Town of Truro Employee/Active Retirees
Health Plan Rates
FY2025 July 1, 2024 - June 30, 2025

Senior Health Plan Rates will be sent in the Fall and are effective January 1, 2025 - December 31, 2025 (Must be retired and Medicare eligible)

	Employee/Retiree Monthly Cost		35%
	Individual	Single Parent/Child	Family
Blue Cross Blue Shield			
Master Health Plus*	716.10	1,434.65	1,789.90
Blue Care Elect PPO	467.95	937.30	1,171.10
Network Blue HMO	358.05	721.70	960.40
Harvard Pilgrim			
Harvard Pilgrim PPO	386.40	772.10	1,021.65
Harvard Pilgrim HMO	351.75	703.85	941.50
Annual In-Network deductible all Health plans	300.00	600.00	900.00

**Grandfathered plan, not available for new enrollments*

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

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

Open Enrollment runs May 1 - May 31, 2024
Please contact the Collector/Treasurer's office with any questions and for applicable forms

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

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

CCMHG Health Plan Benefit Comparison - FY25

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

Effective 07-01-2024	BLUE CROSS BLUE SHIELD				HARVARD PILGRIM HEALTH CARE		
		BLUE CARE ELECT PREFERRED PPO		Master Health Plus		PPO	
BENEFIT	**NETWORK BLUE HMO**	**In-Network**	**Out-of-Network**	**Indemnity Plan**	**HPHC HMO**	**IN-NETWORK**	**OUT-OF-NETWORK**
Deductible - *applies to: In-patient Admission; Out-patient Surgery; ER, High Tech Imaging (MRI, CT, & PET) and Diagnostic Tests & Procedures. Does not apply to routine office visits or pharmacy. Per plan year (July 1 to June 30) -* ***See plan document for full details***	$300 per member $900 per family	$300 per member $900 per family	$400 per member $800 per family	$300 per member $900 per family	$300 per member $900 per family	$300 per member $900 per family	$400 per member $800 per family
Out-of-Pocket (OOP) Maximum - *Once your out-of-pocket expenses for applicable services reaches this amount, you pay $0 for remainder of plan year. NOTE: a separate out-of-pocket maximum for prescription copays added effective July 1, 2015 as required by ACA (in-network only).*	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical:** $3,000 per member	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical:** $3,000 per member
Lifetime Benefit Maximum	None	None	None	None	None	None	None
INPATIENT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and special services) - **Deductible Applies**	$500 copay per admission	$500 copay per admission	20% coinsurance* Nothing for emergency/accident admissions	$700 copay per admission	$500 copay per admission	$500 copay per admission	20% coinsurance*
Physician Services	Nothing	Nothing	20% coinsurance* Nothing for emergency/accident admissions	Nothing	Nothing	Nothing	20% coinsurance*
Skilled Nursing Facility **Deductible Applies**	Nothing to 100 days per calendar year benefit maximum	Nothing to 100 days per calendar year benefit maximum	20% coinsurance* to 100 days per calendar year benefit maximum	Nothing	Limit to 100 days per Plan Year - $500 copayper admission	Limit to 100 days per Plan Year - $500 copayper admission	20% coinsurance*
Rehabilitation Hospital **Deductible Applies**	Nothing to 60 days per calendar year benefit maximum	Nothing to 60 days per calendar year benefit maximum	20% coinsurance* to 60 days per calendar year benefit maximum	Nothing	Limit to 60 days per Plan Year - $500 copay per admission	Limit to 60 days per Plan Year - $500 copay per admission	20% coinsurance*

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

CCMHG Health Plan Benefit Comparison - FY25

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Effective 07-01-2024	BLUE CROSS BLUE SHIELD				HARVARD PILGRIM HEALTH CARE		
		BLUE CARE ELECT PREFERRED PPO		Master Health Plus		PPO	
BENEFIT	NETWORK BLUE HMO	In-Network	Out-of-Network	Indemnity Plan	HPHC HMO	IN-NETWORK	OUT-OF-NETWORK
PHYSICIAN'S OFFICE	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Adult Preventative Exam *(includes preventative lab tests)*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay	$0 copay	20% coinsurance*
PCP Medical Care/ Mental Health Care/ Substance Abuse Care	$20 copay	$20 copay	20% coinsurance*	$20 copay	Copay Level 1 :$20 copay	Copay Level 1 :$20 copay	20% coinsurance*
Well Child Care *(includes preventative lab tests)*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay (including routine physical exams, immunizations, school, camp, sports)	$0 copay (including routine physical exams, immunizations, school, camp, sports)	20% coinsurance*
Routine GYN Exam *(one per calendar year , includes preventative lab tests)*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay	$0 copay	20% coinsurance*
Routine Mammogram	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay	$0 copay	20% coinsurance*
Routine Vision Exam	$0 copay (once every 12 months)	$0 copay (once per calendar year)	20% coinsurance* (once per calendar year)	$0 copay (once every 24 months)	Limited 1 visit per Plan Year - No Charge	Limited 1 visit per Plan Year - No Charge	20% coinsurance*
Specialist Office Visit	$45 copay	$45 copay	20% coinsurance*	$45 copay	Copay Level 2 : $45 copay	Copay Level 2 : $45 copay	20% coinsurance*
OTHER OUTPATIENT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Visiting Nurse Home Health Care Deductible Applies	Nothing	Nothing	20% coinsurance*	Nothing	Nothing	Nothing	20% coinsurance*
Durable Medical Equipment - Deductible Applies	After deductible, member pays 20%, plan pays 80% with no limit. Wigs are covered in full when needed as a result of any form of cancer, leukemia, alopecia areata, alopecia totalis, or permanent hair loss due to injury.	After deductible, member pays 20%, plan pays 80% with no limit. Wigs are covered in full when needed as a result of any form of cancer, leukemia, alopecia areata, alopecia totalis, or permanent hair loss due to injury.	After deductible, member pays 40%, plan pays 60% with no limit. Wigs are covered in full when needed as a result of any form of cancer, leukemia, alopecia areata, alopecia totalis, or permanent hair loss due to injury.	20% coinsurance*	After deductible, member pays 20% until member has paid $1,000 out of pocket, then plan pays in full. Wigs are covered in full when needed as a result of any form of cancer, leukemia, alopecia areata, alopecia totalis, or permanent hair loss due to injury.	After deductible, member pays 20% until member has paid $1,000 out of pocket, then plan pays in full. Wigs are covered in full when needed as a result of any form of cancer, leukemia, alopecia areata, alopecia totalis, or permanent hair loss due to injury.	After deductible, member pays 20% coinsurance until the member has paid $1,000 out of [ocket, then plan pays in full. Wigs subject to deductibel then 20% coinsurance.
Ambulance- Deductible Applies	Nothing	Nothing	Nothing for accident or emergency; 20% coinsurance* other medically necessary ambulance transport	20% coinsurance*	Nothing	Nothing	Emergency transport: Nothing Non emergency transport: 20% coinsurance
Routine Pediatric Dental	Nothing	All charges	All charges	All charges	Covered in full: Preventive care for children up to age 13 2 visits per member per **plan** year including exam, cleaning, x-rays, & flouride treatment.	Covered in full: Preventive care for children up to age 13. 2 visits per member per **plan** year including exam, cleaning, x-rays, & flouride treatment.	Deductible, then 20% coinsurance

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Effective 07-01-2024	**BLUE CROSS BLUE SHIELD**				**HARVARD PILGRIM HEALTH CARE**		
		BLUE CARE ELECT PREFERRED PPO		**Master Health Plus**		**PPO**	
BENEFIT	**NETWORK BLUE HMO**	**In-Network**	**Out-of-Network**	**Indemnity Plan**	**HPHC HMO**	**IN-NETWORK**	**OUT-OF-NETWORK**
Chiropractor Visits	All charges	$20 copay	20% coinsurance*	$20 copay	All charges	All charges	All charges
Prescription Drugs	**Retail:** (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay **Mail Order:** (90 day supply) Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	**Retail:** (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay **Mail Order:** (90 day supply) Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	**Retail:** (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay **Mail Order:** (90 day supply) Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	**Retail:** (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay **Mail Order:** (90 day supply) Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay Non-formulary drugs All charges	**Retail:** (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay **Mail Order:** (90 day supply) Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	**Retail:** (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay **Mail Order:** (90 day supply) Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	no coverage (Optum has over 65.000 pharmacies)
Fitness Benefit	Up to $150 reimbursement toward membership or exercise classes at a health club; and virtual fitness, athletic fees, bicycles, helmets, athletic shoes. See plan details Enroll in a qualified Weight Watchers or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	Up to $150 reimbursement toward membership or exercise classes at a health club; and virtual fitness, athletic fees, bicycles, helmets, athletic shoes. See plan details Enroll in a qualified Weight Watchers or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	Up to $150 reimbursement toward membership or exercise classes at a health club; and virtual fitness, athletic fees, bicycles, helmets, athletic shoes. See plan details Enroll in a qualified Weight Watchers or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	No Fitness Benefit	Up to $300 reimbursement per **calendar** year on fees for 2 members for wellness benefits to include health and fitness club memberships, classes or virtual subscriptions, athletic programs etc. Must be currently enrolled in Harvard Pilgrim at the time of reimbursement and active wellness membership and HPHC member for at least four months within a calendar year.	Up to $300 reimbursement per **calendar** year on fees for 2 members for wellness benefits to include health and fitness club memberships, classes or virtual subscriptions, athletic programs etc. Must be currently enrolled in Harvard Pilgrim at the time of reimbursement and active wellness membership and HPHC member for at least four months within a calendar year.	Up to $300 reimbursement per **calendar** year on fees for 2 members for wellness benefits to include health and fitness club memberships, classes or virtual subscriptions, athletic programs etc. Must be currently enrolled in Harvard Pilgrim at the time of reimbursement and active wellness membership and HPHC member for at least four months within a calendar year.

***After Deductible**

CANARX

Cape Cod Municipal Health Group

Blue Cross Blue Shield

SIMPLE. SAFE. SMART.

SIGN UP TODAY

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

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

Medications FREE to your door!

See reverse for a full list of medications.

CANARX is a voluntary international mail order prescription program offered to eligible employees, non-Medicare eligible retirees and dependents enrolled in the Network Blue HMO, Blue Care Elect Preferred PPO or Master Health Plus with the Cape Cod Municipal Health Group (CCMHG).

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

- **$0 Copay**
- **400+ 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 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: **CCMHG**).
2. Ask your doctor for a prescription for a 3-month supply, with 3 refills.
3. Submit documentation (completed enrollment form, prescription and a copy of your photo ID).
4. Sit back and relax...medication will be mailed direct to your home within 4 weeks!

For More Information

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

January 2024

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

BCBS

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
AFINITOR 2.5MG
AFINITOR 5MG
AFINITOR 10MG
AKLIEF 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
ESTROGEL 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
FINACEA 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
KEPPRA (G) 250MG
KEPPRA (G) 500MG
KEPPRA (G) 750MG
KEPPRA (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 1.2GM
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%
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
NEXLETOL 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
ORILISSA 150MG
ORILISSA 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
TEKTURNA 150MG
TEKTURNA 300MG
TIVICAY 50MG
TOBI PODHALER 28MG
TOBREX 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.

CANARX

Cape Cod Municipal Health Group

Harvard Pilgrim

SIMPLE. SAFE. SMART.

SIGN UP TODAY

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

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

Medications FREE to your door!

See reverse for a full list of medications.

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

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

Getting started is super easy!

1. Check to see if a medication is offered - call 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: **CCMHG**).
2. Ask your doctor for a prescription for a 3-month supply, with 3 refills.
3. Submit documentation (completed enrollment form, prescription and a copy of your photo ID).
4. Sit back and relax...medication will be mailed direct to your home within 4 weeks!

- **$0 Copay**
- **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: CCMHG

January 2024

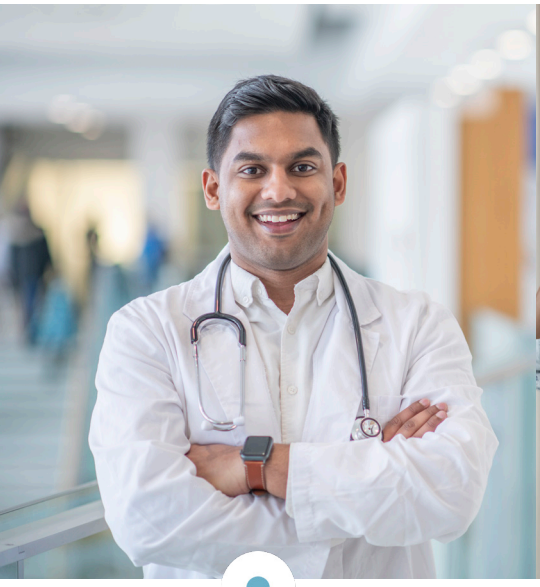
ACIPHEX 20MG
ACTOPLUS (G) 15MG-850MG
ACULAR (G) 0.5%
ACULAR LS (G) 0.4%
ACZONE 5%
ADVAIR DISKUS 100MCG
ADVAIR DISKUS 250MCG
ADVAIR DISKUS 500MCG
ADVAIR HFA 45/21MCG
ADVAIR HFA 115/21MCG
ADVAIR HFA 230/21MCG
AFINITOR 2.5MG
AFINITOR 5MG
AFINITOR 10MG
AKLIEF 50MCG/G
ALOCRIL 2%
ALOMIDE 0.1%
ALPHAGAN-P 0.15%
ALREX 0.2%
ALVESCO 80MCG
ALVESCO 160MCG
AMPYRA (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
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
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%
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
CARDURA XL 4MG
CARDURA XL 8MG
CEQUA (G) 0.09%
CLARINEX 5MG
COLAZAL 750MG
COMBIGAN 0.2-0.5%
COMBIVENT RESPIMAT 20MCG/100MCG
CRESTOR (G) 5MG
CRESTOR (G) 10MG
CRESTOR (G) 20MG
CRESTOR (G) 40MG
CRINONE GEL 8%
DALIRESP 250MCG
DALIRESP 500MCG
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
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
EFFEXOR XR (G) 75MG
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
ESTROGEL 0.06%
EUCRISA 2%
EVOTAZ 300MG-150MG
EXFORGE (G) 5/160MG
EXFORGE (G) 5/320MG
EXFORGE (G) 10/160MG
EXFORGE (G) 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
FELDENE 10MG
FELDENE 20MG
FETZIMA 20MG
FETZIMA 40MG
FETZIMA 80MG
FETZIMA 120MG
FINACEA 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
GENVOYA
GILENYA (G) 0.5MG
GLUCAGEN HYPOKIT 1MG
GLUMETZA ER 1000MG
GLYXAMBI 10MG/5MG
GLYXAMBI 25MG/5MG
IBRANCE 75MG
IBRANCE 100MG
IBRANCE 125MG
ILEVRO 0.3%
IMITREX (G) 100MG
IMITREX NASAL SPRAY 5MG
IMITREX NASAL SPRAY 20MG
IMITREX STATDOSE 6MG/0.5ML
INCRUSE ELLIPTA 62.5MCG
INSPRA (G) 25MG
INSPRA (G) 50MG
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
KEPPRA (G) 250MG
KEPPRA (G) 500MG
KEPPRA (G) 750MG
KEPPRA (G) 1000MG
KERENDIA 10MG
KERENDIA 20MG
KISQALI 200MG
KOMBIGLYZE XR 2.5MG/1000MG
KOMBIGLYZE XR 5MG/500MG
KOMBIGLYZE XR 5MG/1000MG
LAMICTAL CD (G) 25MG
LATUDA 20MG
LATUDA 40MG
LATUDA 60MG
LATUDA 80MG
LATUDA 120MG
LEXAPRO (G) 10MG
LEXAPRO (G) 20MG
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%
LOTEMAX SUSP 0.5%
LUMIGAN 0.01%
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
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 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
PROTONIX (G) 40MG
PROZAC (G) 20MG
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%
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
SUTENT 12.5MG
SUTENT 25MG
SUTENT 37.5MG
SUTENT 50MG
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
TEKTURNA 150MG
TEKTURNA 300MG
TIVICAY 50MG
TOBI PODHALER 28MG
TOBREX OINT 0.3%
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
TRINTELLIX 5MG
TRINTELLIX 10MG
TRINTELLIX 20MG
TRIUMEQ 600-50-300MG
TUDORZA PRESSAIR 400MCG
UCERIS 9MG
ULORIC 80MG
VAGIFEM 10MCG
VALTREX (G) 500MG
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
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%
ZELAPAR 1.25MG
ZETIA (G) 10MG
ZIANA 1.2%-0.025%
ZOLOFT (G) 50MG
ZOLOFT (G) 100MG
ZOMIG NASAL SPRAY 5MG
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.

3 REASONS TO JOIN

The Diabetes Care Rewards Program
at GoodHealthGateway.com

SCAN ME TO JOIN



1. YOUR DOCTORS

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

2. YOUR HEALTH

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

3. YOUR REWARDS

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

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

Join Today

800.643.8028 | Hablamos español.
GoodHealthGateway.com

Cape Cod Municipal Health Group

Good Health GATEWAY®
Diabetes Care Rewards Program

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

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

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

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

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

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

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

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

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

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

Coverage Summary for Cape Cod Municipal Health Group *Voluntary* Group # 000143 Effective 7/1/2024

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

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

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

Additional Benefit Information

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

This plan is eligible for Rollover Maximum

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

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

Delta Dental PPO *Plus Premier*™

DELTA DENTAL®

Easy Access and Great Value – Your Delta Dental Networks

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

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

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

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

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

Learn more at deltadentalma.com

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

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

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

Your Plan is Administered by:
Delta Dental of Massachusetts
800-872-0500
www.deltadentalma.com

465 Medford Street, Ste. 400
Boston, MA 02129

SP562 (9.23) EB

DELTA DENTAL®

Rollover Maximum Benefit Summary

Rollover Maximum Summary for Cape Cod Municipal Health Group

Group #008318

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

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

Rollover Max is easy and automatic.

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

How *Rollover Max* works.

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

Rollover Max increases your dental benefit value.

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

	Your Plan Year Maximum benefit amount.	If your total yearly claims don't exceed this threshold amount.	Then you can roll over this amount to use next year, and beyond.	Your accumulated rollover total will not exceed this amount.
Voluntary	$1,000	$500	$350	$1,000
Contrib.	$1,500	$700	$700	$1,250

How to check your *Rollover Max* balance online:

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

DELTA DENTAL®

Now Here's a Reason to Smile

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

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

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

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

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

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

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

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

RIGHT START 4 KIDS℠

Coverage for age 12 and under

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

No Deductible

Does not apply to orthodontics; orthodontic coinsurance applies

Annual benefit maximum applies

Exclusions and Limitations apply

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

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

Age 12 and under

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

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

UNDERSTANDING YOUR ORTHODONTIC BENEFITS

Coverage

Your dental plan provides the following coverage for orthodontic services:

- Your coverage is based on the maximum allowable fee for orthodontic services.
- Coverage is subject to a lifetime maximum of $1,000 per member.
- **For the Contributory plan, all members (regardless of age) are eligible for coverage.**
- **For the Voluntary plan, dependents up to age 19 are eligible for coverage.**
- A maximum of 24 months of active treatment.

Paying for orthodontic care

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

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

If you've already started your orthodontic treatment

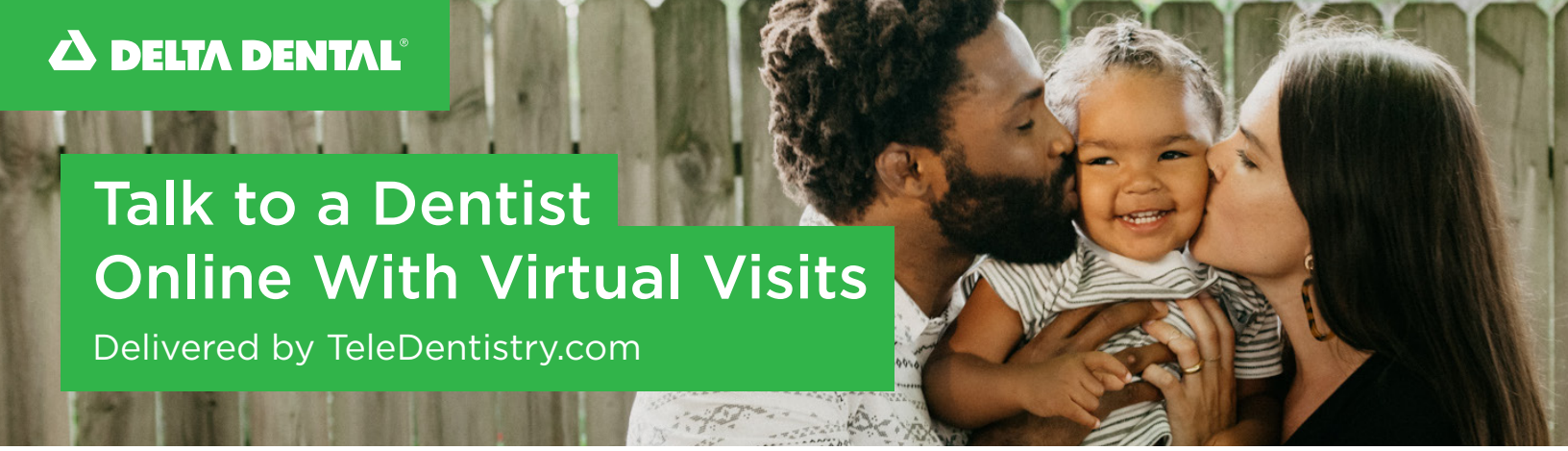
We provide pro-rated orthodontic benefits for members who are in active treatment and banded within 24 months of DDMA effective date. Coverage will be based on the maximum allowable fee, determined by the lower of the dentists submitted fee or contracted fee, and the time remaining in your treatment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

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

Termination of Coverage

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

DELTA DENTAL®



Talk to a Dentist Online With Virtual Visits

Delivered by TeleDentistry.com

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

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

You can schedule a virtual visit when you:

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

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

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

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

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

IT'S EASY TO SCHEDULE A VIRTUAL VISIT

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

Here's how it works:

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

Step 2 – Complete a brief registration and health questionnaire.

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

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

Cape Cod Municipal Health Group

(Access Network)

SUMMARY OF BENEFITS

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

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

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

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

Savings plus convenience plus choice

PLUS Providers add another layer of coverage

$200
Frame allowance

$100
Additional glasses allowance

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

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

The choice is yours

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

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

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION EST. 1961 OPTICAL

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INNOVATIVE ANSWERS FOR TOTAL HEALTH & WELLNESS

Hear all the sweet sounds of life

Hearing loss is more common than you might think. It affects 1 in 9 Americans[1] and can come on so gradually you may not even notice it. But the good news is 95% of hearing loss can be easily treated with hearing aids.[1]

That's why we give you access to affordable hearing care discounts through Amplifon, the nation's largest independent hearing discount network – so you can enjoy all of life's sights and sounds to the fullest.

YOUR HEARING DISCOUNT THROUGH AMPLIFON INCLUDES:

- 40% off hearing exams at thousands of convenient locations nationwide
- 60-day hearing aid trial period with no restocking fees
- Discounted, set pricing on thousands of hearing aids
- Free batteries for 2 years with initial purchase
- Low price guarantee – if you find the same product at a lower price elsewhere, Amplifon will beat it by 5%
- 3-year warranty plus loss and damage coverage

Call 1-844-526-5432 to find a hearing care provider near you and schedule a hearing exam today.

SEE THE GOOD STUFF

Register on eyemed.com or grab the member app (App Store or Google Play) today.

amplifon Hearing Health Care

[1] AmplifonUSA.com/hearing-loss-infor-mation

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