Benefits at a Glance

LEVEL CARE HEALTH MICHIGAN CARPENTERS' HEALTH CARE FUND

REQUESTED DATE OF SERVICE:3/1/2023

013937 ACTIVE EMPLOYEES - ENHANCED

ENHANCED PLAN

Please read the important information at the end of this Benefits at a Glance.

This summary shows the Coinsurance percentage the Plan pays for various services. All payments are based on the Plan's allowance for the services performed.

Benefit	IN-NETWORK	OUT-OF-NETWORK[1]
BENEFIT PERIOD	Calendar year*	Calendar year*
DEDUCTIBLE (EMBEDDED)[2 3]		
• Individual	$250	$500
• Family	$500	$1,000
OUT OF POCKET MAXIMUM (EMBEDDED)[4 5]		
• Individual	$6,350	$12,700
• Family	$12,700	$25,400
LIFETIME MAXIMUM	Unlimited	Unlimited
PREVENTIVE SERVICES		
• Preventive Services	100%	Not Covered
• Adult Immunizations	100%	Not Covered
• Pediatric Immunizations	100%	Not Covered
• Child Exams 2 Visits per 12 Months per 12 Months(IN-NETWORK) 6 Visits per 12 Months per 12 Months(IN-NETWORK) 8 Visits per 12 Months per 12 Months(IN-NETWORK) 1 Visits per year(IN-NETWORK)	100%	Not Covered
• Colonoscopy 1 Visits per year[9]	100%	60% after deductible

Independence

Independence Administrators

Benefit	IN-NETWORK	OUT-OF-NETWORK[1]
• Contraceptives	100%	60% after deductible
• Mammogram 1 Visits per year[9]	100%	60% after deductible
• IUD DEVICE	100%	100% after deductible
• Sigmoidoscopy 1 Visits per year(IN-NETWORK)	100%	Not Covered
OUTPATIENT MEDICAL SERVICES		
• Primary Office Visit/Consultation	$30 copay / 100%	60% after deductible
• Specialist Office Visit/Consultation	$30 copay / 100%	60% after deductible
URGENT CARE		
• Urgent Care	$30 copay / 100%	60% after deductible
RETAIL CLINIC (MINUTE CLINIC)	$30 copay / 100%	60% after deductible
TELEMEDICINE		
• Telemedicine	100%	Not Covered
THERAPY/COUNSELING SERVICES		
• Physical Therapy[6] 60 Visits per year[9]	80% after deductible	60% after deductible
• Occupational Therapy[6] 60 Visits per year[9]	80% after deductible	60% after deductible
• Speech Therapy[6] 60 Visits per year[9]	80% after deductible	60% after deductible
• Cardiac Rehabilitation	80% after deductible	60% after deductible
• Pulmonary Therapy	80% after deductible	60% after deductible
• Orthoptic/Pleoptic Therapy (Vision Therapy)	80% after deductible	60% after deductible
EMERGENCY MEDICAL FACILITY		
• Emergency Medical[7]	$150 copay / 100%	$150 copay / 100%
• Non Emergency	$150 copay / 100%	Not Covered
AMBULANCE SERVICES		
• Emergency Ambulance	80% after deductible	80% after deductible
• Non-Emergency Ambulance	80% after deductible	60% after deductible
INPATIENT MEDICAL SERVICES		
• Inpatient Hospital Services	80% after deductible	60% after deductible
• Inpatient Professional Services	80% after deductible	60% after deductible
OUTPATIENT SURGICAL PROCEDURES		
• Outpatient Surgical Procedures	80% after deductible	60% after deductible
• Short Procedure Facility	80% after deductible	60% after deductible
• Ambulatory Surgical Center	80% after deductible	Not Covered

Benefit	IN-NETWORK	OUT-OF-NETWORK[1]
DIAGNOSTIC TESTING OUTPATIENT		
• Diagnostic Medical	80% after deductible	60% after deductible
• Simple Radiology	80% after deductible	60% after deductible
• Advanced Radiology	80% after deductible	60% after deductible
• Lab and Pathology	80% after deductible	60% after deductible
MATERNITY CARE		
• Initial Prenatal Care Visit	100%	60% after deductible
• Subsequent Prenatal Care Visit	100%	60% after deductible
CRANIAL PROSTHESIS - WIG/HAIRPIECE	Not Covered	Not Covered
CHIROPRACTIC SERVICES		
• Chiropractic Services 24 Visits per year[9]	$30 copay / 100%	60% after deductible
ALLERGY TESTS	100%	60% after deductible
ALLERGY INJECTIONS	100%	80% after deductible
NUTRITIONAL COUNSELING	100%	60% after deductible
DIALYSIS/HEMODIALYSIS	80% after deductible	60% after deductible
PRIVATE DUTY NURSING	50% after deductible	50% after deductible
SKILLED NURSING FACILITY 120 Days per year(IN-NETWORK)	80% after deductible	Not Covered
HOME HEALTH CARE	80% after deductible	80% after deductible
INPATIENT HOSPICE CARE	100%	100%
HOME INFUSION THERAPY	80% after deductible	Not Covered
DURABLE MEDICAL EQUIPMENT	80% after deductible	80% after deductible
ORTHOTICS/PROSTHETICS DEVICES	80% after deductible	80% after deductible
OUTPATIENT MENTAL NERVOUS		
• Psychotherapy Office Visit/Consultation	$30 copay / 100%	60% after deductible
• Psychotherapy Visit	80% after deductible	60% after deductible
DIABETIC SERVICES		
• Diabetic Education	100%	60% after deductible
• Diabetic Equipment	80% after deductible	60% after deductible
• Diabetic Supplies	80% after deductible	60% after deductible
AUTISM SPECTRUM DISORDERS		
• Autism Spectrum Disorders[8]	Not Covered	Not Covered
• Therapies (includes Physical, Occupation, Speech)	Not Covered	Not Covered

This summary represents only a partial listing of benefits and exclusions of the Group Health Plan described in this summary. Benefits and exclusions may be further defined by medical policy. As a result, this Group Health Plan may not cover all of your health care expenses. Read your member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the Group Health Plan. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibxtpa.com.

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to www.ibxtpa.com or call the phone number that is listed on the back of your identification card.

*A calendar year benefit period begins on the first day of the calendar year and ends on the last day of the calendar year. The deductible and out-of-pocket maximum amount starts at $0 at the beginning of each calendar year.

[1]It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the actual charge of the provider.
[2]The in- and out-of-network deductibles cross-apply.
[3]Each member contributes towards his or her own deductible. The deductible is considered met when he or she reaches the individual deductible or the family deductible is met.
[4]Out of pocket includes medical and prescription.
[5]Each member contributes towards his or her own out-of-pocket maximum. The out-of-pocket maximum is considered met when he or she reaches the individual out-of-pocket maximum or the family out-of-pocket maximum is met.
[6]Occupational Therapy, Physical Therapy and Speech Therapy have combined limit.
[7]Copay waived if admitted or for an accidental injury.
[8]Other services, including mental health services and nutritional counseling for autism spectrum are also not covered
[9]Service limits combined across tiers.

Services that require precertification

Standard Precertification List Effective: 1/1/2023

This applies to elective, nonemergency services.

Some services or supplies in this list may not be covered by your benefits plan. Please check your benefit plan documents.

Inpatient services

- Acute rehabilitation admissions
- Elective surgical and nonsurgical inpatient admissions
- Elective inpatient hospital-to-hospital transfers
- Inpatient hospice admissions
- Long term acute care (LTAC) facility admissions
- Skilled nursing facility admissions

Procedures

- Carticel (ACI), osteochondral allograft, and autograft transplantations
- Cochlear implant surgery
- Obesity surgery

Reconstructive procedures and potentially cosmetic procedures

- Blepharoplasty/blepharoptosis repair
- Bone graft, genioplasty, and mentoplasty
- Breast: reconstruction, reduction, augmentation, mammoplasty, mastopexy, insertion and removal of breast implants
- Canthopexy/canthoplasty
- Cervicoplasty
- Chemical peels
- Dermabrasion
- Excision of subcutaneous skin and/or subcutaneous tissue
- Gender reassignment surgery
- Genetically and bioengineered skin substitutes for wound care
- Hair transplants
- Injectable dermal fillers
- Keloid removal
- Lipectomy, liposuction, or any other excess fat removal procedure
- Otoplasty
- Rhinoplasty
- Rhytidectomy
- Scar revision
- Skin closures including:
  - Skin grafts
  - Skin flaps
  - Tissue grafts
- Surgery for varicose veins, including perforators and sclerotherapy

Experimental or investigational

Any procedure, device, or service that may be considered experimental or investigational including:

- New emerging technology/procedures, as well as existing technology and procedures applied for new uses and treatments

Day rehabilitation programs

Elective (nonemergency) ground, air, and sea ambulance transportation

Outpatient private-duty nursing

Interventional pain management services

- Epidural injection procedures and diagnostic selective nerve root blocks
- Paravertebral facet injection/nerve block/ neurolysis
- Regional sympathetic nerve block
- Sacroiliac joint injections
- Implanted spinal cord stimulators

Radiology

- Cardiac blood pool imaging or MUGA-resting or exercise
- Computed tomography (CT), cardiac
- Computed tomography (CT), coronaries
- Computed tomography angiogram (CTA), coronaries
- Magnetic resonance angiography (MRA), cardiac
- Magnetic resonance imaging (MRI), cardiac
- Myocardial perfusion imaging
- Positron emission tomography (PET) scan/ positron emission transverse tomography (PETT) scan
- Single photon emission computerized tomography (SPECT), technetium or thallium

Home-Care Services

- Enteral feeding therapy (tube feeding)
- Home health care
- Home infusion therapy
- Hospice

Prosthetics/orthoses

- Custom ankle-foot orthoses
- Custom knee-ankle-foot orthoses
- Custom knee braces
- Custom limb prosthetics including accessories/ components
- Repair or replacement of all prosthetics/orthoses that require precertification

Durable medical equipment (DME)

- Bone growth stimulators
- Bone-anchored (osseointegrated) hearing aids
- Continuous positive airway pressure (CPAP) device and bi-level (Bi-PAP) devices

- Dynamic adjustable and static progressive stretching devices (excludes CPMs)
- Electric, power, and motorized wheelchairs including custom accessories
- Insulin pumps
- Manual wheelchairs unless they are rented
- Negative pressure wound therapy
- Neuromuscular stimulators
- Power operated vehicles (POV)
- Pressure reducing support surfaces including:
  - Air fluidized bed
  - Non-powered advanced pressure reducing mattress
  - Powered air flotation bed (low air loss therapy)
  - Powered pressure reducing mattress
- Push rim activated power assist devices
- Repair or replacement of all DME items that require precertification
- Speech generating devices

Medical foods

Hyperbaric oxygen therapy

Proton beam therapy

Sleep studies (facility based)

Transplants

All transplant procedures, with the exception of corneal transplants

Mental health/serious mental illness/ substance abuse[1]

- Mental health and serious mental illness
  treatment (inpatient/partial hospitalization programs/intensive outpatient programs)
- Repetitive transcranial magnetic stimulation (rTMS)
- Substance abuse treatment (inpatient/partial hospitalization programs/intensive outpatient programs)

[1] Precertification review for this service is provided by Magellan Healthcare, Inc., an independent company.

Genetic and genomic tests requiring precertification

The following list is a guide to the types of genetic and genomic tests that require precertification. Due to the volume of tests, it is not possible to list each test separately.

Hereditary cancer syndromes

- BRCA gene testing (breast and ovarian cancer syndrome)
- Lynch syndrome gene testing
- Familial adenomatous polyposis gene testing
- PTEN gene testing (Cowden syndrome)
- General cancer type panels (such as colon, breast, or neuroendocrine cancers)

Hereditary heart diseases

- Long QT syndrome gene testing
- Aortic dilation or aneurysm syndrome testing (includes Marfan syndrome)

Other full gene analysis testing

- Cystic fibrosis full gene sequencing and deletion/duplication analysis
- PMP22 full gene sequencing and deletion/ duplication analysis (Charcot-Marie-Tooth, hereditary neuropathy)

Tests for many genetic disorders simultaneously

- Expanded carrier screening panels (such as Carrier Status DNA Insight®, Counsyl Family Prep Screen, Pan-Ethnic Carrier Screening)
- Hearing loss panels
- Intellectual disability panels
- Noonan spectrum disorders panels

Specialty oncology tests

- Cancer gene expression or protein signature tests (such as OncotypeDX®, MammaPrint®, Afirma®, Prosigna®, HeproDX™)
- Tumor molecular profiling (such as FoundationOne®, neoTYPE™, OncoPlexDx®, and many others)
- Tissue of origin testing (for cancer of unknown primary)
- PCA3 testing for prostate cancer

Pharmacogenomic tests

- Cytochrome P450 metabolism gene testing (CYP2D6, CYP2C9, CYP2C19)
- Specialized drug response gene panels (such as Assurex GeneSight®, GeneTrait, Genecept®, Millennium PGTSM)
- Warfarin response testing
- MGMT methylation analysis for glioblastoma

Other specialty tests

- Coronary artery disease risk testing (such as CorusCAD®, CardioIQ®, APOE, ACE, KIF6)
- Heart disease risk testing (such as CorusCAD®, CardioIQ®, APOE, ACE, KIF6, MTHFR)

Genome-wide tests

- Microarray studies
- Whole exome testing
- Whole genome testing
- Mitochondrial genome or nuclear testing

ANY genetic test for more than one gene or condition (often includes words like “panel” or “comprehensive” in the name)

ANY genetic test that will be billed with a non-specific procedure code

- Billed with CPT® codes 81400–81408

- Billed with an unlisted code: 81479, 81599, 84999

Specialty drugs that require precertification

All listed brands and their generic equivalents or biosimilars require precertification. This list is subject to change.

Amyotrophic Lateral Sclerosis agents

- Radicava™ (ravulizumab)
- tofersen*

Antineoplastic agents/Chemotherapy

- Abraxane® (paclitaxel protein-bound particles)
- Adcetris® (brentuximab vedotin)
- Alimta® (pemetrexed disodium)
- Alymsys® (bevacizumab) (except for ophthalmological conditions)
- Avastin®‡ (bevacizumab) (except for ophthalmological conditions)
- Azedra® (iobenguane I- 131)
- Blenrep™ (belantamab mafodotin)
- Blincyto® (blinatumomab)
- Cyramza® (ramucirumab)
- Darzalex® (daratumumab)
- Darzalex Faspro™ (daratumumab/hyaluronidase-fihj)
- Enhertu (fam-trastuzumab-deruxtecan-nxki)
- Erbitux® (cetuximab)
- Erwinaze® (asparaginase *Erwinia chrysanthemi*)
- Herceptin®‡ (trastuzumab)
- Herceptin Hylecta™ Trastuzumab
- Herzuma ® (trastuzumab-pkrb)
- Instiladrin® (nadofaragene firadenovec)
- Kadcyla® (ado-trastuzumab emtansinel)
- Kanjinti™ (trastuzumab-anns)
- Kimmtrak®(tebentafusp-tebn)
- Kyprolis® (carfilzomib)
- Lumoxiti™ (moxetumomab pasudotox-tdfk)
- Margenza™ (margetuximab)
- mirvetuximab soravtansine*
- Monjuvi® (tafasitamab-cxix)
- mosunetuzumab*
- Mvasi™ (bevacizumab- awwb) (except for ophthalmological conditions)
- Ogivri™ (trastuzumab-dkst)
- Ontruzant® (trastuzumab-dttb)
- Opdualag™ (nivolumab and relatlimab-rmbw)
- oportuzumab monatox*
- Padcev™ (enfortumab vedotin-ejfv)
- Pemfexy™ (pemetrexed)
- Perjeta® (pertuzumab)
- Phesgo™ (pertuzumab/trastuzumab/hyaluronidase-zzxf)
- Polivy™ Polatuzumab vedotin-piiq
- Poteligeo™ (mogamulizumab)
- Provenge® (sipuleucel-T)
- Riabni™ (rituximab-arrx)
- Rituxan®‡ (rituximab)
- Rituxan Hycela™ (rituximab/hyaluronidase human)
- Ruxience™ Rituximab-pvvr
- Rybrevant (amivantamab-vmjw)
- Rylaze™ (asparaginase *Erwinia chrysanthemi* [recombinant]-rywn)
- Sarclisa® (isatuximab-irfc)
- SH-111*
- Taclanits* (paclitaxel injection concentrate for suspension)
- teclistamab*
- Tivdak™ (tisotumab vedotin-tftv)
- Trazimera™ (trastuzumab-qyyp)
- tremelimumab*
- Trodelvy™ (sacituzumab govitecan-hziy)
- Truxima® (rituximab-abbs)
- Vegzelma® (bevacizumab-adcd) (excect for ophthalmological conditions)
- Xofigo® (radium Ra 223)
- Yervoy™ (ipilimumab)
- Zepzelca™ (lurbinectedin)
- Zevalin® (ibritumomab tiuxetan)
- Zirabev® (except for ophthalmological conditions)
- Zynlonta™ (loncastuximab tesirine)

Anti-PD-1/ PD-L1 human monoclonal antibodies/Chemotherapy**

- balstilimab*
- Bavencio® (avelumab)
- Imfinzi™ (durvalumab)
- Jemperli (dostarlimab-gxly)
- Keytruda™ (pembrolizumab)
- Libtayo® (cemiplimab-rwlc)
- Opdivo® (nivolumab)
- penpulimab*
- retifanlimab*
- sintilimab*
- Tecentriq™ (atezolizumab)
- tislelizumab*
- toripalimab*

Bone-modifying agents

- Evenity® (romosozumab-aqqg)
- Prolia® (denosumab)
- Xgeva® (denosumab)

Botulinum toxin agents

- Botox® (onabotulinumtoxinA)

Chemotherapy-induced nausea and vomiting (CINV) agents

- Sustol® (granisetron extended-release for injection)

Chimeric antigen receptor (CAR-T) therapies/Chemotherapy**

- Abecma™ (idecabtagene vicleucel)
- Breyanzi® (lisocabtagene maraleucel)
- Carvykti™ (ciltacabtagene autoleucel)
- Kymriah™ (tisagenlecleucel)
- Tecartus™ (brexucabtagene autoleucel)
- Yescarta™ (axicabtagene ciloleucel)

Endocrine/metabolic agents

- Acthar H.P. ® (corticotropin)
- cosyntropin depot*
- Lutathera® (lutetium Lu 177 dotatate) **/chemotherapy**
- Makena® (hydroxyprogesterone caproate)
- Sandostatin® LAR (octreotide) **/chemotherapy**
- Somatuline® depot (lanreotide) **/chemotherapy**

Enzyme replacement agents**

- Aldurazyme® (laronidase)
- Brineura™ (cerliponase alfa)
- Cerezyme® (imiglucerase)
- cipaglucosidase alfa*
- Elaprase® (idursulfase)
- Elelyso® (taliglucerase alfa)
- Fabrazyme® (agalsidase beta)
- Kanuma® (sebelipase alfa)
- Lumizyme® (alglucosidase alfa)
- Mepsevii™ (vestronidase alfa-vjbk)
- Naglazyme® (galsulfase)
- Nexviazyme® (avalglucosidase alfa)
- pegunigalsidase alfa*
- Replagal®* (agalsidase alfa)
- Revcovi™ (elapegademase-lvlr)
- Vimizim™ (elosulfase alfa)
- VPRIV® (velaglucerase alfa)
- Xenpozyme® (olipudase alfa)

Gene Replacement/Gene Editing therapy**

‡ Precertification requirements apply to all FDA-approved biosimilars to this reference product.

* Pending FDA approval.

** All drugs that can be classified under this header require precertification. This includes any unlisted brand or generic names or biosimilars, as well as new drugs that are approved by the FDA in that class during the course of the benefit year.

Specialty drugs that require precertification

(continued)

All listed brands and their generic equivalents or biosimilars require precertification. This list is subject to change.

- beremagene geperpavec*
- etranacogene dezaparvovec*
- Luxturna™ (voretigene neparvovec-rzyl)
- Roctavian* (valoctocogene roxaparvovec)
- Skysona™ (elivaldogene autotemcel)
- Zolgensma® (onasemnogene abeparvovec-xioi)
- Zynteglo® (betibeglogene autotemcel)

Hemophilia/Coagulation factors**

Hyaluronate acid products

- Cingal* (triamcinolone and Monovisc)
- Durolane®
- Euflexxa™
- Gel-One®
- Gelsyn-3™
- GenVisc 850®
- Hyalgan®
- Hymovis®
- Supartz®
- Synojoynt™
- Triluron™
- TriVisc™
- VISCO-3®

Immunological agents

- Actemra® IV (tocilizumab)
- Avsola™ (infliximab-axxq)
- Benlysta® IV (belimumab)
- Entyvio™ (vedolizumab)
- Ilumya™ (infliximab-dyyb)
- Inflectra™ (tildrakizumab- asmn)
- Infliximab (unbranded)
- Ixifi™ (infliximab-qbtx)
- Orencia® IV (abatacept)
- Remicade®‡ (infliximab)
- Renflexis™ (infliximab- abda)
- Saphnelo™(anifrolumab)
- Simponi® Aria (golimumab for infusion)
- Skyrizi ® IV*(risankizumab-rzaa)
- Spevigo® (spesolimab)
- Stelara® IV (ustekinumab)

Intravenous Immune Globulin/ Subcutaneous Immune Globulin (IVIG/SCIG)**

Multiple sclerosis agents**

- Lemtrada® (alemtuzumab)
- Ocrevus™ (ocrelizumab)
- Tysabri® (natalizumab)
- ublituximab*

Neutropenia

- efbemalenograstim*
- Fulphila™ (pegfilgrastim- jmbd)
- Fylnetra® (pegfilgrastim-pbbk)
- Lapelga*
- Neulasta®‡ (pegfilgrastim)
- Neulasta Onpro™ (pegfilgrastim body injector kit)
- Neupogen® (filgrastim)
- Nivestym™ (filgrastim-aafi)
- Nyvepria™ (pegfilgrastim-apgf)
- plinabulin*
- Releuko ™ (filgrastim-ayow)
- Rolvedon™ (eflapegrastim)
- Stimufend® (pegfilgrastim-fpgk)
- Udenyca ™ (pegfilgrastim-cbqv)
- Ziextenzo® (pegfilgrastim-bmez)

Ophthalmic agents

- abicipar*
- Beovu® (brolucizumab-dbll)
- Byooviz™ (ranibizumab-nuna)
- Cimerli™ (ranibizumab-eqrn)
- Eylea®‡ (aflibercept)
- Lucentis®‡ (ranibizumab)
- Susvimo™ (ranibizumab injection, port delivery system)
- Tepezza™ (teprotumumab-trbw)
- Vabysmo® (faricimab-svoa)

Pulmonary arterial hypertension**

- Flolan® (epoprostenol GM)
- Remodulin® (treprostinil)
- Revatio® (sildenafil)
- Trevyent* (treprostinil)
- Tyvaso® (treprostinil)
- Veletri® (epoprostenol AS)
- Ventavis® (iloprost)

Respiratory agents

- Cinqair® (reslizumab)
- Synagis® (respiratory syncytial virus [RSV], monoclonal antibody, recombinant)
- Tezspire™ (tezepelumab-ekko)
- Xolair® (omalizumab)

Respiratory enzymes (Alpha-1 antitrypsin)**

- Aralast
- Glassia™
- Prolastin®
- Zemaira®

Miscellaneous therapeutic agents

- Adakveo® (crizanlizumab-tmca)
- Ampligen®* (rintatolimod)
- Amvuttra™ (vutrisiran)
- Cosela® (trilaciclib)
- Crysvita® (burosumab-twza)
- donislecel*
- Enjaymo (sutimlimab-jome)
- Evkeeza™ (evinacumab)
- Exenatide sustained- release ITCA 650*
- Gamifant® (emapalumab-lzsg)
- Givlaari® (givosiran)
- Ilaris® (canakinumab)
- Krystexxa® (pegloticase)
- Leqvio® (inclisiran)
- narsoplimab*
- Onpattro ™ (patisiran)
- Oxlumo ® (lumasiran)
- Reblozyl® (luspatercept-aamt)
- Remune*
- Rethymic™ (allogeneic processed thymus tissue-agdc)
- Soliris®‡ (eculizumab)
- Spinraza™ (nusinersen)
- teplizumab*
- Ultomiris ™ (ravulizumab-cwvz)
- Uplizna™ (inebilizumab)
- Vyepti™ (eptinezumab-jjmr)
- Vyvgart™ (efgartigimod alfa-fcab)
- Xiaflex®

‡ Precertification requirements apply to all FDA-approved biosimilars to this reference product.

* Pending FDA approval.

** All drugs that can be classified under this header require precertification. This includes any unlisted brand or generic names or biosimilars, as well as new drugs that are approved by the FDA in that class during the course of the benefit year.

Direct ship drugs

[Direct Ship Drug Program]