LOWER PIONEER VALLEY EDUCATIONAL COLLABORATIVE

HEALTH AND WELLNESS INFO PACKET

FY24

FOR MORE DETAILED INFORMATION GO TO
LPVEC.ORG >>STAFF INFORMATION AND FORMS>>BENEFITS>> HEALTH

BENEFITS OPEN ENROLLMENT FOR FY24

OPEN ENROLLMENT PERIOD: MAY 1, 2023 – JUNE 2, 2023

for changes effective 7/1/2023

The Lower Pioneer Valley Educational Collaborative, through its affiliation with Scantic Valley Regional Health Trust (SVRHT), has designated May 1 – June 2 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 continues to offer HMO plans from Blue Cross Blue Shield, Health New England, and Tufts Health Plans and the Blue Care Elect Preferred PPO (Deductible Plan only) from Blue Cross Blue Shield to eligible employees. 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
- Tufts Health Plan EPO 1-800-462-0224

! 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 2, 2023.

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, 2023.

Enrollment forms and all required documents (and premium payment, if applicable) MUST BE RECEIVED BY 4:00 PM EST FRIDAY, JUNE 2, 2023 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

SVRHT INSURANCE RATES
Plan Year: 7/1/2023 - 6/30/2024

HEALTH INSURANCE RATES FY24

PRODUCT	TYPE	COVERAGE	MONTHLY PREMIUM	ACTIVE EMPLOYEES: Collaborative Monthly Share	ACTIVE EMPLOYEES: Employee Monthly Share	ACTIVE EMPLOYEES: Employee Share Per Pay Period	ACTIVE EMPLOYEES: Employee Share Per Pay Period	RETIREES: Non-Medicare Eligible Monthly Share	INACTIVE: COBRA Rates
			100%	70%	30%	26	22	50%	
Network Blue	**HMO**	Single	$930.00	$651.00	$279.00	$128.77	$152.18	$465.00	$948.60
Standard Plan Group #002238438		Family	$2,302.00	$1,611.40	$690.60	$318.74	$376.69	$1,151.00	$2,348.04
Network Blue	**HMO**	Single	$903.00	$632.10	$270.90	$125.03	$147.76	$451.50	$921.06
Deductible Plan Group #004056369		Family	$2,242.00	$1,569.40	$672.60	$310.43	$366.87	$1,121.00	$2,286.84
Health New England	**HMO**	Single	$814.00	$569.80	$244.20	$112.71	$133.20	$407.00	$830.28
Standard Plan Group #S030420016		Family	$2,027.00	$1,418.90	$608.10	$280.66	$331.69	$1,013.50	$2,067.54
Health New England	**HMO**	Single	$786.00	$550.20	$235.80	$108.83	$128.62	$393.00	$801.72
Deductible Plan Group #S030420026		Family	$1,961.00	$1,372.70	$588.30	$271.52	$320.89	$980.50	$2,000.22
Tufts	**EPO**	Single	$941.00	$658.70	$282.30	$130.29	$153.98	$470.50	$959.82
Standard Plan Group #16211		Family	$2,352.00	$1,646.40	$705.60	$325.66	$384.87	$1,176.00	$2,399.04
Tufts	**EPO**	Single	$856.00	$599.20	$256.80	$118.52	$140.07	$428.00	$873.12
Deductible Plan Group #16209		Family	$2,135.00	$1,494.50	$640.50	$295.62	$349.36	$1,067.50	$2,177.70
Blue Care Elect Preferred -	**PPO**	Single	$1,586.00	$1,110.20	$475.80	$219.60	$259.53	$793.00	$1,617.72
Standard Plan Group #002345370		Family	$3,451.00	$2,415.70	$1,035.30	$477.83	$564.71	$1,725.50	$3,520.02

**see below note for hourly employees

DENTAL INSURANCE RATES

no change FY24

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

VISION INSURANCE RATES

no change FY24

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

*** New enrollments/coverage changes for 22 week/10-month paid employees:** 7/1/2023 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.

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.

Relationship	**Documentation**
Employee	Photocopy of town- or city-issued birth certificate **(hospital records are not accepted)**.
Spouse	Photocopy of town- or city-issued marriage certificate **(church or Justice of the Peace certificates are NOT accepted), AND** 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, **AND** 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) **(hospital records are not accepted),** 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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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.

LOWER PIONEER VALLEY EDUCATIONAL COLLABORATIVE
174 BRUSH HILL AVENUE, WEST SPRINGFIELD, MA 01089 PHONE 413-735-2200 FAX 413-735-2280

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.

Z:\WORDOCS\HR\Insurance\HIPAA Special Enrollment Notice.doc

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

NO DEDUCTIBLES

Effective 7-1-23

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.

	BLUE CROSS BLUE SHIELD			HEALTH NEW ENGLAND	TUFTS HEALTH PLAN
		BLUE CARE ELECT PREFERRED PPO			
BENEFIT	**NETWORK BLUE HMO**	**In-Network**	**Out-of-Network**	**HMO**	**Choice Copay EPO**
Deductible	None	None	$400 Individual $800 Family	None	None
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)	$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 100 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 7-1-23

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.

	BLUE CROSS BLUE SHIELD			HEALTH NEW ENGLAND	TUFTS HEALTH PLAN
		BLUE CARE ELECT PREFERRED PPO			
BENEFIT	**NETWORK BLUE HMO**	**In-Network**	**Out-of-Network**	**HMO**	**Choice Copay EPO**
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* waived when there is an active cancer diagnosis
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 - 30 visits per year
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	$20 PCP Office $35 Specialists Office
Adult Preventative Exam *(includes preventative lab*	$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 **breast, hand, arm and feet prosthetics Member pays 20%, plan pays 80%

SVRHT Plan Benefit Comparison

Effective 7-1-23

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.

	BLUE CROSS BLUE SHIELD			HEALTH NEW ENGLAND	TUFTS HEALTH PLAN
		BLUE CARE ELECT PREFERRED PPO			
BENEFIT	**NETWORK BLUE HMO**	**In-Network**	**Out-of-Network**	**HMO**	**Choice Copay EPO**
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	Not Covered
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 to12 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, mindfulless apps, bike shares and Weight Watchers® program.	JENNY CRAIG DISCOUNTS: -$200 in food savings
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		Up to $150 fitness reimbursement per household, per plan year $150 reimbursement per plan year when enrollmed in a weight loss program.

***After Deductible**

SVRHT Plan Benefit Comparison

DEDUCTIBLE PLANS

Deductible Plans - Effective 7-1-23

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	TUFTS HEALTH PLAN
		BLUE CARE ELECT PREFERRED PPO			
BENEFIT	**NETWORK BLUE HMO**	**In-Network**	**Out-of-Network**	**HMO**	**Advantage EPO**
Deductible	$250 per member up to $750 per family	$250 per member up to $750 per family	$400 Individual $800 Family	$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 100 days per plan year

SVRHT Plan Benefit Comparison

Deductible Plans - Effective 7-1-23

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	TUFTS HEALTH PLAN
		BLUE CARE ELECT PREFERRED PPO			
BENEFIT	NETWORK BLUE HMO	In-Network	Out-of-Network	HMO	Advantage EPO
OUTPATIENT HOSPITAL	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)	$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

SVRHT Plan Benefit Comparison

Deductible Plans - Effective 7-1-23

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	TUFTS HEALTH PLAN
		BLUE CARE ELECT PREFERRED PPO			
BENEFIT	**NETWORK BLUE HMO**	**In-Network**	**Out-of-Network**	**HMO**	**Advantage EPO**
PHYSICIAN'S OFFICE	**YOU PAY**	**YOU PAY**	**YOU PAY**	**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	$20 PCP Office $35 Specialists Office
Adult Preventative Exam *(includes preventative lab*	$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	$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 *breast, hand, arm and feet prosthetics Member pays 20%, plan pays 80%

SVRHT Plan Benefit Comparison

Deductible Plans - Effective 7-1-23

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	TUFTS HEALTH PLAN
		BLUE CARE ELECT PREFERRED PPO			
BENEFIT	**NETWORK BLUE HMO**	**In-Network**	**Out-of-Network**	**HMO**	**Advantage EPO**
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	Not Covered
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 to12 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, mindfulless apps, bike shares and Weight Watchers®	JENNY CRAIG DISCOUNTS: -$200 in food savings
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 $150 reimbursement per plan year, when enrolled in a weight loss program

SVRHT Plan Benefit Comparison

Deductible Plans - Effective 7-1-23

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	TUFTS HEALTH PLAN
		BLUE CARE ELECT PREFERRED PPO			
BENEFIT	NETWORK BLUE HMO	In-Network	Out-of-Network	HMO	Advantage EPO
	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	program.	

wellness program
Scantic Valley Regional Health Trust

SVRHT-Insured employees

Blue Cross Blue Shield - BCBS members are entitled to reimbursement for up to $150 per calendar year for qualified fitness centers and $150 per calendar year for WW® & other weight loss programs.

Health New England - Reimburses $200/ind, $400/family, per year for: qualifying fitness club membership; personal trainer fees; aerobic/wellness classes; school and town sports registration fees; CSA farm shares and up to $150 per calendar year for Weight Watchers®.
For the Medicare Advantage plan, HNE offers an allowance of $150 per calendar year for joining a Fitness Club or WW® or for certain Safety Items.

Tufts - Up to $150 per calendar year for fitness center membership; $150 per calendar year for a weight loss program.

Wellness Works! Points Program BCBS, HNE, Tufts Subscribers and spouses (including retirees) through Scantic Valley Regional Health Trust can earn up to a $200 (BCBS). $150 (HNE and Tufts) gift card for participating in various activities.

CanaRx Money-saving program for brand name prescription medications. For more information, call 1-866-893-6337 or go to www.SVRHTCanaRx.com. For additional information, click here

Good Health Gateway Diabetes Care Rewards Program Voluntary program to receive diabetes medications and supplies for $0 co-pays. Call 1-800- 643-8028 or visit www.GoodHealthGateway.com for more information.

MyTelemedicine A convenient and free solution for medical care. As a member, you now receive access to a national network of U.S. board-certified doctors who are available 24/7/365 to treat many of your medical issues by video, phone or email https://www.mytelemedicine.com/

Programs in **red** are available to all employees and family members who get their insurance through the Scantic Valley Regional Health Trust

EVENTS: **"Maintain Campaign"** Our yearly commitment to support everyone's effort to keep our weight in check during the holiday season. It involves a weigh-in before Thanksgiving and a weigh-out after the New Year. Weekly emails containing tips to stay on track are sent to all participants. Everyone who stays within 2 pounds of their weigh-in weight will be entered into a drawing for various incentive gifts. SVRHT Wellness Program Incentives

Numerous additional webinars, challenges, and healthy activities will be available to all employees throughout the year. Watch for information in the monthly newsletters and staff emails. Many programs will have gift card raffles and other raffle prizes for participation.

Smoking Cessation* "Quit Smoking Your Way and We'll Pay"
Benefitted/benefit-eligible employees and their spouses can have smoking cessation-related expenses waived and earn up to $200 in gift cards for staying quit. You must register for this program and schedule verification appointments in order to receive incentives.

Wellness Works! Points Program Employees who do not get health insurance through work can earn up to 10 chances in a raffle for incentives for participating in various activities.

If you have an idea that you would like to see become part of the wellness program, please let us know! Our program gets better when you are engaged!

For more information on any of the programs offered by the SVRTH Wellness Program, please contact Marcy Morrison - Marcy@scantichealth.org or call 617-431-6651

Colonoscopy * Benefitted/benefit-eligible employees and spouses can earn $100 for completing a preventive screening colonoscopy (once every 5 years maximum).

Community Discounts Longmeadow Parks & Recreation, East Longmeadow Recreation Department and Hampden Parks & Recreation Benefitted/benefit-eligible employees receive a 40% discount on most adult fitness programs/classes. Receive discount upon registration.

Local Fitness Center Discounts**

ATTAIN Therapy and Fitness (East Longmeadow) – 15% discount for first responders; 10% discount for school and town employees for adult strength and conditioning classes.

Blue Diamond CrossFit (80 Denslow Road) in East Longmeadow offers a 20% discount for Military, Police, Fire, Teachers and Students (with valid ID)
Century Fitness (East Longmeadow) –Twelve-month membership with no start-up fee for $19.99 per month.

Glenmeadow Retirement Community (Longmeadow) - $10 off monthly Lifestyle Pass for ages 62 and over.

Healthtrax (East Longmeadow) - $10 off per month with yearly membership.
PureBarre (East Longmeadow/Northampton) – 10% off monthly packages and clothing.

Scantic Valley YMCA (Wilbraham) - 50% off of the joiner's fee and 20% discount off of the regular monthly membership rates. **Please tell staff that you are a town employee when purchasing membership

For more information, please see our website, www.scantichealth.org or contact Marcy Morrison - Marcy@Scantichealth.org 617-431-6651
Like us on Facebook! https://www.facebook.com/scanticvalleywellness/

Offers in **purple** are also available for all benefit-eligible employees, even if you don't have town/school insurance.

Life comes with challenges.

Your Assistance Program is here to help.

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

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

Mental Health Sessions
Manage stress, anxiety, and depression, resolve conflict, improve relationships, overcome substance abuse, and address any personal issues.

Life Coaching
Reach personal and professional goals, manage life transitions, overcome obstacles, strengthen relationships, and build balance.

Financial Consultation
Build financial wellness related to budgeting, buying a home, paying off debt, managing taxes, preventing identity theft, and saving for retirement or tuition.

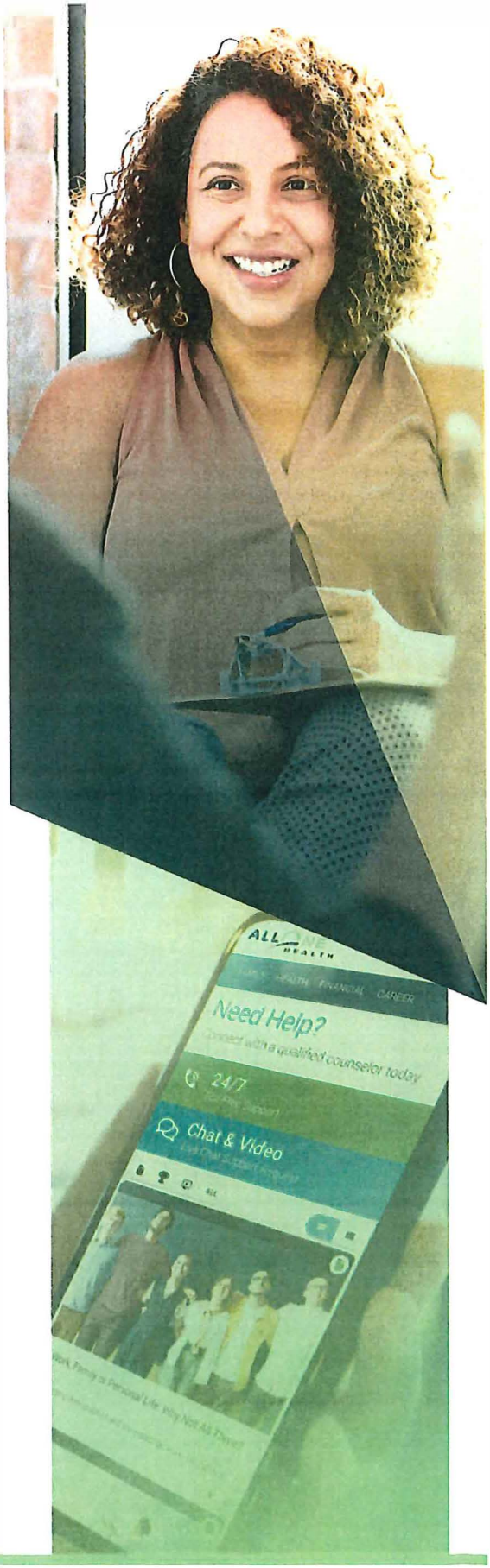
Legal Consultation
Get help with personal legal matters including estate planning, wills, real estate, bankruptcy, divorce, custody, and more.

Work-Life Resources and Referrals
Obtain information and referrals when seeking childcare, adoption, special needs support, eldercare, housing, transportation, education, and pet care.

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

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

Member Portal and App
These digital tools enable you to access your benefits 24/7/365 with online requests and chat options. They also provide easy access to thousands of articles, webinars, podcasts, and tools covering total well-being.



Contact AllOne Health EAP
Call: 800.451.1834
Visit: www.allonehealtheap.com
Code: lpvec

ALLONE HEALTH

FOR HEALTH PLAN MEMBERS OF

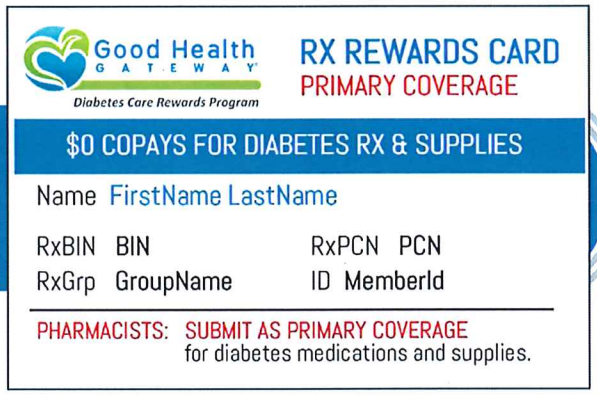
Scantic Valley Regional Health Trust

Good Health GATEWAY®

Diabetes Care Rewards Program

Why participate in the Diabetes Care Rewards Program

We'll help you improve your health and reduce your risk of heart disease and stroke.
Plus you'll get a Good Health Gateway® RX Rewards Card to get your $0 copays on covered diabetes medications and supplies.



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

Register at **GoodHealthGateway.com** to start your 90-day Introductory Period.
Or call our **Good Health Gateway** HelpLine at 800.643.8028 Monday through Thursday 8:30 am - 6:00 pm and Friday 8:30 am - 5:00 pm EST.

During your Introductory Period, you can get $0 copays using your **Good Health Gateway Rx Rewards Card** at your local, in-network pharmacy or through OPTUMRx® Home Delivery.

To keep your $0 copays beyond your Introductory Period, send us a Provider Confirmation Form or other acceptable documentation showing you completed the medical exams and lab tests listed below. Upload your documents through the website, send by mail, or fax to 877.378. 4480.

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

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

Continue to get your $0 copays as long as you keep your diabetes labs and exams up to date.

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

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

800.643.8028
GOODHEALTHGATEWAY.COM

Available to the following member employers of the Scantic Valley Regional Health Trust:

Hampden Wilbraham Regional School District
Lower Pioneer Valley Educational Collaborative

Town of:
- East Longmeadow
- Hampden
- Longmeadow
- Wilbraham

For employees and their covered dependents of the above employers insured through one of the following Scantic Valley Regional Health Trust sponsored health plans:

Blue Cross Blue Shield of Massachusetts
Network Blue HMO, Network Blue HMO Deductible, Blue Care Elect Preferred PPO, Blue Care Elect Preferred PPO Deductible

Health New England
HNE HMO, HNE HMO Deductible

Tufts Health Plan
Tufts Choice Co-pay EPO, Tufts Advantage EPO Deductible

CANARX

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 a health 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.

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

Getting started is super easy!

1. Check to see if a medication is offered. Call **1-866-893-6337** and speak with a CANARX representative or view the complete formulary and print enrollment material at **www.canarx.com** (WebID: **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!

For More Information

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

April 2023

For More Information: Call 1-866-893-6337

HNE

ACIPHEX 20MG
ACTONEL 35MG
ACTONEL 150MG
ACTOPLUS 15MG-850MG
ACZONE 5%
ADVAIR DISKUS 100MCG
ADVAIR DISKUS 250MCG
ADVAIR DISKUS 500MCG
ADVAIR HFA 45/21MCG
ADVAIR HFA 115/21MCG
ADVAIR HFA 230/21MCG
AFINITOR 2.5MG
AFINITOR 5MG
AFINITOR 10MG
AKLIEF 50MCG/G
ALOCRIL 2%
ALOMIDE 0.1%
ALPHAGAN-P 0.15%
ALREX 0.2%
ALVESCO 80MCG
ALVESCO 160MCG
AMPYRA 10MG
ANORO ELLIPTA 62.5/25MCG
APTIOM 200MG
APTIOM 400MG
APTIOM 600MG
APTIOM 800MG
ARAVA 10MG
ARAVA 20MG
ARNUITY ELLIPTA 100MCG
ARNUITY ELLIPTA 200MCG
AROMASIN 25MG
ASMANEX TWISTHALER 110MCG
ASMANEX TWISTHALER 220MCG
ASTAGRAF XL 1MG
ASTAGRAF XL 5MG
ATACAND 4MG
ATACAND 8MG
ATACAND 16MG
ATACAND 32MG
ATACAND HCT 16MG/12.5MG
ATACAND HCT 32MG/12.5MG
ATACAND HCT 32MG/25MG
ATELVIA DR 35MG
ATROVENT HFA 20UG
AUBAGIO 14MG
AZELEX 20%
AZILECT 0.5MG
AZILECT 1MG
AZOPT 1%
AZOR 20/5MG
AZOR 40/5MG
AZOR 40/10MG
BANZEL 200MG
BANZEL 400MG
BECONASE AQ 42MCG
BEPREVE 1.5%
BETIMOL 0.25%
BETIMOL 0.5%
BETOPTIC S 0.25%
BEYAZ
BIJUVA 1MG-100MG
BIKTARVY
50MG-200MG-25MG
BINOSTO 70MG
BREO ELLIPTA 100/25MCG
BREO ELLIPTA 200/25MCG
BRILINTA 60MG
BRILINTA 90MG
BYSTOLIC 2.5MG
BYSTOLIC 5MG
BYSTOLIC 10MG
BYSTOLIC 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
CAMBIA 50MG
CARDURA XL 4MG
CARDURA XL 8MG
CELEBREX 100MG
CELEBREX 200MG
CEQUA 0.09%
CLARINEX 5MG
CLIMARA PATCH 25MCG
CLIMARA PATCH 50MCG
CLIMARA PATCH 75MCG
CLIMARA PATCH 100MCG
COMBIGAN 0.2-0.5%
COMBIVENT RESPIMAT 20MCG/100MCG
COMTAN 200MG
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
DALIRESP 500MCG
DEPAKOTE 250MG
DEPAKOTE 500MG
DETROL 1MG
DETROL 2MG
DETROL LA 2MG
DETROL LA 4MG
DEXILANT DR 30MG
DEXILANT DR 60MG
DIFFERIN CREAM 0.1%
DIFFERIN GEL 0.3%
DIOVAN (G) 40MG
DIOVAN (G) 80MG
DIOVAN (G) 160MG
DIOVAN (G) 320MG
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%
EPIVIR / HBV 100MG
EPZICOM (G) 600MG-300MG
ESTROGEL 0.06%
EUCRISA 2%
EVISTA 60MG
EVOTAZ 300MG-150MG
EXELON 4.6MG/24HR
EXELON 9.5MG/24HR
EXELON 13.3MG/24HR
EXFORGE 5/160MG
EXFORGE 5/320MG
EXFORGE 10/160MG
EXFORGE 10/320MG
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
FETZIMA 20MG
FETZIMA 40MG
FETZIMA 80MG
FETZIMA 120MG
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 0.5MG
GLUCAGEN HYPOKIT 1MG
GLYXAMBI 10MG/5MG
GLYXAMBI 25MG/5MG
HEPSERA (G) 10MG
IBRANCE 75MG
IBRANCE 100MG
IBRANCE 125MG
ILEVRO 0.3%
IMITREX NASAL SPRAY 5MG
IMITREX NASAL SPRAY 20MG
IMITREX STATDOSE 6MG/0.5ML
INCRUSE ELLIPTA 62.5MCG
INSPRA 25MG
INSPRA 50MG
INVEGA 3MG
INVEGA 6MG
INVEGA 9MG
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
JULUCA 50MG-25MG
KAZANO 12.5/500MG
KAZANO 12.5/1000MG
KERENDIA 10MG
KERENDIA 20MG
KISQALI 200MG
KOMBIGLYZE XR 2.5MG/1000MG
KOMBIGLYZE XR 5MG/500MG
KOMBIGLYZE XR 5MG/1000MG
LATUDA 20MG
LATUDA 40MG
LATUDA 60MG
LATUDA 80MG
LATUDA 120MG
LEXIVA 700MG
LIALDA 1.2GM
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%
LOVENOX (G) 40MG
LOVENOX (G) 60MG
LOVENOX (G) 80MG
LOVENOX (G) 100MG
LUMIGAN 0.01%
MESTINON TS 180MG
METROGEL PUMP 1%
MICARDIS 20MG
MICARDIS 40MG
MICARDIS 80MG
MICARDIS HCT 40/12.5MG
MICARDIS HCT 80/12.5MG
MICARDIS HCT 80/25MG
MIGRANAL 4MG/ML
MIRAPEX ER 0.375MG
MIRAPEX ER 0.75MG
MIRAPEX ER 1.5MG
MIRAPEX ER 2.25MG
MIRAPEX ER 3MG
MIRAPEX ER 3.75MG
MIRAPEX ER 4.5MG
MIRVASO 0.33%
MOTEGRITY 1MG
MOTEGRITY 2MG
MULTAQ 400MG
MYRBETRIQ 25MG
MYRBETRIQ 50MG
NAMENDA 10MG
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
NEXLETOL 180MG
NEXLIZET 180MG-10MG
NUBEQA 300MG
NURTEC ODT 75MG
ODEFSEY 200MG-25MG-25MG
OLUMIANT 2MG
OMNARIS 50MCG
ONGLYZA 2.5MG
ONGLYZA 5MG
ORILISSA 150MG
ORILISSA 200MG
OSPHENA 60MG
OTEZLA 30MG
PENTASA 500MG
PLAQUENIL 200MG
PRADAXA 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
PREVACID SOLUTAB 15MG
PREVACID SOLUTAB 30MG
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 500MG
RAPAFLO 4MG
RAPAFLO 8MG
RAPAMUNE 0.5MG
RAPAMUNE 1MG
RAPAMUNE 2MG
RELPAX 20MG
RELPAX 40MG
RENAGEL 800MG
RESTASIS MULTIDOSE 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
SEASONIQUE 0.15/0.03/0.01MG
SEGLUROMET 2.5MG-500MG
SEGLUROMET 2.5MG-1000MG
SEGLUROMET 7.5MG-500MG
SEGLUROMET 7.5MG-1000MG
SEREVENT DISKUS 50MCG
SEROQUEL XR (G) 50MG
SEROQUEL XR (G) 150MG
SEROQUEL XR (G) 200MG
SEROQUEL XR (G) 300MG
SEROQUEL XR (G) 400MG
SIMBRINZA 1%/0.2%
SLYND 4MG
SOOLANTRA 1%
SPIRIVA 18MCG
SPIRIVA RESPIMAT 2.5MCG
STEGLATRO 5MG
STEGLATRO 15MG
STEGLUJAN 5MG-100MG
STEGLUJAN 15MG-100MG
STIOLTO RESPIMAT 2.5/2.5MCG
STRATTERA 10MG
STRATTERA 18MG
STRATTERA 25MG
STRATTERA 40MG
STRATTERA 60MG
STRATTERA 80MG
STRATTERA 100MG
STRIVERDI RESPIMAT 2.5MCG
SYMTUZA
SYNAREL NASAL
SYNJARDY 5MG/500MG
SYNJARDY 5MG/1000MG
SYNJARDY 12.5MG/500MG
SYNJARDY 12.5MG/1000MG
TASIGNA 150MG
TASIGNA 200MG
TASMAR 100MG
TAZORAC CREAM 0.05%
TAZORAC GEL 0.05%
TAZORAC GEL 0.1%
TECFIDERA (G) 120MG
TECFIDERA (G) 240MG
TEKTURNA 150MG
TEKTURNA 300MG
TIVICAY 50MG
TOBI PODHALER 28MG
TOBREX OINT 0.3%
TOLAK 4%
TOPICORT CREAM 0.25%
TOVIAZ 4MG
TOVIAZ 8MG
TRADJENTA 5MG
TRELEGY ELLIPTA 100-62.5-25MCG
TRELEGY ELLIPTA 200-62.5-25MCG
TRIBENZOR 20/5/12.5MG
TRIBENZOR 40/5/12.5MG
TRIBENZOR 40/5/25MG
TRIBENZOR 40/10/12.5MG
TRIBENZOR 40/10/25MG
TRILEPTAL (G) 150MG
TRILEPTAL (G) 300MG
TRILEPTAL (G) 600MG
TRINTELLIX 5MG
TRINTELLIX 10MG
TRINTELLIX 20MG
TRIUMEQ 600-50-300MG
TUDORZA PRESSAIR 400MCG
UCERIS 9MG
ULORIC 80MG
UROCIT-K 10MEQ
URSO 250MG
VAGIFEM 10MCG
VECTICAL 3MCG/GM
VELPHORO 500MG
VENTOLIN HFA 90MCG
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 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
YAZ 3/0.02MG
ZELAPAR 1.25MG
ZETIA (G) 10MG
ZIAGEN (G) 300MG
ZIANA 1.2%-0.025%
ZOMIG NASAL SPRAY 5MG
ZOMIG ZMT 2.5MG
ZOVIRAX CREAM 5%
ZYCLARA PACKET 3.75%
ZYCLARA PUMP 3.75%
ZYTIGA (G) 250MG
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.

April 2023