IMPORTANT DATES:

April 25, 2023 ~ Open Enrollment Begins

May 12, 2023 ~ Open Enrollment Closes

July 1, 2023 ~ COVERAGE EFFECTIVE DATE

EXPLANATION OF DOCUMENTS

1. **Benefit Information/Employee Authorization – ALL EMPLOYEES MUST COMPLETE and RETURN with selection, signature, date and any required documents.**

2. **Waiver** – To be used if waiving **some or all** benefits offered. Please be sure to make selections on page (1) and sign/date page (2).

3. **Health Benefits/Prescription**
   a. Available Plan Options. Please keep in mind the following guidelines:
      -- *Employees **hired prior to July 1, 2020** may choose from all plans listed.*
      -- *Employees **hired after July 1, 2020** may only select the New Jersey Educators Health Plan or the Garden State Health Plan.*
      -- *Full-time Custodians should follow the same guidelines above. Single coverage is offered, however dependents may be added at an additional cost.*
      --*Paraprofessionals, Permanent Teacher Substitutes, Permanent Paraprofessional Substitutes and Permanent Custodial Substitutes may participate in the AETNA HDHP Plan providing single coverage only. Dependents may be added at an additional cost.*
   b. Rate Chart – This is the monthly rate charged to the Board of Education—your payment is based on salary.
   c. Contribution Work Sheets:
      1. New Jersey Educators Health Plan (NJEHP) – Chapter 44
      2. Garden State Health Plan (GSHP) – Chapter 44
      3. All other plans are calculated pursuant to Chapter 78. Please contact Nancy Gibbins for your contribution amount.
   d. New Digital ID Card Information – Prescription/Express Scripts
   e. Open Enrollment Guide is a (27)-page document explaining benefit features
   f. Enrollment/Application Form **required for any changes** (remember to sign & date)

4. **Delta Dental**
   a. Plan Options – brief overview of our (3) plan options
   b. Rate Chart – This is the monthly rate charged to the Board of Education—your payment is based on salary. Please contact Nancy Gibbins for your contribution percentage.
   c. Enrollment/Application Form **required for any changes** (remember to sign & date)

5. **VSP (Vision Coverage)**
   a. Explanation of benefits and VSP Plan features
   b. Rate Chart -- This is the monthly rate charged to the Board of Education—your

payment is based on salary. Please contact Nancy Gibbins for your contribution percentage.

c. Enrollment/Application Form **required for any changes** (remember to sign & date)

If you have any questions, please email me at ngibbins@wtsd.org. PLEASE remember to submit your information prior to **MAY 12, 2023.**

Thank you for your time and attention. I appreciate your cooperation.

Nancy

Benefit Information
Employee Authorization
July 1, 2023 – June 30, 2024

☐ No changes to existing benefits plan **AND** you **DO NOT** waive any benefits offered
**** Please check box and sign below***

☐ No changes to existing benefits plan and you waive **SOME** benefits offered
**** Please check box, complete waiver and sign below***

☐ No changes and you waive **ALL** benefits offered
[Must complete even if you have waived in prior years]
**** Please check box, complete waiver and sign below***

☐ A change to one or more of your benefit plans
**** Please check box, complete appropriate application(s) and sign below***

Changes to be made, please circle all that apply and provide explanation in 'Note' section:

- Change of plan -- *Example: Aetna HNO 10 to NJEHP or Delta Preferred to DeltaCareFlagship, etc.*
- Change of waiver requests -- *Example: currently waive HB/Rx and now want to waive vision or you don't waive anything and would like to waive benefit, etc.*
- Addition/deletion of dependents -- *Example: adding spouse or child to vision plan, eliminating spouse from HB/Rx plan, etc. Be sure to include names of those added or deleted.*
- Other – Please provide as much information as possible on the space provided below:

NOTES:

_____
_____
_____
_____
_____
_____
_____

_____
Please Print Employee Name

_____ _____
Employee Signature Date

WATERFORD TOWNSHIP BOARD OF EDUCATION

WAIVER UNDER CAFETERIA PLAN OF PARTICIPATION

WHEREAS, in accordance with the cafeteria plan (the "Plan"), the Employee has elected to waive coverage for himself or herself and his or her eligible dependents of the health plans for which the Employee would otherwise be entitled to receive, and

WHEREAS, such waiver is knowing and voluntary on the part of the Employee;

Please choose the following insurance plans to opt out:

- ☐ Health Insurance
- ☐ Prescription Insurance
- ☐ Dental Insurance
- ☐ Vision

NOW, THEREFORE, in consideration of the promises contained herein, and subject to the provisions of the Plan, it is hereby agreed as follows:

1. Waiver of Participation in the selection of health insurance – In accordance with the Plan, the Employee, for himself or herself, his or her heirs, assigns, successors, spouse, and dependents hereby waives any right on his or her part of his or her part and the part of his or her spouse and dependents to participate in the benefits maintained by the Employer. In making this knowing and voluntary waiver, Employee on behalf of himself or herself, his or her spouse and dependents understands and agrees that they will have no coverage or benefits whatsoever under the selected plans(s) from above and that this waiver may not be revoked during the plan year, except to the extent permitted under the Plan in the event of a change in status or in the event of retirement.

2. Release and Indemnification – The Employee, for himself or herself, his or her heirs, assigns, successors, spouse and dependents covenants and agrees never to make a claim under the insurance plans(s) selected above and further fully releases the Employer, its officers, directors, employees and agents and insurance carriers from any liability arising in connection with any claim by the Employee, his or her heirs, assigns, successors, spouse and dependents for any benefits or coverage under the above selected plan(s), and the Employee, for himself or herself, his or her heirs, assigns, successors, spouse and dependents agrees to defend and indemnify the Employer, its officers, directors, employees and agents from any liability, loss, damages, costs or expenses (including, but not limited to attorneys' fees) arising in connection with this Waiver or any claim for benefits or coverage under the above selected plan(s). The employee also agrees to sign any waiver required by the State Health Benefits Program Coverage.

3. Waiver Irrevocable During the Plan Year, Except Upon a Change in Status or in the Event of Retirement – Employee acknowledges and agrees that his or her decision to enter into this Waiver is knowing and voluntary, that he or she fully understands all the provisions of the Waiver and that this Waiver may be revoked during the plan year only to the extent permitted under the Plan in the event of a change in status or in the event of a retirement.

The following events are considered a change in status:

a. legal marital status – marriage, death of spouse, divorce, legal separation or annulment;

b. number of dependents – birth, adoption, placement for adoption or death of a dependent;

c. employment status – termination or commencement of employment by the employee, spouse or dependent;

d. work schedule – including a switch between part-time and full-time, a strike or lockout, a reduction or increase in hours or unpaid leave of absence;

e. change in dependent's status – a dependent satisfies or ceases to satisfy the requirements for coverage due to age, student status or similar circumstances;

f. residence or worksite – a change in the place of residence or work of the employee, spouse or dependent.

4. No Representations by Employer as to Possible Tax Consequences – Employer had made no representations to Employee with regard to the tax consequences of the Agreement and the Employer shall have no liability with regard to any such tax consequences.

5. Certification of Other Insurance – The Employee hereby certifies that he or she has existing and in effect other health and hospitalization insurance which provides coverage for himself or herself and for his or her eligible dependents. Please provide the following information regarding your current health/hospitalization insurance:

Policyholder Name: _____

Carrier Name: _____

Policy Number: _____

_____

Employee Name (print)

_____ _____

Employee Signature Date

HEALTH

AND

PRESCRIPTION

SouthernCoastal

WATERFORD TWP BOE

	AETNA HNO $10		AETNA HNO $15		AETNA HNO NJEHP		Aetna HMO ($10)	AETNA HDHP [HSA Compatible]		AETNA HNO GSHP	
	Only Available to employees hired before 7/1/2020		Only Available to employees hired before 7/1/2020				Only Available to employees hired before 7/1/2020	Only Available to employees hired before 7/1/2020		[illegible]	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible											
Individual	None	$100	None	$100	None	$350	$100 on select services	$1,500.00		None	$350
Family	None	$250	None	$250	None	$700		$3,000.00		None	$700
Out of Pocket Annual Limit											
Individual	$400	$2,000	$5,880	$2,000	$500	$2,000	$5,880	$2,500	$3,500	$500	$2,000
Family	$1,000	$5,000	$11,760	$5,000	$1,000	$5,000	$11,760	$5,000	$7,000	$1,000	$5,000
Out of Network Restrictions	n/a	none	n/a	none	n/a	Chiropractic, Acupuncture & PT have Limited Fee Schedule***	n/a	n/a	none	n/a	Chiropractic, Acupuncture & PT have Limited Fee Schedule***
Referral by Primary Care Physician Required	Not Required	Not Applicable	Not Required	Not applicable	Not Required	Not applicable	[1] See footnote	Not Required	Not applicable	Not Required	Not applicable
Preventive Care											
PrevCare/Screenings/Immunizations (as per ACA Guideline	$0 copay	20% after Deductible	$0 copay	Not Covered	$0 copay	Not Covered	$0 copay	$0 copay	Not Covered	$0 copay	Not Covered
Physician's Office Visit											
Primary Care Services	$10 Copay	20% after Deductible	$15 copay	30% after Deductible	$10 copay	30% after Deductible	$10 Copay	20% after Deductible	40% after Deductible	$10 copay	30% after Deductible
Specialist Services	$10 Copay	20% after Deductible	$15 copay	30% after Deductible	$15 copay	30% after Deductible	$10 Copay	20% after Deductible	40% after Deductible	$15 copay	30% after Deductible
Maternity OB Visit	$10 copay for first visit, then 100%	20% after Deductible	$15 copay for first visit, then 100%	30% after Deductible	$15 copay for first visit, then 100%	30% after Deductible	$10 Copay	20% after Deductible	40% after Deductible	$15 copay for first visit, then 100%	30% after Deductible
Emergency Medical Care											
Urgent Care	$10 copay	20% after Deductible	$15 Copay	30% after Deductible	$15 Copay	30% after Deductible	$10 Copay	20% after Deductible	40% after Deductible	$15 Copay	30% after Deductible
Emergency Room (medical emergencies & accidents)	$25 copay	$25 copay	$50 copay	$50 copay	$125 copay	$125 copay	$35 Copay	20% after Deductible	20% after Deductible	$125 copay	$125 copay
Ambulance	10%	20% after Deductible	10%	30% after Deductible	10%	30% after Deductible	No Charge	20% after Deductible	40% after Deductible	10%	30% after Deductible
Inpatient Hospital Care											
Inpatient Coverage including Mental Health Services	No Charge	20% after Deductible	No Charge	30% after Deductible	No Charge	30% after Deductible	No Charge	20% after Deductible	40% after Deductible	No Charge	30% after Deductible
Other Services											
Durable Medical Equipment	10%	20% after Deductible	10%	30% after Deductible	10%	30% after Deductible	100% after $100 Ded	20% after Deductible	40% after Deductible	10%	30% after Deductible
Pharmacy											
Maximum Out of Pocket**	$1,430 Indiv / $2,860 Family		$1,430 Indiv / $2,860 Family		$1,600 Indiv / $3,200 Family		$1,430 Indiv / $2,860 Family	Included in the In Ntwrk Medical Max Out of Pocket		$1,600 Indiv / $3,200 Family	
Retail (30 day supply)	$3 Generic / $10 Brand		$3 Generic / $10 Brand		**RETAIL (30day supply):** $5 Generic; $10 Brand w/NO Generic available; For Brand name drugs that have a Generic Available member pays the Difference between Brand and Generic*		$3 Generic / $10 Brand	20% after Deductible		**RETAIL (30day supply):** $5 Generic; $10 Brand w/NO Generic available; For Brand name drugs that have a Generic Available member pays the Difference between Brand and Generic*	
Mail Order (90 day supply)	$3 Generic / $10 Brand		$3 Generic / $10 Brand		**MAIL ORDER (90day supply):** $10 Generic; $20 Brand w/NO Generic available; For Brand name drugs that have a Generic Available member pays the Difference between Brand and Generic*		$3 Generic / $10 Brand	20% after Deductible		**MAIL ORDER (90day supply):** $10 Generic; $20 Brand w/NO Generic available; For Brand name drugs that have a Generic Available member pays the Difference between Brand and Generic*	
					Utilization Programs Required:					Utilization Programs Required:	
					Mandatory Generic*					**Mandatory Generic***	
					Step Therapy*					**Step Therapy***	
					Closed Formulary*					**Closed Formulary***	
					*Policy allows clinical review to access desired medication at corresponding cost share					*Policy allows clinical review to access desired medication at corresponding cost share	

[1] Deductible is only durable medical equipment and appliances

***Chiropractic, Acupuncture & Physical Therapy have a different fee schedule.
Reimbursement will be capped as follows:
Chiropractic $35; Acupuncture $60; Physical Therapy $52

ILLUSTRATIVE ONLY
All Benefits Subject to Medical Necessity

/6/2022

Waterford Township Board of Education
2023 Contract Rates

HEALTH

COASTAL HIF

7/1/2023-6/30/2024

Aetna HNO $15

single	$943.00
parent/ch(n)	$1,751.00
couple	$1,883.00
family	$2,695.00
dep 31	$826.00

Aetna HNO $10

single	$991.00
parent/ch(n)	$1,841.00
couple	$1,980.00
family	$2,831.00
dep 31	$868.00

Aetna EPO $10

single	$ 906.00
parent/ch(n)	$ 1,689.00
couple	$ 1,816.00
family	$ 2,595.00
dep 31	$794.00

Aetna ACPOS II HDHP 1500

single	$770.00
parent/ch(n)	$1,435.00
couple	$1,543.00
family	$2,206.00
dep 31	$677.00

Aetna - Educators Plan

single	$977.00
parent/ch(n)	$1,816.00
couple	$1,955.00
family	$2,794.00
dep 31	$856.00

Aetna - Garden State Plan

single	$941.00
parent/ch(n)	$1,748.00
couple	$1,880.00
family	$2,688.00
dep 31	$824.00

PRESCRIPTION

Express Scripts

7/1/2023-6/30/2024

$3/$10/$10

single	$ 214.00
parent/ch(n)	$ 399.00
couple	$ 430.00
family	$ 616.00
dep 31	$ 189.00

NJEHP/GSHP

7/1/2023-6/30/2024

single	$ 191.00
parent/ch(n)	$ 357.00
couple	$ 385.00
family	$ 551.00
dep 31	$ 170.00

NJ EDUCATORS PLAN $10/$15 with Rx

	SINGLE	PARENT/CHILD(REN)	COUPLE	FAMILY
$0 - 40,000	1.7%	2.2%	2.8%	3.3%
$40,001 - $50,000	1.9%	2.5%	3.3%	3.9%
$50,001 - $60,000	2.2%	2.8%	3.9%	4.4%
$60,001 - $70,000	2.5%	3.0%	4.4%	5.0%
$70,001 - $80,000	2.8%	3.3%	5.0%	5.5%
$80,001 - $90,000	3.0%	3.6%	5.5%	6.0%
$90,001 - $100,000	3.3%	3.9%	6.0%	6.6%
$100,001 - $125,000	3.6%	4.4%	6.6%	7.2%

***EMPLOYEES WITH SALARIES HIGHER THAN $125,000, SHALL PAY THE $125,000 PERCENTAGE RATE.*

(To calculate by hand follow instructions below)

Enter Salary Here →		(Box 1) Enter Salary
Enter Contribution % from the chart above →		(Box 2) Enter Contribution % from chart above

For Example if your salary is $50,000 and you elect family coverage: $50,000 x 3.9% ($50,000 x 0.039 = $1,950/year)

Annual Contribution		(Box 3) Multiply Box 1 x Box 2
Per Pay (20 pays/year)	/pay	(Box 4) Divide Box 3 by 20
OR		
Per Pay (24 pays/year)	/pay	(Box 5) Divide Box 3 by 24

CHAPTER 44 CONTRIBUTION WORKSHEET

GARDEN STATE HEALTH PLAN with Rx ONLY (this does not include any possible dental or vision

	SINGLE	PARENT/CHILD(REN)	COUPLE	FAMILY
$0 - 40,000	1.50%	1.50%	1.50%	1.65%
$40,001 - $50,000	1.50%	1.50%	1.65%	1.95%
$50,001 - $60,000	1.50%	1.50%	1.95%	2.20%
$60,001 - $70,000	1.50%	1.50%	2.20%	2.50%
$70,001 - $80,000	1.50%	1.65%	2.50%	2.75%
$80,001 - $90,000	1.50%	1.80%	2.75%	3.00%
$90,001 - $100,000	1.65%	1.95%	3.00%	3.30%
$100,001 - $125,000	1.80%	2.20%	3.30%	3.60%

******EMPLOYEES WITH SALARIES HIGHER THAN $125,000, SHALL PAY THE $125,000 PERCENTAGE RATE.***

(To calculate by hand follow instructions below)

INTERACTIVE CALCULATOR:

Enter Salary Here → _____ *(Box 1) Enter Salary (must not exceed $125,000)*

Enter Contribution % from the chart above → _____ *(Box 2) Enter Contribution % from chart above*

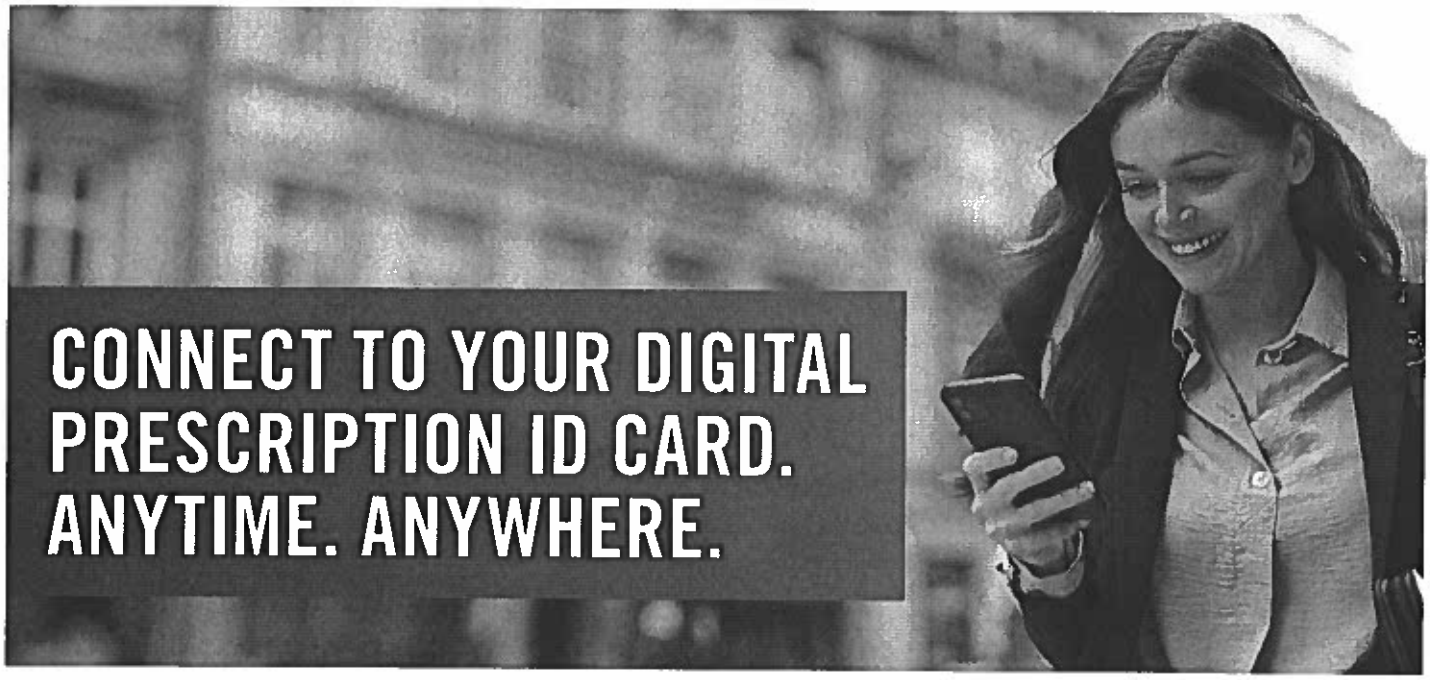
For Example if your salary is $50,000 and you elect family coverage: $50,000 x 1.95% ($50,000 x 0.0195 = $975/year)

Annual Contribution	$0.00	*(Box 3) Multiply Box 1 x Box 2*
Per Pay (20 pays/year)	$ - / pay	*(Box 4) Divide Box 3 by 20*

OR

Per Pay (24 pays/year)	$ - / pay	*(Box 5) Divide Box 3 by 24*

Attention: Your prescription ID card is now digital.



No more digging through cards at the pharmacy counter. Easily create your digital profile at **express-scripts.com** or on the **Express Scripts® mobile app** to gain instant access to your prescription ID card. You can view your card online or on the app, download it to your digital wallet, or even print a card from our site.

A digital profile also helps you connect to:

- Lower-cost medication options
- Nearby, in-network pharmacies
- More ways to manage your medications

Don't wait till you're at the pharmacy. Connect to your ID card today.

Visit **express-scripts.com** or download the **Express Scripts® mobile app** to create your profile in a few easy steps. You can also text **JOIN** to **69717** for a link to our registration page.

Scan here to download our mobile app.

Download on the App Store

GET IT ON Google Play

If you are unable to access your digital ID card, please call **800.711.5672** for assistance.

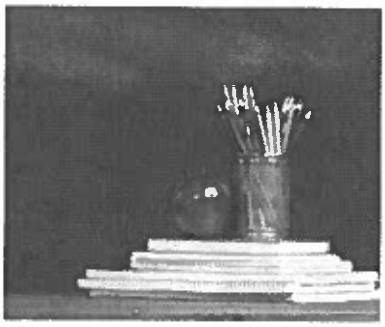
Express Scripts manages your prescription benefit on behalf of your employer, health plan or other organization.

EXPRESS SCRIPTS®

SouthernCoastal FUND

2023-2024

OPEN ENROLLMENT GUIDE



Through membership in the Southern Coastal Health Insurance Fund, your employer offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your benefit options through your employer's membership with the Fund and choose the best coverage for you and your family.

Important Information regarding

COVID-19 coverage effective July 1, 2023

SEE PAGE 10 FOR DETAILS

IT'S TIME TO REVIEW YOUR BENEFITS FOR 2023

Enrollment Deadline:
MAY 12, 2023

THE FUND WILL HOLD A PASSIVE OPEN ENROLLMENT

"Passive" open enrollment means if you are currently enrolled in benefits, your current plan elections will remain in place from July 1, 2023 through June 30, 2024, unless you elect to make a change.

To obtain enrollment forms to make a change, please contact your Benefits Administrator.

WHAT IS THE SOUTHERN COASTAL HEALTH INSURANCE FUND?

The Fund was established to provide public entities with a platform to purchase health insurance coverage in a shared-services environment.

ENROLLMENT INSTRUCTIONS

You must complete an enrollment form and return it to your benefits administrator by May 12, 2023 if:

- You wish to add coverage for an eligible dependent
- You are currently enrolled and wish to terminate coverage for yourself or a covered dependent
- You would now like to elect coverage for yourself and your eligible dependent(s) in your employer's health benefits effective on July 1, 2023
- You are an employee, non-Medicare retiree or COBRA participant that is currently enrolled in coverage and you wish to change your current plan elections, effective July 1, 2023

QUALIFIED LIFE EVENTS

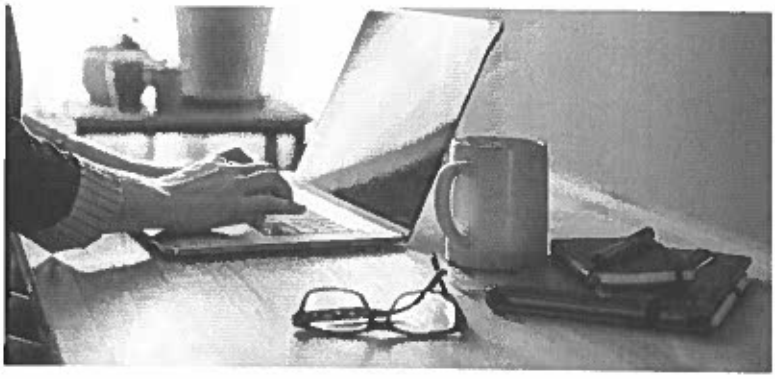
You cannot make changes to your elections or covered dependents during the plan year unless you experience a qualified life events. To make a change, you must contact your personnel department within 60 days of the event. Qualified life events include:

- Marriage
- Loss or reduction of coverage for you or your spouse
- Birth or adoption of a child
- Death of a covered dependent
- Divorce

ID CARDS

New ID card will only be issued if you making changes to your plan elections for 2023.

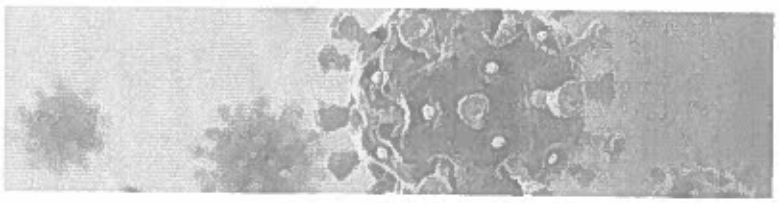
BENEFITS CONTACTS & RESOURCES



QUESTIONS REGARDING	CONTACT	PHONE NUMBER	WEBSITE/ADDRESS
Eligibility, enrollment, plan options, contributions, Qualifying Life Events, etc.	Please contact your entity's Human Resources/Benefits Office		
Medical Benefits - Aetna Benefit questions, claims, locating a provider, printing new ID Cards	Aetna	800.370.4526	www.aetna.com
Prescription Drug Benefits	Express Scripts	800.467.2006	www.express-scripts.com
Dental Benefits	Please see the reverse side of your ID card		

All plans above may not be offered by your employer. If you are not sure in which plan you are enrolled and/or eligible to elect, please refer to your ID card or contact your employer.

COVID-19 RESOURCES



STATE OF NJ

- www.covid19.nj.gov - For up-to-date information, resources, and guidance on questions about getting tested for COVID-19, contact tracing and, traveling to or from State of New Jersey.
- www.covid19.nj.gov/vaccine - For up-to-the-minute information on vaccine distribution.

STATE OF PENNSYLVANIA: www.health.pa.gov- Up-to-the-minute information on vaccine distribution.

AETNA: https://www.aetna.com/individuals-families/member-rights-resources/covid19.html

EXPRESS SCRIPTS: https://www.express-scripts.com/corporate/coronavirus-resource-center

HOW TO FIND IN-NETWORK PROVIDERS:

TO FIND PARTICIPATING AETNA PROVIDERS:

- STEP 1: Visit Aetna's website at www.aetna.com
- STEP 2: At the middle of the of the webpage on the right, click on "Find A Doctor"
- STEP 3: On right side of page under Guest, select "Plan from an employer" (1st choice on the list)
- STEP 4: Under Continue as a Guest, enter your zip code, city, state or county
- STEP 5: You will be asked to "Select a Plan". Use the Key below to help you make the correct selection:

IF YOU'RE ENROLLING IN...	DOCFIND PLAN SELECTION IS...
All PPO Plans: PPO Admin, PPO 15, PPO 10, EHP	Category Heading = Aetna Open Access Plans Plan Name = Aetna Choice POS II (Open Access)
Aetna Garden State Plan (SI GSHP AWH CPII DocFind Lookup: CLICK HERE)	Category Heading = Aetna Whole Health Plan Plan Name = (NJ) Aetna Whole Health New Jersey Choice POS II

Easily compare up to five doctors and hospitals at once. You can compare specialties, education, board certifications, quality reviews, and more.

EXPRESS SCRIPTS DIGITAL ID CARDS

NEW! YOUR PRESCRIPTION ID CARD IS NOW DIGITAL.

Connect to your digital prescription ID card. Anytime. Anywhere.

No more digging through cards at the pharmacy counter. Easily create your digital profile at www.express-scripts.com or on the Express Scripts mobile app to gain instance access to your prescription ID card. You can view your card online or even on the app, download it to your digital wallet, or even print a card from the Express Scripts website.

A digital profile also helps you connect to:

- Lower-cost medical options
- Nearby, in-network pharmacies
- More ways to manage your medications

DON'T WAIT UNTIL YOU ARE AT THE PHARMACY. CONNECT TO YOUR ID CARD TODAY.

Visit www.express-scripts.com or download the Express Scripts mobile app to create your profile in a few easy steps. You can also text JOIN to 69717 for a link to the Express Scripts registration page.

Scan the QR code to download the mobile app from the App Store or Google Play.

UNDERSTANDING YOUR PRESCRIPTION DRUG PROGRAM

HOW TO GET STARTED WITH EXPRESS SCRIPTS HOME DELIVERY

Contact Express Scripts

- For transfers from a retail pharmacy, sign in at Express-Scripts.com, or
- Speak with speak with a prescription benefit specialist by calling 800.698.3757 (7:30 a.m. – 5 p.m., Central, Monday-Friday)

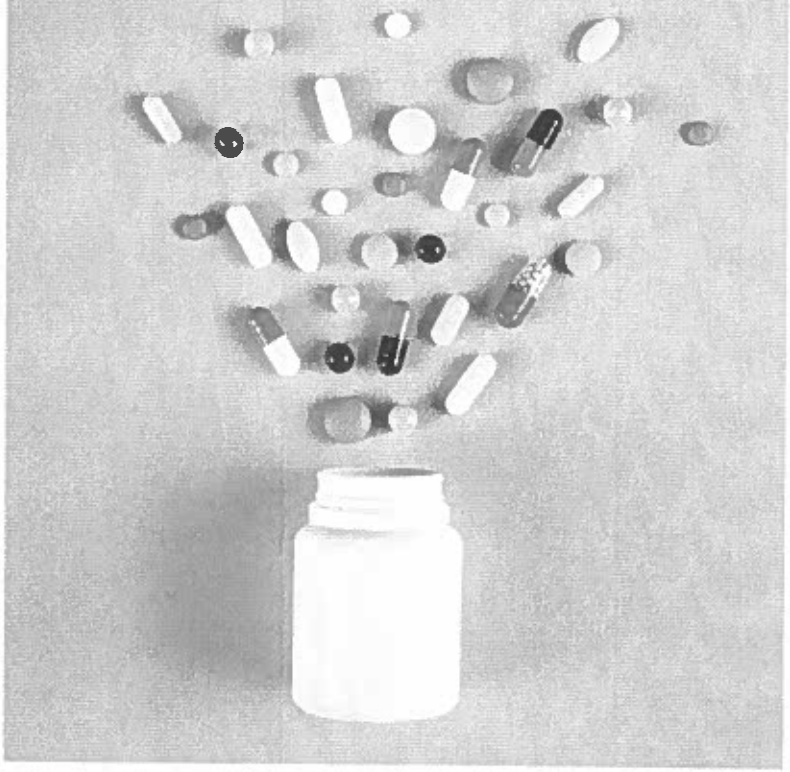
DIY—Do It Yourself

- Complete a home delivery order form
- Get a 90-day prescription from your doctor plus refills for up to one year (if applicable)
- Include your home delivery copayment (acceptable forms include credit/debit card, check or money order)
- Mail your form and prescription to Express Scripts at the address on the form. You can also have your doctor ePrescribe or fax your prescription.

Your medication will arrive by mail within 8 days of receipt of your initial prescription.

RECOMMENDED DRUG DOSING

Your Prescription Drug plan includes a program that reviews prescribed drug quantities to ensure your medications are being safely prescribed in accordance with FDA guidelines. The drug quantity review program provides the medications you need for good health, while making sure the dose you are receiving is considered safe. For instance, if FDA guidelines allow one pill/dose per day the program will allow a maximum of 30 pills for a month's supply. This quantity will give you the right amount to take for a daily dose considered safe and effective.



SAVE TIME AND MONEY!

Avoid long waits at the Emergency Room and reduce your out-of-pocket costs by utilizing Telemedicine and Urgent Care Centers for ailments that are not life-threatening. Both of these options provide fast, effective care—when you need care fast.

KNOW WHERE TO GET CARE

Visits to the ER can be very costly, so before you go to the ER, consider whether your condition is truly an emergency or if you can receive care from Telemedicine or at an Urgent Care Center instead.

Telemedicine	Urgent Care Center	Emergency Room
• Cold/Flu • Allergies • Animal/ insect bite • Bronchitis • Skin problems • Respiratory infection • Sinus problems • Strep throat • Pink eye/ Eye irritation • Urinary issues • Dematology • Behavioral health	• Allergic reactions • Bone x-rays, sprains or strains • Nausea, vomiting, diarrhea • Fractures • Whiplash • Sports injuries • Cuts and minor lacerations • Infections • Tetanus vaccinations • Minor burns and rashes	• Heart attack • Stroke symptoms • Chest pain, numbness in limbs or face, difficulty speaking, shortness of breath • Coughing up blood • High fever with stiff neck, confusion or difficulty breathing • Sudden loss of consciousness • Excessive blood loss

HOW TO ACCESS TELEMEDICINE 24/7

$0 COST TELEMEDICINE VS. VIRTUAL OFFICE VISITS

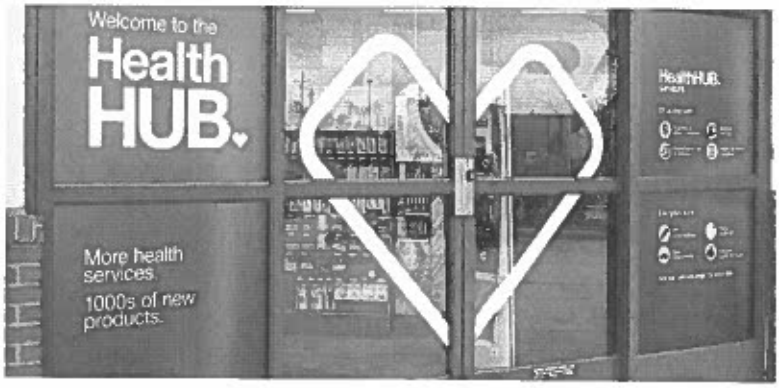
Please note that Telemedicine services are different from virtual/telephonic office visits with your participating provider. Most Fund Health Plans have a $0 copay for the Telemedicine services (Teledoc).

Virtual/Telephonic Office Visits with your participating provider may require a copay or coinsurance in accordance with your specific health plan. For more information on your cost-share for virtual office visits, please consult your insurance carrier at the customer service number on the back of your ID card.

TELADOC (Aetna members)

- Call 1.855.Teladoc (835.2362)
- Visit www.Teladoc.com/Aetna
- Go to Teladoc.com/Mobile to learn more or download the mobile app from the App Store or Google Play

CVS MINUTE CLINICS AND HEALTH HUBS*



minute clinic®

CVS Minute Clinics offer a broad range of services to keep you and your family healthy. In addition to diagnosing and treating illnesses, injuries and skin conditions, they provide wellness services including vaccinations, physicals, screenings and monitoring for chronic conditions.

- Located in select CVS pharmacies and Target stores nationwide
- No appointment necessary
- Visits usually last less than 30 minutes
- A record of your visit can be sent to your family doctor
- Open seven days a week with convenient evening hours

CVS MINUTE CLINIC PRACTITIONERS CAN:

- Treat common illnesses, like strep throat, ear ache, pink eye and sinus infection
- Treat minor injuries and skin conditions
- Provide vaccinations such as flu, pneumonia and hepatitis A/B
- Write prescriptions when appropriate
- Treat patients 18 months and older

HealthHUB®

CVS® HealthHUB offers an expanded range of health services and wellness products for everyday care and chronic conditions. To learn more or to find a HealthHUB location, visit CVS.com/HealthHUB.

HEALTH HUBS OFFER THE FOLLOWING SERVICES:

- Nutritional Counseling
- Durable Medical Equipment
- A Health Concierge
- Enhanced Minute Clinic service offerings
- Enhanced Pharmacist counseling services
- Community programs and meeting spaces

* *Prior to visiting a Minute Clinic or Health Hub, please check with your medical insurer to find out which facilities in your area may be participating with your plan.*

GET TO KNOW GUARDIAN NURSES

Struggling with a healthcare issue?

TAKE ADVANTAGE OF THIS

Our Mobile Care Coordinator RNs, backed by a team of registered nurses, are ready to respond whenever you are struggling with a healthcare issue.

GUARDIAN NURSES CAN:

- VISIT YOU AT HOME or in the hospital to assess your care needs.
- GO WITH YOU to see doctors, to ask questions and to get answers.
- BE YOUR GUIDE, coach and advocate for any healthcare issue.
- MAKE APPOINTMENTS so you can be seen as quickly as possible.
- IDENTIFY PROVIDERS for all care needs and second opinions.
- RESOLVE PROBLEMS with billing, claims and health insurance.
- GET THINGS YOU NEED such as healthcare equipment.
- PROVIDE DECISION SUPPORT when considering treatments or surgery.
- EXPLAIN A NEW DIAGNOSIS to help you make informed decisions.

WHO IS ELIGIBLE?

The services of our Mobile Care Coordinator Nurses are available to members of the Southern Coastal Fund and their covered dependents. All services are offered at no charge to you and are confidential.

Southern Coastal Fund
Mobile Care Coordinator®
Powered by Guardian Nurses Healthcare Advocates

GUARDIAN NURSES
Healthcare Advocates

To request help from our Mobile Care Coordinator or the team at Guardian Nurses, call 609.276.4990, 856.239.3823 or 609.276.5001.

MAXIMIZE YOUR BENEFITS

ALWAYS CONSIDER YOUR IN-NETWORK OPTIONS FIRST

You will typically pay less for covered services when providers are in-network with your medical plan. In-network providers agree to discounted fees. You are responsible only for any copay or deductible that is included in your plan design.

The amount you are required to pay out-of-pocket for out-of-network services may be significant.

TO LOCATE PARTICIPATING IN-NETWORK PROVIDERS:

- Aetna Participants: Visit www.aetna.com and select "Find a Doctor."

MAKE SURE YOU ARE USING IN-NETWORK LABS

- Aetna Participants may use either Quest Diagnostics or LabCorp for lab work.

** Please Note: COVID-19 vaccines, including boosters are covered at $0 copay at in-network locations only. COVID-19 At Home Testing Kits are not covered by the plan. Members are responsible for the full cost of the kits. Diagnostic COVID-19 testing at labs and other providers will remain covered but will be applied at the appropriate cost share.*

IN-PATIENT OR OBSERVATION:

The difference between *inpatient* and *observation* status is important because benefits and provider payments are based on the status. Patients admitted under observation status are considered outpatients, even though they may stay in the hospital and receive treatment in a hospital bed.

Hospital admission status may affect coverage for services such as skilled nursing. Some health plans, including Medicare, require a three-day hospital inpatient stay minimum before covering the cost of rehabilitative care in a skilled nursing care center. However, observation stays regardless of length, do not count towards the requirement.

A new law requires hospitals to give Medicare patients notice of an observation status within 36 hours. This status determines how the hospital bills your health plan. Even if you are NOT under Medicare, when you or your family member arrives at the hospital, you can ask questions like:

- Is the patient's status *inpatient* or *observation*?
- How long will the hospital stay be?
- Will there be a need for specialized skilled or rehab care after discharged?

Asking these questions throughout the hospital stay is important because hospitals can change the status from one day to the next. You can ask to have the status changed, but it is important to do so while still in the hospital. If necessary, you can request the hospital's patient advocate for assistance.

LEGAL NOTICES

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

The Fund offers a series of health coverage options. You should receive a Summary of Benefits and Coverage (SBC) during Open Enrollment. These documents summarize important information about all health coverage options in a standard format. Please contact Human Resources if you have any questions or did not receive your SBC.

Patient Protection and Affordable Care Act

Please note: the Fund medical plans are considered compliant with the Patient Protection and Affordable Care Act. There are no annual limits, dependent children can be covered to age 26 and preventive care is covered at 100% with no member cost-sharing and the pre-existing exclusion limitations have been removed.

As new Health Care Reform requirements become effective, the Fund plans will be modified. We are fully committed to complying with all regulations and intend to notify you as soon as possible of any change(s).

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other benefits. If you have any questions, please speak with Human Resources.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - MEDICAID
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): www.mycohibi.com
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

LEGAL NOTICES

Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website:
https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra
Phone: 678-561-1162 Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-766-9012

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website:
https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website:
https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website:
www.mymaineconnection.gob/benefits/s/?language=en_US
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website:
https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 617-886-8102

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

MONTANA – Medicaid
Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website:
http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website:
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website:
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website:
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website:
https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/

PLEASE NOTE: This communication only applies to the benefits that your employer has through the Coastal Health Insurance Fund.

EXPRESS SCRIPTS®

2023
National Preferred Formulary Exclusion List Changes

The excluded medications shown below are not covered on the Express Scripts National Preferred Formulary beginning July 1, 2023, unless otherwise noted. In most cases, if you fill a prescription for one of these drugs, you will pay the full retail price.

Single-Source Brand Exclusions

Drug Class	Excluded Medications	Preferred Alternatives
Cataplexy Treatment	XYREM	SODIUM OXYBATE, XYWAV
Central Nervous System Stimulants	METHYLPHENIDATE ER 45 MG & 63 MG*, METHYLPHENIDATE ER 72 MG, RELEXXII ER 45 MG & 63 MG*, RELEXXI ER 72 MG	dexmethylphenidate er, dextroamphetamine sulfate er, dextroamphetamine-amphetamine er, methylphenidate cd, methylphenidate er, methylphenidate la, DYANAVEL XR, MYDAYIS, QUILLICHEW ER, QUILLIVANT XR, VYVANSE
Metabolic Agents	RAVICTI	sodium phenylbutyrate, PHEBURANE
Ophthalmic Agents - Vascular Endothelial Growth Inhibitors	LUCENTIS	BYOOVIZ, CIMERLI
Pulmonary Anti-Inflammatory Inhalers	ALVESCO, ARMONAIR DIGIHALER*, FLOVENT DISKUS~, FLOVENT HFA~, FLUTICASONE PROPIONATE HFA*, PULMICORT FLEXHALER*	ARNUITY ELLIPTA, ASMANEX HFA, ASMANEX TWISTHALER, QVAR REDIHALER

Multi-Source Brand Exclusions

The generic equivalents of the following brand-name medications are covered on the National Preferred Formulary. FDA-approved generic medications meet strict standards and contain the same active ingredients as their corresponding brand-name medications, although they may have a different appearance.

APTENSIO XR

GILENYA

* Current 2023 exclusion in this class
~Exclusion impacts new starts only

EXPRESS SCRIPTS®

2023 National Preferred Formulary Exclusions

The excluded medications shown below are not covered on the Express Scripts drug list. In most cases, if you fill a prescription for one of these drugs, you will pay the full retail price.

Take action to avoid paying full price. If you're currently using one of the excluded medications, please ask your doctor to consider writing you a new prescription for one of the following preferred alternatives. Additional covered alternatives may be available. Costs for covered alternatives may vary. Log on to **express-scripts.com/covered** to compare drug prices. Not all the drugs listed are covered by all prescription plans; check your benefit materials for the specific drugs covered and the copayments for your plan. For specific questions about your coverage, please call the number on your member ID card.

Express Scripts manages your prescription plan for your employer, plan sponsor, health plan or benefit fund. These excluded medications do not apply to Medicare plans.

Drug Class	Excluded Medications	Preferred Alternatives
ANTIINFECTIVES Antibiotic Agents - Vancomycins (Oral)	FIRVANQ	vancomycin capsules, vancomycin oral solution
Antifungal Agents (Oral)	TOLSURA	itraconazole
Antivirals (Oral)	SITAVIG, XERESE	acyclovir oral or cream, famciclovir, valacyclovir
Chagas Disease Agents	LAMPIT	BENZNIDAZOLE
AUTONOMIC & CENTRAL NERVOUS SYSTEM Alpha-2 Adrenergic Agonists (for Opioid Withdrawal)	LUCEMYRA	clonidine
Alzheimer's Agents	ADUHELM, LEQEMBI	No alternatives recommended
Amyotrophic Lateral Sclerosis (ALS) Agents	RELYVRIO	No alternatives recommended
Anticonvulsants	EPRONTIA	topiramate sprinkle capsules
	FINTEPLA	DIACOMIT, EPIDIOLEX
	ZONISADE	zonisamide
Antimigraine Agents	ONZETRA XSAIL, ZOLMITRIPTAN NASAL SPRAY 2.5 MG	sumatriptan nasal spray, ZOMIG NASAL 2.5 MG
	VYEPTI	AIMOVIG, AJOVY, EMGALITY
Antiparkinsonism Agents	APOKYN	KYNMOBI
	DHIVY	carbidopa/levodopa
	GOCOVRI ER	amantadine capsules, amantadine tablets, amantadine oral solution
	ONGENTYS	entacapone
	XADAGO, ZELAPAR	rasagiline, selegiline
Antipsychotics (Injectable)	INVEGA HAFYERA	ABILIFY MAINTENA, ARISTADA, RISPERDAL CONSTA
Antipsychotics (Oral)	LYBALVI	aripiprazole, asenapine, olanzapine, paliperidone er, quetiapine, quetiapine er, ziprasidone, LATUDA
	QUETIAPINE 150 MG TABLETS	quetiapine, quetiapine er
Antispasmodic Agents	BACLOFEN SOLUTION, FLEQSUVY, LYVISPAH, OZOBAX	baclofen tablets
Anxiolytic Agents	LOREEV XR	lorazepam tablets
Cataplexy Treatment	XYREM~	SODIUM OXYBATE, XYWAV
Central Nervous System Stimulants	METHYLPHENIDATE ER 45 MG & 63 MG, METHYLPHENIDATE ER 72 MG~, RELEXXII ER 45 MG & 63 MG, RELEXXII ER 72 MG~	dexmethylphenidate er, dextroamphetamine sulfate er, dextroamphetamine/amphetamine er, methylphenidate cd, methylphenidate er, methylphenidate la, DYANAVEL XR, MYDAYIS, QUILLICHEW ER, QUILLIVANT XR, VYVANSE
	XELSTRYM	dextroamphetamine/amphetamine er, dextroamphetamine er, DYANAVEL XR, MYDAYIS ER, VYVANSE

~ Medications will be excluded beginning 07/01/2023.

(continued)

CRP2311_3229A 204612
EXCL-NPF-23 (04/01/2023)

Drug Class	Excluded Medications	Preferred Alternatives
AUTONOMIC & CENTRAL NERVOUS SYSTEM *(continued)* Duchenne Muscular Dystrophy (DMD) Agents	AMONDYS 45, EXONDYS 51, VILTEPSO, VYONDYS 53	No alternatives recommended
	EMFLAZA	prednisone solution, prednisone tablets
Multiple Sclerosis Agents	BRIUMVI	KESIMPTA, OCREVUS
	EXTAVIA	AVONEX, BETASERON, PLEGRIDY, REBIF
	TASCENSO ODT	fingolimod, AUBAGIO, BAFIERTAM, MAYZENT, PONVORY, VUMERITY
Narcotic Analgesics & Combinations	APADAZ, BENZHYDROCODONE/ACETAMINOPHEN	hydrocodone/acetaminophen
	CONZIP, QDOLO, TRAMADOL 100 MG TABLETS, TRAMADOL ER CAPSULES, TRAMADOL SOLUTION	tramadol er tablets, tramadol tablets
	NUCYNTA	hydrocodone/acetaminophen, morphine sulfate, oxycodone, tramadol, tramadol/acetaminophen
	NUCYNTA ER, OXYCODONE ER, XTAMPZA ER	hydrocodone bitartrate er, hydromorphone er, morphine sulfate er, oxymorphone hcl er, HYSINGLA ER, OXYCONTIN
	PRIMLEV, PROLATE SOLUTION	oxycodone/acetaminophen
	ROXYBOND	oxycodone
	SEGLENTIS	tramadol tablets plus celecoxib
Narcotic Antagonists	ZIMHI	naloxone syringes
Sedative-Hypnotic Agents	DORAL, QUAZEPAM	estazolam, lorazepam
Selective Serotonin Reuptake Inhibitors (SSRIs) Antidepressants	CITALOPRAM CAPSULES, PEXEVA, SERTRALINE CAPSULES	citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline
Serotonin/Norepinephrine Reuptake Inhibitor Antidepressants	DRIZALMA SPRINKLE, VENLAFAXINE BESYLATE ER	desvenlafaxine er, duloxetine, venlafaxine hcl er, FETZIMA
Transmucosal Fentanyl Analgesics	FENTANYL CITRATE BUCCAL TABLETS, FENTORA, LAZANDA, SUBSYS	fentanyl citrate lozenges
Miscellaneous Antidepressants	AUVELITY ER	bupropion, citalopram, duloxetine, paroxetine, sertraline, venlafaxine, FETZIMA
	BUPROPION XL 450 MG, FORFIVO XL	bupropion xl 150 mg or 300 mg
	SPRAVATO	olanzapine/fluoxetine, bupropion, desvenlafaxine er, duloxetine, escitalopram, mirtazapine, sertraline
CARDIOVASCULAR ACE Inhibitors	QBRELIS	lisinopril
Alpha-Adrenergic Agonists	CLONIDINE ER 0.17 MG, NEXICLON XR	clonidine patches, clonidine tablets
Angiotensin Receptor Blockers (ARBs) and Combinations	EDARBI	candesartan, irbesartan, losartan, olmesartan, telmisartan, valsartan
	EDARBYCLOR	candesartan/hydrochlorothiazide, irbesartan/hydrochlorothiazide, losartan/hydrochlorothiazide, olmesartan/hydrochlorothiazide, telmisartan/hydrochlorothiazide, valsartan/hydrochlorothiazide, chlorthalidone plus valsartan
	VALSARTAN SOLUTION	valsartan tablets
Anticoagulants	PRADAXA, SAVAYSA	ELIQUIS, XARELTO
Beta Blockers & Combinations	HEMANGEOL	propranolol solution
	INDERAL XL, INNOPRAN XL	propranolol er
	KAPSPARGO SPRINKLE	metoprolol succinate

– *Medications will be excluded beginning 07/01/2023.*

(continued)

Drug Class	Excluded Medications	Preferred Alternatives
CARDIOVASCULAR *(continued)* Calcium Channel Blockers	CONJUPRI, LEVAMLODIPINE	amlodipine, felodipine er, nifedipine er, nisoldipine
	KATERZIA, NORLIQVA	amlodipine tablets
Diuretics	CAROSPIR	spironolactone
	FUROSCIX, SOAANZ	bumetanide, furosemide, torsemide
	THALITONE	chlorthalidone
Fenofibrates	ANTARA, FENOFIBRATE CAPSULES (30 MG, 50 MG, 90 MG, 150 MG), LIPOFEN	fenofibrate capsules (43 mg, 67 mg, 130 mg, 134 mg, 200 mg), fenofibrate tablets, fenofibric acid
HMG & Cholesterol Inhibitor Combinations	ALTOPREV, EZALLOR SPRINKLE	atorvastatin, fluvastatin er, lovastatin, pravastatin, rosuvastatin, simvastatin tablets, LIVALO
	ROSUVASTATIN/EZETIMIBE	ezetimibe plus atorvastatin or rosuvastatin
PCSK9 & siRNA Inhibitors	LEQVIO, PRALUENT	REPATHA
Miscellaneous Cardiovascular Agents	ASPRUZYO SPRINKLE ER	ranolazine er
	CORLANOR	atenolol, bisoprolol, carvedilol, metoprolol succinate, metoprolol tartrate, propranolol
	NORPACE CR	amiodarone, quinidine sulfate, sotalol
DERMATOLOGICAL Agents for Hyperhidrosis	DRYSOL, QBREXZA	Over-the-Counter aluminum chloride containing products
Oral Agents for Acne	ABSORICA LD	isotretinoin capsules
	DORYX DR 80 MG, DORYX MPC, DOXYCYCLINE HYCLATE DR 80 MG	doxycycline hyclate, doxycycline monohydrate
	MINOCYCLINE BIPHASIC TABLETS, MINOCYCLINE ER CAPSULES, XIMINO	minocycline 24 hour er tablets
Rosacea Agents (Oral)	DOXYCYCLINE 40 MG CAPSULES, ORACEA	Oral: doxycycline hyclate, doxycycline monohydrate Topical: azelaic acid, ivermectin, metronidazole
Rosacea Agents (Topical)	NORITATE	metronidazole
	ZILXI	azelaic acid, ivermectin, metronidazole, sodium sulfacetamide/sulfur, FINACEA FOAM
Topical Agents for Acne	CLENIA PLUS, SULFACETAMIDE/SULFUR 9%-4.25% SUSPENSION	sodium sulfacetamide/sulfur 8%-4% suspension
	FABIOR, TAZAROTENE FOAM	tazarotene cream, tretinoin
	VELTIN	clindamycin/benzoyl peroxide, clindamycin/tretinoin, erythromycin/benzoyl peroxide, ONEXTON
	WINLEVI	azelaic acid, clindamycin phosphate gel, clindamycin/tretinoin, dapsone, erythromycin gel, tretinoin, ONEXTON
Topical Agents for Actinic Keratosis	CARAC, FLUOROURACIL 0.5% CREAM, KLISYRI, ZYCLARA	diclofenac 3% gel, fluorouracil 2% solution, fluorouracil 5% cream, imiquimod 5% cream
Topical Antifungals	ECOZA, ERTACZO, LULICONAZOLE, OXISTAT LOTION, SULCONAZOLE, XOLEGEL	ciclopirox, clotrimazole, econazole, ketoconazole, naftifine, oxiconazole
	MICONAZOLE/ZINC OXIDE/PETROLATUM, VUSION	clotrimazole, ketoconazole, miconazole, nystatin
Topical Corticosteroids	CLOCORTOLONE PUMP, IMPEKLO, HALOBETASOL 0.05% FOAM, IMPOYZ, LEXETTE, SERNIVO, ULTRAVATE, VERDESO FOAM	generic topical corticosteroids
Vitamin D Analogs (Topical)	CALCIPOTRIENE FOAM, SORILUX	calcipotriene, calcitriol

~ *Medications will be excluded beginning 07/01/2023.*

(continued)

Drug Class	Excluded Medications	Preferred Alternatives
DERMATOLOGICAL *(continued)* Miscellaneous Topical Dermatological Agents	ALCORTIN A	generic topical corticosteroids plus mupirocin
	CONDYLOX, VEREGEN	imiquimod 5% cream, podofilox solution
	LIDOCAINE/TETRACAINE, PLIAGLIS	lidocaine cream, lidocaine/prilocaine cream
	TAZORAC 0.05% CREAM	tazarotene 0.1% cream
	TRI-LUMA	fluocinolone acetonide, hydroquinone, tretinoin
DIABETES Biguanidine Agents	METFORMIN 625 MG TABLETS	metformin 500 mg or 850 mg tablets
Blood Glucose Meters & Test Strips	ASCENSIA (CONTOUR) ONETOUCH SOLUTIONS STARTER KIT ROCHE (ACCU-CHEK) TEMPO (WELCOME KIT, REFILL KIT, SMART BUTTON) TRIVIDIA (TRUETEST, TRUETRACK) ALL OTHER METERS & TEST STRIPS THAT ARE NOT LISTED AS PREFERRED	FREESTYLE KITS/METERS (FREESTYLE, FREEDOM, FREESTYLE FREEDOM LITE, FREESTYLE INSULINX, FREESTYLE LITE) FREESTYLE TEST STRIPS (FREESTYLE, FREESTYLE INSULINX, FREESTYLE LITE) ONETOUCH KITS/METERS (ULTRA2, ULTRAMINI, VERIO, VERIO FLEX) ONETOUCH TEST STRIPS (ULTRA, VERIO) PRECISION XTRA METERS, TEST STRIPS
Diabetic Pen Needles & Syringes	PEN NEEDLES & SYRINGES BY: ARKRAY HOME AIDE DIAGNOSTICS HTL-STREFA NOVO NORDISK OWEN MUMFORD PRODIGY DIABETES CARE SIMPLE DIAGNOSTICS TRIVIDIA (NIPRO DIAGNOSTICS) ULTIMED ALL OTHER DIABETIC PEN NEEDLES & SYRINGES THAT ARE NOT LISTED AS PREFERRED	BD DIABETES PEN NEEDLES BD DIABETES SYRINGES
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors & Combinations	ALOGLIPTIN, NESINA, ONGLYZA, TRADJENTA	JANUVIA
	ALOGLIPTIN/METFORMIN, JENTADUETO, JENTADUETO XR, KAZANO, KOMBIGLYZE XR	JANUMET, JANUMET XR
	ALOGLIPTIN/PIOGLITAZONE	pioglitazone plus JANUVIA
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors/Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors Combinations	QTERN	GLYXAMBI, STEGLUJAN
Glucagon-Like Peptide-1 Agonists	ADLYXIN, VICTOZA	BYDUREON BCISE, BYETTA, OZEMPIC, TRULICITY
Glucose-Elevating Drugs	GLUCAGEN HYPOKIT, GLUCAGON EMERGENCY KIT (by Fresenius), ZEGALOGUE	glucagon emergency kit (by Amphastar), BAQSIMI, GVOKE
Insulins	ADMELOG, AFREZZA, APIDRA, FIASP, HUMALOG TEMPO, INSULIN ASPART, INSULIN LISPRO, LYUMJEV TEMPO, NOVOLOG, RELION NOVOLOG	HUMALOG, LYUMJEV
	BASAGLAR TEMPO, INSULIN DEGLUDEC, INSULIN GLARGINE (BY WINTHROP), INSULIN GLARGINE-YFGN, LANTUS	LEVEMIR, SEMGLEE (YFGN), TOUJEO, TRESIBA
	INSULIN ASPART PROTAMINE, NOVOLOG 70/30 MIX, RELION NOVOLOG 70/30 MIX	HUMALOG 75/25 MIX
	NOVOLIN, RELION NOVOLIN	HUMULIN
Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors & Combinations	INVOKAMET, INVOKAMET XR	SEGLUROMET, SYNJARDY, SYNJARDY XR, XIGDUO XR
	INVOKANA	FARXIGA, JARDIANCE, STEGLATRO
EAR/NOSE Nasal Steroids	BECONASE AQ, OMNARIS, QNASL, ZETONNA	flunisolide, fluticasone, mometasone

– *Medications will be excluded beginning 07/01/2023.*

(continued)

Drug Class	Excluded Medications	Preferred Alternatives
EAR/NOSE *(continued)* Otic Antibiotics & Combination Products	CETRAXAL	ciprofloxacin otic, ofloxacin otic
	CIPRO HC, CIPROFLOXACIN/FLUOCINOLONE OTIC	ciprofloxacin/dexamethasone otic
ENDOCRINE Cushing's Agents	ISTURISA	SIGNIFOR
	KORLYM	ketoconazole, LYSODREN, SIGNIFOR
	RECORLEV	ketoconazole, LYSODREN
Gonadotropin-Releasing Hormone (GnRH) Analogs (for Central Precocious Puberty)	FENSOLVI	LUPRON DEPOT-PED, TRIPTODUR
Growth Hormones	HUMATROPE, NUTROPIN AQ NUSPIN, SAIZEN, SAIZENPREP, SKYTROFA, ZOMACTON	GENOTROPIN, NORDITROPIN FLEXPRO, OMNITROPE
Somatostatin Analogs	LANREOTIDE, SANDOSTATIN LAR DEPOT	SOMATULINE DEPOT
	SIGNIFOR LAR	For Acromegaly: SOMATULINE DEPOT For Cushing's Disease: SIGNIFOR
Testosterone Products	AVEED	testosterone cypionate, testosterone enanthate
	KYZATREX, TLANDO	testosterone gel, testosterone solution, ANDRODERM PATCHES
Thyroid Replacement Therapy	LEVOTHYROXINE CAPSULES, THYQUIDITY, TIROSINT, TIROSINT-SOL	levothyroxine tablets
Miscellaneous Endocrine Agents	CORTROPHIN GEL	No alternatives recommended
GASTROINTESTINAL Antidiarrheal Agents	MYTESI	diphenoxylate/atropine, loperamide
Antiemetics (Oral)	AKYNZEO CAPSULES	granisetron, ondansetron, aprepitant, VARUBI TABLETS
	ANTIVERT	meclizine
	ANZEMET	granisetron, ondansetron
	BONJESTA	doxylamine/pyridoxine hcl
	EMEND POWDER PACKETS	aprepitant, VARUBI TABLETS
Bowel Evacuants	CLENPIQ, OSMOPREP, PLENVU, SUTAB	magnesium sulfate/potassium sulfate/sodium sulfate solution, peg 3350/ascorbic acid powder packets
Corticosteroids (Rectal Formulations)	CORTIFOAM	hydrocortisone enema, UCERIS FOAM
Fecal Microbiota Agents	REBYOTA	No alternatives recommended
Gallstone Dissolution Agents	RELTONE	ursodiol
Gastroparesis Agents	GIMOTI	No alternatives recommended
Helicobacter Pylori Agents	PYLERA	lansoprazole/amoxicillin/clarithromycin, TALICIA
Hemorrhoidal Preparations	HYDROCORTISONE/PRAMOXINE 25-18 MG SUPPOSITORIES	hydrocortisone ac suppositories, pramoxine/hydrocortisone cream
	PROCTOFOAM-HC	pramoxine/hydrocortisone cream
Inflammatory Bowel Agents	DIPENTUM	balsalazide disodium, mesalamine dr, mesalamine er, sulfasalazine, PENTASA 250 MG CAPSULES
Irritable Bowel Syndrome & Chronic Constipation Agents	IBSRELA, MOTEGRITY, ZELNORM	lubiprostone, LINZESS, TRULANCE
Pancreatic Enzymes	PERTZYE	CREON, PANCREAZE, ZENPEP
Proton Pump Inhibitors	ESOMEPRAZOLE STRONTIUM, NEXIUM PACKETS, PRILOSEC SUSPENSION, RABEPRAZOLE DR SPRINKLE	dexlansoprazole, esomeprazole magnesium, lansoprazole, omeprazole, pantoprazole, rabeprazole
Miscellaneous Gastrointestinal Agents	DARTISLA ODT	glycopyrrolate tablets

~ *Medications will be excluded beginning 07/01/2023.*

(continued)

Drug Class	Excluded Medications	Preferred Alternatives
HEMATOLOGICAL Antiplatelet Agents	ASPIRIN/OMEPRAZOLE DR, YOSPRALA DR	aspirin plus omeprazole, esomeprazole, lansoprazole, pantoprazole or rabeprazole
Erythropoiesis-Stimulating Agents	ARANESP, EPOGEN, MIRCERA	PROCRIT, RETACRIT
Factor Deficiency Agents & Related Products	NOVOSEVEN RT	SEVENFACT
	NUWIQ, RECOMBINATE, XYNTHA, XYNTHA SOLOFUSE	ADVATE, ADYNOVATE, AFSTYLA, ELOCTATE, ESPEROCT, JIVI, KOGENATE FS, KOVALTRY, NOVOEIGHT
Granulocyte Colony Stimulating Factors	FYLNETRA, NEULASTA, NYVEPRIA, ROLVEDON, STIMUFEND, UDENYCA	FULPHILA, ZIEXTENZO
	GRANIX, NEUPOGEN, RELEUKO	NIVESTYM, ZARXIO
Iron Replacement Agents	MONOFERRIC	sodium ferric gluconate complex, VENOFER
Sickle Cell Disease Agents	OXBRYTA	hydroxyurea, DROXIA
	SIKLOS	DROXIA
Thrombocytopenia Agents	MULPLETA	DOPTELET
HEPATITIS Hepatitis C	LEDIPASVIR/SOFOSBUVIR, MAVYRET, SOFOSBUVIR/VELPATASVIR, SOVALDI	EPCLUSA, HARVONI, VOSEVI, ZEPATIER
HIV Antiretrovirals Note: Current patients established on therapy are allowed to continue therapy.	CABENUVA	atazanavir plus lamivudine, darunavir plus lamivudine, lopinavir/ritonavir plus lamivudine, DOVATO, JULUCA, TIVICAY plus lamivudine, TIVICAY plus EDURANT
	COMPLERA	ODEFSEY
	DELSTRIGO	efavirenz/emtricitabine/tenofovir disoproxil fumarate, efavirenz/lamivudine/tenofovir disoproxil fumarate, BIKTARVY, GENVOYA, ODEFSEY, SYMFI, SYMFI LO, SYMTUZA, TRIUMEQ
	PIFELTRO	efavirenz, EDURANT
	PREZCOBIX	atazanavir, lopinavir/ritonavir, ritonavir, PREZISTA
	RUKOBIA ER	Coverage may be approved for the treatment of human immunodeficiency virus-1 infection in heavily treatment-experienced patients with multidrug-resistant infection.
	STRIBILD	BIKTARVY, GENVOYA
MUSCULOSKELETAL & RHEUMATOLOGY Gout Therapy	ALLOPURINOL 200 MG TABLETS	allopurinol 100 mg tablets
	COLCHICINE CAPSULES	colchicine tablets, MITIGARE
Muscle Relaxants & Antispasmodic Agents	METHOCARBAMOL 1,000 MG TABLETS	methocarbamol 500 mg tablets
Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)	DICLOFENAC 35 MG CAPSULES, INDOMETHACIN 20 MG CAPSULES, KETOROLAC NASAL SPRAY, RELAFEN DS, TIVORBEX, ZIPSOR, ZORVOLEX	diclofenac, etodolac, flurbiprofen, ibuprofen, indomethacin, ketoprofen, meloxicam, nabumetone, naproxen, oxaprozin, piroxicam
	ELYXYB	celecoxib
	FENOPROFEN 200 MG CAPSULES, FENORTHO	fenoprofen calcium tablets, etodolac, flurbiprofen, ibuprofen, ketoprofen, meloxicam, nabumetone
	INDOCIN SUPPOSITORIES	etodolac, flurbiprofen, ibuprofen, indomethacin, ketoprofen, meloxicam, nabumetone, naproxen
	INDOCIN SUSPENSION, MELOXICAM SUSPENSION	ibuprofen suspension, naproxen suspension
Topical Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)	DICLOFENAC EPOLAMINE PATCHES	FLECTOR PATCHES, LICART PATCHES
OBSTETRICAL & GYNECOLOGICAL Combination Patches	CLIMARA PRO	COMBIPATCH

– *Medications will be excluded beginning 07/01/2023.*

(continued)

Drug Class	Excluded Medications	Preferred Alternatives
OBSTETRICAL & GYNECOLOGICAL *(continued)* Contraceptives	BALCOLTRA, LO LOESTRIN FE, NATAZIA, NEXTSTELLIS, TWIRLA, TYBLUME	generic oral, patch and ring contraceptives
	PHEXXI	Barrier methods of contraception, such as condoms, diaphragms, spermicides or sponges.
	SLYND	generic progestin-only oral contraceptives
Estrogen & Estrogen Modifiers for Vaginal Symptoms	ESTRING, IMVEXXY, INTRAROSA, OSPHENA	estradiol cream, estradiol vaginal inserts, PREMARIN CREAM
	FEMRING	estradiol cream, estradiol patches, estradiol tablets, estradiol vaginal inserts, PREMARIN CREAM
Estrogen/Progestin Combinations (Oral)	BIJUVA, PREMPHASE, PREMPRO	estradiol/norethindrone acetate, ethinyl estradiol/norethindrone acetate
Estrogens (Oral)	MENEST, PREMARIN TABLETS	estradiol tablets
Human Chorionic Gonadotropin‡	PREGNYL	NOVAREL, OVIDREL
Ovulatory Stimulants (Follitropins)	FOLLISTIM AQ	GONAL-F, GONAL-F RFF, GONAL-F RFF REDI-JECT
Prenatal Vitamins	PREGENNA, TRINAZ	generic prenatal vitamins
Topical Estrogen Agents	ELESTRIN, ESTROGEL, EVAMIST	estradiol gel, estradiol patches
Vaginal Progesterones	CRINONE 4%	medroxyprogesterone, megestrol, norethindrone, progesterone
	CRINONE 8%	ENDOMETRIN
ONCOLOGY Acute Myeloid Leukemia (AML) Agents	ONUREG	No alternatives recommended
	REZLIDHIA	TIBSOVO
Bendamustine Agents	VIVIMUSTA	bendamustine, BENDEKA, TREANDA
Bevacizumab-Containing Agents	ALYMSYS, AVASTIN	ZIRABEV
Breast Cancer Agents	KISQALI, KISQALI FEMARA CO-PACK, PIQRAY	IBRANCE, VERZENIO
Interferons	BESREMI	hydroxyurea, PEGASYS
Multiple Myeloma Agents	BLENREP, XPOVIO	bortezomib, DARZALEX, KYPROLIS, NINLARO, POMALYST, REVLIMID, THALOMID
Myelodysplastic Syndrome Agents	INQOVI	decitabine
Myelofibrosis Agents	INREBIC	JAKAFI
Non-Small Cell Lung Cancer Agents	KRAZATI	Coverage may be approved for the treatment of KRAS G12C-mutated non-small cell lung cancer
	TEPMETKO	TABRECTA
Prostate Cancer Agents	CAMCEVI, LEUPROLIDE DEPOT, TRELSTAR	ELIGARD, FIRMAGON
Renal Cell Cancer Agents	FOTIVDA	CABOMETYX, INLYTA, LENVIMA
Rituximab-Containing Agents	RIABNI, RITUXAN, RITUXAN HYCELA, TRUXIMA	RUXIENCE
Trastuzumab-Containing Agents	HERCEPTIN, HERCEPTIN HYLECTA, HERZUMA, OGIVRI, ONTRUZANT	KANJINTI, TRAZIMERA
	PHESGO	PERJETA plus KANJINTI or TRAZIMERA
Tyrosine Kinase Inhibitors	QINLOCK	imatinib, sorafenib, sunitinib malate, SPRYCEL, STIVARGA, TASIGNA, VOTRIENT
	SCEMBLIX	imatinib, BOSULIF, ICLUSIG, SPRYCEL, TASIGNA
	TRUSELTIQ	PEMAZYRE

‡ *Please note that product placement is subject to change throughout the year based upon changes in market dynamics.*

~ *Medications will be excluded beginning 07/01/2023.*

(continued)

Drug Class	Excluded Medications	Preferred Alternatives
OPHTHALMIC Antiglaucoma Agents (Beta-Adrenergic Blockers)	BETIMOL	timolol drops, betaxolol drops, carteolol drops, levobunolol drops
Antiglaucoma Agents (Ophthalmic Prostaglandins)	DURYSTA, XELPROS	bimatoprost drops, latanoprost drops, tafluprost drops, travoprost drops
Antiglaucoma Agents (Other)	RHOPRESSA, ROCKLATAN	betaxolol drops, bimatoprost drops, dorzolamide/timolol drops, latanoprost drops, levobunolol drops, tafluprost drops, timolol drops, travoprost drops
Blepharoptosis Agents	UPNEEQ	No alternatives recommended
Ophthalmic Agents - Vascular Endothelial Growth Inhibitors	LUCENTIS~	BYOOVIZ, CIMERLI
	SUSVIMO	No alternatives recommended
	VABYSMO	EYLEA
Ophthalmic Agents - Other	CYSTADROPS	CYSTARAN
	VERKAZIA	azelastine drops, bepotastine drops, cromolyn drops, epinastine drops, olopatadine drops
	VUITY	No alternatives recommended
Ophthalmic Anti-Allergic	ALOCRIL, ALOMIDE, ALREX, LASTACAFT, ZERVIATE	azelastine drops, bepotastine drops, cromolyn drops, epinastine drops, olopatadine drops
Ophthalmic Anti-Inflammatory	FLAREX, FML FORTE, FML S.O.P., MAXIDEX, PRED MILD	dexamethasone drops, fluorometholone drops, loteprednol drops, prednisolone drops
Ophthalmic Combinations	TOBRADEX ST, ZYLET	tobramycin/dexamethasone drops
Ophthalmic Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	ACUVAIL, BROMSITE, NEVANAC	bromfenac drops, diclofenac drops, ketorolac drops
Ophthalmic Quinolone Antibiotics	BESIVANCE, CILOXAN OINTMENT	ciprofloxacin drops, gatifloxacin drops, levofloxacin drops, moxifloxacin drops, ofloxacin drops
OSTEOARTHRITIS Hyaluronic Acid Derivatives	DUROLANE, GEL-ONE, GELSYN-3, GENVISC 850, HYALGAN, HYMOVIS, SUPARTZ FX, SYNOJOYNT, SYNVISC, SYNVISC-ONE, TRILURON, TRIVISC, VISCO-3	EUFLEXXA, MONOVISC, ORTHOVISC
RENAL Nephropathic Cystinosis Agents	PROCYSBI	CYSTAGON
Nocturnal Polyuria Agents	NOCTIVA	desmopressin tablets
Overactive Bladder Agents	VESICARE LS	oxybutynin, oxybutynin er, MYRBETRIQ ER SUSPENSION
Phosphate Binders	FOSRENOL POWDER PACKETS	lanthanum, sevelamer carbonate, sevelamer hcl, PHOSLYRA, VELPHORO
RESPIRATORY Epinephrine Auto-Injector Systems	EPINEPHRINE AUTO-INJECTOR (BY A-S MEDICATION, AMNEAL PHARMA, AVKARE)	epinephrine auto-injector (by Mylan, Teva), EPIPEN, EPIPEN JR
Idiopathic Pulmonary Fibrosis Agents	PIRFENIDONE 534 MG TABLETS	pirfenidone, OFEV
Immunological Agents for Asthma	CINQAIR	DUPIXENT, FASENRA, NUCALA, TEZSPIRE, XOLAIR
Long-Acting Beta Agonist Inhalers	STRIVERDI RESPIMAT	SEREVENT DISKUS
Long-Acting Muscarinic Antagonist Inhalers	INCRUSE ELLIPTA, TUDORZA PRESSAIR	SPIRIVA HANDIHALER, SPIRIVA RESPIMAT
Long-Acting Muscarinic Antagonist/ Long-Acting Beta-Agonist Combination Inhalers	DUAKLIR PRESSAIR	ANORO ELLIPTA, BEVESPI AEROSPHERE, STIOLTO RESPIMAT
Pulmonary Anti-Inflammatory Inhalers	ALVESCO~, ARMONAIR DIGIHALER, FLOVENT DISKUS~, FLOVENT HFA~, FLUTICASONE PROPIONATE HFA, PULMICORT FLEXHALER	ARNUITY ELLIPTA, ASMANEX HFA, ASMANEX TWISTHALER, QVAR REDIHALER

~ *Medications will be excluded beginning 07/01/2023.*

(continued)

Drug Class	Excluded Medications	Preferred Alternatives
RESPIRATORY *(continued)* Pulmonary Anti-Inflammatory/ Beta-Agonist Combination Inhalers	AIRDUO RESPICLICK, BUDESONIDE/FORMOTEROL, FLUTICASONE/SALMETEROL (BY A-S MEDICATION, TEVA), FLUTICASONE/VILANTEROL	fluticasone/salmeterol (by Hikma, Prasco, Proficient Rx), ADVAIR HFA, BREO ELLIPTA, DULERA, SYMBICORT
Pulmonary Arterial Hypertension (PAH) Agents	TADLIQ	sildenafil 20 mg tablets, sildenafil oral suspension, tadalafil 20 mg tablets
Short-Acting Beta$_2$-Agonist Inhalers	ALBUTEROL SULFATE HFA (BY A-S MEDICATION, PRASCO), LEVALBUTEROL HFA, PROAIR DIGIHALER, PROAIR RESPICLICK, VENTOLIN HFA, XOPENEX HFA	albuterol sulfate hfa (by Cipla, Civica, Exelan, Lupin, Perrigo, Sandoz, Teva & West-Ward)
MISCELLANEOUS AGENTS Allergen Immunotherapy	PALFORZIA	No alternatives recommended
Benign Prostatic Hyperplasia Agents	ENTADFI	finasteride 5 mg plus tadalafil 5 mg
Gaucher Disease Agents	ELELYSO, VPRIV	CEREZYME
Glucocorticoids	ALKINDI SPRINKLE	hydrocortisone tablets
	HEMADY	dexamethasone tablets
Hereditary Angioedema	BERINERT	CINRYZE, RUCONEST
Immune Globulins	CUTAQUIG	SC: GAMMAGARD LIQUID, GAMUNEX-C, XEMBIFY
	GAMMAKED	IV: GAMMAGARD LIQUID, GAMMAGARD S-D, GAMUNEX-C SC: GAMMAGARD LIQUID, GAMUNEX-C, XEMBIFY
Immunosuppressant Agents	ENVARSUS XR	tacrolimus
	LUPKYNIS	mycophenolate mofetil plus systemic corticosteroid
	OTREXUP, REDITREX	RASUVO
	XATMEP	methotrexate
Infused TNF Antagonists	AVSOLA, INFLIXIMAB, REMICADE, RENFLEXIS	INFLECTRA
Metabolic Agents	RAVICTI~	sodium phenylbutyrate, PHEBURANE
Neuromyelitis Optica Spectrum Disorder Agents	UPLIZNA	ENSPRYNG
Osteoporosis - Bone Modifiers	EVENITY, PROLIA	alendronate, ibandronate, risedronate, zoledronic acid, FORTEO, TYMLOS
Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis	AMVUTTRA, ONPATTRO	No alternatives recommended
Vasculitis Agents	TAVNEOS	azathioprine, methotrexate, mycophenolate, RUXIENCE

~ Medications will be excluded beginning 07/01/2023.

(continued)

Indication Based Management

Drug Class	Excluded Medications	Preferred Alternatives
Spinal Conditions (nr-axSpA)	COSENTYX	Preferred: TALTZ, CIMZIA Preferred after Step through CIMZIA: RINVOQ ER
Inflammatory Conditions‡ where AMJEVITA (NDCs starting with 72511) is indicated	AMJEVITA (NDCs starting with 72511)	See Below for Preferred Alternatives
Inflammatory Conditions‡ where COSENTYX is indicated	COSENTYX	See Below for Preferred Alternatives

Drug Class	Nonpreferred Medications	Preferred Alternatives
Inflammatory Conditions‡	All other Brand Name medications for Inflammatory Conditions are Nonpreferred. Approval may be granted following a coverage review. A trial of one or more Preferred medications is required prior to initiating therapy with a Nonpreferred medication. A formulary exception may be granted for a patient already established on therapy with a Nonpreferred medication.	Preferred: AMJEVITA (NDCs starting with 55513), ENBREL, HUMIRA, OTEZLA, SKYRIZI, STELARA SC, TALTZ, TREMFYA Preferred after Step through AMJEVITA (NDCs starting with 55513) or HUMIRA: ACTEMRA SC Preferred after Step through AMJEVITA (NDCs starting with 55513), ENBREL or HUMIRA: RINVOQ ER, XELJANZ, XELJANZ XR ULCERATIVE COLITIS ONLY Preferred after Step through AMJEVITA (NDCs starting with 55513) or HUMIRA: SIMPONI 100 MG, XELJANZ, XELJANZ XR ULCERATIVE COLITIS ONLY Preferred after Step through AMJEVITA (NDCs starting with 55513), HUMIRA or STELARA SC: ZEPOSIA

‡ Please note that product placement for treatment of Inflammatory Conditions in the Inflammatory Conditions Care Value (ICCV) Program are subject to change throughout the year based upon changes in market dynamics, new indications for existing products, biosimilar and new product launches.

Excluded Medications/Products at a Glance

ABILIFY^
ABSORICA LD
ACANYA^
ACIPHEX^
ACUVAIL
ADCIRCA^
ADDERALL^, ADDERALL XR^
ADLYXIN
ADMELOG
ADUHELM
AFINITOR^, AFINITOR DISPERZ^
AFREZZA
AIRDUO RESPICLICK
AKYNZEO CAPSULES
ALBUTEROL SULFATE HFA (BY A-S MEDICATION, PRASCO)
ALCORTIN A
ALINIA TABLETS^
ALKINDI SPRINKLE
ALLOPURINOL 200 MG TABLETS
ALOCRIL
ALOGLIPTIN
ALOGLIPTIN/METFORMIN
ALOGLIPTIN/PIOGLITAZONE
ALOMIDE
ALREX
ALTOPREV
ALVESCO~
ALYMSYS
AMBIEN^, AMBIEN CR^
AMITIZA^
AMJEVITA (NDCs starting with 72511)
AMONDYS 45
AMPYRA^
AMRIX^
AMVUTTRA
ANDROGEL^
ANTARA
ANTIVERT
ANUSOL-HC^
ANZEMET
APADAZ
APIDRA
APOKYN
APTENSIO XR^~
ARANESP
ARIMIDEX^
ARKRAY PEN NEEDLES & SYRINGES
ARMONAIR DIGIHALER
ASACOL HD^
ASCENSIA (CONTOUR)
ASPIRIN/OMEPRAZOLE DR
ASPRUZYO SPRINKLE ER
ATACAND^, ATACAND HCT^
ATRALIN^
ATRIPLA^
AUVELITY ER
AVALIDE^, AVAPRO^
AVASTIN
AVEED
AVODART^
AVSOLA
AZOPT^
AZOR^
BACLOFEN SOLUTION
BALCOLTRA
BANZEL^
BARACLUDE TABLETS^
BASAGLAR TEMPO
BECONASE AQ
BENICAR^, BENICAR HCT^
BENZHYDROCODONE/ACETAMINOPHEN
BEPREVE^
BERINERT
BESIVANCE
BESREMI
BETIMOL
BIJUVA
BLENREP
BONJESTA
BRISDELLE^
BRIUMVI
BROMSITE
BUDESONIDE/FORMOTEROL
BUPAP^
BUPROPION XL 450 MG
BUTRANS^
BYSTOLIC^
CABENUVA
CALCIPOTRIENE FOAM
CAMCEVI
CANASA^
CARAC
CAROSPIR
CELEBREX^
CELEXA^
CETRAXAL
CIALIS^
CILOXAN OINTMENT
CINQAIR
CIPRO HC
CIPROFLOXACIN/FLUOCINOLONE OTIC
CITALOPRAM CAPSULES
CLENIA PLUS
CLENPIQ
CLIMARA PRO
CLINDAGEL^
CLOCORTOLONE PUMP
CLONIDINE ER 0.17 MG
COLCHICINE CAPSULES
COLCRYS^
COMPLERA
CONCERTA^
CONDYLOX
CONJUPRI
CONZIP
COREG^
CORLANOR
CORTIFOAM
CORTROPHIN GEL
COSENTYX
COSOPT^, COSOPT PF^
COZAAR^, HYZAAR^
CRESTOR^
CRINONE
CUPRIMINE^
CUTAQUIG
CUVPOSA^
CYMBALTA^
CYSTADANE^
CYSTADROPS
CYTOMEL^
DALIRESP^
DARTISLA ODT
DELSTRIGO
DELZICOL^
DETROL^, DETROL LA^
DEXILANT^
DHIVY
DICLOFENAC 35 MG CAPSULES
DICLOFENAC EPOLAMINE PATCHES
DIOVAN^, DIOVAN HCT^
DIPENTUM
DIVIGEL^
DORAL
DORYX DR 50 MG^ & 200 MG^
DORYX DR 80 MG, DORYX MPC, DOXYCYCLINE HYCLATE DR 80 MG
DOXYCYCLINE 40 MG CAPSULES
DRIZALMA SPRINKLE
DRYSOL
DUAKLIR PRESSAIR
DUREZOL^
DUROLANE
DURYSTA
ECOZA
EDARBI, EDARBYCLOR
EFFEXOR XR^
ELELYSO
ELESTRIN
ELIDEL^
ELYXYB
EMEND CAPSULES^, TRIFOLD PACK^
EMEND POWDER PACKETS
EMFLAZA
ENTADFI
ENVARSUS XR
EPANED^
EPINEPHRINE AUTO-INJECTOR (BY A-S MEDICATION, AMNEAL PHARMA, AVKARE)
EPOGEN
EPRONTIA
ERTACZO
ESBRIET^
ESOMEPRAZOLE STRONTIUM
ESTRACE CREAM^
ESTRING
ESTROGEL
EVAMIST
EVEKEO^
EVENITY
EXFORGE^, EXFORGE HCT^
EXJADE^
EXONDYS 51
EXTAVIA
EZALLOR SPRINKLE
FABIOR
FEMRING
FENOFIBRATE CAPSULES (30 MG, 50 MG, 90 MG, 150 MG)
FENOPROFEN 200 MG CAPSULES
FENORTHO
FENSOLVI
FENTANYL CITRATE BUCCAL TABLETS
FENTORA
FERAHEME^
FIASP
FINTEPLA
FIRAZYR^
FIRVANQ
FLAREX
FLEQSUVY
FLOVENT DISKUS~, FLOVENT HFA~
FLUOROURACIL 0.5% CREAM
FLUTICASONE PROPIONATE HFA
FLUTICASONE/SALMETEROL (BY A-S MEDICATION, TEVA)
FLUTICASONE/VILANTEROL
FML FORTE, FML S.O.P.
FOCALIN^, FOCALIN XR^
FOLLISTIM AQ
FORFIVO XL
FOSRENOL CHEWABLE TABLETS^
FOSRENOL POWDER PACKETS
FOTIVDA
FUROSCIX
FYLNETRA
GAMMAKED
GANIRELIX ACETATE^
GEL-ONE
GELSYN-3
GENERESS FE^

~ Medications will be excluded beginning 07/01/2023.

(continued)

Excluded Medications/Products at a Glance *(continued)*

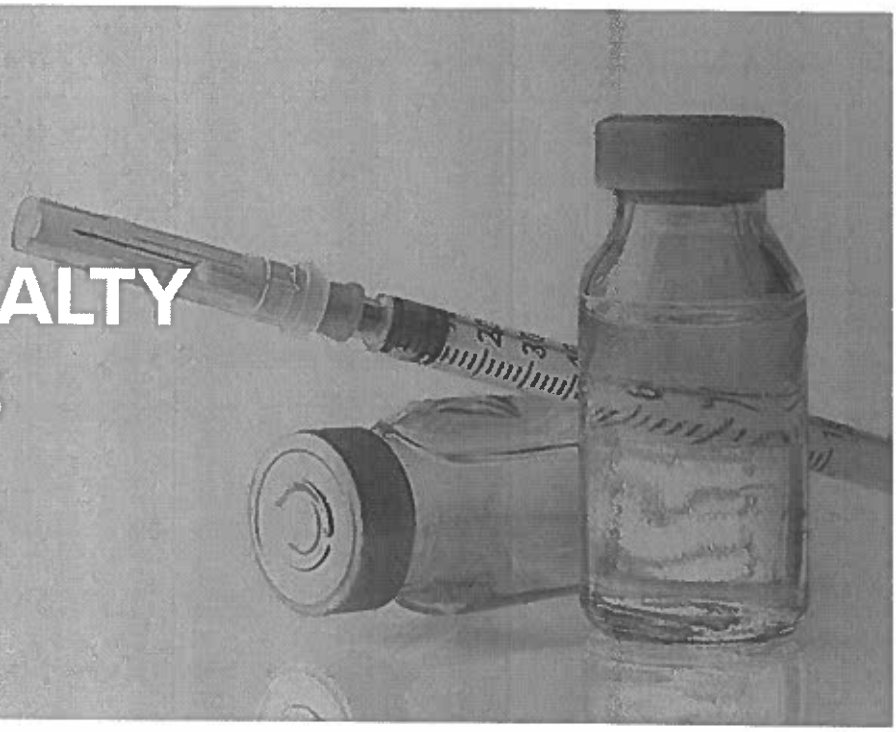
GENVISC 850
GILENYA^~
GIMOTI
GLEEVEC^
GLUCAGEN HYPOKIT
GLUCAGON EMERGENCY KIT (by Fresenius)
GLUMETZA^
GOCOVRI ER
GRANIX
HALOBETASOL 0.05% FOAM
HEMADY
HEMANGEOL
HERCEPTIN, HERCEPTIN HYLECTA
HERZUMA
HOME AIDE DIAGNOSTICS PEN NEEDLES & SYRINGES
HTL-STREFA PEN NEEDLES & SYRINGES
HUMALOG TEMPO
HUMATROPE
HYALGAN
HYDROCORTISONE/PRAMOXINE 25-18 MG SUPPOSITORIES
HYMOVIS
IBSRELA
IMITREX^
IMPEKLO
IMPOYZ
IMVEXXY
INCRUSE ELLIPTA
INDERAL LA^
INDERAL XL, INNOPRAN XL
INDOCIN SUPPOSITORIES, INDOCIN SUSPENSION
INDOMETHACIN 20 MG CAPSULES
INFLIXIMAB
INQOVI
INREBIC
INSULIN ASPART, INSULIN ASPART PROTAMINE
INSULIN DEGLUDEC
INSULIN GLARGINE (BY WINTHROP)
INSULIN GLARGINE-YFGN
INSULIN LISPRO
INTRAROSA
INTUNIV^
INVEGA HAFYERA
INVOKAMET, INVOKAMET XR, INVOKANA
ISTALOL^
ISTURISA
JADENU^, JADENU SPRINKLE^
JENTADUETO, JENTADUETO XR
KAPSPARGO SPRINKLE
KATERZIA
KAZANO
KEPPRA^, KEPPRA XR^
KERYDIN^
KETOROLAC NASAL SPRAY
KISQALI, KISQALI FEMARA CO-PACK
KLISYRI
KLONOPIN^
KOMBIGLYZE XR
KORLYM
KRAZATI
KYZATREX
LAMICTAL^, LAMICTAL ODT^, LAMICTAL XR^
LAMPIT
LANREOTIDE
LANTUS
LASTACAFT
LAZANDA
LEDIPASVIR/SOFOSBUVIR
LEQEMBI
LEQVIO
LETAIRIS^
LEUPROLIDE DEPOT
LEVALBUTEROL HFA
LEVAMLODIPINE
LEVOTHYROXINE CAPSULES
LEXAPRO^
LEXETTE
LIALDA^
LIBRAX^
LIDOCAINE/TETRACAINE
LIDODERM^
LIPITOR^
LIPOFEN
LO LOESTRIN FE
LOCOID^, LOCOID LIPOCREAM^
LOESTRIN^, LOESTRIN FE^
LOREEV XR
LOTREL^
LOTRONEX^
LOVAZA^
LOVENOX^
LUCEMYRA
LUCENTIS~
LULICONAZOLE
LUNESTA^
LUPKYNIS
LYBALVI
LYRICA^, LYRICA CR^
LYUMJEV TEMPO
LYVISPAH
MAVYRET
MAXALT^, MAXALT MLT^
MAXIDEX
MELOXICAM SUSPENSION
MENEST
MESTINON^
METFORMIN 625 MG TABLETS
METHOCARBAMOL 1,000 MG TABLETS
METHYLPHENIDATE ER 45 MG, 63 MG, 72 MG~
MICARDIS^, MICARDIS HCT^
MICONAZOLE/ZINC OXIDE/PETROLATUM
MINASTRIN 24 FE^
MINIVELLE^
MINOCYCLINE BIPHASIC TABLETS
MINOCYCLINE ER CAPSULES
MIRCERA
MIRCETTE^
MONOFERRIC
MOTEGRITY
MOVIPREP^
MULPLETA
MYTESI
NALFON CAPSULES^
NAMENDA XR^
NATAZIA
NATROBA^
NESINA
NEULASTA
NEUPOGEN
NEURONTIN^
NEVANAC
NEXICLON XR
NEXIUM CAPSULES^
NEXIUM PACKETS
NEXTSTELLIS
NOCTIVA
NORITATE
NORLIQVA
NORPACE^
NORPACE CR
NORTHERA^
NORVASC^
NOVO NORDISK PEN NEEDLES
NOVOLIN, RELION NOVOLIN
NOVOLOG, NOVOLOG MIX, RELION NOVOLOG, RELION NOVOLOG MIX
NOVOSEVEN RT
NOXAFIL TABLETS^
NUCYNTA, NUCYNTA ER
NUTROPIN AQ NUSPIN
NUVARING^
NUVIGIL^
NUWIQ
NYVEPRIA
OGIVRI
OMNARIS
ONETOUCH SOLUTIONS STARTER KIT
ONFI^
ONGENTYS
ONGLYZA
ONPATTRO
ONTRUZANT
ONUREG
ONZETRA XSAIL
ORACEA
OSMOPREP
OSPHENA
OTREXUP
OWEN MUMFORD PEN NEEDLES
OXBRYTA
OXISTAT CREAM^
OXISTAT LOTION
OXYCODONE ER
OZOBAX
PALFORZIA
PENNSAID^
PERCOCET^
PERFOROMIST^
PERTZYE
PEXEVA
PHESGO
PHEXXI
PIFELTRO
PIQRAY
PIRFENIDONE 534 MG TABLETS
PLAQUENIL^
PLAVIX^
PLENVU
PLIAGLIS
PRADAXA
PRALUENT
PRED MILD
PREGENNA
PREGNYL
PREMARIN TABLETS, PREMPHASE, PREMPRO
PREVACID^, PREVACID SOLUTAB^
PREZCOBIX
PRILOSEC SUSPENSION
PRIMLEV
PRISTIQ^
PROAIR DIGIHALER, PROAIR RESPICLICK
PROAIR HFA^
PROCTOFOAM-HC
PROCYSBI
PRODIGY DIABETES CARE
PROLATE SOLUTION
PROLIA
PROTONIX^
PROVENTIL HFA^
PROVIGIL^
PROZAC^
PULMICORT FLEXHALER
PULMICORT RESPULES^
PYLERA
PYRIDIUM^
QBRELIS
QBREXZA
QDOLO
QINLOCK
QNASL
QTERN
QUARTETTE^
QUAZEPAM
QUETIAPINE 150 MG TABLETS
RABEPRAZOLE DR SPRINKLE
RANEXA^
RAPAFLO^
RAVICTI~
REBYOTA
RECOMBINATE
RECORLEV
REDITREX
RELAFEN DS
RELEUKO
RELEXXII ER 45 MG, 63 MG, 72 MG~
RELPAX^
RELTONE
RELYVRIO
REMICADE
RENAGEL^
RENFLEXIS
RETIN-A MICRO 0.04% & 0.1%^
REZLIDHIA
RHOPRESSA, ROCKLATAN
RIABNI
RITALIN^, RITALIN LA^
RITUXAN, RITUXAN HYCELA
ROCHE (ACCU-CHEK)
ROLVEDON
ROSUVASTATIN/EZETIMIBE
ROXYBOND
ROZEREM^
RUKOBIA ER
SABRIL^
SAFYRAL^
SAIZEN, SAIZENPREP
SAMSCA^
SANDOSTATIN LAR DEPOT
SAPHRIS^
SAVAYSA
SCEMBLIX
SEASONIQUE^, LOSEASONIQUE^
SEGLENTIS
SENSIPAR^
SERNIVO
SEROQUEL^, SEROQUEL XR^
SERTRALINE CAPSULES
SIGNIFOR LAR
SIKLOS
SIMPLE DIAGNOSTICS PEN NEEDLES & SYRINGES
SINGULAIR^
SITAVIG
SKYTROFA
SLYND
SOAANZ
SOFOSBUVIR/VELPATASVIR
SORILUX
SOVALDI
SPRAVATO
STIMUFEND
STRATTERA^
STRIBILD
STRIVERDI RESPIMAT
SUBOXONE^
SUBSYS
SULCONAZOLE
SULFACETAMIDE/SULFUR 9%-4.25% SUSPENSION
SUPARTZ FX
SUPREP^
SUSVIMO
SUTAB
SYNOJOYNT
SYNTHROID^
SYNVISC, SYNVISC-ONE
TADLIQ
TARGRETIN CAPSULES^
TASCENSO ODT
TAVNEOS
TAYTULLA^
TAZAROTENE FOAM
TAZORAC 0.05% CREAM
TAZORAC 0.1% CREAM^, TAZORAC GEL^
TECFIDERA^
TEKTURNA^
TEMPO (WELCOME KIT, REFILL KIT, SMART BUTTON)
TEPMETKO
TESTIM^
THALITONE
THIOLA^
THYQUIDITY
TIKOSYN^
TIMOPTIC OCUDOSE^
TIROSINT, TIROSINT-SOL
TIVORBEX
TLANDO
TOBI SOLUTION^
TOBRADEX ST
TOLSURA
TOPAMAX^
TOPICORT SPRAY^
TOPROL XL^
TRADJENTA
TRAMADOL 100 MG TABLETS
TRAMADOL ER CAPSULES
TRAMADOL SOLUTION
TRANSDERM-SCOP^
TRAVATAN Z^
TRELSTAR
TREXIMET^
TRI-LUMA
TRIBENZOR^
TRICOR^
TRILEPTAL^
TRILURON
TRINAZ
TRIVIDIA (NIPRO DIAGNOSTICS) PEN NEEDLES & SYRINGES
TRIVIDIA (TRUETEST, TRUETRACK)
TRIVISC
TRUSELTIQ
TRUVADA^
TRUXIMA
TUDORZA PRESSAIR
TWIRLA
TYBLUME
UDENYCA
ULORIC^
ULTIMED PEN NEEDLES & SYRINGES
ULTRAVATE
UPLIZNA
UPNEEQ
UROXATRAL^
VABYSMO
VAGIFEM^
VALIUM^
VALSARTAN SOLUTION
VALTREX^
VANOS^
VELTIN
VENLAFAXINE BESYLATE ER
VENTOLIN HFA
VERDESO FOAM
VEREGEN
VERKAZIA
VESICARE^
VESICARE LS
VIAGRA^
VICTOZA
VIIBRYD^
VILTEPSO
VIMOVO^
VIMPAT^
VISCO-3
VIVELLE-DOT^
VIVIMUSTA
VIVLODEX^
VPRIV
VUITY
VUSION
VYEPTI
VYONDYS 53
VYTORIN^
WELCHOL^
WELLBUTRIN SR^, WELLBUTRIN XL^
WINLEVI
XADAGO
XALATAN^
XANAX^, XANAX XR^
XATMEP
XELPROS
XELSTRYM
XENAZINE^
XERESE
XIMINO
XOLEGEL
XOPENEX HFA
XPOVIO
XTAMPZA ER
XYNTHA, XYNTHA SOLOFUSE
XYREM~
YASMIN^
YOSPRALA DR
ZAVESCA^
ZEGALOGUE
ZEGERID^
ZELAPAR
ZELNORM
ZERVIATE
ZETIA^
ZETONNA
ZILXI
ZIMHI
ZIOPTAN^
ZIPSOR
ZOCOR^
ZOLMITRIPTAN NASAL SPRAY 2.5 MG
ZOLOFT^
ZOMACTON
ZOMIG TABLETS^
ZONEGRAN^
ZONISADE
ZORVOLEX
ZOVIRAX OINTMENT^
ZYCLARA
ZYLET
ZYTIGA^

^ Multisource brand exclusion – The generic equivalent of this brand-name medication is covered under your plan. FDA-approved generic medications meet strict standards and contain the same active ingredients as their corresponding brand-name medications, although they may have a different appearance. As new generic medications become available, additional multisource brand products may become excluded.

~ Medications will be excluded beginning 07/01/2023.

PAY $0 FOR SELECT SPECIALTY MEDICATIONS

Participate in the SaveOnSP program



Specialty medications can cost a lot of money. That's why your plan offers a program called SaveOnSP, to lower your out-of-pocket costs to $0.

Participate in SaveOnSP and save.

Over 250 specialty medications are eligible for the SaveOnSP program.[1] If you're filling an eligible medication, a representative from SaveOnSP will contact you to discuss the program.

You'll pay $0 for your medication when you participate in SaveOnSP. If you choose not to participate, you'll pay a higher copay when you fill your medication.

Conditions covered by SaveOnSP include, but are not limited to:

- Hepatitis C
- Multiple Sclerosis
- Psoriasis
- Inflammatory Bowel Disease
- Rheumatoid Arthritis
- Cancer

Here's an example of how it works.[2]

John's taking a specialty medication that's eligible for the SaveOnSP program. His copay is currently $70. His new copay will be $1,000.

- **When he participates in SaveOnSP, he won't pay anything ($0) out-of-pocket.** He will work with SaveonSP to enroll with the applicable manufacturer copay assistance program.
- **If he decides not to participate in SaveOnSP, he'll pay his full copay of $1,000 out-of-pocket.**

In both of these examples, John's copay wouldn't count toward his deductible or out-of-pocket maximum.

1. The drug classes, medications and associated copays included in this program are subject to change. Check your plan materials to see which medications are eligible for the SaveOnSP program.
2. For illustrative purposes only. Plans may vary.

EXPRESS SCRIPTS® SaveOnSP

State Benchmark = All States except CA, CO, UT
2023 Copay Assistance Benefit Drug List

Please call 1-800-683-1074 to participate. Once you've enrolled in copay assistance and consented to SaveOnSP monitoring your pharmacy account, your responsibility will be as low as $0.

Effective January 1, 2023

The specialty medications included in the copay assistance benefit drug list are specific to your plan's prescription drug benefit and subject to change at any time. Prescription drug benefit plan terms will always take precedence. Medications with prior authorization criteria must be approved in advance by the plan and follow applicable laws and/or regulations. The specialty medications included on this list will have a 30 percent coinsurance. By enrolling in the available manufacturer assistance program and consenting to SaveOnSP monitoring your pharmacy account, **your final cost will be as low as $0.** The coinsurance amount may vary. Specialty medications will be filled through your approved specialty pharmacy.

A

Abraxane
Actemra
Adakveo
Adbry
Adcetris
Adcirca
Advate
Adynovate
Afinitor
Afstyla
Aldurazyme
Alecensa
AlphaNine
Alprolix
Alunbrig
Amjevita*
Ampyra
Arcalyst
Asceniv
Aubagio
Austedo
Avastin
Avonex
Avsola

B

Bavencio
Benefix
Benlysta
Beovu
Berinert
Blenrep
Bosulif
Braftovi
Brukinsa

C

Cablivi
Cabometyx
Calquence
Camzyos
Carbaglu
Cayston
Cerdelga
Cholbam
Cibinqo
Cimzia
Cinryze
Copaxone
Cosentyx
Crysvita
Cuvitru
Cyramza
Cystadrops

D

Dojolvi
Doptelet
Dupixent

E

Elaprase
Elelyso
Eloctate
Empliciti
Enbrel
Enhertu
Enjaymo
Entyvio
Erbitux
Erivedge
Erleada
Esperoct
Evenity
Evkeeza
Exjade
Exkivity
Exondys 51
Extavia
Eylea

F

Fabrazyme
Farydak
Fasenra
Feiba NF
Ferriprox
Fintepla
Firazyr
Firdapse
Folotyn
Forteo
Fotivda
Fulphila

G

Galafold
Gamifant
Gammagard
Gattex
Gazyva
Gilenya
Gilotrif
Givlaari
Glatiramer Acetate
Glatopa
Gleevec
Gocovri
Granix

H

Haegarda
Hemlibra
Herceptin
Herceptin Hylecta
Herzuma
Humate-P
Humira
Hyqvia

I

Ibrance
Iclusig
Idelvion
Ilumya
Imcivree
Imfinzi
Increlex
Inflectra
Ingrezza
Inlyta
Inqovi
Inrebic
Istodax
Ixempra
Ixinity

J

Jadenu
Jakafi
Jemperli
Jevtana
Jivi
Juxtapid
Jynarque

K

Kadcyla
Kalbitor
Kalydeco
Kanjinti
Kanuma
Kesimpta
Keveyis
Kevzara
Kisqali
Kisqali Femara Co-Pack
Kogenate FS
Koselugo
Kovaltry
Krystexxa
Kuvan
Kyprolis

L

Lenvima
Letairis
Leukine
Libtayo
Livmarli
Lonsurf
Lorbrena
Lucentis
Lumakras
Lumizyme
Lupkynis
Luxturna
Lynparza

M

Makena
Margenza
Mayzent
Mekinist
Mektovi
Mvasi

N

Nerlynx
Neulasta
Neupogen
Nexavar
Nexviazyme
Ninlaro
Nityr
Nivestym
Northera
Novoeight
Novoseven RT
Nplate
Nubeqa
Nucala
Nulibry

* Drug available upon launch to market.

Nuplazid
Nuwiq
Nyvepria

O

Ocaliva
Ocrevus
Ogivri
Olumiant
Ontruzant
Onureg
Opdivo
Opdualag
Orencia
Orenitram
Orfadin
Orgovyx
Orladeyo
Otezla
Oxbryta
Oxervate
Oxlumo

P

Padcev
Palynziq
Pemazyre
Perjeta
Phesgo
Piqray
Plegridy
Polivy
Poteligeo
Procysbi
Promacta
Pulmozyme

Q

Qinlock

R

Radicava
Ravicti
Rebif
Rebinyn
Recombinate
Remicade
Renflexis
Retevmo
Revatio
Revcovi
Riabni
Rinvoq
Rituxan
Rituxan Hycela
Rixubis
Rubraca
Ruxience
Rybrevant
Rydapt

S

Sandostatin Lar Depot
Saphnelo
sapropterin
Sarclisa
Scemblix
Serostim
Signifor
Signifor LAR
Siliq
Skyrizi
Skytrofa
sodium oxybate*
Soliris
Somatuline Depot
Somavert
Spinraza
Sprycel
Stelara
Stivarga
Strensiq
Sublocade
Susvimo
Sutent

T

Tafinlar
Tagrisso
Takhzyro
Taltz
Talzenna
Tasigna
Tavalisse
Tavneos
Tazverik
Tecentriq
Tecfidera
Tegsedi
Tepmetko
Thiola
Tivdak
Tobi
Tracleer
Trazimera
Tremfya
treprostinil
Tretten
Trikafta
Triptodur
Trodelvy
Truseltiq
Truxima
Tukysa
Turalio
Tykerb
Tysabri
Tyvaso

U

Udenyca
Ultomiris

V

Vabysmo
Valchlor
Vectibix
Venclexta
Verzenio
Viltepso
Vistogard
Vonvendi
Votrient
Voxzogo
Vumerity
Vyleesi
Vyndamax
Vyndaqel
Vyondys 53
Vyxeos

W

Wakix
Welireg
Wilate

X

Xalkori
Xeljanz
Xembify
Xenazine
Xermelo
Xgeva
Xolair
Xospata
Xpovio
Xtandi
Xyntha
Xyrem

Y

Yervoy

Z

Zarxio
Zejula
Zelboraf
Zeposia
Ziextenzo
Zirabev
Zokinvy
Zolgensma
Zynlonta
Zytiga

* Drug available upon launch to market.

SouthernCoastal FUND

c/o PERMA PO BOX 99106
Camden, NJ 08101

Benefits Enrollment Form

Employer Name:______________________________

EMPLOYEE/PARTICIPANT INFORMATION (Employee or Dep. 31)

Please PRINT and fill this section out COMPLETELY

Social Security #:	Last Name:		First Name:		M.I.:
Gender: ☐ Male ☐ Female	Date of Birth:		Address:		
City:	State:	Zip:	Home Phone #:	Work Phone #:	
E-mail:		PCP # (if required):	Division (if any):		
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		**Requested Effective Date:**			

DEPENDENT INFORMATION (Spouse, Child or Children)

Please PRINT and fill this section out COMPLETELY

Please list all eligible dependents only.

Spouse

Social Security #:	First Name:	Last Name:	M.I.:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	

Child(ren)

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Relationship:			

CONTINUED ON REVERSE SIDE

PLAN SELECTIONS

Medical Coverage

Carrier Name:_____ **Plan Name:**_____

Type of Coverage: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child(ren)

Prescription Coverage (If Prescription is through Coastal/Express-Scripts)

Carrier Name:_____ **Plan Name:**_____

Type of Coverage: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child(ren)

Dental Coverage (If Dental is through the Coastal Fund)

Carrier Name:_____ **Plan Name:**_____

Type of Coverage: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child(ren)

TYPE OF ACTIVITY

☐ New Hire Date: _____ ☐ Open Enrollment Date: _____ ☐ Rehire Date: _____

☐ Termination of Employment
Date: _____

☐ COBRA (please check box indicating reason for COBRA eligibility):
- ☐ Employment Terminated ☐ Reduction in hours ☐ Divorce
- ☐ Spouse/dependent child of deceased employee ☐ Loss of dependent child status under plan rules
- ☐ Spouse/dependent's loss of coverage due to employee's Medicare entitlement

Addition of Dependent (legal documentation required)

☐ Marriage ☐ Civil Union ☐ Birth ☐ Adoption/Guardianship/Foster Care Date of Event: _____

Add Coverage: ☐ Medical ☐ Rx ☐ Dental

Deletion of Dependent Date of Event: _____ Dependent Name: _____

☐ Divorce (legal documentation required) ☐ Death of spouse or child ☐ Child over age limit/ineligible

Remove Coverage: ☐ Medical ☐ Rx ☐ Dental

Other

☐ Dependent Age 31 ☐ Newly Eligible (PT or FT)

☐ Death (Name of Deceased): _____ Date of Death: _____

☐ Other (Give Reason):

EMPLOYEE CERTIFICATION

I certify that all of the information supplied on this form is true to the best of my knowledge. I understand if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment. I understand that there is no guarantee of continuous participation by medical service providers, doctors or facilities in the Plans. If either my physician or medical center terminates participation in the Plan, I must select another doctor or medical center participating in the same plan. I authorize any hospital, physician or health care provider to furnish my medical plan or its assignee with such medical information about myself or my covered dependents as the medical plans or assignee may require. I also attest that the dependents listed here (if applicable) meet the dependent eligibility criteria of the Plan. I understand that in the event I cover any dependent that does not meet the eligibility provisions of the Plan that doing so shall invalidate their coverage and potentially my coverage and that I may be subject to penalties. I further agree that the SHIF may, at any time, request that I supply evidence that substantiates the eligibility status of any person I cover as a dependent under the Plan.

Print Name: _____ Employee Signature: _____

Date: _____

DENTAL

DELTA DENTAL

DELTA DENTAL OF NEW JERSEY, INC.
WATERFORD TOWNSHIP BOARD OF EDUCATION
Group # 7232

Plan Design	Delta Dental Premier® Program 7232-0003	Delta Dental PPO℠ Program 7232-6003	DeltaCare® Plan NJ6 7232-9001
Preventive & Diagnostic	100%	100%	$0.00*
Basic	80%	80%	$0.00
Crowns	80%	80%	$75.00-$290.00
Prosthodontics	60%	60%	$60.00-$300.00
Orthodontics	N/A	N/A	$2,400.00
			* $20.00 for Sealants
Annual Maximum	$2,000.00	$2,000.00	None
Lifetime Ortho Maximum	N/A	N/A	See Above
Deductible	$25	$25	None

Visit your own dentist. If you do not have a dentist, there is a directory available with your plan administrator listing participating dentists. You may call 1-800-DELTA-OK and a list of participating dentists located in your area will be mailed directly to your home or you may access our Website at www.deltadentalnj.com.

During your FIRST appointment, tell your dentist that you are covered under this program. Give him/her your Group's name, its Delta Dental Group Number and your Social Security number. Your dependents, if covered, should give YOUR SOCIAL SECURITY NUMBER.

If you have any questions regarding your dental benefits, you may contact our Customer Service Department Monday through Thursday, 8:00 a.m. to 6:30 p.m. EST and Friday, 8:00 a.m. to 5:00 p.m. EST, at 1-800-452-9310.

This comparison contains a general description of your dental care program for your use as a convenient reference. Complete details of your program appear in the group contract between your plan sponsor and Delta Dental of New Jersey, Inc. which governs the benefits and operation of your program. The group contract would control if there should be any inconsistency or difference between its provisions and the information in this comparison.

2023

DELTA DENTAL MONTHLY RATES
JULY 1, 2023 – JUNE 30, 2024

DELTA DENTAL PREMIER

Single =	$ 57.25
Family =	173.37

DELTA DENTAL PREFERRED (Delta Dental PPO)

Single =	$ 45.79
Family =	138.67

DELTA DENTAL FLAGSHIP (DeltaCare)

1 Party =	$ 28.19
2 Party =	55.41
3 Party =	92.31

ENROLLMENT / CHANGE REQUEST

Employer Group Information
Group Name: _____

To be completed by Employer
Group Number: _____

Sublocation /
Store Location: _____

[A]

TYPE OF ACTIVITY – (Employer complete)

1. **Enrollment**: _____ New Enrollee / Subscriber
   Effective Date: _____ Date of Hire: _____

2. **Change** (check all that apply): **Date of Event:**
   - _____ Add Spouse _____
   - _____ Add Domestic Partner _____
   - _____ Add Dependent Child _____
   - _____ Name Change _____
   - _____ Change Plan _____
   - _____ Other _____
   - _____ Add/Change Office ID #'s _____

3. **Remove or Terminate** (check all that apply): **Effective Date:**
   - _____ Remove Spouse* _____
   - _____ Remove Domestic Partner* _____
   - _____ Remove Dependent Child _____
   - _____ Employee Withdrawal / Termination _____

   NOTE: Employee must be enrolled for spouse/dependent(s) to have coverage
   * Please complete Add/Change/Remove and Name columns in Section D.

*****_PROVIDE REASON FOR SELECTIONS IN #2 OR #3 ABOVE_: _____

4. **Continuation of coverage**, ie. COBRA, State, Total disability. Not all options are available or applicable. Contact Employer for available options.
   Coverage for: _____Employee _____Dependents
   Length of Continuation: _____ 12 months _____18 months _____29 months _____ 36 months _____Total Disability –Attach proof of total disability.
   Date of loss of coverage: _____ Date of Qualifying Event: _____
   Billing: _____ Home _____Group

[B]

EMPLOYEE INFORMATION (Employee to complete sections B-G)

Last Name, First Name, Middle Initial: _____ Social Security Number: _____ Home Phone: _____
Email Address: _____ Home Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____
Employer Name: _____ Date of Employment: _____/_____/_____ Hours worked per week: _____
Employer Address: _____ City: _____ State: _____ Zip: _____

[C]

PLAN OPTION

Delta Dental Premier _____ Delta Dental PPO (Preferred) _____ DeltaCare (Flagship) _____

[D] **INDIVIDUALS COVERED**

List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time, post-secondary student, or disability.

	A (add) C (change) R (remove)	Last Name, First Name, Middle Initial	Sex M / F	Birthdate MM/DD/YYYY	Social Security No.	Other Health Coverage Check if Yes	Previous Coverage Check if Yes
Employee	_____	_____	_____	_____	_____	_____	_____
Domestic Partner **	_____	_____	_____	_____	_____	_____	_____
Spouse	_____	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____	_____

**(if coverage offered)

[E] **OTHER / PREVIOUS INSURANCE**

Is your spouse employed? ( ) NO ( ) YES If you answered 'YES', please provide the following:

--Name of spouse's employer: _____ Address of spouse's employer: _____

If you checked 'yes' to Other Health Coverage (Section D), please provide the following:

--Name of insurance carrier, HMO, or other source: _____ Policy Number: _____

--If enrolled in Medicare Parts A and/or B, identify the coverage and provide the Medicare ID#: _____

If you checked 'yes' to Previous Coverage (Section D), please provide the following:

--Name(s) of persons: _____ Effective Date: _____ Date Coverage Terminated: _____

-- Name of previous carrier: _____ Plan Number: _____

[F] **DEPENDENT INFORMATION**

Does any dependent listed in Section D live at a different address that the Employee? ( ) NO ( ) YES If you checked 'YES', please provide the following:

--Who and at what address? _____

-- Explain the circumstances _____

If any dependent's last name differs from yours, explain the circumstances: _____

[G] **EMPLOYEE SIGNATURE**

If you have any questions concerning the benefits and services provided by or excluded under this Agreement, contact a Customer Service Agent at 1-800-452-9310 before signing this form.

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on this Employee Enrollment/Change Request.

I authorize deductions from my earnings for any required contributions.

Employee Signature – Required: _____ **Date:** _____ **Email Address:** _____

[H] **EMPLOYER VERIFICATION (to be completed by employer)**

Employer Signature – Required: _____ **Title:** _____ **Date:** _____

EMPLOYER INSTRUCTIONS

Complete the Employer Group Information in the upper left corner of the form.

Section A / Type of Activity –

- Check boxes indicating reason(s) for submitting application

Section H / Employer Verification

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed

EMPLOYEE INSTRUCTIONS (complete sections B-G)

Section B / Employee Information

- Complete all information in order for your application to be processed

Section C / Plan Option

- Check one Plan Option box

Section D / Individuals Covered

- Add/Change/Remove-use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependents, if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status. If dependent is disabled and being continued beyond the limiting age, attach proof of disability.
- If you or your dependent(s) have other Health coverage, check off the "Yes" box(es) and complete Section 'F'-Other/Previous Insurance.
- From the appropriate provider directory, locate the office ID# for the dentist (if applicable). Indicate office ID# selection(s) on the form.

Section E / Pre-Existing Conditions Statement

- Complete this section for all new enrollments. Exceptions: For Small Employer Group coverage, this section must be completed only by persons enrolling in the group coverage in a group of 2-5 employees and by late entrants.

Section F / Other-Previous Insurance

- Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, a a church plan or Medicare.

Section G / Dependent Information

- Complete this section for all new enrollments or coverage changes.

Section H / Employee Signature

- Complete this section for all new enrollments, coverage changes and terminations
- Employee must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section I / Employer Verification

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

CONDITIONS OF ENROLLMENT

Application Acknowledgment and Agreements

1. On behalf of myself and the dependents listed on page two I agree to the following:
   a) I authorize the sources stated below to give Delta Dental of New Jersey, Inc. or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or medical condition. Authorization sources are any physician or medical professional, any hospital, clinic or other medical care institution; any carrier any consumer reporting agency; any employer.
   b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which Delta Dental of New Jersey, Inc. has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
   c) In know that I have the right to receive a copy of the authorization if I request one.
   d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in a Delta Dental of New Jersey, Inc. plan or group policy coverage is provided by Delta Dental of New Jersey, Inc. in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Delta Dental of New Jersey, Inc.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes false or misleading information on an Enrollment/Change Request Form for a health benefits plan is subject criminal and civil penalties.

VISION

Your VSP Vision Benefits Summary

WATERFORD TOWNSHIP BOARD OF EDUCATION and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Signature
EFFECTIVE DATE:
01/01/2023

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$0	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES		**$20**	
FRAME*	• $140 featured frame brands allowance • $120 frame allowance • 20% savings on the amount over your allowance • $120 Walmart†/Sam's Club† frame allowance • $65 Costco† frame allowance	Included in Prescription Glasses	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every 24 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 40% on other lens enhancements	$0 $80 - $90 $120 - $160	Every 24 months
CONTACTS (INSTEAD OF GLASSES)	• $120 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 24 months
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.

*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
†Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

A Look at Your VSP Vision Coverage

With VSP and WATERFORD TOWNSHIP BOARD OF EDUCATION, your health comes first.

As a member, you'll get access to savings and personalized vision care from a VSP network doctor for you and your family.

Value and savings you love.
Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.
Maximize your benefits at a Premier Program location, including thousands of private practice doctors and over 700 Visionworks retail locations nationwide.

vsp PREMIER PROGRAM

Preferred private practice and retail in-network choices

private practice doctors

Visionworks

Quality vision care you need.
You'll get great care from a VSP network doctor, including a WellVision Exam†. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!
Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

vsp vision care

More Ways to Save

Extra
$20
to spend on Featured Brands†

bebe · CALVIN KLEIN · COLE HAAN · DRAGON · FLEXON · LACOSTE · and more

See all brands and offers at **vsp.com/offers**.

+

Up to
40%
Savings on lens enhancements‡

Create an account today.
Contact us: **800.877.7195** or **vsp.com**

VSP – VISION COVERAGE

MONTHLY RATES

JULY 1, 2023 – JUNE 30, 2024

Single =	$ 8.71
Couple =	13.93
Parent/Child(ren) =	14.22
Family =	22.93

VISION SERVICE PLAN (VSP)
MEMBERSHIP ENROLLMENT/CHANGE APPLICATION

Section 1—Member Information

Last Name: _____ First Name: _____ Middle Initial: ____

Social Security Number: _____ Date of Birth: _____

Home Address: _____

_____

Home Email Address: _____

___New Enrollment ___Change in Current Coverage ___Reinstate ___Cancel Coverage

Section 2—Member Authorization

I authorize payroll deductions for:

☐ Employee Only ☐ Employee/Spouse ☐ Employee/Children ☐ Employee/Family ☐ Decline

I agree to remain enrolled for the entire enrollment period, assuming I remain employed, unless I experience an IRS qualifying event. Premium rates for subsequent 12-month renewals are subject to negotiation between my employer and Vision Service Plan.

Signature: _____ Date: _____

Section 3—Dependent Information

Please provide the information requested below for all of your dependents:

Last Name	First Name	Middle Initial	SSN	Date of Birth	A = Add Dependent R = Remove Dependent C = Change (name chg)

----------OFFICE USE ONLY----------

Hire Date: _____ Effective Date: _____

Notes: _____

_____

Revised: 4.24.23 / ng