

Local 734 Welfare Fund / Pension Fund

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Changes to your Prescription Drug Benefits

April 2008

To All Plan Participants:

Please read this notice carefully and keep it with your Summary Plan Description booklet (SPD) for future reference. In an ongoing effort to provide comprehensive prescription drug benefits for participants at a reasonable cost, the Trustees have made the changes described in this notice.

New Benefit Schedule for Prescription Drugs

Effective June 1, 2008, the following schedule of benefits will apply to all covered prescription drugs purchased through both the retail drug program and the mail order pharmacy:

Participant copays:

Generic drugs.....	10%
Formulary brand name drugs	20%
Non-formulary brand name drugs.....	30%
Lifestyle drugs.....	40%

Each prescription fill or refill will be subject to a \$5 minimum, and a \$200 maximum, copay.

Remember, if a brand name drug is chosen when a generic equivalent is available, the participant will be responsible for the difference in cost between the brand name drug and the generic equivalent **in addition to** the copay shown above.

Out-of-Pocket Limits:

Per person	\$3,000
Per family	\$5,000

Once the out-of-pocket limit for prescription drugs has been met during a calendar year, the Plan will pay 100% of the individual's or family's covered prescription drugs during the remainder of that calendar year.

The annual deductible that used to apply to prescription drugs was removed by the Trustees as of January 1, 2008.

A **formulary** is a list of brand name drugs that have been evaluated by physicians and pharmacists, and have been determined to be the most effective treatments for certain conditions for most patients, and have been determined to be reasonably priced.

Lifestyle drugs are drugs that are not medically necessary to treat a specific illness or injury, and an individual's health is not at direct risk if the drugs are not taken. Some examples are:

- *Erectile dysfunction drugs* such as Viagra
- *Weight-loss drugs* for participants who meet the criteria stated on page 46 of your SPD
- *Proton-pump inhibitors (PPIs)*—see the note below for restrictions on the coverage of PPIs
- *Non-sedating anti-histamines (NSAHs)*—see the note below for restrictions on the coverage of NSAHs

PPIs and NSAHs Not Covered Except for Medical Necessity

Beginning June 1, 2008, proton pump inhibitors (PPIs), such as Nexium, Prevacid and Prilosec, and non-sedating anti-histamines (NSAHs), such as Claritin and Allegra, will no longer be covered under the Plan, as these drugs can be purchased over-the-counter. In very rare instances, medical necessity may require a patient to use the prescription version instead of the over-the-counter version. Med-Care Management **must** review the necessity for these drugs and pre-authorize them *before* they are purchased. If Med-Care Management pre-authorizes a PPI or NSAH, such prescriptions will be paid the same as any other lifestyle drug. This means that the Plan will pay 60% of the drug, and you will pay 40%, subject to the \$5 minimum and \$200 maximum copays and to the out-of-pocket limits.

Med-Care Management can be contacted by calling 800-367-1934.

Remember that you can purchase a 90-day supply of prescription drugs through Walgreens stores.

Please contact the Fund Office at 773-594-2810 if you have any questions about your prescription drug benefits.