Town of Truro Employee/Active Retirees
Health Plan Rates
FY2026 July 1, 2025 - June 30, 2026

Senior Health Plan Rates will be sent in the Fall and are effective January 1, 2026 - December 31, 2026 (Must be retired and Medicare eligible)

	Employee/Retiree Monthly Cost		35%
	Individual	Single Parent/Child	Family
Blue Cross Blue Shield			
Master Health Plus*	762.65	1,527.75	1,906.10
Blue Care Elect PPO	498.40	998.20	1,247.05
Network Blue HMO	381.15	768.60	1,022.70
Harvard Pilgrim			
Harvard Pilgrim PPO	411.60	822.15	1,088.15
Harvard Pilgrim HMO	374.50	749.70	1,002.75
Annual In-Network deductible all Health plans	300.00	600.00	900.00

**Grandfathered plan, not available for new enrollments*

Enrolling in one of the above plans gives access to the following free benefits:
CanaRx Free Mail Order Prescriptions
Diabetes Care Program
Access to provider specific TeleHealth

	Voluntary - No Employer Contribution		
	Individual	Single Parent/Child	Family
Delta Dental PPO Plus Premier	42.00	84.00	109.00
EyeMed Vision Care	7.53	14.31	21.02

Open Enrollment runs May 1 - May 31, 2025
Please contact the Collector/Treasurer's office with any questions and for applicable forms

Comparison charts and additional resources can be found online at bit.ly/truro-oer

More information is available online, Cape Cod Municipal Health Group
www.ccmhg.com

CCMHG Health Plan Benefit Comparison - FY26

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

Effective 07-01-2025	BLUE CROSS BLUE SHIELD				HARVARD PILGRIM HEALTH CARE		
		BLUE CARE ELECT PREFERRED PPO		Master Health Plus		PPO	
BENEFIT	**NETWORK BLUE HMO**	**In-Network**	**Out-of-Network**	**Indemnity Plan**	**HPHC HMO**	**IN-NETWORK**	**OUT-OF-NETWORK**
Deductible - *applies to: In-patient Admission; Out-patient Surgery; ER, High Tech Imaging (MRI, CT, & PET) and Diagnostic Tests & Procedures. Does not apply to routine office visits or pharmacy. Per plan year (July 1 to June 30) -* ***See plan document for full details***	$300 per member $900 per family	$300 per member $900 per family	$400 per member $800 per family	$300 per member $900 per family	$300 per member $900 per family	$300 per member $900 per family	$400 per member $800 per family
Out-of-Pocket (OOP) Maximum - *Once your out-of-pocket expenses for applicable services reaches this amount, you pay $0 for remainder of plan year. NOTE: a separate out-of-pocket maximum for prescription copays added effective July 1, 2015 as required by ACA (in-network only).*	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical:** $3,000 per member	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical:** $3,000 per member
Lifetime Benefit Maximum	None	None	None	None	None	None	None
INPATIENT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and special services) - **Deductible Applies**	$500 copay per admission	$500 copay per admission	20% coinsurance* Nothing for emergency/accident admissions	$700 copay per admission	$500 copay per admission	$500 copay per admission	20% coinsurance*
Physician Services	Nothing	Nothing	20% coinsurance* Nothing for emergency/accident admissions	Nothing	Nothing	Nothing	20% coinsurance*
Skilled Nursing Facility **Deductible Applies**	Nothing to 100 days per calendar year benefit maximum	Nothing to 100 days per calendar year benefit maximum	20% coinsurance* to 100 days per calendar year benefit maximum	Nothing	Limit to 100 days per Plan Year - $500 copayper admission	Limit to 100 days per Plan Year - $500 copayper admission	20% coinsurance*
Rehabilitation Hospital **Deductible Applies**	Nothing to 60 days per calendar year benefit maximum	Nothing to 60 days per calendar year benefit maximum	20% coinsurance* to 60 days per calendar year benefit maximum	Nothing	Limit to 60 days per Plan Year - $500 copay per admission	Limit to 60 days per Plan Year - $500 copay per admission	20% coinsurance*

CCMHG Health Plan Benefit Comparison - FY26

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

Effective 07-01-2025	BLUE CROSS BLUE SHIELD				HARVARD PILGRIM HEALTH CARE		
		BLUE CARE ELECT PREFERRED PPO		Master Health Plus		PPO	
BENEFIT	NETWORK BLUE HMO	In-Network	Out-of-Network	Indemnity Plan	HPHC HMO	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT HOSPITAL	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Emergency Room Visits for Emergency or Accident Care - Deductible Applies	$100 copay (waived if admitted or for observation stay)	$100 copay (waived if admitted or for observation stay)	$100 copay (waived if admitted or for observation stay)	Nothing for first treatment of accident; $100 copay for emergency medical care	$100 copay, (waived if admitted)	$100 copay, (waived if admitted)	$100 copay, (waived if admitted)
Emergency Room Visits for Medical Care - Deductible Applies	$100 copay (waived if admitted or for observation stay)	$100 copay (waived if admitted or for observation stay)	$100 copay (waived if admitted or for observation stay)	$100 copay (waived if admitted or for observation stay)	$100 copay, (waived if admitted)	$100 copay, (waived if admitted)	$100 copay, waived if admitted
Surgery - Deductible Applies	$250 copay	$250 copay	20% coinsurance*	$250 copay	$250 copay	$250 copay	20% coinsurance*
Radiation and Chemotherapy	Deductible applies	Deductible applies	20% coinsurance*	Nothing	Nothing	Nothing	20% coinsurance*
Diagnostic X-ray and Lab - Deductible Applies	Nothing	Nothing	20% coinsurance*	Nothing	Nothing	Nothing	20% coinsurance*
Routine Colonoscopy *(without surgery)*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay	$0 copay	20% coinsurance*
High Cost Radiology (MRI, CT & PET) - Deductible Applies	$100 copay	$100 copay	20% coinsurance*	$100 copay	$100 copay	$100 copay	20% coinsurance*
Hemodialysis - Deductible Applies	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay	$0 copay	20% coinsurance*
Physical Therapy	$20 copay to 60 visits per calendar year	$20 copay to 100 visits per calendar year	20% coinsurance* to 100 visits per calendar year	$20 copay to 60 visits per calendar year	Copay Level 1 : $20 copay per visit, 30 visits per Plan Year	Copay Level 1 : $20 copay per visit, 30 visits per Plan Year	20% coinsurance*
PHYSICIAN'S OFFICE	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Surgery - NO DEDUCTIBLE	$20/$45 co-pay	$20/$45 co-pay	20% coinsurance*	$45 co-pay	Copay Level 1 provider : $20 copay per visit Copay Level 2 provider : $45 per visit	Copay Level 1 provider : $20 copay per visit Copay Level 2 provider : $45 per visit	20% coinsurance*

CCMHG Health Plan Benefit Comparison - FY26

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

Effective 07-01-2025	BLUE CROSS BLUE SHIELD				HARVARD PILGRIM HEALTH CARE		
		BLUE CARE ELECT PREFERRED PPO		Master Health Plus		PPO	
BENEFIT	NETWORK BLUE HMO	In-Network	Out-of-Network	Indemnity Plan	HPHC HMO	IN-NETWORK	OUT-OF-NETWORK
PHYSICIAN'S OFFICE	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Adult Preventative Exam *(includes preventative lab tests)*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay	$0 copay	20% coinsurance*
PCP Medical Care/ Mental Health Care/ Substance Abuse Care	$20 copay	$20 copay	20% coinsurance*	$20 copay	Copay Level 1 :$20 copay	Copay Level 1 :$20 copay	20% coinsurance*
Well Child Care *(includes preventative lab tests)*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay (including routine physical exams, immunizations, school, camp, sports)	$0 copay (including routine physical exams, immunizations, school, camp, sports)	20% coinsurance*
Routine GYN Exam *(one per calendar year , includes preventative lab tests)*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay	$0 copay	20% coinsurance*
Routine Mammogram	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay	$0 copay	20% coinsurance*
Routine Vision Exam	$0 copay (once every 12 months)	$0 copay (once per calendar year)	20% coinsurance* (once per calendar year)	$0 copay (once every 24 months)	Limited 1 visit per Plan Year - No Charge	Limited 1 visit per Plan Year - No Charge	20% coinsurance*
Specialist Office Visit	$45 copay	$45 copay	20% coinsurance*	$45 copay	Copay Level 2 : $45 copay	Copay Level 2 : $45 copay	20% coinsurance*
OTHER OUTPATIENT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Visiting Nurse Home Health Care Deductible Applies	Nothing	Nothing	20% coinsurance*	Nothing	Nothing	Nothing	20% coinsurance*
Durable Medical Equipment - Deductible Applies	After deductible, member pays 20%, plan pays 80% with no limit. Wigs are covered in full when needed as a result of any form of cancer, leukemia, alopecia areata, alopecia totalis, or permanent hair loss due to injury.	After deductible, member pays 20%, plan pays 80% with no limit. Wigs are covered in full when needed as a result of any form of cancer, leukemia, alopecia areata, alopecia totalis, or permanent hair loss due to injury.	After deductible, member pays 40%, plan pays 60% with no limit. Wigs are covered in full when needed as a result of any form of cancer, leukemia, alopecia areata, alopecia totalis, or permanent hair loss due to injury.	20% coinsurance*	After deductible, member pays 20% until member has paid $1,000 out of pocket, then plan pays in full. Wigs are covered in full when needed as a result of any form of cancer, leukemia, alopecia areata, alopecia totalis, or permanent hair loss due to injury.	After deductible, member pays 20% until member has paid $1,000 out of pocket, then plan pays in full. Wigs are covered in full when needed as a result of any form of cancer, leukemia, alopecia areata, alopecia totalis, or permanent hair loss due to injury.	After deductible, member pays 20% coinsurance until the member has paid $1,000 out of [ocket, then plan pays in full. Wigs subject to deductibel then 20% coinsurance.
Ambulance- Deductible Applies	Nothing	Nothing	Nothing for accident or emergency; 20% coinsurance* other medically necessary ambulance transport	20% coinsurance*	Nothing	Nothing	Emergency transport: Nothing Non emergency transport: 20% coinsurance
Routine Pediatric Dental	Nothing	All charges	All charges	All charges	Covered in full: Preventive care for children up to age 13 2 visits per member per **plan** year including exam, cleaning, x-rays, & flouride treatment.	Covered in full: Preventive care for children up to age 13. 2 visits per member per **plan** year including exam, cleaning, x-rays, & flouride treatment.	Deductible, then 20% coinsurance

CCMHG Health Plan Benefit Comparison - FY26

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

Effective 07-01-2025	BLUE CROSS BLUE SHIELD				HARVARD PILGRIM HEALTH CARE		
		BLUE CARE ELECT PREFERRED PPO		Master Health Plus Indemnity Plan		PPO	
BENEFIT	**NETWORK BLUE HMO**	**In-Network**	**Out-of-Network**		**HPHC HMO**	**IN-NETWORK**	**OUT-OF-NETWORK**
Chiropractor Visits	All charges	$20 copay	20% coinsurance*	$20 copay	All charges	All charges	All charges
Prescription Drugs	**Retail:** (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay **Mail Order:** (90 day supply) Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	**Retail:** (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay **Mail Order:** (90 day supply) Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	**Retail:** (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay **Mail Order:** (90 day supply) Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	**Retail:** (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay **Mail Order:** (90 day supply) Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay Non-formulary drugs All charges	**Retail:** (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay **Mail Order:** (90 day supply) Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	**Retail:** (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay **Mail Order:** (90 day supply) Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	no coverage (Optum has over 65.000 pharmacies)
Fitness Benefit	Up to $150 reimbursement toward membership or exercise classes at a health club; and virtual fitness, athletic fees, bicycles, helmets, athletic shoes. See plan details Enroll in a qualified Weight Watchers or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	Up to $150 reimbursement toward membership or exercise classes at a health club; and virtual fitness, athletic fees, bicycles, helmets, athletic shoes. See plan details Enroll in a qualified Weight Watchers or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	Up to $150 reimbursement toward membership or exercise classes at a health club; and virtual fitness, athletic fees, bicycles, helmets, athletic shoes. See plan details Enroll in a qualified Weight Watchers or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	No Fitness Benefit	Up to $300 reimbursement per **calendar** year on fees for 2 members for wellness benefits to include health and fitness club memberships, classes or virtual subscriptions, athletic programs etc. Must be currently enrolled in Harvard Pilgrim at the time of reimbursement and active wellness membership and HPHC member for at least four months within a calendar year.	Up to $300 reimbursement per **calendar** year on fees for 2 members for wellness benefits to include health and fitness club memberships, classes or virtual subscriptions, athletic programs etc. Must be currently enrolled in Harvard Pilgrim at the time of reimbursement and active wellness membership and HPHC member for at least four months within a calendar year.	Up to $300 reimbursement per **calendar** year on fees for 2 members for wellness benefits to include health and fitness club memberships, classes or virtual subscriptions, athletic programs etc. Must be currently enrolled in Harvard Pilgrim at the time of reimbursement and active wellness membership and HPHC member for at least four months within a calendar year.

***After Deductible**

CANARX

Cape Cod Municipal Health Group

SIMPLE. SAFE. SMART.

SIGN UP TODAY

Receive a one-time $25 Gift Card for enrolling in the CANARX program with a qualifying prescription for a 90-day supply with 3 refills!

***Offer available to new program members only.**

Medications FREE to your door!

Visit CCMHGCanaRx.com for a full list of medications.

CANARX is a voluntary international mail order prescription program offered to eligible employees, non-Medicare eligible retirees and dependents enrolled in the Blue Cross Blue Shield or Harvard Pilgrim Health Plans with the Cape Cod Municipal Health Group (CCMHG).

Brand name medications, in the original factory-sealed manufacturers packaging, are delivered DIRECT TO YOUR DOOR from certified pharmacies in Canada, the United Kingdom and Australia. YOU PAY NOTHING thanks to the savings CANARX brings to your plan.

Getting started is super easy!

1. Check to see if a medication is offered. Call **1-866-893-6337** and speak with a CANARX representative or view the complete formulary and print enrollment material at **www.canarx.com** (WebID: **CCMHG**).
2. Ask your doctor for a prescription for a 3-month supply, with 3 refills.
3. Submit documentation (completed enrollment form, prescription and a copy of your photo ID).
4. Sit back and relax...medication will be mailed direct to your home within 4 weeks!

- **$0 Copay**
- **300+ FREE Brand Name Medications**
- **Easy, convenient refills**
- **Refills only, no "new to you" meds**
- **No additional costs**

For More Information

1-866-893-6337
www.canarx.com
WebID: CCMHG

January 2023

▼ 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 prescribers, 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.

3 REASONS TO JOIN

The Diabetes Care Rewards Program
at GoodHealthGateway.com

SCAN ME TO JOIN

1. YOUR DOCTORS

See your doctors to complete routine diabetes labs and exams recommended by the American Diabetes Association.

2. YOUR HEALTH

Manage your diabetes effectively with the help of our timely reminders to see your doctors so you live healthy and feel well.

3. YOUR REWARDS

Earn $0 copays on your diabetes medications and supplies when you join at no cost to you and complete your labs and exams.

The **Good Health Gateway**® Diabetes Care Rewards Program is a free benefit offered by Cape Cod Municipal Health Group to their health plan members. **Participation is voluntary and confidential.**

Join Today

800.643.8028 | Hablamos español.
GoodHealthGateway.com

Cape Cod Municipal Health Group

Good Health GATEWAY®
Diabetes Care Rewards Program

This program is administered by Abacus Health Solutions and sponsored by your employer/health plan sponsor through the Cape Cod Municipal Health Group.

Available to the following member employers of the Cape Cod Municipal Health Group:

Barnstable County
Barnstable County Retirement Association
Barnstable Fire District
Bourne Recreation Authority
Bourne Water District
Buzzards Bay Water District
Cape Cod Collaborative
Cape Cod Light Compact
Cape Cod Lighthouse Charter School
Cape Cod Regional Technical School
Cape Cod Regional Transit Authority
Centerville, Osterville, Marston's Mills Fire District
Cotuit Fire District
County of Dukes County
Dennis Water District
Dennis-Yarmouth RSD
Hyannis Fire District
Martha's Vineyard Charter School
Martha's Vineyard Commission
Martha's Vineyard Land Bank
Martha's Vineyard Refuse
Martha's Vineyard RSD
Martha's Vineyard Regional Transit Authority
Mashpee Water District
Monomoy RSD
Nauset RSD
North Sagamore Water District
Oak Bluffs Water District
Orleans, Brewster, Eastham, Groundwater Protection District
Sandwich Water District
Up-Island RSD
Upper Cape Cod Regional Vocational Technical School
Veterans Services of Cape Cod
West Barnstable Fire District

Towns of:
- Aquinnah
- Barnstable
- Brewster
- Chatham
- Chilmark
- Dennis
- Eastham
- Edgartown
- Falmouth
- Gosnold
- Harwich
- Mashpee
- Oak Bluffs
- Orleans
- Provincetown
- Tisbury
- Truro
- Wellfleet
- West Tisbury
- Yarmouth

For employees and their covered dependents insured through one of the following Cape Cod Municipal Health Group sponsored health plans:

Blue Cross Blue Shield of Massachusetts
Blue Care Elect Preferred PPO, Network Blue HMO, Master Health Plus, Blue Cross HSA* qualified health plan

Harvard Pilgrim Health Care
HMO, PPO, Harvard Pilgrim HSA* qualified health plan

*Some restrictions may apply. Please call our HelpLine at 800-643-8028 if you have questions.

This program is not available to retirees on Medicare supplemental health plans.

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

Coverage Summary for Cape Cod Municipal Health Group *Voluntary* Group # 000143 Effective 7/1/2025

Deductible: $50 per individual / $150 per family. Deductible waived for Diagnostic and Preventive categories.
Calendar Year Maximum: $1,500 per person.

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

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

Additional Benefit Information

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

This plan is eligible for Rollover Maximum

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

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

Delta Dental PPO *Plus Premier*™

DELTA DENTAL®

Easy Access and Great Value – Your Delta Dental Networks

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

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

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

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

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

Learn more at deltadentalma.com

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

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

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

Your Plan is Administered by:
Delta Dental of Massachusetts
800-872-0500
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DELTA DENTAL®

Rollover Maximum Benefit Summary

Rollover Maximum Summary for Cape Cod Municipal Health Group

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

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

Rollover Max is easy and automatic.

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

How *Rollover Max* works.

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

Rollover Max increases your dental benefit value.

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

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

How to check your *Rollover Max* balance online:

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

DELTA DENTAL®

Now Here's a Reason to Smile

Delta Dental of Massachusetts' Right Start 4 Kids℠ Benefit Eliminates Dental Care Costs for Children

Did you know that cavities and poor oral health are the most common health problem for children in the United States? Poor oral health can cause pain and infections that may lead to problems with eating, speaking, playing and self-esteem.

In fact, children with poor oral health are three times more likely to miss school and have lower grades.[1] And this, in turn, can lead to lost workdays and unexpected expenses for families.

Yet, with good oral care, cavities are nearly 100% preventable.

Delta Dental of Massachusetts' Right Start 4 Kids℠ benefit can make it easier – and more affordable – for you to take care of your children's oral health.

Right Start 4 Kids℠ pays 100% of the cost of covered care with participating dentists up to your plans' benefit limit. That includes covered care for diagnostic, preventive, basic and major services for children up to their 13th birthday.

And we make it easy for you to take advantage of the benefits. Just get your care from a Delta Dental PPO™ or a Delta Dental Premier® dentist and we will automatically apply the Right Start 4 Kids℠ benefit - there's no need to fill out any claim forms or paperwork.*

Right Start 4 Kids℠ is backed by the power of Preventistry™, Delta Dental of Massachusetts' groundbreaking and unique approach to transforming the oral health care system. Preventistry combines clinical innovation, actionable data and digital engagement to provide a higher level of care and improve the health of our members.

RIGHT START 4 KIDS℠

Coverage for age 12 and under

100% coverage for covered services (preventive, basic, major)*

No Deductible

Does not apply to orthodontics; orthodontic coinsurance applies

Annual benefit maximum applies

Exclusions and Limitations apply

*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.

Sample PPO *Plus Premier* Right Start 4 Kids℠ Plan Design

Age 12 and under

Benefit	Right Start 4 Kids℠ Benefit*
Deductible	None
Preventive/Diagnostic Coinsurance	100%
Basic Restorative Coinsurance	100%
Major Restorative Coinsurance	100%

1 American Journal of Public Health - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3222359/

UNDERSTANDING YOUR ORTHODONTIC BENEFITS

Coverage

Your dental plan provides the following coverage for orthodontic services:

- 50% of your orthodontic costs.
- Your coverage is based on the maximum allowable fee for orthodontic services.
- Coverage is subject to a lifetime maximum of $1,000 per member.
- All members are eligible for coverage.
- A maximum of 24 months of active treatment.

Paying for orthodontic care

In most cases, Delta Dental issues reimbursements for orthodontic care in automatic monthly payments not to exceed 12 installments. The first payment is based on the date of banding/placement of appliances. Additional payments will be issued automatically on a monthly basis assuming you are still eligible for orthodontic benefits.

If you begin orthodontic treatment after your effective date of coverage and you receive care from a network dentist, Delta Dental will reimburse your dentist directly and send you and your dentist an Explanation of Benefits (EOB). The EOB will detail any payments made to the dentist. It is up to you and your dentist to develop a payment plan for the balance minus any Delta Dental adjustments.

If you've already started your orthodontic treatment

We provide pro-rated orthodontic benefits for members who are in active treatment and banded within 24 months of DDMA effective date. Coverage will be based on the maximum allowable fee, determined by the lower of the dentists submitted fee or contracted fee, and the time remaining in your treatment plan once your coverage with Delta Dental begins.

To determine your coverage, we exclude the banding allowance, which we estimate to be 30% of total cost of treatment. Since that cost was incurred before your coverage began with Delta Dental, it is not covered.
We process your benefit on the remaining 70% of the maximum allowable fee. Payment will vary based on banding date and effective date with Delta Dental. If banded less than 5 months from DDMA effective date, benefit is issued in automatic monthly payments. If banded more than 5 months from effective date with DDMA, benefit is issued in one lump payment. All payments are issued provided patient is in active treatment and covered by Delta Dental.

Termination of Coverage

In the event your coverage terminates before you complete your orthodontic treatment the automatic monthly payments will cease.

DELTA DENTAL®

Talk to a Dentist Online With Virtual Visits

Delivered by TeleDentistry.com

Delta Dental of Massachusetts members can now schedule a virtual visit with a dentist 24/7 using their smartphone, tablet or computer

Virtual visits are available to Delta Dental of Massachusetts members for urgent dental problems through their existing Delta Dental coverage. A virtual visit is an effective way to receive care and avoid the emergency room.

You can schedule a virtual visit when you:

- Are having a dental emergency or an urgent dental concern.
- Need access to a dentist after hours and your dentist isn't available.
- Need to consult with a dentist while traveling.

TeleDentistry.com dentists diagnose the problem and provide treatment options. You will be referred to a Delta Dental dentist for follow-up care.

The TeleDentistry.com dentist will email you consultation notes and direct you to follow up with your provider. If you have not established care with a Delta Dental network dentist, TeleDentistry.com will provide you with a list of local Delta Dental network dentists for follow-up care.

This service supplements Delta Dental's current plan coverage and should be used after business hours, holidays and weekends, or when your regular dentist is unavailable.

TeleDentistry.com services are only available to current Delta Dental of Massachusetts members. A TeleDentistry.com consultation counts as a problem-focused exam under your dental plan.

IT'S EASY TO SCHEDULE A VIRTUAL VISIT

Delta Dental has partnered with TeleDentistry.com to provide virtual visits.

Here's how it works:

Step 1 – Go online to teledentistry.com/ddma.

Step 2 – Complete a brief registration and health questionnaire.

Step 3 – You'll be connected with a TeleDentistry.com dentist to begin your visit.

TeleDentistry.com is backed by the power of Preventistry™, Delta Dental of Massachusetts' groundbreaking and unique approach to transforming the oral health care system. Preventistry combines clinical innovation, actionable data and digital engagement to provide a higher level of care and improve the health of our members.

Cape Cod Municipal Health Group

(Access Network)

SUMMARY OF BENEFITS

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

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

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

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

Savings plus convenience plus choice

PLUS Providers add another layer of coverage

$200
Frame allowance

$100
Additional glasses allowance

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

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

The choice is yours

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

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

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION EST. 1961 OPTICAL

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