Massachusetts
PROVINCETOWN

TOWN TREASURER

NEW FULL TIME EMPLOYEE

Welcome to the Town of Provincetown!

Please fill in the information below, and complete the attached documents. Please also provide a copy of a state or federally issued ID/driver's license, and a copy of your birth certificate. Enclosed you will find information related to the health and other benefits offered through the Town for your review and selection.

Name: _____

Social Security Number: _____

Mailing Address: _____

_____

Phone Number: _____

E-Mail Address: _____

Once complete, please forward to the Provincetown Finance Department.

Alexander N. Williams | **Treasurer** | **Town of Provincetown** | *260 Commercial Street MA 02657*
508.487.7000 x521| ***awilliams@provincetown-ma.gov***

Form W-4 (2019)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. ***Head of household please note:*** Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

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Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2019

1 Your first name and middle initial	Last name	**2 Your social security number**
Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married filing separately, check "Married, but withhold at higher Single rate."	
City or town, state, and ZIP code	**4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2019, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ►	**7**	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ► **Date** ►

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	**9** First date of employment	**10** Employer identification number (EIN)

income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line G. Other credits. You may be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as tax credits for education (see Pub. 970). If you do so, your paycheck will be larger, but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account. Enter "-0-" on lines E and F if you use Worksheet 1-6.

Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income, such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income not subject to withholding, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at *www.irs.gov/W4App*. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn $60,000 per year and your spouse earns $20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("-0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at *www.irs.gov/W4App* to make your withholding more accurate.

Tip: If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

New hire reporting. Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to ***www.acf.hhs.gov/css/employers.***

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

Box 8. Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

Box 9. If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

Box 10. Enter the employer's employer identification number (EIN).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself	**A**	
B	Enter "1" if you will file as married filing jointly	**B**	
C	Enter "1" if you will file as head of household	**C**	
D	Enter "1" if: • You're single, or married filing separately, and have only one job; or • You're married filing jointly, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**D**	
E	**Child tax credit.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $71,201 ($103,351 if married filing jointly), enter "4" for each eligible child. • If your total income will be from $71,201 to $179,050 ($103,351 to $345,850 if married filing jointly), enter "2" for each eligible child. • If your total income will be from $179,051 to $200,000 ($345,851 to $400,000 if married filing jointly), enter "1" for each eligible child. • If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter "-0-"	**E**	
F	**Credit for other dependents.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $71,201 ($103,351 if married filing jointly), enter "1" for each eligible dependent. • If your total income will be from $71,201 to $179,050 ($103,351 to $345,850 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents). • If your total income will be higher than $179,050 ($345,850 if married filing jointly), enter "-0-"	**F**	
G	**Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here. If you use Worksheet 1-6, enter "-0-" on lines E and F	**G**	
H	Add lines A through G and enter the total here ►	**H**	

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income not subject to withholding and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work,** and the combined earnings from all jobs exceed $53,000 ($24,450 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

1	Enter an estimate of your 2019 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 10% of your income. See Pub. 505 for details	**1**	$
2	Enter: $24,400 if you're married filing jointly or qualifying widow(er); $18,350 if you're head of household; $12,200 if you're single or married filing separately	**2**	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	**3**	$
4	Enter an estimate of your 2019 adjustments to income, qualified business income deduction, and any additional standard deduction for age or blindness (see Pub. 505 for information about these items)	**4**	$
5	**Add** lines 3 and 4 and enter the total	**5**	$
6	Enter an estimate of your 2019 nonwage income not subject to withholding (such as dividends or interest)	**6**	$
7	**Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses	**7**	$
8	**Divide** the amount on line 7 by $4,200 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction	**8**	
9	Enter the number from the **Personal Allowances Worksheet,** line H, above	**9**	
10	**Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 of that worksheet on page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	**10**	

Two-Earners/Multiple Jobs Worksheet

Note: Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

1 Enter the number from the **Personal Allowances Worksheet,** line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) . . . . . 1 _____

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don't enter more than "3" . . . . . 2 _____

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . . 3 _____

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet . . . . . 4 _____

5 Enter the number from line 1 of this worksheet . . . . . 5 _____

6 **Subtract** line 5 from line 4 . . . . . 6 _____

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . . 7 $ _____

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . 8 $ _____

9 **Divide** line 8 by the number of pay periods remaining in 2019. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2019. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . 9 $ _____

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $7,000	0
5,001 - 9,500	1	7,001 - 13,000	1
9,501 - 19,500	2	13,001 - 27,500	2
19,501 - 35,000	3	27,501 - 32,000	3
35,001 - 40,000	4	32,001 - 40,000	4
40,001 - 46,000	5	40,001 - 60,000	5
46,001 - 55,000	6	60,001 - 75,000	6
55,001 - 60,000	7	75,001 - 85,000	7
60,001 - 70,000	8	85,001 - 95,000	8
70,001 - 75,000	9	95,001 - 100,000	9
75,001 - 85,000	10	100,001 - 110,000	10
85,001 - 95,000	11	110,001 - 115,000	11
95,001 - 125,000	12	115,001 - 125,000	12
125,001 - 155,000	13	125,001 - 135,000	13
155,001 - 165,000	14	135,001 - 145,000	14
165,001 - 175,000	15	145,001 - 160,000	15
175,001 - 180,000	16	160,001 - 180,000	16
180,001 - 195,000	17	180,001 and over	17
195,001 - 205,000	18		
205,001 and over	19		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $24,900	$420	$0 - $7,200	$420
24,901 - 84,450	500	7,201 - 36,975	500
84,451 - 173,900	910	36,976 - 81,700	910
173,901 - 326,950	1,000	81,701 - 158,225	1,000
326,951 - 413,700	1,330	158,226 - 201,600	1,330
413,701 - 617,850	1,450	201,601 - 507,800	1,450
617,851 and over	1,540	507,801 and over	1,540

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You aren't required to provide the information requested on a form that's subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name _____ **Employee ID#** _____

Employer Name _____ **Employer ID#** _____

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is $395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, “Windfall Elimination Provision.”

Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500 - $400=$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, “Government Pension Offset.”

For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee _____ **Date** _____

NOTICE TO EMPLOYEES RECEIVING GOVERNMENT PENSIONS

The earnings of employees receiving government pension payments, with the exception of Social Security (including public school pensions), are limited to the following restrictions:

1. Total hours worked in one calendar year cannot exceed 960 hours.

2. The amount earned, when added to the amount of the pension, should not exceed what the employee's former position would be paying if the employee still held that job.

3. If the amount earned is found to exceed these maximums, pension monies in the amount of the excess will be refunded to the government entity which manages the pension.

I, the undersigned, attest that: (check one)

☐ **I do not receive a government pension.**

☐ **I do receive a government pension, and will abide by the restrictions stated above, informing my supervisor when my hourly and salary limitations are reaching their maximum.**

I, _____, have read and understand the above restrictions and will comply with these requirements.

Signature: _____ Date: _____

New Member Enrollment Form

Barnstable County Retirement Association **508-775-1110**
750 Attucks Lane **800-553-5569**
Hyannis, MA 02601 **Fax 508-775-1344**

Employee Name

Last:	First:	Middle:	Social Security Number - -
Date of Birth: ____ / ____ / ____ *A copy of your Birth Certificate must be provided*	Sex: M☐ F☐	Birth Name or Former Name: *(if different)*	
Are you a Veteran? Y☐ N☐	If Yes, Dates of Active Military Service: *Provide a copy of your military discharge- Form DD 214*		

Mailing Address

Street:	City/Town:	State/Zip Code:

Residential Address *(if different)*

Street:	City/Town:	State/Zip Code:

Phone:	Marital Status: M☐ S☐ W☐ D☐	# of Children:
Spouse's Name:	Spouse's Date of Birth:	

Employment

Agency/Department:	Start Date:
Job Title/Position:	Rate of Regular Compensation:

Past Retirement Membership Information

Are you retired from any Massachusetts public retirement system? Y☐ N☐		
Were you ever a member of any other Massachusetts public retirement system? Y☐ N☐ *If yes, please list the system, membership dates, status of funds.* *(attach list if more space needed)*		
Name of Retirement System:	Dates: From_____ To_____	Funds still on Deposit: Y☐ N☐
Name of Retirement System:	Dates: From_____ To_____	Funds still on Deposit: Y____ N____

If you were a part-time employee for a municipality at any time, you may be eligible to purchase past creditable service. Please contact the retirement office for further information.

Employee Full Name:	Social Security Number:

I hereby authorize the Treasurer to withhold the proper percent of my regular compensation due on each pay period and to deposit such deductions to my credit in my annuity savings funds. I understand the full amount of such deductions, with regular interest as provided by law, will be returned upon my written request if I terminate my service, unless I plan to accept a position which would entitle me to become a member of any other contributory retirement system in the Commonwealth. In the event that I die before retiring, my beneficiary or beneficiaries may receive survivor benefits or a refund of my accumulated total deductions as allowed by law.

I sign this form under the pains of perjury. I affirm that the information presented in this form is correct, complete and accurately presented. I understand that giving false or incomplete information may subject me to the loss of my benefits as well as civil and criminal penalties.

The Barnstable County Retirement Board requires a copy of your birth record, proof of name change (if applicable), and military discharge papers, DD-214 (if applicable), be submitted with this form.

Member's Signature_____ **Date**_____

MUST BE COMPLETED BY PAYROLL/PERSONNEL DEPARTMENT

Name of Employee:	Job Title or Position:	
Date of Hire: ____ / ____ / ____	Start Date with BCRA: ____ / ____ / ____	Date of First Deduction: ____ / ____ / ____
Salary Information: Annual: $_____	Weekly/biweekly: $_____	Hourly: $_____
Employment Status (check all that applies): ☐ Permanent ☐ Temporary ☐ Full-Time ☐ Part-Time, % worked _____	Rate of Retirement Deduction: ☐ 9% ☐ 8% ☐ 7% ☐ 5% ☐ Additional 2% If 5%, 7% or 8%, state reason:	
Is this an Elected Position? Y____ N____	If Yes, Date First Elected: ____ / ____ / ____	

Authorized Signature:_____ **Date**_____

Print Name:_____

- ☐ **Beneficiary Form is completed with signature and witness signature**
- ☐ **Birth Certificate is attached**
- ☐ **SSA-1945 is attached**
- ☐ **Military DD-214 is attached *(if applicable)***

Revised 2019

Employee Name: _____

(Last) (First) (Middle)

Nomination of Beneficiary

Beneficiary Information

Beneficiary or beneficiaries nominated will receive the proportion designated upon your death. As a member, you have the right to change the nominated beneficiary(ies) at any time.

A BENEFICIARY FORM WITH CORRECTIONS OR ERASURES WILL NOT BE ACCEPTED

THE FOLLOWING ***MUST*** BE COMPLETED TO ESTABLISH MEMBERSHIP

Name and Address Of Beneficiary	Beneficiary Date of Birth	Relationship to Member	Designation Primary/Contingent	Proportion of Benefit

Please mail signed **ORIGINAL** to the Barnstable County Retirement Association

Signature: _____ **Date**_____

Signature of Witness: _____ **Witness CANNOT be Beneficiary**

You are Required to Name a Primary-Must Total 100%. If for some reason the Primary Beneficiary(ies) is/are unable to collect their portion of the benefit then the Contingent (secondary) Beneficiary(ies) will. If naming a Contingent, please Specify. *A Change of Beneficiary Form* must be used if you wish to change your designated beneficiary(ies). You may obtain this form and others at *www.barnstablecounty.org,* under *Affiliated Organizations,* select ***Retirement Association***. Or contact the Barnstable County Retirement Office 508-775-1110.

Revised 2019

Authorization for Direct Deposit – Town of Provincetown

Name		Social Security Number
Address		
City/Town	State	Zip
E-Mail Address		Phone

Amount of First Direct Deposit, or "ALL"	Account Type: (If Checking, attach voided check) ☐Checking Account ☐Savings Account
Bank Routing Number	Bank Account Number
Name of Bank	

Amount of Second Direct Deposit (Blank if none)	Account Type: (If Checking, attach voided check) ☐Checking Account ☐Savings Account
Bank Routing Number	Bank Account Number
Name of Bank	

Amount of Third Direct Deposit (Blank if none)	Account Type: (If Checking, attach voided check) ☐Checking Account ☐Savings Account
Bank Routing Number	Bank Account Number
Name of Bank	

I hereby authorize the Town of Provincetown to directly deposit my pay to the account(s) listed above. This authorization will remain in effect until I modify or cancel it in person.

Signature	Date

Please return completed form to your payroll administrator.

Current Health Plan Rates 07/01/2018 - 06/30/2019 07/01/2019 - 06/30/2020		INDIVIDUAL Monthly Cost	PARENT/CHILD Monthly Cost	FAMILY Monthly Cost
Traditional Deductible				
	Blue Cross Blue Care Elect PPO	$ 336.30	$ 674.70	$ 842.40
	Blue Cross Network Blue HMO	$ 257.40	$ 519.30	$ 690.90
	Harvard Pilgrim PPO	$ 280.50	$ 561.00	$ 742.20
	Harvard Pilgrim HMO	$ 255.60	$ 511.20	$ 683.70
High Deductible with HSA*				
	Blue Cross Blue Care Elect PPO	$ 280.50	$ 563.40	$ 703.50
	Blue Cross Network Blue HMO	$ 215.40	$ 435.00	$ 578.10
	Harvard Pilgrim PPO	$ 222.00	$ 449.70	$ 597.30
	Harvard Pilgrim HMO	$ 201.60	$ 408.90	$ 543.00
Delta Dental PPO Plus Premier		$ 42.00	$ 84.00	$ 109.00
EyeMed Vision Care		$ 7.53	$ 14.31	$ 21.02

High Deductible Health Savings Account Plans are not available until July 1, 2019 (can be added during open enrollment)

The Town of Provincetown is a member of the Cape Cod Municipal Health Group. Please visit CCMHG.com for additional information on the plans listed above.

CCMHG Health Plan Benefit Comparison - FY20

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 07-01-2019

	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 - FY20

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 07-01-2019	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	Nothing	Nothing	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 Physician Office $20 Hospital Setting	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	$20/35 co-pay	$20/35co-pay	20% coinsurance*	$20 co-pay	Copay Level 1 provider : $20 copay per visit Copay Level 2 provider : $35 per visit	Copay Level 1 provider : $20 copay per visit Copay Level 2 provider : $35 per visit	20% coinsurance*

CCMHG Health Plan Benefit Comparison - FY20

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 07-01-2019

	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.
Ambulance- Deductible Applies	Nothing	Nothing	Nothing for accident or emergency; 20% coinsurance* other medically necessary ambulance transport	20% coinsurance*	Nothing	Nothing	Nothing
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.	All charges

CCMHG Health Plan Benefit Comparison - FY20

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Effective 07-01-2019

	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
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	**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
Fitness Benefit	Up to $150 reimbursement toward membership or exercise classes at a health club. 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. 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. 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 $150 reimbursement per **calendar** year. Must be an active member of HPHC for at least 4 months and a member of any qualified health & fitness club for 4 consecutive months.	Up to $150 reimbursement per **calendar** year. Must be an active member of HPHC for at least 4 months and a member of any qualified health & fitness club for 4 consecutive months.	Up to $150 reimbursement per **calendar** year. Must be an active member of HPHC for at least 4 months and a member of any qualified health & fitness club for 4 consecutive months.

***After Deductible**

CCMHG *HSA Qualified High Deductible* Plan Benefit Comparison - FY20

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 07-01-2019 **CIF = Covered In Full**	**BLUE CROSS BLUE SHIELD**			**HARVARD PILGRIM HEALTH CARE**		
		BLUE CARE ELECT PPO Saver			**PPO**	
BENEFIT	**HMO Blue New England Saver**	**In-Network**	**Out-of-Network**	**HPHC HMO**	**IN-NETWORK**	**OUT-OF-NETWORK**
Deductible - Deductible to be satisfied , then Covered in Full, except prescription copays and out-of-network services. Per plan year (July 1 to June 30) - Single Paren/Single Child (SP/SC) plan design is the same as the Family plan. *Note* - the family plan Deductible must be satisfied before the plan begins to pay. **See plan document for full details**	**$2,000 per Individual plan** **$4,000 per Family plan**	**$2,000 per Individual plan** **$4,000 per Family plan**	**$2,000 per Individual plan** **$4,000 per Family plan**	**$2,000 per Individual plan** **$4,000 per Family plan**	**$2,000 per Individual plan** **$4,000 per Family plan**	**$2,000 per Individual plan** **$4,000 per Family plan**
Single Parent/Single Child (SP/ **Out-of-Pocket (OOP) Maximum -** Once your out-of-pocket expenses for applicable services reaches this amount, you pay $0 for the remainder of plan year.	**Medical & Rx Combined:** $5,000 per member $10,000 per family	**Medical & Rx Combined:** $5,000 per member $10,000 per family	**Medical & Rx Combined:** $5,000 per member $10,000 per family	**Medical & Rx Combined:** $5,000 per member $10,000 per family	**Medical & Rx Combined:** $5,000 per member $10,000 per family	**Medical & Rx Combined:** $5,000 per member $10,000 per family
Lifetime Benefit Maximum	None	None	None	None	None	None
INPATIENT	**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	Deductible then Covered in Full (CIF)	Deductible then Covered in Full (CIF)	Deductible, then 20% coinsurance	Deductible then Covered in Full (CIF)	Deductible then Covered in Full (CIF)	Deductible, then 20% coinsurance
Physician Services	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Skilled Nursing Facility	Deductible then CIF - 100 days per calendar year benefit maximum	Deductible then CIF - 100 days per calendar year benefit maximum	Deductible then 20% coinsurance to 100 days per calendar year benefit maximum	Deductible then CIF - 100 days per calendar year benefit maximum	Deductible then CIF - 100 days per calendar year benefit maximum	Deductible then 20% coinsurance - limit to 100 days per plan year
Rehabilitation Hospital	Deductible then CIF - 60 days per calendar year benefit maximum	Deductible then CIF - 60 days per calendar year benefit maximum	Deductible then 20% coinsurance to 60 days per calendar year benefit maximum	Deductible then CIF - 60 days per calendar year benefit maximum	Deductible then CIF - 60 days per calendar year benefit maximum	Deductible then 20% coinsurance - limit to 60 days per plan year

CCMHG *HSA Qualified High Deductible* Plan Benefit Comparison - FY20

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 07-01-2019 CIF = Covered In Full	BLUE CROSS BLUE SHIELD			HARVARD PILGRIM HEALTH CARE		
		BLUE CARE ELECT PPO Saver			PPO	
BENEFIT	HMO Blue New England Saver	In-Network	Out-of-Network	HPHC HMO	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT HOSPITAL	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Emergency Room Visits for Emergency or Accident Care	Deductible then CIF	Deductible then CIF	Deductible then CIF	Deductible then CIF	Deductible then CIF	Deductible then CIF
Emergency Room Visits for Medical Care	Deductible then CIF	Deductible then CIF	Deductible then CIF	Deductible then CIF	Deductible then CIF	Deductible then CIF
Surgery	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Radiation and Chemotherapy	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Diagnostic X-ray and Lab	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Routine Colonoscopy *(without surgery)*	$0 copay	$0 copay	Deductible, then 20% coinsurance	$0 copay	$0 copay	Deductible, then 20% coinsurance
High Cost Radiology (MRI, CT & PET)	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Hemodialysis	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Physical Therapy	Deductible then Covered in Full (CIF) - up to 60 visits per calendar year	Deductible then Covered in Full (CIF) - up to 100 visits combined per calendar year	Deductible, then 20% coinsurance - up to 100 visits combined per calendar year	Deductible then Covered in Full (CIF) - up to 30 visits per calendar year	Deductible then Covered in Full (CIF) - up to 30 visits per calendar year	Deductible, then 20% coinsurance up to 30 visits combined per calendar year
PHYSICIAN'S OFFICE	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Surgery	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance

CCMHG *HSA Qualified High Deductible* Plan Benefit Comparison - FY20

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 07-01-2019 **CIF = Covered In Full**	**BLUE CROSS BLUE SHIELD**			**HARVARD PILGRIM HEALTH CARE**		
		BLUE CARE ELECT PPO Saver			**PPO**	
BENEFIT	**HMO Blue New England Saver**	**In-Network**	**Out-of-Network**	**HPHC HMO**	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICIAN'S OFFICE	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Adult Preventative Exam *as defined by the ACA*	CIF	CIF	Deductible, then CIF	CIF	CIF	Deductible, then CIF
PCP Medical Care/ **Mental Health Care/** **Substance Abuse Care**	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Well Child Care *as defined by the ACA*	CIF	CIF	Deductible, then 20% coinsurance	CIF	CIF	Deductible, then 20% coinsurance
Routine GYN Exam *(As defined by the ACA- one per calendar year , includes preventative lab tests)*	CIF	CIF	Deductible, then 20% coinsurance	CIF	CIF	Deductible, then 20% coinsurance
Routine Mammogram As defined by the ACA	CIF	CIF	Deductible, then 20% coinsurance	CIF	CIF	Deductible, then 20% coinsurance
Routine Vision Exam	CIF (once every 12 months)	CIF (once per calendar year)	20% coinsurance (once per calendar year)	CIF (1 visit per year)	CIF (1 visit per year)	20% coinsurance (1 visit per year)
Specialist Office Visit	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
OTHER OUTPATIENT						**YOU PAY**
Visiting Nurse **Home Health Care** **Deductible Applies**	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Durable Medical Equipment	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Ambulance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Routine Pediatric **Dental**	Nothing	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.	All charges

CCMHG *HSA Qualified High Deductible* Plan Benefit Comparison - FY20

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 07-01-2019

CIF = Covered In Full

BENEFIT	BLUE CROSS BLUE SHIELD			HARVARD PILGRIM HEALTH CARE		
		BLUE CARE ELECT PPO Saver			PPO	
	HMO Blue New England Saver	In-Network	Out-of-Network	HPHC HMO	IN-NETWORK	OUT-OF-NETWORK
Chiropractor Visits (limited to 20 visits per year)	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Prescription Drugs - <u>IMPORTANT NOTE</u> - Deductible applies, once deductible is met, copays will apply - NOTE- the drugs on the preventative list are not subject to the deductible. The lists are available at http://ccmhg.com/high-deductible-hsa-qualified-health-plans/	**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	**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
Fitness Benefit	Up to $150 reimbursement toward membership or exercise classes at a health club. 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. 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. See plan details. Enroll in a qualified Weight Watchers or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	Up to $150 reimbursement per **calendar** year. Must be an active member of HPHC for at least 4 months and a member of any qualified health & fitness club for 4 consecutive months.	Up to $150 reimbursement per **calendar** year. Must be an active member of HPHC for at least 4 months and a member of any qualified health & fitness club for 4 consecutive months.	Up to $150 reimbursement per **calendar** year. Must be an active member of HPHC for at least 4 months and a member of any qualified health & fitness club for 4 consecutive months.

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

Coverage Summary for Cape Cod Municipal Group Voluntary Group #000143 Effective 7/1/2019

Deductible: $50 per individual / $150 per family. Deductible waived for Diagnostic and Preventive categories

Calendar Year Maximum: $1,000 per person.

Category / Procedure	Qualifications	Co-insurance In Network	Co-insurance Out of Network*
Diagnostic		100%	100%
Comprehensive Evaluation	Once every 60 months.		
Periodic Oral Exam	Twice per calendar year..		
Panoramic or Full Mouth X-rays	Once every 60 months.		
Bitewing X-rays	Twice per calendar year .		
Single Tooth X-rays	As needed.		
Preventive		100%	100%
Teeth Cleaning	Twice per calendar year.		
Fluoride Treatments	Twice per calendar year for members under age 19.		
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 molars, every 4 years per tooth for members through age 15. Sealants also covered for members age 16 up to age 19 with a recent cavity and are at risk for decay.		
Restorative		80%	80%
Silver Fillings	Once every 24 months per surface per tooth.		
White Fillings (Front Teeth)	Once every 24 months per surface per tooth.		
Inlays and White Fillings (Back Teeth)	Covered only for single surfaces. Once every 24 months per surface, per tooth, multi-surfaces will be processed as a silver filling and the patient is responsible for the difference between the silver filling and the Delta Dental negotiated fee for white fillings, where permitted by state law. In other states, the patient may be responsible for paying up to the provider's full submitted charge for white fillings.		
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)		80%	80%
Periodontal Surgery	One surgical procedure per quadrant in 36 months.		
Scaling and Root Planing	Once in 24 months, per quadrant. No more than 2 quadrants per date of service.		
Periodontal Cleaning	Once every 3 months following active periodontal treatment. Not to be combined with preventive cleanings.	100%	100%
Bone Grafts/GTR	No more than 2 teeth per quadrant per 36 months on natural teeth.	80%	80%
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		50%	50%
Dentures	Once within 60 months (age 16 and older).		
Fixed Bridges	Once within 60 months (age 16 and older).		
Implants (only in lieu of a 3-unit bridge)	Endosteal Implant: Only when replacing one missing tooth and when adjacent teeth are healthy and do not require crowns. Once per 60 months per Implant. (Pre-estimate recommended).		
Implant Abutments	Once per implant only when surgical implant is benefitted.		
Major Restorative		50%	50%
Crowns or Onlay	When teeth cannot be restored with regular fillings. 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 to age 19. $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 met in fourth quarter are carried over.
Deductible waived for periodontal cleanings.

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.
$1,000	$500	$350	$1,000

*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

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 283,000 participating dentist locations and Delta Dental Premier, the largest dental network in the country with more than 358,000 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.
- You will enjoy the greatest savings when visiting Delta Dental PPO network dentists due to even deeper discounts.
- 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/

Simply visit **www.deltadentalma.com** to find a participating dentist in your area.

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 1-800-872-0500.

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
1-800-872-0500
www.deltadentalma.com

465 Medford Street
Boston, MA 02129

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Cape Cod Municipal Health

More, for less…

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are for in-network providers only

Hello, Neighbor

- You're on the ACCESS Network
- For a complete list of providers near you, use our Provider Locator on eyemed.com or call 1-866-723-0596.
- For Lasik providers, call 1-877-5LASER6, or visit eyemedlasik.com.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Frames	$0 Copay, $150 Allowance, 80% of charge over $150	Up to $75
Standard Plastic Lenses		
Single Vision	$20 Copay	Up to $42
Bifocal	$20 Copay	Up to $78
Trifocal	$20 Copay	Up to $130
Standard Progressive Lens	$20 Copay	Up to $140
Premium Progressive Lens	$20, 80% of charge less than $120	Up to $140
Lens Options (paid by the member in addition to the price of the lenses)		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$0	Up to $12
Standard Polycarbonate	$0	Up to $32
Standard Polycarbonate-Kids under 19	$0	Up to $32
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lenses (Contact lens allowance includes materials only. Benefit allowance provides no remaining balance for future use within the same benefit year.)		
Conventional	$0 Copay, $150 Allowance, 15% off balance over $150	Up to $120
Disposable	$0 Copay, $150 Allowance, balance over $150	Up to $120
Medically Necessary	$0 Copay, Paid in Full	Up to $200
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Additional Pairs Discount	Members also receive a 40% discount off complete pair eyeglass purchase and 15% off conventional contact lenses once the funded benefit has been used.	N/A
Frequency		
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

*Frame, Lens & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.