travel Reimbursement Benefit	
See the Benefit Handbook for details	Not covered
Urgent Care Services	
Doctor On Demand	Deductible, then no charge

Benefit		Your Cost Sharing
Urgent Care Services (Continued)		
Important Note: Doctor On Demand is a specific network of providers contracted to provide virtual Urgent Care services. For more information on Doctor On Demand, including how to access them, please visit our website at www.harvardpilgrim.org .		
Convenience care clinic		Deductible, then no charge
Urgent care center		Deductible, then no charge
Hospital urgent care center		Deductible, then no charge
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefit. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."		
Vision Services		
Routine eye examinations – limited to 1 exam per Plan Year		No charge
Vision hardware for special conditions		Deductible, then no charge
Voluntary Sterilization in a Physician's Office		
		Deductible, then no charge
Voluntary Termination of Pregnancy		
		Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery – Outpatient." For services provided in a physician's office, see "Office based treatments and procedures." For inpatient hospital care, see "Hospital –Inpatient Services." No charge
Wigs and Scalp Hair Protheses as required by law		
– Limited to \$350 per Plan Year (see the Benefit Handbook for details)		Deductible, then no charge

Visit deltadentalma.com for detailed benefit information

**Coverage Summary for
Cape Cod Municipal Health Group
Group # 008318
Effective 7/1/2026**

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

Co-insurance

Category / Procedure	Qualifications	In Network	Out of Network*
**Diagnostic Comprehensive Evaluation Periodic Oral Evaluation Panoramic or Full Mouth X- rays Bitewing X-rays Single Tooth X-rays	Once every 60 months. Twice every 12 months. Once every 36 months. Twice every 12 months. As needed.	100%	100%
**Preventive Teeth Cleaning Fluoride Treatments Space Maintainers Sealants	Twice every 12 months. Twice every 12 months. Required due to the premature loss of teeth. For members under age 14 and not for the replacement of primary or permanent anterior teeth. Unrestored permanent bicuspid and permanent molars, once per 48 months per tooth for members to age 19.	100%	100%
Restorative Fillings (Silver and White) Inlays Protective Restorations Stainless Steel Crowns	Once every 24 months per surface per tooth. 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. Once per tooth. Once every 24 months per tooth (on primary teeth only).	80%	80%
Oral Surgery Extractions General Anesthesia	Once per tooth. General Anesthesia and IV sedation allowed with covered surgical impacted teeth only (up to one hour).	80%	80%
Periodontics (on natural teeth only) Periodontal Surgery Scaling and Root Planing Periodontal Cleaning Bone Grafts/GTR	One surgical procedure per quadrant in 36 months. Once in 24 months, per quadrant. No more than 2 quadrants per date of service. 4 times every 12 months, not to be combined with regular cleanings. No more than 2 teeth per quadrant per 36 months on natural teeth.	80% 100%	80% 100%
Endodontics Root Canal Treatment Root Canal Retreatment Vital Pulpotomy	Once per tooth. Once per tooth after 24 months have elapsed from initial treatment. Limited to deciduous teeth.	80%	80%
Prosthetic Maintenance Bridge or Denture Repair Crown or Onlay Repair Rebase or Reline of Dentures Recement of Crowns, Onlays & Bridges	Once per bridge/denture per 12 months, after 24 months of initial insertion. Once per tooth per 12 months after 24 months of initial placement Once per denture within 36 months. Once per crown, onlay or bridge.	80%	80%
Emergency Dental Care Palliative treatment	Three occurrences in 6 months.	80%	80%
Prosthodontics Dentures Fixed Bridges Implants Implant Abutments	Once within 60 months (age 16 and older). Once within 60 months (age 16 and older). Once per tooth per 60 months. (Pre-estimate recommended). Once per implant only when surgical implant is benefitted.	60%	60%
Major Restorative Crowns or Onlay Cast Posts/Buildups	Once within 60 months per tooth (age 12 and older). Once per tooth per 60 months only benefitted to retain a crown.	60%	60%
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 4 th 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*™



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

TIME TO FOCUS ON THE DETAILS

Let's answer some FAQs

A LOOK AT YOUR BENEFITS

How do I find out what my EyeMed benefits cover?

If you're thinking about EyeMed, you'll want to connect with your employer to learn about the benefit options. Already a member? The easiest way to find your benefit information is to create a member account on eyemed.com/member or grab the EyeMed App (App Store or Google Play).

Does EyeMed offer any added discounts?

Absolutely. Your benefits already help you save on your copay and allowance, but EyeMed also brings you special offers and discounts¹—easily accessible when you log into Member Web. And for an extra level of savings, check out some of our in-network providers (called PLUS Providers) who offer a \$0 exam copay and extra frame allowance. Find them with our Provider Locator on Member Web.

Can I use my EyeMed benefits online?

Instantly apply your in-network benefits at checkout with free shipping, free returns and no paperwork at these participating providers: lenscrafters.com, targetoptical.com, ray-ban.com, glasses.com and contactsdirect.com. The best part? All of these online options are PLUS Providers, too.

MEMBER HOW-TO TIPS

How do I find an eye doctor in my network?

The Provider Locator on Member Web and in the EyeMed App has thousands of in-network eye doctors to choose from. Filter your search to find providers near you with the brands, hours and services you want. And keep an eye out for PLUS Providers since they offer even more savings.

What is a PLUS Provider?

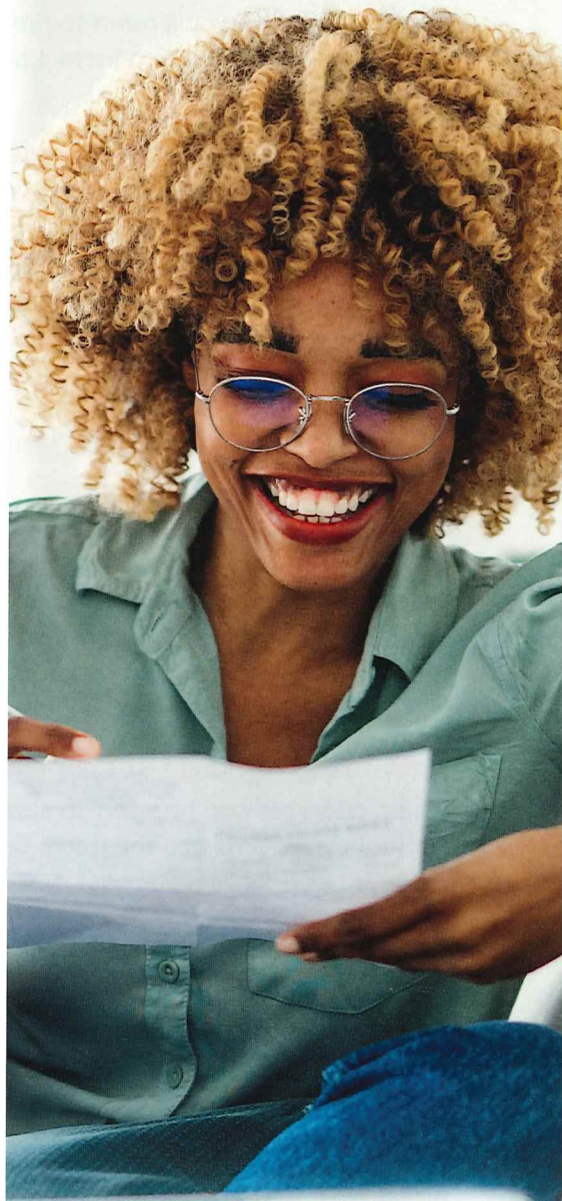
Certain in-network providers offer an extra level of savings built right into your vision care—like an enhanced frame allowance. Providers with the  are PLUS Providers—look for this symbol when choosing a provider.

How do I use my benefits?

At EyeMed, we're all about easy. Just choose an in-network eye doctor from our Provider Locator, schedule your visit and go in for care or eyewear. You don't even need your ID card—just give them your name and birthday. When you stay in-network, we'll handle all the paperwork.



eye[®]
Med



How do I get on-the-go access?

The EyeMed App can do almost everything Member Web can. Find a provider (including PLUS Providers), set an appointment,* review your benefits, check claims, estimate costs, find special offers, show your ID card – even store your vision prescriptions and set exam reminders. Download it through the App Store or Google Play.

How do I submit a claim?

When you see one of our in-network eye doctors, there's no need to submit a claim – we'll handle the paperwork on our end. If you go out-of-network, then you'll need to file an out-of-network claim using our out-of-network claim form. Log into your Member Web account to find one.

How do I get an ID card replacement or extra cards?

If you lose your card or need extras for your family, log into Member Web at eyemed.com/member to print a replacement, or log into your account on the app to access your ID card digitally. Here's a tip: you don't even need the card when you visit your eye doctor.

VISION AND YOUR HEALTH

I don't wear glasses and can see fine.

Do I still need an eye exam?

Getting an eye exam isn't just about needing glasses. It's also about your health. An eye exam can detect eye health problems like glaucoma or cataracts, but it can also help identify signs of some diseases, like high blood pressure, diabetes and high cholesterol.² Choose an in-network eye doctor to save on an eye exam—and choose a PLUS Provider to save even more.

How often should I get an eye exam?

Vision changes can happen so slowly, you may not even notice them. Annual eye exams are the norm unless your doctor suggests more frequent checks. We suggest making it part of your regular preventive care routine.

At what age should my child first visit the eye doctor?

The American Academy of Ophthalmology recommends having a newborn's eyes checked for basic indicators of eye health and a second screening between 6 and 12 months for healthy eye alignment and movement. The doctor may check for nearsightedness, farsightedness, astigmatism, amblyopia (or "lazy eye"), proper eye movement and eye alignment, and how the eye reacts to light and darkness. They also recommend an exam between the ages of 3 and 5, and every year after that.³

My child gets a vision screening at school, so there's no need for an eye exam, right?

A vision screening does not take the place of an eye exam. School screenings generally check for color blindness and your child's ability to see far away. A comprehensive exam will evaluate the entire structure of the eye.

The EyeMed logo, featuring the word "eye" in a lowercase, rounded font above the word "Med" in a similar font, both in white on a red square background.

Thinking of becoming a member? Learn more at eyemed.com/enroll

Looking to keep your vision healthy? Learn how at eyesiteonwellness.com

Already a member? Manage benefits at eyemed.com/member

*Not available at all locations

¹Discounts are not insurance. Available at participating in-network providers. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Additional limitations and exclusions may apply. Log into your member account for full details.

²Mukamal, R.; "20 Surprising Health Problems an Eye Exam Can Catch"; American Academy of Ophthalmology; aao.org; April 29, 2022.

³Gudgel, D.; "Eye Screening for children"; American Academy of Ophthalmology; aao.org; March 23, 2021. This information is available broadly and is not plan or state specific. Offers are not valid in the state of Texas.

Savings plus convenience plus choice

PLUS Providers add another layer of
coverage

\$200

Frame 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.

This information is available broadly and is not plan or state specific.

PDF-2303-M-1084

INDEPENDENT
PROVIDER
NETWORK



LENSCRAFTERS®

PEARLE
EST. 1961
VISION

OPTICAL®

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
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 Tier 1 - 4	\$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
Anti Reflective Coating - Premium Tier 1 - 4	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	\$0 copay	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 66% off hearing aids; call 1-877-203-0675	Up to 66% off hearing aids; call 1-877-203-0675	Not covered
EXAM SERVICES			
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	
Lenses	Once every calendar year	Once every calendar year	
Frame	Once every calendar year	Once every calendar year	
Contact Lenses	Once every calendar year	Once every calendar year	
Additional Glasses Allowance	Once every calendar year	Once every calendar year	

(Routine Benefit: Plan allows the member to receive either contacts or frame and lens services.)

(Additional Glasses Allowance: Plan allows the 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. 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. 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 Vision Examination or 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; lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. Member receives a 20% discount on items not covered by the plan at In-Network locations. Discount does not apply to Provider's professional services or contact lenses. 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 the online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products. The Plan reserves the right to make changes to the products on each tier and to the member out-of-pocket costs. Fixed tier pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Services and amounts listed above are subject to change at any time. Discounts are not insured benefits. 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.

Enroll within
30 days of
your Qualified
Event

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, vision care services; prescription medications; over-the-counter 'medicines' (not vitamins or supplements); orthodontics; prescription eyeglasses, contact lenses, laser eye surgery; alternate health therapies (e.g. chiropractic, acupuncture); mental health services, and **MORE!**

Max. Annual Health Care Election: \$3,400

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

Benefit Cards. New Health Care FSA enrollees will be mailed **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 available balance from the plan year, 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 day care expenses for eligible dependents (as defined by the IRS) under age 13, elderly dependents, and dependents with special needs. Includes day care, pre-school, before/after school care, day camp, and elder day care. *This is a claim-based reimbursement plan (no benefit card); participants must submit claim(s) each plan year to receive accrued funds.*

Max. Annual Dep. Care Election: \$7,500 per family.

Make Your
Money Go
UP
TO **30%**
Further!
depending on your
tax status

For eligible expenses
incurred between your
Qualified Event Date
and **12/31/2026**.***

To **ENROLL** or **MAKE QUALIFIED CHANGE(S)**: Complete a *New Hire/Change of Status Form* & return it to **Human Resources** within 30 days of your Date of Hire or Qualified Event Date.

— IMPORTANT —

Re-enrollment is not automatic! To continue your FSA benefit beyond the end of the current plan year, you must **actively re-enroll** during your employer's annual open enrollment period.

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://buyfsa.com/blogs/fsa-hsa-eligibility-list> for more info. on eligibility of specific products and services.

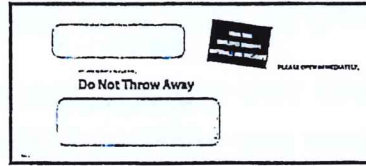
** Overnight camp and school tuition for kindergarten and above are not FSA-eligible; day camp is eligible when utilized as a form of childcare in order for the parent(s)/guardian(s) to be able to work; extra-curricular and enrichment programs/activities that aren't daycare/childcare-based are not eligible;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

*** Cafeteria Plan Advisors holds flex-spending (FSA) funds until eligible expenses are incurred and claim(s) submitted. Funds may be forfeited in accordance with IRS Publication 969 if eligible expenses are not incurred by the plan year deadline through the use of the provided debit card (if applicable) or claim submission, or the date upon which employment ends, whichever comes first.



Important Information About Your PREPAID BENEFITS CARD

If you're newly enrolled in the Flexible Spending Account Program, you will automatically receive the new blue Prepaid Benefits Card. You'll receive two cards at your home address for you and your family members to use. The Cards will arrive in a special envelope that looks like this – so please don't throw it out!



Your Prepaid Benefits Card is loaded with the value of your annual FSA\HSA election amount (less any amounts you have already spent in this plan year.) Using your Card helps you keep cash in your wallet and makes accessing your FSA funds easy. The Card can be used, instead of cash, to pay for qualified health care expenses such as:

- Prescription and health plan copayments, deductibles and coinsurance
- "Amount Due" on medical/dental statements
- Orthodontics
- Mail-order or online prescription invoices
- Vision services and eyeglasses
- LASIK surgery
- Eligible over-the-counter (OTC) items

**If applicable, eligible Commuter Transit and/or Parking expenses. The card will be loaded with funds after they are deducted from your paycheck and posted to your account*

You'll simply swipe your Card each time you incur a qualified health care expense and the amount of your purchase will be deducted from your FSA– automatically. You can also fill in your Card number on bills you receive from providers to pay the amount you owe. You'll have no claim forms to complete and you won't have to wait to get a check in the mail. You can check balances or account details anytime – online at www.cpa125.com or via the mobile app -- **CPA FLEX MOBILE**. It's that easy!

It's Important to Save Your Receipts!

Your Prepaid Benefits Card will definitely improve your cash flow. However, be aware that the IRS requires the Card be used only for eligible expenses. Most of the time, we can verify the eligibility of the expense automatically. Yet, there are instances when you'll receive a letter/notification asking you to furnish an itemized receipt to verify the expense. When you receive such a request, make sure you submit the receipts as soon as possible to avoid having your Card suspended until receipts have been submitted and approved.

What is an itemized receipt?

An itemized receipt must include: merchant or provider name, services received or item purchased, date of service, and amount of the expense. Cancelled checks, handwritten receipts, card transaction receipts or previous balance receipts cannot be used to verify an expense.

Using Your Card is as Easy as 1-2-3!

Look for additional information about how to use your new Prepaid Benefits Cards included with your card packet in the mail. We hope you enjoy this new exciting feature of your plan! Remember, the Card will not work at gas stations or restaurants – only at health care related providers.

Save your card. Every year you re-enroll, the funds get loaded on to this card!

Your HSA can do
more than you think

Get clear guidance, helpful tools, and eligible products at HSA Store®.



100% eligibility guarantee



2,500+ HSA qualified products



No receipts needed

Cover the unexpected

Shop essentials for the whole family, including first aid, cold & flu relief, skincare, diagnostics, baby care, and more.

HSA Store® makes it simple

Your one-stop shop for everything HSA, from everyday care to smart health tools.

- Get clear answers with the HSA Eligibility List™
- Find tax-free essentials all in one place
- Manage your HSA with confidence and ease



\$5 off

Use code:
2026SAVE5

Offer exp. 12/31/2026.



Scan to shop

Health Savings Account

An HSA lets you save money for future healthcare costs while also saving on taxes. How? HSAs are the only benefit with a triple-tax advantage:¹ Tax-free contributions. Tax-free account growth. And tax-free spending on HSA-qualified expenses. It's your healthcare emergency safety net.

- ✓ Rolls over every year – funds never expire
- ✓ Available tax-free investing, just like a 401(k)²
- ✓ Requires an eligible high-deductible health plan (HDHP)

Less tax.
More paycheck.

Get \$30 tax savings for every \$100 you contribute.³

HSA

Tax-free

No HSA

Taxed

2027 HSA Contribution Limits



\$4,500

Individual plan



\$9,000

Family plan

Members 55+ can contribute an extra \$1,000.

Scan to download the
HealthEquity mobile app.



You can set up your account directly in the app – no need to register online.

Spend tax-free on HSA-qualified expenses.

- Medical
- Vision
- Dental
- Rx and OTC

Discover more: HealthEquity.com/QME



See how much
you can save.

HealthEquity.com/Learn/HSA

¹HSAs are federally tax-deductible for qualified medical expenses and usually state-deductible; consult a tax advisor for details. | ²Investments are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. Investing through the HealthEquity investment platform is subject to the terms and conditions of the Health Savings Account Custodial Agreement and any applicable investment supplement. | ³Example for illustration only; savings based on a 30% federal and state tax bracket. | HealthEquity does not provide legal, tax or financial advice.

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HSASTDFLYCST27



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

Designed for the Employees of

Cape Cod Collaborative

FAMILY MATTERS. NO MATTER WHAT.®

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 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.



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

Designed for the Employees of

Cape Cod Collaborative

FAMILY MATTERS. NO MATTER WHAT.®

ELIGIBILITY & BENEFIT FEATURES

Class 2: All Full Time Active Drivers and 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.

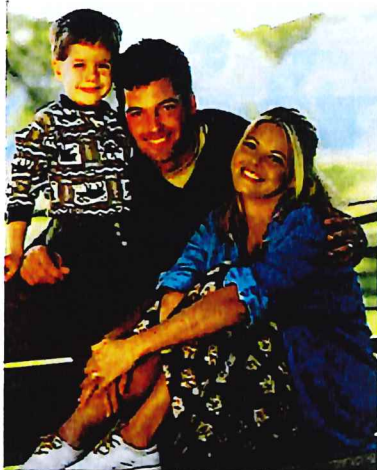
Conversion: Employees have 31 days from the date of termination to convert their basic life insurance to an individual permanent life insurance policy without evidence of insurability. The premium will be based on Boston Mutual's usual rate for the insured's age on the date of conversion. Coverage will 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 - 120 Royall Street • Canton, MA 02021 • www.bostonmutual.com



Voluntary Life and Accidental Death & Dismemberment

Added Protection for You and Your Family...

Everyone has the need for financial security, but the needs of each employee can vary. To help meet these needs, Boston Mutual Life Insurance Company and Cape Cod Collaborative is proud to offer a Group Term Voluntary Life and Accidental Death & Dismemberment program for you and your family.

Eligibility:

You, as an active full-time employee, your spouse under age 70, your unmarried children ages 14 days to 19 years (to age 25 if a full-time student), and handicapped children over the age of 19 are eligible for coverage. Dependents may not be insured if they are confined in a medical facility. Dependent coverage is available only if you, the employee, also elects coverage.

Available Insurance:

You have the flexibility to choose coverage in units of \$10,000 to a maximum of \$500,000. However, the maximum coverage amount may not exceed five times your annual salary.

Family Coverage:

You may insure your spouse in units of \$5,000 to a maximum of \$100,000, not to exceed 50% of your coverage amount.

Dependent children age 1-19 years (up to 25 if full-time student) are eligible for \$10,000.

Dependent children 14 days to 1 year are eligible for \$1,000.

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

Medical Questions:

If you and your dependents enroll within 31 days of becoming eligible, you and your spouse may purchase a specific amount of insurance on a guaranteed basis. No medical questions asked for coverage at or under the Guaranteed Issue Amount.

Guaranteed Issue Amounts:

Age	Employee	Spouse
Under 60	\$100,000	\$30,000
60-69	\$50,000	\$20,000
*70 and Over	\$10,000	- Not Eligible -

* Employee's insurance reduction schedule applies (Refer to the section: "Are there Reductions?").

Guaranteed Issue coverage will become effective for eligible enrollees on the later of, the effective date of the group policy or the date the application is approved by Boston Mutual. Proof of good health satisfactory to Boston Mutual is required for amounts above the Guaranteed Issue Amounts or beyond the 31 day eligibility period.

Premium Cost:

Sample Weekly payroll deductions for you and your spouse are shown below:

Weekly Premium Rate Costs for Life and AD&D						
Per Volume of Insurance						
Age	Monthly Premium Rate per \$1,000	10,000	30,000	50,000	80,000	100,000
under 34	0.08	0.18	0.55	0.92	1.48	1.85
35-39	0.11	0.25	0.76	1.27	2.03	2.54
40-44	0.16	0.37	1.11	1.85	2.95	3.69
45-49	0.26	0.60	1.80	3.00	4.80	6.00
50-54	0.41	0.95	2.84	4.73	7.57	9.46
55-59	0.68	1.57	4.71	7.85	12.55	15.69
60-64	1.00	2.31	6.92	11.54	18.46	23.08
65-69	1.64	3.78	11.35	18.92	30.28	37.85
70-74	2.91	6.72	20.15	33.58	53.72	67.15
75-79	4.91	11.33	33.99	56.65	90.65	113.31
80-84	4.91	11.33	33.99	56.65	90.65	113.31

Premium rates are based on age and change as each individual moves to a higher age bracket. Premium rates for members age 85 and over are available. Please contact your Benefits Administrator for details.

Dependent Cost:

The total monthly premium cost to insure all eligible dependent children for Life Insurance is only \$1.80 per Family Unit. All life coverage for dependent children is Guaranteed Issue.

Portability Privilege:

If you leave your employment prior to age 60, the coverage is "portable" for yourself, your spouse under age 60 and all eligible dependent children if elected within 31 days. The coverage would not include Waiver of Premium or Accidental Death and Dismemberment.

Conversion Privilege:

Yes, you may convert your Voluntary Life coverage for yourself, spouse, and children to a whole life policy without proof of good health, if you apply within 31 days of the date coverage terminated, and it did not terminate due to non-payment of premium. The premiums are based on Boston Mutual's usual rate for the insured's age on the date of conversion.



FAMILY MATTERS. NO MATTER WHAT.®

Group Long Term Disability Benefit Summary

Designed for the Employees of
Cape Cod Collaborative

ELIGIBILITY & BENEFIT FEATURES

Class 2: All Full Time Active Drivers and 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 180 consecutive days and was receiving payments under the plan, the eligible survivor will be paid a one-time lump sum benefit. This benefit will be equal to 3 times your last gross monthly benefit payment. 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

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BOSTON MUTUAL LIFE INSURANCE COMPANY

Whole Life Insurance

Lifelong Protection For You and Your Family

With flexible coverage options, guaranteed pricing, and cash value growth, you can customize a life insurance plan that fits your needs and budget.

How It Works

Whole life insurance offers lifetime coverage, ensuring you and your loved ones are always protected. With rates that don't go up and a guaranteed payout, it provides peace of mind and long-term financial security. Your coverage starts immediately upon enrollment. Plus, the cash value grows over time, allowing you to borrow from it if needed.*

*Borrowing is subject to interest payments.

Locked-In Rates

Once you lock in your premium rate, your coverage and your rate stay the same for life as long as you keep up with payments. One less cost you have to worry about going up over time!

Your representative can work with you to decide how much coverage you need and what amount fits your budget.

Note: *Larger amounts may need special approval.*

Your coverage starts protecting you as soon as you enroll. Once you lock in your premium rate, your coverage and your rate stay the same for life as long as you keep up with payments.



How Life Insurance Takes Care of Your Family

Signing up for life insurance means there will be cash available for your loved ones to cover things like mortgage payments and other expenses should something happen. Just let us know who you'd like to receive the payment if something happens to you.

The money can help cover:

- ✓ Everyday expenses like the mortgage, bills, and keeping the household running
- ✓ Planning a special farewell that celebrates your life and legacy
- ✓ Providing long-term financial security for the people who matter most to you

Our Whole Life workplace insurance is an endowment at age 95 life insurance policy, which means the face value would be paid to the insured, if living, at age 95.

Take the Next Step

Whether you're ready to enroll or just have questions, your company's human resources representative is ready to help.



FAMILY MATTERS. NO MATTER WHAT.®

ECIP

*Employee
Critical
Illness plus*

Employee Critical Illness Plus SPECIFIED DISEASE INSURANCE *Financial Protection for the Unexpected*



- Includes Cancer Benefit
- Initial Occurrence
- Additional Occurrence
- Reoccurrence
- Spouse Coverage Available
- Child Coverage at No Additional Cost
- Health Screening Benefit

*Protection for the
Unexpected!*



THIS IS A LIMITED BENEFIT POLICY

NOTICE TO BUYER: This insurance provides a limited benefit in the event You are diagnosed with the specified diseases. This policy is a supplement and not a substitute for a health benefit plan. You must have a health benefit plan in order to purchase this insurance.

Approved for use in: MA

BOSTON MUTUAL LIFE INSURANCE COMPANY - 120 Royall Street • Canton, MA 02021

ECIP *Employee Critical Illness plus* Tobacco/No Tobacco Premium Rates

RATES INCLUDE THE FOLLOWING: Specified Critical Illness including Cancer, Pre-Existing Condition Exclusion and the \$50 Health Screening Benefit Rider. Spouse is eligible to apply for 50% of the employee amount. Includes 25% benefit for eligible children.

Employee Non-Tobacco Rates

Face Purchase - Weekly Premiums

Issue Ages	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$1.06	\$1.71	\$2.35	\$3.00	\$3.65	\$4.29	\$4.94	\$5.59	\$6.23	\$6.88
30-39	\$1.62	\$2.82	\$4.02	\$5.22	\$6.42	\$7.62	\$8.82	\$10.02	\$11.22	\$12.42
40-49	\$2.61	\$4.80	\$6.99	\$9.19	\$11.38	\$13.57	\$15.76	\$17.96	\$20.15	\$22.34
50-59	\$4.15	\$7.89	\$11.63	\$15.37	\$19.11	\$22.85	\$26.59	\$30.33	\$34.06	\$37.80
60-69	\$6.79	\$13.15	\$19.52	\$25.89	\$32.26	\$38.63	\$45.00	\$51.37	\$57.74	\$64.11
70 +	\$6.79	\$13.15	\$19.52	\$25.89	\$32.26	\$38.63	\$45.00	\$51.37	\$57.74	\$64.11

Employee Tobacco Rates

Face Purchase - Weekly Premiums

Issue Ages	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$1.32	\$2.22	\$3.12	\$4.02	\$4.92	\$5.82	\$6.72	\$7.62	\$8.52	\$9.42
30-39	\$2.31	\$4.20	\$6.09	\$7.99	\$9.88	\$11.77	\$13.66	\$15.56	\$17.45	\$19.34
40-49	\$4.25	\$8.08	\$11.91	\$15.74	\$19.57	\$23.40	\$27.23	\$31.06	\$34.89	\$38.73
50-59	\$7.34	\$14.26	\$21.19	\$28.11	\$35.03	\$41.96	\$48.88	\$55.80	\$62.73	\$69.65
60-69	\$12.69	\$24.97	\$37.25	\$49.53	\$61.80	\$74.08	\$86.36	\$98.64	\$110.91	\$123.19
70 +	\$12.69	\$24.97	\$37.25	\$49.53	\$61.80	\$74.08	\$86.36	\$98.64	\$110.91	\$123.19

Spouse Non-Tobacco Rates

Face Purchase - Weekly Premiums

Issue Ages	\$2,500	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
18-29	\$0.74	\$1.06	\$1.38	\$1.71	\$2.03	\$2.35	\$2.68	\$3.00	\$3.32	\$3.65
30-39	\$1.02	\$1.62	\$2.22	\$2.82	\$3.42	\$4.02	\$4.62	\$5.22	\$5.82	\$6.42
40-49	\$1.51	\$2.61	\$3.70	\$4.80	\$5.90	\$6.99	\$8.09	\$9.19	\$10.28	\$11.38
50-59	\$2.28	\$4.15	\$6.02	\$7.89	\$9.76	\$11.63	\$13.50	\$15.37	\$17.24	\$19.11
60-69	\$3.60	\$6.79	\$9.97	\$13.15	\$16.34	\$19.52	\$22.71	\$25.89	\$29.08	\$32.26

Spouse Tobacco Rates

Face Purchase - Weekly Premiums

Issue Ages	\$2,500	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
18-29	\$0.87	\$1.32	\$1.77	\$2.22	\$2.67	\$3.12	\$3.57	\$4.02	\$4.47	\$4.92
30-39	\$1.36	\$2.31	\$3.25	\$4.20	\$5.15	\$6.09	\$7.04	\$7.99	\$8.93	\$9.88
40-49	\$2.33	\$4.25	\$6.16	\$8.08	\$9.99	\$11.91	\$13.82	\$15.74	\$17.66	\$19.57
50-59	\$3.88	\$7.34	\$10.80	\$14.26	\$17.72	\$21.19	\$24.65	\$28.11	\$31.57	\$35.03
60-69	\$6.55	\$12.69	\$18.83	\$24.97	\$31.11	\$37.25	\$43.39	\$49.53	\$55.67	\$61.80

Health Screening Benefits

We will pay a \$50 benefit if an insured has any one of the covered screening tests after the 30 day waiting period. This benefit is paid only once per calendar year, regardless of the number of tests. This benefit is paid regardless of the results of the test. Payment of this benefit will not reduce the amount payable for the diagnosis of a critical illness. There is no limit to the number of years the insured can receive the health screening benefit; it will be paid as long as the policy remains in force. This benefit is payable for the covered employee (and spouse if spouse coverage is included). This benefit is not paid for dependent children. The covered health screening tests include:

Health Screening Test is defined as:

1. Stress test on a bicycle or treadmill
2. Fasting blood glucose test
3. Blood test for triglycerides
4. Lipid Panel (total cholesterol count)
5. Bone marrow testing
6. CA 15-3 (blood test for breast cancer)
7. CA 125 (blood test for ovarian cancer)
8. CEA (blood test for colon cancer)
9. Chest X-ray
10. Electrocardiogram (EKG)
11. Colonoscopy
12. Flexible sigmoidoscopy
13. Hemocult stool analysis
14. Mammography / Breast Ultrasound
15. Pap smear (including ThinPrep Pap Test)
16. PSA (blood test for prostate cancer)
17. Serum Protein Electrophoresis (blood test for myeloma)
18. Thermography
19. Oral Cancer screening using ViziLite OraTest or other similar test
20. Biopsy for Skin Cancer

- Over 1.6 million new cancer cases are expected to be diagnosed in 2012.
- Cancer survival rates continue to improve. The 5-year survival rate for all cancers diagnosed between 2001 and 2007 is now 67%. However cancer is the second most common cause of death in the US, accounting for nearly 1 in every 4 deaths.
- Each year, 785,000 Americans will have a new coronary attack, 470,000 will have a recurrent attack.
- On average, someone in the US has a stroke every 40 seconds.

*Cancer Facts & Figures 2012 - American Cancer Society
Heart and Stroke Statistical Update - 2012 American Heart Association*

INDIVIDUAL ELIGIBILITY

All full-time employees, as defined by the master policy are eligible. If an employee is eligible, his/her spouse ages 18-69, is eligible for coverage.

SPOUSE COVERAGE AVAILABLE

The employee may elect to apply for spouse coverage. Benefit amounts for the spouse are 50% of the employee amount. If the employee does not meet the underwriting requirements, the spouse may still be eligible for coverage. Spouse means a person of the opposite or same sex recognized as the insured's spouse/partner under the laws of the state.

CHILDREN COVERAGE AT NO ADDITIONAL CHARGE

Each eligible child is covered at 25% of the primary insured amount at no additional charge. The definition of children may vary by state. Please review your certificate carefully.

EFFECTIVE DATE OF COVERAGE

Coverage is effective on the date the application is signed, provided that the employee is actively at work and premiums for the coverage are paid.

PORTABILITY

The coverage is portable providing your coverage has been in force for 1 month after your certificate date and the group contract remains in force. Coverage will be continued at the same premium and coverage amounts then in force.

INITIAL OCCURRENCE BENEFIT

Lump Sum Benefits payable upon initial diagnosis of a covered illness or condition. Employee benefit amounts are available from \$5,000 to \$50,000.

ADDITIONAL OCCURRENCE BENEFIT

If an insured collects benefits for a Critical Illness under the plan and later has one of the remaining covered illnesses/procedures, then we will pay the benefit amount for each additional illness provided the occurrences are separated by at least 6 months. If separated by less than 6 months, a 25% benefit is payable.

RE-OCCURRENCE BENEFIT

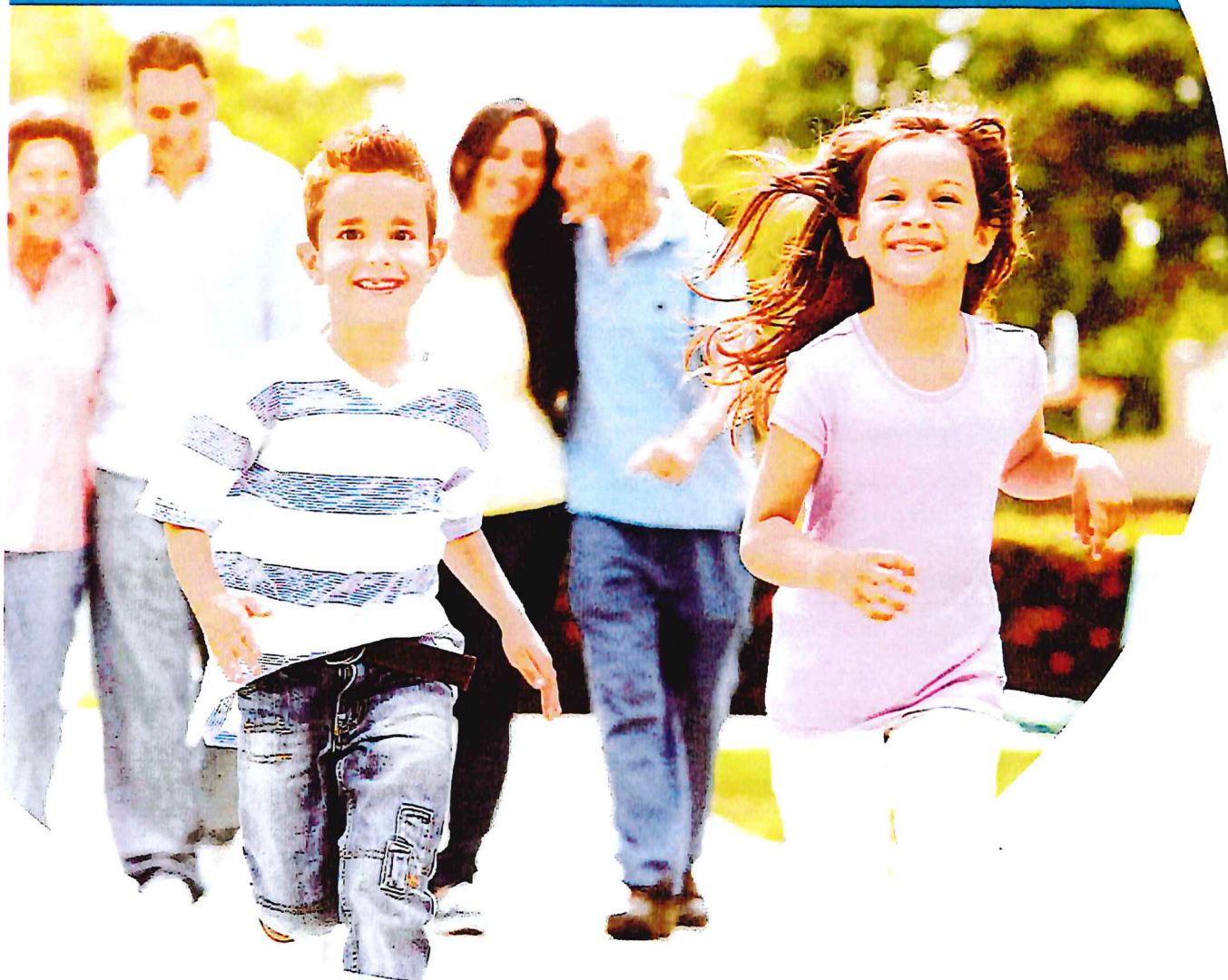
If an insured collects benefits for a covered condition and is later diagnosed with the same condition, we will pay the benefit again provided that the two dates of diagnosis are separated by at least 6 months. (12 months treatment free for Cancer/Carcinoma in situ).

Critical Illnesses	Percent of Benefit Amount
Cancer	100%
Carcinoma in situ	30%
Skin Cancer	\$300 one-time (lifetime)
Heart Attack (Myocardial Infarction)	100%
Coronary Artery Bypass Surgery	30%
Angioplasty & Stent Insertion	30%
Stroke (Apoplexy or Cerebral Vascular Accident)	100%
Coma	100%
Paralysis	100%
Severe Burns	100%
Major Organ Transplant	100%
Alzheimer's Disease	100%
ALS (Lou Gehrig's Disease)	100%
Loss of Sight/Speech/Hearing	100%
End Stage Renal Disease	100%
Benign Brain Tumor	100%

All covered conditions are subject to the definitions found in the employee's certificate.

Eligible Children are also covered for the following childhood Specified Critical Illnesses at 25% of the employee benefit amount:

- Cerebral Palsy
- Cleft Lip or Palate
- Down Syndrome
- Cystic Fibrosis
- Spina Bifida



Group Accident Coverage...

A limited supplemental policy providing accident insurance



FAMILY MATTERS. NO MATTER WHAT.®

120 Royall Street, Canton, MA 02021 | 18135 Burke Street - Suite 120, Omaha, NE 68022

Accidents do happen...

Here are a few examples of how Boston Mutual's Group Accident benefits can work for you and your family if you have an accident.*

Your child at play...

Johnny was playing soccer and was tripped in his pursuit of that perfect shot. His parents rushed him to the Emergency Room where he was treated for a fractured ankle. Johnny was admitted to the hospital for one night. Fortunately, he was covered by Boston Mutual's Group Accident insurance.



The benefits his family received under this policy were as follows:

Emergency Room	\$200	Ankle Fracture (<i>open reduction</i>)	\$1,200
X-Ray	\$50	Follow-Up Treatment (<i>2 visits</i>)	\$200
Hospital Admission	\$2,000	Physical Therapy (<i>2 visits</i>)	\$60
Hospital Confinement (<i>1 day</i>)	\$500		

Total: \$4,210



On your way home from work...

While driving home from work, Steve was hit by another driver who ran a red light. Steve was rushed by ambulance to the hospital. Steve suffered multiple injuries and incurred significant medical expenses.

The benefits received under this policy were as follows:

Ground Ambulance	\$200	Concussion	\$300
Hospital Admission (<i>ICU admit</i>)	\$4,000	Ruptured Spleen (<i>abdominal surgery</i>)	\$1,000
ICU Benefit (<i>8 days</i>)	\$8,000	Fractured Leg (<i>open reduction</i>)	\$3,200
Hospital Confinement (<i>12 days</i>)	\$6,000	Physical Therapy (<i>10 visits</i>)	\$300
Blood Benefit	\$200	Follow-up Treatment (<i>2 visits</i>)	\$200
		X-Ray	\$50

Total: \$23,450

* Benefit amounts may vary based on your specific plan. *The above examples are for illustrative purposes only.*

The benefits of this policy are paid in addition to other insurance coverage you may have. The check is made out to you. This coverage is not intended to replace your primary health insurance.

Life comes with challenges. **Your Assistance Program is here to help.**

Your Assistance Program can help you reduce stress, improve mental health, and make life easier by connecting you to the right information, resources, and referrals.

All services are free, confidential, and available to you and your family members. This includes access to short-term counseling and the wide range of services listed below:

Mental Health Sessions

Manage stress, anxiety, and depression, resolve conflict, improve relationships, and address any personal issues. Choose from in-person sessions, video counseling, or telephonic counseling.

Life Coaching

Reach personal and professional goals, manage life transitions, overcome obstacles, strengthen relationships, and achieve greater balance.

Financial Consultation

Build financial wellness related to budgeting, buying a home, paying off debt, resolving general tax questions, preventing identity theft, and saving for retirement or tuition.

Legal Referrals

Receive referrals for personal legal matters including estate planning, wills, real estate, bankruptcy, divorce, custody, and more.

Work-Life Resources and Referrals

Obtain information and referrals when seeking childcare, adoption, special needs support, eldercare, housing, transportation, education, and pet care.

Personal Assistant

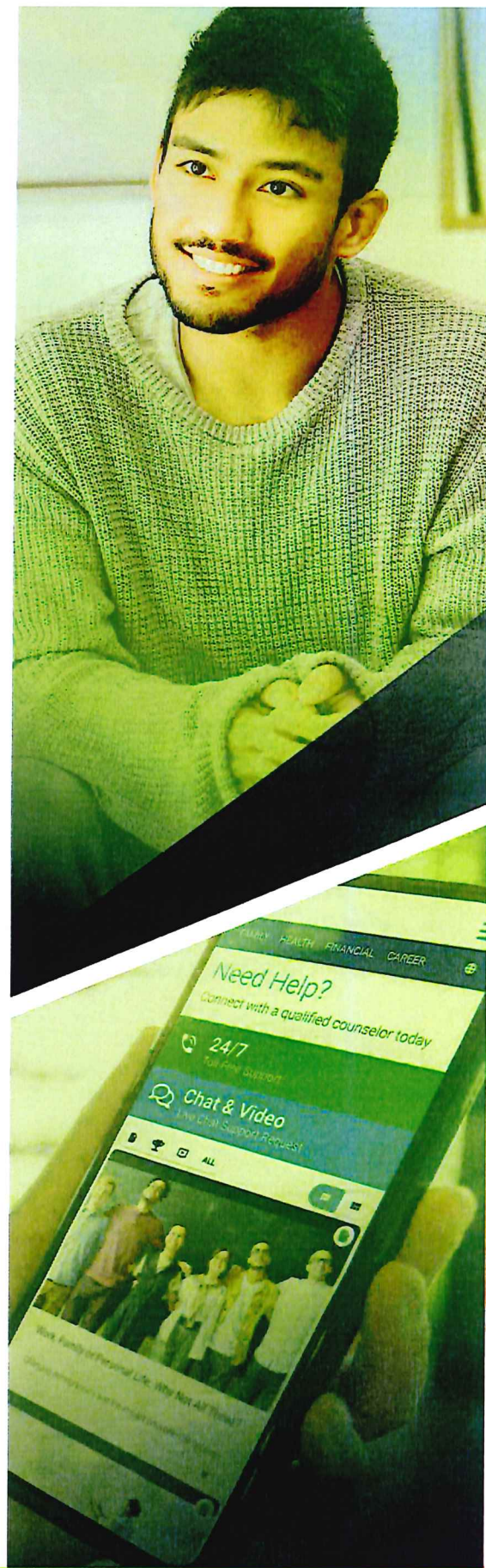
Save time with referrals for travel and entertainment, seeking professional services, cleaning services, home food delivery, and managing everyday tasks.

Medical Advocacy

Get help navigating insurance, obtaining doctor referrals, securing medical equipment, and planning for transitional care and discharge.

Member Portal

Access your benefits 24/7/365 through your member portal with online requests and chat options. Explore thousands of self-help tools and resources including articles, assessments, podcasts, and resource locators.



Contact: Perspectives

Call: **800-456-6327**

Visit: mega.allonehealth.com

Access Code: **MEGA**

ALLONE
HEALTH

The New AllOne Health Member Portal Is Here

The AllOne Health Member Portal has been rebuilt to work seamlessly with the AllOne Health mobile app, giving you simple, secure access to support anytime, anywhere.

HOW TO GET STARTED

1. **Sign Up for the New Member Portal**
Visit mega.allonehealth.com
2. **Create Your Account**
Create your account by entering your email, password and the **Company Code** at the bottom of this flyer.
3. **Use One Login Everywhere**
Your login works for **both** the online portal and the mobile app. You can download the **AllOne Health App** from the [Apple App Store](#) or [Google Play](#).

WHAT TO EXPECT

- ✓ One login for both the portal and mobile app
- ✓ Faster access to counseling, resources, and support
- ✓ Modern, mobile-friendly experience
- ✓ Built to support your whole health

START EXPLORING



Book Virtual
Counseling
Sessions



Chat with
Izzy, Your AI
Mental Health
Navigator



Submit
Requests
and Find
Resources



Call Directly
for 24/7 Live
Human
Support

IMPORTANT LOGIN INFORMATION

The old AllOne Health portal is being retired, and your old portal email and password will NOT work in the new portal or app.

- **If you already downloaded the new AllOne Health App** and created an account, use the same login for the portal
- **New users** will need to create a new account using their company code listed at the bottom of this flyer



Sign Up Today
Support is always within reach—built around you.
Call: 800-451-1834
Visit: mega.allonehealth.com
Company Code: MEGA

ALLONE
HEALTH



As an eligible plan member, you can receive brand-name prescription medications for FREE through the CANARX program! We offer some of the most highly prescribed medications today, including ...

- Advair
- Eliquis
- Flovent
- Januvia
- Symbicort
- Xarelto

For a complete list and to enroll online, or download an enrollment form, visit canarx.com

WebID: CCMHG

“

Friendly, competent, efficient and great to deal with.

- James,
Ellicott City, MD

”

“

This service is a fantastic way to get your medications at zero copay.

- Bill,
Choctaw, OK

”

**READY TO START SAVING?
ENROLL ONLINE TODAY AND
RECEIVE A \$50 GIFT CARD!**

See website for more details



For eligible plan members.

1-866-893-6337
canarx.com



WebID:
CCMHG



Member FAQs



HOW CAN THESE MEDICATIONS BE OFFERED AT A ZERO COPAY?

The substantial savings opportunities that the CANARX mail order programs provide are due to the fact that in the countries (Canada, the United Kingdom and Australia) where CANARX assists individuals in shopping, prevailing prices are substantially lower for the same drugs than they are in the United States. CANARX works with government-licensed pharmacies to supply brand-name medications, packaged and sealed by the original manufacturer, for delivery to all participants. This lower cost for medications allows CANARX to offer this program at a zero copay to the participant.

WHERE DO THESE MEDICATIONS COME FROM?

All medications are sourced from Tier 1 countries as designated by U.S. Congress for safety purposes. Tier 1 countries are deemed by the U.S. government to have equivalent or greater safety and licensing regulations as the United States. CANARX ensures that all medications are packaged by the manufacturer, distributed by government-regulated wholesalers, prescribed by practicing physicians, labeled and dispensed by licensed local pharmacists, and delivered directly to the patient. In addition, CANARX professionals regularly inspect all licensed pharmacies to ensure that safety standards and regulations are met.

WHAT IS THE DIFFERENCE BETWEEN THE MEDICATIONS FROM THE UNITED STATES AND THOSE SHIPPED FROM INTERNATIONAL SOURCES?

Medications shipped by CANARX pharmacies meet the strict manufacturing requirements of Tier 1 countries and are government-regulated. Although the drugs you receive may in limited circumstance look slightly different or have a different name than what you are used to, for all intents and purposes they are identical. For example, a drug may be a capsule in the U.S. but a tablet in another country.

WILL THE CANARX PROGRAM REPLACE OUR CURRENT PRESCRIPTION BENEFIT PLAN?

No. CANARX is a voluntary program that can only be used for select brand-name medications listed on the CANARX formulary. You will need to use your current prescription benefit plan for medications not listed on the formulary, such as generic medications, controlled substances and antibiotics.

DO I HAVE TO USE CANARX FOR ALL OF MY BRAND-NAME MEDICATIONS?

No. But if your medication is available through CANARX, the copay savings could be substantial. At any time, you can revert back to purchasing your medications at your local pharmacy or mail order provider.

HOW DO I ENROLL?

Please submit a completed enrollment form, a copy of your photo identification, and a new prescription for each medication you wish to fill through the CANARX program. Enrollment forms can be completed online, or a hard copy can be faxed, uploaded to our secure site, or mailed to CANARX. Photo identification can be submitted via the online enrollment form, scanned and uploaded to our secure site, emailed, or mailed. Prescriptions can be mailed or faxed directly from your prescriber's office. A three-month prescription with three refills should be requested from your prescriber – and a 30-day prescription for local filling should ensure your continued course of therapy during your enrollment period. Unsure if your medication is available through the CANARX program? Check your group formulary online or reach out to our service representatives for confirmation.

WHY DO I HAVE TO COMPLETE AN ENROLLMENT FORM?

CANARX requires this form to be completed for the safety of the patient. Your current medication list and health history are used for physician review and to complete a drug utilization review that could identify possible interactions.

HOW LONG IS THE PROCESS?

Once all correspondence is received and registration is confirmed, it takes three to five business days to process internally. Your order is then sent to the international pharmacy for dispensing. Please allow four weeks for delivery of your package.

DO I NEED TO CALL CANARX FOR REFILLS?

CANARX maintains a calling schedule for all of our customers. When your refills are due, CANARX will attempt to reach you by phone three times. If unsuccessful, a letter will be issued as a reminder for you to contact us.

WHAT IS YOUR RETURN POLICY?

Once medications have left the dispensing pharmacy, CANARX by law cannot accept medications back.

1-866-893-6337 | canarx.com



HOW DO YOU ENSURE MY SAFETY?

All medications are delivered in the original sealed package supplied from the brand-name manufacturer's approved facility. The medications are dispensed and mailed directly to the patient by a licensed pharmacy in a Tier 1 country.

DO YOU OFFER GENERIC MEDICATIONS?

No. CANARX only offers brand-name medications that represent savings.

WHAT DOES THE "G" MEAN ON THE FORMULARY?

Medication names appearing with a (G) are available in a generic version locally with a potentially greater savings.

WHY IS THE MEDICATION NOT AVAILABLE?

- Generic drugs are excluded because they usually cost less in the U.S.
- Medications requiring refrigeration are excluded since they may spoil during transit.
- Narcotics and controlled substances are excluded because of safety concerns as well as laws and regulations.
- Medications likely to be required right away, such as antibiotics for an infection, are excluded because of the time required to ship them abroad.
- The medication may be available for purchase locally at a lower cost to your health plan.
- There may not be sourcing for the medication at our approved pharmacies.

WHERE ELSE CAN I OBTAIN MY MEDICATIONS?

Medications not available through CANARX should be ordered through your U.S. prescription provider.

ARE THERE ANY OTHER MEDICATIONS AVAILABLE THAT I CAN TAKE OR CAN BE SUBSTITUTED?

You may ask your physician to review the list of available medications for a possible alternative. When switching to an available medication, a local trial is required.

WHY CAN'T I SEND IN A PRESCRIPTION FOR A NEW MEDICATION AND INSTEAD HAVE TO FILL IT LOCALLY FIRST?

When taking a new-to-you medication a local trial is required in which initial counseling would be received from a local pharmacy. This ensures that you know how to properly take the medication and are aware of possible side effects. The trial also ensures there are no adverse reactions to the medication and that your physician has determined it is appropriate to continue therapy prior to ordering a three-month supply.

I HAVE QUESTIONS REGARDING MY MEDICATIONS, IS THERE A PHARMACIST AVAILABLE TO ANSWER MY QUESTIONS?

A pharmacist is available to answer questions. There is also a 24-hour emergency line.

WHO PAYS THE SHIPPING COSTS?

There are no individual shipping charges. All shipping costs are covered by the program.

WHAT IS THE STANDARD SHIPPING TIME?

Please allow four weeks for delivery of a package.

DO I HAVE TO SIGN FOR MY PACKAGE?

CANARX does not require a signature upon delivery. However, it may be a requirement of the U.S. Postal Service and left to their discretion.

WHAT IF I DO NOT WISH TO HAVE MY MEDICATIONS SHIPPED IN THE ORIGINAL MANUFACTURER PACKAGING AND PREFER BOTTLES?

All medications are shipped in the sealed, original manufacturer packaging as an added safety feature. If you wish to have medication bottles or child-proof caps, they can be included in the order at no cost, but the medication will have to be transferred into the bottles upon receipt.

CAN I HAVE THE MEDICATIONS SHIPPED TO MY P.O. BOX?

Yes. However, CANARX requires to have the home address on file.

IS PERSONAL IMPORTATION PERMITTED?

Yes. CANARX has designed its program to comply with personal importation guidelines that allow you to import up to a 90-day supply of medicines that your doctor has prescribed for you for your personal use. Contact us today for more information.

MY DOCTOR SAYS THEY CANNOT PROVIDE A WRITTEN PRESCRIPTION. WHAT NOW?

When a prescription is being filled locally, the doctor may be restricted by e-prescribing mandates. These mandates provide exceptions in specific cases, such as the medication being filled out of state. Advise your doctor the medication is being filled out of state and a physical prescription is required. Prescriptions can either be mailed directly to us or faxed from your physician's office at 1-866-715-6337.



Why participate in the Diabetes Care Rewards Program

We'll help you improve your health and reduce your risk of heart disease and stroke. And you'll get a **Good Health Gateway® RX Rewards Card** to get your \$0 copays.

How to get your Good Health Gateway RX Rewards Card for \$0 copays



Register at GoodHealthGateway.com

Or call our **Good Health Gateway** HelpLine at

800.643.8028 Monday through Thursday 8:30 am - 6:00 pm and Friday 8:30 am - 5:00 pm EST.



Send us a Provider Confirmation Form or other acceptable documentation showing you completed the medical exams and lab tests listed below. Upload your documents through the website, send by mail, or fax to 877.378.4480.

Any of the exams/labs completed in the past year will count toward the requirement.

- Annual foot exam
- Annual eye exam
- Annual laboratory work-up of your fasting blood lipid levels
- Annual laboratory work-up of your urine/protein levels
- Laboratory work-up of your Hemoglobin A1c levels every 6 months



Get \$0 copays on covered diabetes medications and supplies using your **Good Health Gateway Rx Rewards Card** at your local, in-network pharmacy or through OPTUMRx® Home Delivery when the program requirements are met.



RX REWARDS CARD
PRIMARY COVERAGE

\$0 COPAYS FOR DIABETES RX & SUPPLIES

Name **FirstName LastName**

RxBIN BIN RxCN PCN

RxGrp GroupName ID MemberId

PHARMACISTS: SUBMIT AS PRIMARY COVERAGE
for diabetes medications and supplies.

Cape Cod Municipal Health Group is committed to helping you achieve your best health status. Rewards for participating in this wellness program are available to employees and their dependents on a Cape Cod Municipal Health Group health plan who meet the program requirements. If your doctor determines you do not need one of the activities required in this program, they can simply indicate not needed beside that requirement, and you will receive credit for this requirement.

Participation in the program is voluntary and confidential. HIPAA privacy and security standards are used to ensure the protection of your healthcare information.

800.643.8028
GOODHEALTHGATEWAY.COM

3 Ways to Contact Good Health Gateway® Member Services



CALL

Call 800.643.8028 | Hablamos Español.

Monday - Thursday
8:30 am - 6:00 pm ET

Friday
8:30 am - 5:00 pm ET



E-MAIL

E-mail_services@goodhealthgateway.com

E-mail responses will be sent within 2 business days.



ASK A QUESTION ONLINE

**Ask a Question online at
GoodHealthGateway.com**

Click the blue "Ask a Question" button at the bottom of the screen. Responses will be sent by email within 2 business days.

Please be aware that the information you send through e-mail and/or online is not secure. We cannot guarantee the privacy or security of the information you enter in either platform. For questions that require you to share personal health, medical, or medication information, we recommend you call our Member Services Team.

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**

PinnacleCare is a member of the Sun Life family of companies. PinnacleCare and its employees do not diagnose medical conditions, recommend treatment options or provide medical care, and any information or services provided should not be considered medical advice. Any medical decisions should be made only after consultation with and at the direction of your medical provider. Any person or entity who provides health care services following a referral or other service provided does so independently and not as an agent or representative of PinnacleCare.

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CAPE COD COLLABORATIVE

**** Continuation Coverage Rights Under COBRA****

Introduction

This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information: must pay or aren't required to pay*] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- *[add if Plan provides retiree health coverage: Commencement of a proceeding in bankruptcy with respect to the employer;]*; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days *[or enter longer period permitted under the terms of the Plan]* after the qualifying event occurs. You must provide this notice to: *[Enter name of appropriate party]*. *[Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.]*

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. *[Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.]*

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, [Children's Health Insurance Program \(CHIP\)](#), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

¹ <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

[Enter name of the Plan and name (or position), address and phone number of party or parties from whom information about the Plan and COBRA continuation coverage can be obtained on request.]

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 2025, the Before Tax amount is between 1% and 100% of your compensation or \$23,500.00, 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 Options¹

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.

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

Transfers and Allocation Changes¹

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.

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

Rollovers¹

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.

¹Governmental 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
- Unforeseeable 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.

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RO1632507-0621

MEANINGFUL NOTICE / PLAN SUMMARY INFORMATION

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 (OMNI/TSACG). Visit the OMNI/TSACG 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 are eligible to participate in the 403(b) plan immediately upon employment; however, private contractors, appointed/elected trustees and/or school board members are not eligible to participate in the 403(b) plan. 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 and 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. 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. OMNI/TSACG monitors 403(b) plan contributions and notifies the employer in the event of an excess contribution.

THE BASIC CONTRIBUTION LIMIT FOR 2026 IS \$24,500.

Additional provisions allowed:

2026 AGE-BASED ADDITIONAL AMOUNT

Participants who are age 50 to 59 or 64 or older by 12/31/2026 qualify to make an additional contribution of up to \$8,000 to their 403(b) accounts. Participants aged 60, 61, 62, or 63 on 12/31/2026 can contribute an additional amount of up to \$11,250.

Note: Individuals whose prior-year social security wages were \$150,000 and above must contribute this amount to a Roth plan.

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. An 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.

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>.

2026

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, withdrawals or distributions. Participants may request these distributions by completing the necessary forms obtained from the provider and plan administrator as required. All completed forms should be submitted to the plan administrator for processing. Prior to taking a loan, participants should consult a tax advisor.

PLAN-TO-PLAN TRANSFERS

A plan-to-plan transfer is defined as the movement of a 403(b) account from a previous employer's plan and retaining the same account with the authorized investment provider under the new employer'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 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's 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's plan. Details and terms of the loan are established by the provider. Participants must repay their loans through monthly payments as directed by the provider.

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 certify and may be asked to provide evidence that the distribution is being taken for specific reasons. 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>



A DAYBRIGHT FINANCIAL COMPANY

Waypoint Academy
1175 Route 28 South
Yarmouth, MA 02664
(508) 564-5099 Fax: (508) 564-5263
School day: 8:00 AM - 2:30 PM
Early Dismissal: 11:15 PM
Summer ESY 8:00 AM - 1:00 PM

Progress Reports:

Q1: Nov 2nd Q3: April 2nd
Q2: Jan 21st Q4: June 21st

July

3rd- Independence Day/CCC Closed
ESY Wk 1: 7/6/26-7/9/26
Wk 2: 7/13/26-7/16/26
Wk 3: 7/20/26-7/23/26
Wk 4: 7/27/26-7/30/26

September

1st- Staff Days/No Students
2nd- First Day of School for Students
4th- No School
7th- Labor Day/No School
18th- In Service/Half Day for Students

(19 Days)

November

6th- In Service/Half Day for Students
11th- Veterans Day/No School
25th- Thanksgiving Break/No School

(17 Days)

January

1st- Holiday Break/No School
18th- Martin Luther King Jr. Day/No School
29th- In Service/Half Day for Students

(19 Days)

March

26th- Staff Training/No School Students

(22 Days)

May

21st- In Service/Half Day for Students
31st- Memorial Day/No School

(20 Days)

CAPE COD COLLABORATIVE PUBLIC DAY SCHOOL 2026-2027 CALENDAR

Approved by CCC BOD on 01/14/2026

JULY 2026						
S	M	T	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

AUGUST 2026						
S	M	T	W	Th	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

SEPTEMBER 2026						
S	M	T	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

OCTOBER 2026						
S	M	T	W	Th	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

NOVEMBER 2026						
S	M	T	W	Th	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

DECEMBER 2026						
S	M	T	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

JANUARY 2027						
S	M	T	W	Th	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

FEBRUARY 2027						
S	M	T	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

MARCH 2027						
S	M	T	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

APRIL 2027						
S	M	T	W	Th	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

MAY 2027						
S	M	T	W	Th	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

JUNE 2027						
S	M	T	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

STAR PROGRAM

418 Bumps River Rd
Osterville, MA 02655
(508) 420-6950 Fax: (508) 420-6959
School day: 9:00 AM - 3:00 PM
Early Dismissal: 11:45 AM
Summer ESY 9:00 AM - 2:00 PM

Progress Report:

Term 1: Nov 24th Term 2: March 11th
Term 3: June 21st

August

ESY Wk 5: 8/03/26-8/06/26
Wk 6: 8/10/26-8/13/26
26th&27th - New Staff Orientation
31st- Staff Days/No Students

October

9th- All Cape Professional Development/No School for Students
12th- Indigenous Peoples Day/No School

(20 Days)

December

11th- In Service/Half Day for Students
24th-31st Winter Vacation/No School

(17 Days)

February

15th- Presidents' Day/No School
16th- 19th- February Vacation/No School
26th- In Service/ Half day for students

(15 Days)

April

9th- In Service/Half Day for Students
19th- Patriot's day
20th- 23rd- April Vacation/No School

(17 Days)

June

18th- Juneteenth/No School
21st- Half Day/tentative last day of school for students (180th day)
28th- 185th (Includes 5 Inclement Weather days)

(14 Days)

■ First/Last Day of School

■ No School-Holidays & Staff Training Days

■ Half Day of School for Students

■ ESY(Extended School Year)

