



BENEFITS OPEN ENROLLMENT FOR FY27

OPEN ENROLLMENT PERIOD: MAY 01, 2026 – JUNE 5, 2026

for changes effective 7/1/2026

The Lower Pioneer Valley Educational Collaborative, through its affiliation with Scantic Valley Regional Health Trust (SVRHT), has designated May 1 – June 5 as the annual Open Enrollment period for all eligible employees. Please use this opportunity to assess your benefit needs and revise your health, dental, and/or vision insurance coverage selections.

LPVEC offers all eligible employees HMO plans from Blue Cross Blue Shield, Health New England and Harvard Pilgrim Health Care. The Blue Cross Blue Shield Blue Care Elect Preferred PPO is also available. The Benefit Comparison Charts provided in this packet are a high-level overview of the plans offered.

A complete Summary of Benefits and additional information for each health plan is available on the Scantic Valley Regional Health Trust website at: www.scantichealth.org.

Group numbers are provided on the Insurance Rate Sheet in this packet. If you have specific questions about plan coverage, contact Member Services at the number below and reference the appropriate Group #:

- Blue Cross/Blue Shield 1-800-486-1136
- Health New England 1-800-310-2835
- Harvard Pilgrim Health 1-888-333-4742.

! No action is required by you if you are currently on a LPVEC sponsored health, dental, or vision plan and do not wish to make any changes to your coverage!
You will remain on your current coverage plan(s) without having to re-enroll.

LPVEC continues to offer 2 options for the Dental Blue Freedom plan. The Dental Blue Freedom offers the largest network of dentists nationwide including more than 90 percent of dentists in Massachusetts. **The Calendar Year Benefit Maximum is \$2,000.** There is NO increase to the premium for these plans for the upcoming fiscal year.

LPVEC will also continue to offer the Blue 20/20 Vision plan that includes Hearing discounts on the Blue 20/20 Standard Vision Access Network Plan. Blue 20/20 can save you money on eyeglasses, contacts, and preventive care, including eye exams. You also get access to one of the nation's largest vision networks. Blue 20/20 includes discounts for hearing exams and hearing aids. More information is included in this packet. There is NO increase to the premium for these plans for the upcoming fiscal year.

All enrollment forms and supporting documents (if required) must be received by the LPVEC Payroll Department by end of business on Friday, June 5, 2026

Remember: Once enrolled in a health and/or dental plan, you will not be able to make changes until the next Open Enrollment period, unless there is a qualifying event.

*If you do not receive insurance cards and/or enrollment information by July 1, contact your selected insurance company.

! Important

If you are enrolling in any plan for the first time and are on the 22-week pay period schedule (Hourly employees such as Drivers, Monitors, and some classroom staff), you must submit a check, payable to LPVEC, for the July and August premium in full with your enrollment form. Regular payroll deductions will begin in September. *Please reference rate sheet for monthly employee share costs.*

OPEN ENROLLMENT CHANGES ARE EFFECTIVE JULY 1, 2026.

Enrollment forms and all required documents (and premium payment, if applicable) MUST BE RECEIVED BY 4:00 PM EST FRIDAY, JUNE 5, 2026 TO ALLOW SUFFICIENT TIME FOR PROCESSING. SEND ALL DOCUMENTS TO PAYROLL VIA ONE OF THE FOLLOWING METHODS:

- SCAN AND EMAIL TO PAYROLL@LPVEC.ORG
- SEND BY INTEROFFICE MAIL TO PAYROLL
- OR MAIL TO:
LPVEC, PAYROLL
174 BRUSH HILL AVENUE
WEST SPRINGFIELD, MA 01089



Lower Pioneer Valley Educational Collaborative

Member of SCANTIC VALLEY REGIONAL HEALTH TRUST

Dear LPVEC Employee,

As part of a continuing effort to help control the rising cost of health insurance premiums for its employers and employees, Scantic Valley Regional Health Trust, through which your employer purchases health insurance, requires its members to verify the eligibility of each employee and the employee's dependent when enrolling employees in a family health insurance plan. **All Scantic Valley Regional Health Trust subscribers who are enrolled in a plan are required to comply with this requirement.**

The following is a list of the necessary documentation that must be submitted to verify eligibility for each employee and employee's dependent enrolled on a LPVEC health insurance policy.

<u>Relationship</u>	<u>Documentation</u>
Employee	Photocopy of town- or city-issued birth certificate (<u>hospital records are not accepted</u>).
Spouse	Photocopy of town- or city-issued marriage certificate (<u>church or Justice of the Peace certificates are NOT accepted</u>), <u>AND</u> Page 1 of your filed Federal Tax Return (1040 or 1040A.) Social Security numbers and income may be blacked out. Federal Tax Return requirement does not apply to same-sex marriages (affidavit will be provided).
Divorced or Separated Spouse	Photocopy of the health insurance provision language from divorce/ separation agreement, <u>AND</u> first page listing names of both parties or signature page.
Child up to age 26	Photocopy of town- or city-issued birth certificate (long form listing parents' names) (<u>hospital records are not accepted</u>), or Court Order documenting guardianship, or adoption papers.

Documents such as marriage or birth certificates may be obtained at the Clerk's Office in the City/Town where the event occurred. Please note there may be a delay in obtaining certain documentation. We urge you to contact the appropriate offices as soon as possible.

The following page explains dependent eligibility under Scantic Valley Regional Health Trust and carrier guidelines. For dependents that are not eligible, insurance may be available through the Health Connector, an online health insurance marketplace for residents of Massachusetts. Go to www.mahealthconnector.org for more information.

Failure to comply with this requirement will result in the removal of your dependent(s) from the health plan.

LOWER PIONEER VALLEY EDUCATIONAL COLLABORATIVE

174 BRUSH HILL AVENUE, WEST SPRINGFIELD, MA 01089 PHONE 413-735-2200 FAX 413-735-2280

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Lower Pioneer Valley Educational Collaborative

Member of SCANTIC VALLEY REGIONAL HEALTH TRUST

Scantic Valley Regional Health Trust REGULATIONS FOR COVERING SPOUSES/DEPENDENTS

Eligible Spouses - The subscriber may enroll an eligible spouse for coverage under his or her health plan membership. An 'eligible spouse' includes the subscriber's legal spouse.

In the event of a divorce or legal separation, the person who was the spouse of the subscriber prior to the divorce or legal separation will remain eligible for coverage under the subscriber's health plan membership, whether or not the judgment was entered prior to the effective date of this health plan. The former spouse will remain eligible for this coverage only until the subscriber is no longer required by the judgment to provide health insurance for the former spouse or the subscriber or former spouse remarries, whichever comes first.

If the subscriber remarries, the former spouse may continue coverage under a separate health plan membership with the subscriber's group, provided the divorce judgment requires that the subscriber provide health insurance for the former spouse. This is true even if the subscriber's new spouse is not enrolled under the subscriber's health plan membership. However, the former spouse must move from family coverage to individual coverage and additional premiums will be required; the former spouse only remains eligible under the group if the divorce decree provided for such coverage. If the former spouse remarries, the former spouse's eligibility ends.

Eligible Dependents - The subscriber may enroll eligible dependents for coverage under his or her health plan membership. The subscriber's 'eligible dependents' include: a dependent child who is between the ages of 19 and 26 (19 and 25 for BCBS members). These include the subscriber's or legal spouse's dependent children who qualify as dependents as subject of a court order that require the subscriber to provide health insurance for the children. These may include:

1. A newborn child – the effective date of coverage for a newborn child will be the child's date of birth provided that the subscriber formally notified the plan sponsor within 30 days of the date of birth.
2. An adopted child – the effective date of coverage for an adopted child will be the date of placement with the subscriber for the purpose of adoption. The effective date of coverage for an adoptive child who has been living with the subscriber and for whom the subscriber has been getting foster care payments will be the date the petition to adopt is filed. If the subscriber is enrolled under a family plan as of the date he or she assumes custody of a child for the purpose of adoption, the child's health care services for injury or sickness will be covered from the date of custody.
3. A child who is recognized under a Qualified Medical Child Support Order as having the right to enroll for health care coverage.
4. A dependent child who is between the ages of 19 and 26 (19 and 25 for BCBS members).
5. An unmarried disabled dependent child may maintain coverage under the subscriber's health plan membership. The child must be either mentally or physically handicapped so as not to be able to earn his or her own living, as determined by the health plan carrier. The subscriber must make arrangements for the disabled child to continue coverage under the family contract no more than 30 days after the date the child would normally lose eligibility.

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IMPORTANT – PLEASE READ

Special Enrollment Notice

The Patient Protection and Affordable Care Act passed by Congress in 2010 requires that we provide a **Summary of Benefit and Coverage (SBC)** for each of the health plans available to you during the open enrollment period.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or other dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage.) However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage.)

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact a Human Resources representative at 413-735-2200 or email to PAYROLL@LPVEC.ORG.

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HEALTH INSURANCE RATES

PRODUCT	TYPE	COVERAGE	MONTHLY PREMIUM	ACTIVE EMPLOYEES				RETIREES	INACTIVE	INCREASE
				Collaborative Monthly Share	Employee Monthly Share	Employee Share Per Pay Period	Employee Share Per Pay Period	Non-Medicare Eligible Monthly Share	COBRA Rates	
			100%	70%	30%	26	22	50%		
Network Blue Standard Plan Group #002238438	HMO	Single	\$1,078.00	\$754.60	\$323.40	\$149.26	\$176.40	\$539.00	\$1,099.56	11.5%
		Family	\$2,669.00	\$1,868.30	\$800.70	\$369.55	\$436.75	\$1,334.50	\$2,722.38	11.5%
Network Blue Deductible Plan Group #004056369	HMO	Single	\$1,047.00	\$732.90	\$314.10	\$144.97	\$171.33	\$523.50	\$1,067.94	11.5%
		Family	\$2,600.00	\$1,820.00	\$780.00	\$360.00	\$425.45	\$1,300.00	\$2,652.00	11.5%
Health New England Standard Plan Group #S030420016	EPO	Single	\$936.00	\$655.20	\$280.80	\$129.60	\$153.16	\$468.00	\$954.72	10.5%
		Family	\$2,329.00	\$1,630.30	\$698.70	\$322.48	\$381.11	\$1,164.50	\$2,375.58	10.5%
Health New England Deductible Plan Group #S030420026	EPO	Single	\$903.00	\$632.10	\$270.90	\$125.03	\$147.76	\$451.50	\$921.06	10.5%
		Family	\$2,253.00	\$1,577.10	\$675.90	\$311.95	\$368.67	\$1,126.50	\$2,298.06	10.5%
Harvard Pilgrim Health Standard Plan Group #1777210015	EPO	Single	\$1,126.00	\$788.20	\$337.80	\$155.91	\$184.25	\$563.00	\$1,148.52	10.5%
		Family	\$2,813.00	\$1,969.10	\$843.90	\$389.49	\$460.31	\$1,406.50	\$2,869.26	10.5%
Harvard Pilgrim Health Deductible Plan Group #1777200015	EPO	Single	\$1,024.00	\$716.80	\$307.20	\$141.78	\$167.56	\$512.00	\$1,044.48	10.5%
		Family	\$2,553.00	\$1,787.10	\$765.90	\$353.49	\$417.76	\$1,276.50	\$2,604.06	10.5%
Blue Care Elect Preferred - Standard Plan Group #002345370	PPO	Single	\$1,896.00	\$1,327.20	\$568.80	\$262.52	\$310.25	\$948.00	\$1,933.92	15%
		Family	\$4,127.00	\$2,888.90	\$1,238.10	\$571.43	\$675.33	\$2,063.50	\$4,209.54	15%

**see below note for hourly employees

DENTAL INSURANCE RATES

no change from FY25

PRODUCT	TYPE	COVERAGE	MONTHLY PREMIUM	ACTIVE EMPLOYEES			RETIREES	INACTIVE	
				Employee Monthly Share	Employee Share Per Pay Period	* Employee Share Per Pay Period	Non-Medicare Eligible Monthly Share	COBRA Rates	
			100%	100%	26	22	100%		
Dental Blue Freedom 100/50/50%, \$2,000 max, \$25/\$75 deductible	OPTION 1	Single	\$48.24	OPTION 1	\$48.24	\$22.26	\$26.31	\$48.24	\$49.20
		Family	\$130.11		\$130.11	\$60.05	\$70.97	\$130.11	\$132.71
Dental Blue Freedom 100/80/50%, \$2,000 max, \$50/\$150 deductible	OPTION 2	Single	\$55.20	OPTION 2	\$55.20	\$25.48	\$30.11	\$55.20	\$56.30
		Family	\$148.93		\$148.93	\$68.74	\$81.23	\$148.93	\$151.91

VISION INSURANCE RATES

no change from FY25

PRODUCT	TYPE	COVERAGE	MONTHLY PREMIUM	ACTIVE EMPLOYEES			RETIREES	INACTIVE	
				Employee Monthly Share	Employee Share Per Pay Period	* Employee Share Per Pay Period	Non-Medicare Eligible Monthly Share	COBRA Rates	
			100%	100%	26	22	100%		
Blue 20/20 Access Network Group Plan #20288		Single	\$7.82	Single	\$7.82	\$3.61	\$4.27	\$7.82	\$7.98
		Employee+Spouse only	\$13.30	Employee+Spouse only	\$13.30	\$6.14	\$7.25	\$13.30	\$13.57
		Empl+child/children(no spouse)	\$13.69	children(no spouse)	\$13.69	\$6.32	\$7.47	\$13.69	\$13.96
		Family	\$21.51	Family	\$21.51	\$9.93	\$11.73	\$21.51	\$21.94

* New enrollments/coverage changes for 22 week/10-month paid employees:

7/1/2026 enrollment

A check **must** be submitted payable to LPVEC for the cost of the employee share premiums for the months of July and August with your enrollment form. Regular deductions will begin in the month of September.

**** For hourly employees, your first check in September may not have enough pay to cover your regular biweekly insurance premium. If that is the case, we will be making up the amount not paid/still owed in the next two paychecks.**

**SCANTIC VALLEY REGIONAL HEALTH TRUST
(SVRHT)**

IMPORTANT - PLEASE READ

The attached benefit comparison charts are a high level overview of the plans offered by SVRHT.

The plan documents available to registered users on the carrier sites are the documents that describe full and complete plan details.

The carrier documents are the only documents that coverage is based on.

Should you have a question about specific coverage, you will need to contact the Member Service number on your ID card for detail or visit the carrier website.

SVRHT Plan Benefit Comparison

Effective 7-1-26

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.

BENEFIT	BLUE CROSS BLUE SHIELD			HEALTH NEW ENGLAND	HARVARD PILGRIM
	NETWORK BLUE HMO	BLUE CARE ELECT PREFERRED PPO		HMO	HMO
		In-Network	Out-of-Network		
Deductible	None	None	\$400 Individual \$800 Family	None	None
Out-of-Pocket (OOP) Maximum <i>- Once your out-of-pocket expenses for applicable services reaches this amount, you pay \$0 for remainder of plan year (July 1 to June 30).</i>	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
Lifetime Benefit Maximum	None	None	None	None	None
INPATIENT	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)	\$500 copay	\$500 copay	20% coinsurance* Processes at in-network rate for emergency/accident admissions	\$500 copay	\$500 copay
Physician Services	Nothing	Nothing	20% coinsurance* Processes at in-network rate for emergency/accident admissions	Nothing	Nothing
Skilled Nursing Facility	Nothing to 100 days per calendar year benefit maximum	Nothing to 100 days per calendar year benefit maximum combined with out of network days	20% coinsurance* to 100 days per calendar year benefit maximum, combined with in-network days	\$0 copay for up to 100 days per calendar year, combined with inpatient rehabilitation	Nothing up to 100 days per plan year
Rehabilitation Hospital	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	\$0 copay for up to 100 days per calendar year, combined with skilled care.	Nothing up to 60 days per plan year
OUTPATIENT HOSPITAL	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Emergency Room Visits for Emergency or Accident Care	\$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)
Emergency Room Visits for Medical Care	\$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

SVRHT Plan Benefit Comparison

Effective 7-1-26

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.

BENEFIT	BLUE CROSS BLUE SHIELD			HEALTH NEW ENGLAND	HARVARD PILGRIM
	NETWORK BLUE HMO	BLUE CARE ELECT PREFERRED PPO		HMO	HMO
		In-Network	Out-of-Network		
Surgery	\$150 copay	\$150 copay	20% coinsurance*	\$150 copay	\$150 copay
Radiation and Chemotherapy	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay
Diagnostic X-ray and Lab	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay
Routine Colonoscopy (without symptoms)	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay
High Cost Radiology (MRI, CT & PET)	\$100 copay* - copay waived if received at non-hospital facilities	\$100 copay* - copay waived if received at non-hospital facility	20% coinsurance* No deductible for OON	Outpatient hospital based services \$100 copay; \$0 for non-hospital based services	\$100 copay ²
Hemodialysis	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay
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 (60 visits per calendar year for PT and OT)	\$35 co-pay - (60 visits per calendar year for PT and OT)
PHYSICIAN'S OFFICE	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Surgery	\$20 PCP Office \$35 Specialists Office	\$20 PCP Office \$35 Specialists Office	20% coinsurance*	\$20 PCP Office \$35 Specialists Office	No charge
Adult Preventative Exam (includes preventative lab tests)	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay
PCP Medical Care/ Mental Health Care/ Substance Abuse Care	\$20 copay	\$20 copay	20% coinsurance*	\$20 copay	\$20 copay
Well Child Care (includes preventative lab tests)	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay
Routine GYN Exam (one per calendar year, includes preventative lab tests)	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay
Routine Mammogram	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay
Routine Vision Exam	\$0 copay (once every 12 months)	\$0 copay (once per calendar year)	20% coinsurance after deductible(once per calendar year)	\$0 copay (once per calendar year)	\$20 copay (once per plan year)
Specialist Office Visit	\$35 copay	\$35 copay	20% coinsurance*	\$35 copay	\$35 copay
OTHER OUTPATIENT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Visiting Nurse Home Health Care	Nothing (Includes Hospice Care)	Nothing	20% coinsurance*	Nothing	Nothing
Durable Medical Equipment	Member pays 20%, plan pays 80% with no limit	Member pays 20%, plan pays 80% with no limit*	40% coinsurance after deductible	Member pays 20%, plan pays 80% with no limit	Member pays 30%, plan pays 70% with no limit

SVRHT Plan Benefit Comparison

Effective 7-1-26

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.

BENEFIT	BLUE CROSS BLUE SHIELD			HEALTH NEW ENGLAND	HARVARD PILGRIM
	NETWORK BLUE HMO	BLUE CARE ELECT PREFERRED PPO		HMO	HMO
		In-Network	Out-of-Network		
Ambulance	Nothing (for emergency or medically necessary transport)	Nothing (for emergency or medically necessary transport)	Nothing for accident or emergency; 20% coinsurance* other medically necessary ambulance transport	\$25 co-pay per member per day (included Chair Van services)	Nothing (for emergency or medically necessary transport)
Routine Pediatric Dental (under age 12)	Nothing (covered services each six months)	All charges	All charges	Not covered	\$20 copay up to age 13
Chiropractor Visits	\$20 copay per visit (up to 12 visits per calendar year)	\$20 copay per visit (up to 12 visits per calendar year)	20% coinsurance (up to 12 visits per calendar year)	\$20 copay per visit (up to 12 visits per calendar year)	\$20 copay per visit (up to 12 visits per year)
Prescription Drugs	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay CVS Caremark is the PBM	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay CVS Caremark is the PBM	OON NOT COVERED	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay OptumRx is the PBM for retail and mail order.	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay Optum is the PBM
Weight Loss	Up to \$150 per family toward fees paid hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals, WeightWatchers®	Up to \$150 per family toward fees paid hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals, WeightWatchers®	Up to \$150 per family toward fees paid hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals, WeightWatchers®	Up to \$200/ind and \$400/fam reimbursement per calendar year towards fitness club membership, Aerobic and Wellness classes, Personal Trainer fees and school and town sports registration fees, wellness and fitness apps, nutrition apps, mindfulness apps, bike shares and Weight Watchers® program.	Discount and Savings programs available such as Eat Right Now, Inside Tracker, Daily Burn, ProSourceFit, and more Up to \$150 fitness reimbursement per household, per plan year
Fitness Benefit	Up to \$150 reimbursement per family a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training programs; or virtual /online fitness memberships, subscriptions, programs providing the same. Now includes home gym equipment	Up to \$150 reimbursement per family a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training programs; or virtual /online fitness memberships, subscriptions, programs providing the same. Now includes home gym equipment	Up to \$150 reimbursement per family a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training programs; or virtual /online fitness memberships, subscriptions, programs providing the same. Now includes home gym equipment		

*After Deductible

SVRHT Plan Benefit Comparison

Deductible Plans - Effective 7-1-26

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.

*After Deductible	BLUE CROSS BLUE SHIELD			HEALTH NEW ENGLAND	HARVARD PILGRIM
BENEFIT	NETWORK BLUE HMO	BLUE CARE ELECT PREFERRED PPO		HMO	Best Buy HMO
Deductible	\$250 per member up to \$750 per family	In-Network	Out-of-Network	\$250 per member up to \$750 per family	\$250 per member up to \$750 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 (July 1 to June 30).	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
Lifetime Benefit Maximum	None	None	None	None	None
INPATIENT	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*	\$500 copay*	20% coinsurance* Processes at in-network rate for emergency/accident admissions	\$500 copay*	\$500 copay*
Physician Services	Nothing	Nothing	20% coinsurance* Processes at in-network rate for emergency/accident admissions	Nothing	Nothing
Skilled Nursing Facility - Deductible Applies	Nothing* to 100 days per calendar year benefit maximum	Nothing* to 100 days per calendar year benefit maximum combined with out of network days	20% coinsurance* to 100 days per calendar year benefit maximum, combined with in-network days	*\$0 copay for up to 100 days per calendar year, combined with inpatient rehabilitation	Nothing* up to 100 days per plan year
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	*\$0 copay for up to 100 days per calendar year, combined with inpatient rehabilitation	Nothing* up to 60 days per plan year

SVRHT Plan Benefit Comparison

Deductible Plans - Effective 7-1-26

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.

*After Deductible	BLUE CROSS BLUE SHIELD			HEALTH NEW ENGLAND	HARVARD PILGRIM
BENEFIT	NETWORK BLUE HMO	BLUE CARE ELECT PREFERRED PPO		HMO	Best Buy HMO
OUTPATIENT HOSPITAL	YOU PAY	In-Network YOU PAY	Out-of-Network 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)	\$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	\$100 copay*, waived if admitted
Surgery - Deductible Applies	\$150 copay*	\$150 copay*	20% coinsurance*	\$150 copay*	\$150 copay*
Radiation and Chemotherapy - Deductible Applies	\$0 copay*	\$0 copay*	20% coinsurance*	\$0 copay*	\$0 copay*
Diagnostic X-ray and Lab - Deductible Applies	\$0 copay*	\$0 copay*	20% coinsurance*	\$0 copay*	\$0 copay*
Routine Colonoscopy (without symptoms)	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay
High Cost Radiology (MRI, CT & PET) - Deductible Applies	\$100 copay* - copay waived if received at non-hospital facilities	\$100 copay* - copay waived if received at non-hospital facility	20% coinsurance* No deductible for OON	Outpatient hospital based services \$100 copay*; \$0 for non-hospital based services	\$100 copay*
Hemodialysis - Deductible Applies	\$0 copay*	\$0 copay*	20% coinsurance*	\$0 copay*	\$0 copay*
Physical Therapy - Deductible Applies	\$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 (60 visits per calendar year for PT and OT)	Deductible, then covered in full up to 60 visits per year combined with occupational therapy

SVRHT Plan Benefit Comparison

Deductible Plans - Effective 7-1-26

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*After Deductible	BLUE CROSS BLUE SHIELD			HEALTH NEW ENGLAND	HARVARD PILGRIM
BENEFIT	NETWORK BLUE HMO	BLUE CARE ELECT PREFERRED PPO		HMO	Best Buy HMO
PHYSICIAN'S OFFICE	YOU PAY	In-Network	Out-of-Network	YOU PAY	YOU PAY
Surgery - NO Deductible	\$20 PCP Office \$35 Specialists Office	\$20 PCP Office \$35 Specialists Office	20% coinsurance*	\$20 PCP Office \$35 Specialists Office	Office based treatments and procedures deductible, then no charge
Adult Preventative Exam <i>(includes preventative lab)</i>	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay
PCP Medical Care/ Mental Health Care/ Substance Abuse Care	\$20 copay	\$20 copay	20% coinsurance*	\$20 copay	\$20 copay
Well Child Care <i>(includes preventative lab tests)</i>	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay
Routine GYN Exam <i>(one per calendar year, includes preventative lab tests)</i>	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay
Routine Mammogram	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay
Routine Vision Exam	\$0 copay (once every 12 months)	\$0 copay (once per calendar year)	20% coinsurance after deductible	\$0 copay (once per calendar year)	\$20 copay (once per plan year)
Specialist Office Visit	\$35 copay	\$35 copay	20% coinsurance*	\$35 copay	\$35 copay
OTHER OUTPATIENT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Visiting Nurse Home Health Care - Deductible Applies	Nothing* (Includes Hospice Care)	Nothing*	20% coinsurance*	Nothing*	Nothing*
Durable Medical Equipment - Deductible Applies	Member pays 20%, plan pays 80% with no limit	Member pays 20%, plan pays 80% with no limit*	40% coinsurance after deductible	Member pays 20%, plan pays 80% with no limit	Covered in full after deductible

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*After Deductible	BLUE CROSS BLUE SHIELD		HEALTH NEW ENGLAND	HARVARD PILGRIM	
BENEFIT	NETWORK BLUE HMO	BLUE CARE ELECT PREFERRED PPO		HMO	Best Buy HMO
		In-Network	Out-of-Network		
Ambulance - Deductible Applies	Covered in full after ded (for emergency or medically necessary transport)	Covered in full after deductible (for emergency or medically necessary transport)	Deductible then 20% coinsurance* other medically necessary ambulance transport	\$25 co-pay per member per day (included Chair Van services)	Covered in full after deductible
Routine Pediatric Dental (under age 12)	Nothing (covered services each six months)	Not Covered	Not Covered	Not Covered	\$20 copay up to age 13
Chiropractor Visits	\$20 copay per visit (up to 12 visits per calendar year)	\$20 copay per visit (up to 12 visits per calendar year)	20% coinsurance (up to 12 visits per calendar year)	\$20 copay per visit (up to 12 visits per calendar year)	\$20 copay per visit (up to 12 visits per year)
Prescription Drugs	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay CVS Caremark is the PBM	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay CVS Caremark is the PBM	OON NOT COVERED	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay OptumRx is the PBM for retail and mail order.	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay Optum Rx is the PBM
Weight Loss	Up to \$150 per family toward fees paid hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals, WeightWatchers®	Up to \$150 per family toward fees paid hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals, WeightWatchers®	Up to \$150 per family toward fees paid hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals, WeightWatchers®	Up to \$200/ind and \$400/fam reimbursement per calendar year towards fitness club membership, Aerobic and Wellness classes, Personal Trainer fees and school and town sports registration fees, wellness and fitness apps, nutrition apps, mindfulness apps, bike shares and Weight Watchers® program.	Discount and Savings programs available such as Eat Right Now, Inside Tracker, Daily Burn, ProSourceFit, and more
Fitness Benefit	Up to \$150 reimbursement per family a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training	Up to \$150 reimbursement per family a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training	Up to \$150 reimbursement per family a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training		Up to \$150 fitness reimbursement per household, per plan year.

SVRHT Plan Benefit Comparison

Deductible Plans - Effective 7-1-26

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*After Deductible	BLUE CROSS BLUE SHIELD		HEALTH NEW ENGLAND	HARVARD PILGRIM
BENEFIT	NETWORK BLUE HMO	BLUE CARE ELECT PREFERRED PPO		Best Buy HMO
		In-Network	Out-of-Network	
	programs; or virtual /online fitness memberships,subscriptions , programs providing the same. Now includes home gym equipment	programs; or virtual /online fitness memberships,subscriptions , programs providing the same. Now includes home gym equipment	and strength-training programs; or virtual /online fitness memberships,subscriptions , programs providing the same. Now includes home gym equipment	



Scantic Valley Regional Health Trust

Towns of East Longmeadow, Hampden, Longmeadow and Wilbraham, the Hampden-Wilbraham Regional School District and the Lower Pioneer Valley Educational Collaborative

SIMPLE. SAFE. SMART.



SIGN UP TODAY

Medications FREE to your door!

See reverse for a full list of medications.

CANARX is a voluntary international mail order prescription program that is available to eligible employees, non-Medicare eligible retirees and their dependents enrolled in the **HMO** or **PPO** plan with the Scantic Valley Regional Health Trust (SVRHT).

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 CANARX at **1-866-893-6337** or to view the complete formulary - and enroll online or download an enrollment form - visit www.canarx.com (WebID: **SVRHT**).
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
- ✓ 400+ 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: SVRHT

ACTONEL (G) 35MG
 ACTONEL (G) 150MG
 ACTOPLUS (G)
 15MG-850MG
 ACTOS (G) 15MG
 ACTOS (G) 30MG
 ACTOS (G) 45MG
 ACZONE 5%
 ADCIRCA (G) 20MG
 ADVAIR DISKUS 100MCG
 ADVAIR DISKUS 250MCG
 ADVAIR DISKUS 500MCG
 ADVAIR HFA 45/21MCG
 ADVAIR HFA 115/21MCG
 ADVAIR HFA 230/21MCG
 AFINATOR 2.5MG
 AFINATOR 5MG
 AFINATOR 10MG
 AKLIFER 50MCG/G
 ALOMIDE 0.1%
 ALPHAGAN-P 0.15%
 ALREX 0.2%
 ALVESCO 80MCG
 ALVESCO 160MCG
 AMPYRA (G) 10MG
 ANAPROX DS 550MG
 ANORO ELLIPTA
 62.5/25MCG
 APTIOM 200MG
 APTIOM 400MG
 APTIOM 600MG
 APTIOM 800MG
 ARAZLO 0.045%
 ARNUITY ELLIPTA 100MCG
 ARNUITY ELLIPTA 200MCG
 AROMASIN (G) 25MG
 ARTHROTEC 50MG
 ARTHROTEC 75MG
 ASMANEX TWISTHALER
 110MCG
 ASMANEX TWISTHALER
 220MCG
 ASTAGRAF XL 1MG
 ASTAGRAF XL 5MG
 ATACAND 4MG
 ATACAND 8MG
 ATACAND 16MG
 ATACAND 32MG
 ATACAND HCT
 32MG/25MG
 ATACAND HCT
 16MG/12.5MG
 ATACAND HCT
 32MG/12.5MG
 ATELVIA DR 35MG
 ATROVENT HFA 20UG
 AUBAGIO (G) 14MG
 AVODART (G) 0.5MG
 AZILECT (G) 0.5MG
 AZILECT (G) 1MG
 BANZEL 200MG
 BANZEL 400MG
 BECONASE AQ 42MCG
 BENICAR (G) 20MG
 BENICAR (G) 40MG
 BENICAR HCT (G)
 20MG/12.5MG
 BENICAR HCT (G)
 40MG/12.5MG
 BENICAR HCT (G)
 40MG/25MG
 BEPREVE 1.5%
 BETIMOL 0.25%
 BETIMOL 0.5%
 BETOPTIC S 0.25%
 BEVESPI AEROSPHERE
 9MCG-4.8MCG
 BEYAZ
 BIJUVA 1MG-100MG
 BIKTARVY
 50MG-200MG-25MG
 BINOSTO 70MG
 BREO ELLIPTA 100/25MCG
 BREO ELLIPTA 200/25MCG
 BREZTRI AEROSPHERE
 160MCG-9MCG-4.8MCG
 BRILINTA 60MG
 BRILINTA 90MG
 BYSTOLIC (G) 2.5MG
 BYSTOLIC (G) 5MG
 BYSTOLIC (G) 10MG
 BYSTOLIC (G) 20MG
 CADUET 5/10MG
 CADUET 5/20MG
 CADUET 5/40MG
 CADUET 5/80MG
 CADUET 10/10MG
 CADUET 10/20MG
 CADUET 10/40MG
 CADUET 10/80MG
 CELEBREX 100MG
 CELEBREX 200MG
 CEQUA (G) 0.09%
 CLIMARA PATCH 25MCG
 CLIMARA PATCH 50MCG
 CLIMARA PATCH 75MCG
 COMBIGAN 0.2-0.5%
 COMBIVENT RESPIMAT
 20MCG/100MCG
 CORGARD 80MG
 COSOPT PF 2%/0.5%
 CRESTOR (G) 5MG
 CRESTOR (G) 10MG
 CRESTOR (G) 20MG
 CRESTOR (G) 40MG
 CRINONE GEL 8%
 CYMBALTA (G) 20MG
 CYMBALTA (G) 30MG
 CYMBALTA (G) 60MG
 CYTOTEC (G) 200MCG
 DALIRESP 250MCG
 DALIRESP 500MCG
 DEPAKOTE (G) 250MG
 DEPAKOTE (G) 500MG
 DETROL LA (G) 2MG
 DETROL LA (G) 4MG
 DEXILANT DR 30MG
 DEXILANT DR 60MG
 DIFFERIN CREAM 0.1%
 DIFFERIN GEL (G) 0.3%
 DIOVAN (G) 40MG
 DIOVAN (G) 80MG
 DIOVAN (G) 160MG
 DIOVAN (G) 320MG
 DIOVAN HCT (G) 320/25MG
 DIVIGEL 0.25MG
 DIVIGEL 0.5MG
 DIVIGEL 1MG
 DOVATO 50MG-300MG
 DULERA 100MCG/5MCG
 DULERA 200MCG/5MCG
 DUOBRII 0.01%-0.045%
 DYMISTA 137/50MCG
 EDARBI 40MG
 EDARBI 80MG
 EDARBYCLOR
 40MG/12.5MG
 EDARBYCLOR
 40MG/25MG
 EDECRIN 25MG
 EDURANT 25MG
 ELIDEL 1%
 ELIQUIS 2.5MG
 ELIQUIS 5MG
 ELMIRON 100MG
 ENTRESTO 24MG-26MG
 ENTRESTO 49MG-51MG
 ENTRESTO 97MG-103MG
 EPIDUO FORTE 0.3%/2.5%
 EPIDUO GEL PUMP
 0.1%/2.5%
 EPIPEN 0.3MG
 EPIPEN JR 0.15MG
 EPIVIR / HBV (G) 100MG
 ESTRUGEL 0.06%
 EUCRISA 2%
 EVISTA (G) 60MG
 EVOTAZ 300MG-150MG
 EXELON (G) 4.6MG/24HR
 EXELON (G) 9.5MG/24HR
 EXELON (G) 13.3MG/24HR
 EXFORGE HCT
 160/12.5/5MG
 EXFORGE HCT
 160/12.5/10MG
 EXFORGE HCT
 160/25/5MG
 EXFORGE HCT
 160/25/10MG
 EXFORGE HCT
 320/25/10MG
 FARESTON 60MG
 FARXIGA 5MG
 FARXIGA 10MG
 FELDENE 10MG
 FELDENE 20MG
 FETZIMA 20MG
 FETZIMA 40MG
 FETZIMA 80MG
 FETZIMA 120MG
 FOSAMAX GEL 15%
 FLAREX 0.1%
 FLOVENT 44MCG
 FLOVENT 110MCG
 FLOVENT 220MCG
 FLOVENT DISKUS 100MCG
 FLOVENT DISKUS 250MCG
 FOSAMAX PLUS D
 70MG-2800IU
 FOSAMAX PLUS D
 70MG-5600IU
 FOSRENOL CHEW 500MG
 FOSRENOL CHEW 750MG
 FOSRENOL CHEW 1000MG
 FOSRENOL POWDER
 750MG
 FOSRENOL POWDER
 1000MG
 GENVOYA
 GILENYA (G) 0.5MG
 GLUCAGEN HYPOKIT 1MG
 GLUMETZA ER 1000MG
 GLYXAMBI 10MG/5MG
 GLYXAMBI 25MG/5MG
 IBRANCE 75MG
 IBRANCE 100MG
 IBRANCE 125MG
 IMITREX NASAL SPRAY
 5MG
 IMITREX NASAL SPRAY
 20MG
 IMITREX STATDOSE
 6MG/0.5ML
 INCRUSE ELLIPTA 62.5MCG
 INSPRA (G) 25MG
 INSPRA (G) 50MG
 INVEGA 3MG
 INVOKAMET 50MG-500MG
 INVOKAMET 50MG-1000MG
 INVOKAMET 150MG-500MG
 INVOKAMET 150MG-1000MG
 INVOKANA 100MG
 INVOKANA 300MG
 IRESSA 250MG
 ISENTRESS 400MG
 JAKAFI 5MG
 JAKAFI 10MG
 JAKAFI 15MG
 JAKAFI 20MG
 JALYN 0.5MG/0.4MG
 JANUMET 50/500MG
 JANUMET 50/1000MG
 JANUMET XR
 50MG/500MG
 JANUMET XR
 50MG/1000MG
 JANUMET XR
 100MG/1000MG
 JANUVIA 25MG
 JANUVIA 50MG
 JANUVIA 100MG
 JARDIANCE 10MG
 JARDIANCE 25MG
 JENTADUETO
 2.5MG-500MG
 JENTADUETO
 2.5MG-850MG
 JENTADUETO
 2.5MG-1000MG
 JUBLIA 10%
 JULUCA 50MG-25MG
 KAZANO 12.5/500MG
 KAZANO 12.5/1000MG
 KEPPPA (G) 250MG
 KEPPPA (G) 500MG
 KEPPPA (G) 750MG
 KEPPPA (G) 1000MG
 KERENDIA 10MG
 KERENDIA 20MG
 KISQALI 200MG
 KOMBIGLYZE XR
 2.5MG/1000MG
 KOMBIGLYZE XR
 5MG/500MG
 KOMBIGLYZE XR
 5MG/1000MG
 LAMICTAL (G) 150MG
 LAMICTAL (G) 200MG
 LATUDA 20MG
 LATUDA 40MG
 LATUDA 60MG
 LATUDA 80MG
 LATUDA 120MG
 LEXIVA 700MG
 LIALDA 1.2MG
 LINZESS 72MCG
 LINZESS 145MCG
 LINZESS 290MCG
 LIPITOR (G) 10MG
 LIPITOR (G) 20MG
 LIPITOR (G) 40MG
 LIPITOR (G) 80MG
 LOTEMAX GEL 0.5%
 LOTEMAX OINT 0.5%
 LOTEMAX SUSP 0.5%
 LUMIGAN 0.01%
 MESTINON TS 180MG
 METRO CREAM 0.75%
 METROGEL PUMP 1%
 MIGRANAL 4MG/ML
 MIRVASO 0.33%
 MOTEGRITY 1MG
 MOTEGRITY 2MG
 MULTAQ 400MG
 MYRBETRIQ 25MG
 MYRBETRIQ 50MG
 NATAZIA 3/2-2/2-3/1MG
 NESINA 6.25MG
 NESINA 12.5MG
 NESINA 25MG
 NEUPRO 1MG
 NEUPRO 2MG
 NEUPRO 3MG
 NEUPRO 4MG
 NEUPRO 6MG
 NEUPRO 8MG
 NEVANAC 3MG/ML
 NEXAVAR 200MG
 NEXIUM (G) 20MG
 NEXIUM (G) 40MG
 NEXLETO 180MG
 NEXLIZET 180MG-10MG
 NORITATE CREAM 1%
 NORVASC (G) 5MG
 NORVASC (G) 10MG
 NUBEQA 300MG
 NURTEC ODT 75MG
 ODEFSEY
 200MG-25MG-25MG
 OLUMIANT 2MG
 OMNARIS 50MCG
 ONGLYZA 2.5MG
 ONGLYZA 5MG
 ORLISSA 150MG
 ORLISSA 200MG
 OSPHENA 60MG
 OTEZLA 30MG
 PENTASA 500MG
 PLAQUENIL 200MG
 PLAVIX (G) 75MG
 PRADAXA 150MG
 PRED FORTE 1%
 PREMARIN 0.3MG
 PREMARIN 0.625MG
 PREMARIN 1.25MG
 PREMARIN CREAM
 0.625MG/GM
 PREMPRO 0.3MG/1.5MG
 PRESTALIA 3.5MG/2.5MG
 PRESTALIA 7MG/5MG
 PRESTALIA 14MG/10MG
 PREZISTA 800MG
 PRISTIQ 50MG
 PRISTIQ 100MG
 PROMETRIUM 100MG
 PROTOPIC OINT 0.03%
 PROTOPIC OINT 0.1%
 QTERN 10-5MG
 QVAR REDIHALER 40MCG
 QVAR REDIHALER 80MCG
 RANEXA (G) 500MG
 RAPAFLO (G) 4MG
 RAPAFLO (G) 8MG
 RAPAMUNE 0.5MG
 RAPAMUNE 2MG
 RELPAX (G) 20MG
 RELPAX (G) 40MG
 RENAGEL 800MG
 RESTASIS MULTIDOSE (G)
 0.05%
 RESTASIS VIALS 0.05%
 RETIN A MICRO GEL PUMP
 0.04%
 RETIN-A MICRO GEL PUMP
 0.1%
 REXULTI 0.25MG
 REXULTI 0.5MG
 REXULTI 1MG
 REXULTI 2MG
 REXULTI 3MG
 REXULTI 4MG
 RINVOQ 15MG
 RINVOQ 30MG
 RYBELSUS 3MG
 RYBELSUS 7MG
 RYBELSUS 14MG
 SAPHRIS 5MG
 SAPHRIS 10MG
 SENSIPAR (G) 30MG
 SENSIPAR (G) 60MG
 SEREVENT DISKUS 50MCG
 SIMBRINZA 1%/0.2%
 SINGULAIR (G) 10MG
 SLYND 4MG
 SOOLANTRA 1%
 SPIRIVA 18MCG
 SPIRIVA RESPIMAT 2.5MCG
 STEGLUJAN 5MG-100MG
 STEGLUJAN 15MG-100MG
 STIOLTO RESPIMAT
 2.5/2.5MCG
 STRIVERDI RESPIMAT
 2.5MCG
 SYMBICORT
 160MCG-4.5MCG
 SYMTUZA
 SYNAREL NASAL
 SYNJARDY 5MG/500MG
 SYNJARDY 5MG/1000MG
 SYNJARDY 12.5MG/500MG
 SYNJARDY 12.5MG/1000MG
 TASIGNA 150MG
 TASIGNA 200MG
 TASMAR 100MG
 TAZORAC GEL 0.05%
 TECFIDERA (G) 120MG
 TECFIDERA (G) 240MG
 TEKTURNIA 150MG
 TEKTURNIA 300MG
 TIVICAY 50MG
 TOBI PODHALER 28MG
 TOBEX OINT 0.3%
 TOPAMAX (G) 100MG
 TOVIAZ 4MG
 TOVIAZ 8MG
 TRADJENTA 5MG
 TRELEGY ELLIPTA
 100-62.5-25MCG
 TRELEGY ELLIPTA
 200-62.5-25MCG
 TRINTELLIX 5MG
 TRINTELLIX 10MG
 TRINTELLIX 20MG
 TRIUMEQ 600-50-300MG
 TUDORZA PRESSAIR
 400MCG
 UCERIS 9MG
 ULORIC 80MG
 UROCIT-K (G) 10MEQ
 URSO 250MG
 VAGIFEM 10MCG
 VECTICAL 3MCG/GM
 VELPHORO 500MG
 VENTOLIN HFA 90MCG
 VESICARE (G) 5MG
 VESICARE (G) 10MG
 VIIBRYD 10MG
 VIIBRYD 20MG
 VIIBRYD 40MG
 VIMOVO 375/20MG
 VIMOVO 500/20MG
 VIREAD (G) 300MG
 VIVELLE-DOT 25MCG
 VIVELLE-DOT 37.5MCG
 VIVELLE-DOT 50MCG
 VIVELLE-DOT 75MCG
 VIVELLE-DOT 100MCG
 VRAYLAR 1.5MG
 VRAYLAR 3MG
 VRAYLAR 4.5MG
 VRAYLAR 6MG
 VUMERITY 231MG
 VYTORIN 10/10MG
 VYTORIN 10/20MG
 VYTORIN 10/40MG
 VYTORIN 10/80MG
 WAKIX 4.5MG
 WAKIX 17.8MG
 WELCHOL (G) 625MG
 WELLBUTRIN XL (G) 150MG
 WELLBUTRIN XL (G) 300MG
 XADAGO 50MG
 XADAGO 100MG
 XALATAN 50MCG/ML
 XARELTO 2.5MG
 XARELTO 10MG
 XARELTO 15MG
 XARELTO 20MG
 XELJANZ 5MG
 XELJANZ 10MG
 XELJANZ XR 11MG
 XENAZINE 25MG
 XENICAL 120MG
 XIGDUO XR 5/1000MG
 XIGDUO XR 10/500MG
 XIGDUO XR 10/1000MG
 XIIDRA 5%
 YASMIN 28 (G)
 YAZ (G) 3/0.02MG
 ZELAPAR 1.25MG
 ZETIA (G) 10MG
 ZIANA 1.2%-0.025%
 ZOMIG (G) 2.5MG
 ZOMIG NASAL SPRAY 5MG
 ZOVIRAX CREAM 5%
 ZYCLARA PACKET 3.75%
 ZYCLARA PUMP 3.75%
 ZYTIGA (G) 500MG

NOTE: Medication names appearing with (G) are available in a Generic version from your local or U.S. mail order pharmacy. This list is subject to change. Please call 1-866-893-6337 toll free to verify the availability of your medication through this program.