

Prescription Drug Plan

EFFECTIVE FEB. 1, 2009

PRESCRIPTION DRUG PLAN



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- **CARD PROGRAM - MEDCO HEALTH SOLUTIONS**
 - Obtain drugs at any participating pharmacy
 - 30-day supply or 100 unit doses (whichever is less)
 - Co-payments:
 - Tier I (Generic) \$5.00
 - Tier II (Preferred Brand) \$15.00
 - Tier III (Non-Preferred Brand) \$35.00
- **RETAIL MAINTENANCE NETWORK PHARMACY PROGRAM (MEDCO)**
 - Obtain drugs at any participating pharmacy
 - 90-day supply or 100 unit doses of maintenance drugs (whichever is greater) after two (2) refills
 - Co-payments:
 - Tier I (Generic) \$10.00
 - Tier II (Preferred Brand) \$40.00
 - Tier III (Non-Preferred Brand) \$80.00
- **MEDCO BY MAIL**
 - Obtain maintenance drugs by mail
 - 90-day supply or 100 unit doses of maintenance drugs (whichever is greater) after two (2) refills
 - Co-payments:
 - Tier I (Generic) \$10.00
 - Tier II (Preferred Brand) \$30.00
 - Tier III (Non-Preferred Brand) \$70.00
- **COST CARE PROGRAM**

For members who exceed \$1,200.00 per year in prescription costs, this program allows members and their dependents to obtain medication in a cost-effective manner.
- **NYC PICA DRUG PROGRAM**

Injectible and Chemotherapy drugs with a \$100 annual deductible. For Information, call 800-467-2006.

IMPORTANT INFORMATION

FORMS HOTLINE: 212-539-0539

WEBSITE ADDRESS:

WWW.UFTWF.ORG

MEDCO MEMBER SERVICES:

800-723-9182

MEDCO BY MAIL:

800-723-9182

WEBSITE ADDRESS:

WWW.MEDCO.COM

ACCREDITO: 800-501-7260

PRESCRIPTION DRUG PLAN

**The UFT Welfare Fund Prescription Drug Plan
is administered by:**

**Medco Health Solutions, Inc.
100 Parsons Pond Dr., E2-2
Franklin Lakes, NJ 07417-2603
800-723-9182**

Who is covered and when?

All in-service covered members and eligible dependents, as defined in the General Information section, are covered for prescription drug benefits. **FOR RETIREES:** Eligibility for the drug program continues for the month in which you retire or leave on deferred payability plus two (2) months. For example, if you retire February 15, your drug coverage will continue through the end of April.

What types of prescriptions are covered?

- Prescriptions for legend drugs (drugs that can be dispensed only by a prescription). These drugs must be for specific use(s) as approved by the Food and Drug Administration (FDA), and obtained at a pharmacy. These usages, referred to as "labeled" uses, include conditions, periods, dosage schedules, etc. for all drugs monitored by the FDA and printed in the manufacturer's monograph and established industry references as recognized by the Fund. However, the Fund's Medical Advisor may require a medical justification in order to give authorization for coverage or continued coverage of a particular drug.
- Prescriptions which require compounding and include an approved therapeutic dose of a legend drug.
- Enteral Formulas.

**For information covering
intravenous/infusion therapy, contact your
basic health carrier.**

What is the UFT Welfare Fund/Medco Prescription Drug Identification (ID) Card?

Each eligible member is issued an UFT Welfare Fund/Medco Prescription Drug Identification (ID) Card authorizing any participating pharmacy to fill prescriptions that come under the scope of the plan. The plastic

card is embossed with an alternate ID number (other than your Social Security Number) and the member's name. Dependents names do not appear on the card.

The member receives two (2) cards. Additional cards are available upon request to the Welfare Fund.

New members will be issued cards automatically, provided a properly completed Enrollment Form has been submitted to the Welfare Fund.

It is the responsibility of the member to update all dependent information.

When does eligibility for prescription drugs terminate?

The front side of the ID card states: "CARD NOT VALID AFTER EMPLOYMENT TERMINATES OR AFTER RETIREMENT*."

* Eligibility for the drug program continues for the month in which you retire, or leave on deferred payability, plus two (2) months. For example, if you retire February 15, your drug coverage will continue through the end of April.

Members who leave on deferred payability should notify the Welfare Fund by submitting their retirement system letter.

Please note: Members on leave with pay are considered to have in-service status. Members on leave without pay do not have coverage unless covered by SLOAC.

Is there an annual maximum for the drug benefit?

Yes. Benefits are limited to a \$100,000.00 maximum per family per calendar year, based upon the date the prescription was dispensed. For UFT Welfare Fund members and their spouse/domestic partner who are also in-service UFT Welfare Fund members (SCOB), this total is \$200,000.00. These members must notify the Fund of this relationship in order for the \$200,000.00 total to be applied.

What is the Prescription Benefit Record (PBR)?

Every December, a Prescription Benefit Record (PBR) is sent to all members with information regarding:

- each prescription drug obtained;
- where it was obtained;

- address and dependent information (e.g., name, date of birth...);
- for whom it was prescribed;
- cost to the Fund;
- how much can be saved by utilizing generic drugs;
- co-payments incurred.

If you discover any discrepancies in any of the above items, contact the Fund Office by indicating the discrepancy directly on the PBR and returning it to the Fund.

How are benefits obtained?

Members may obtain benefits by using any of the following:

- a participating pharmacy network; **or**
- mail order service; **or**
- direct reimbursement.

What is direct reimbursement?

Under direct reimbursement, you are required to pay for the full cost of the drug and then submit to the Fund for payment. Reimbursement is made according to the fee schedule or the actual charge, whichever is less. This may arise in the following situations:

- you present a prescription to a participating pharmacy without your UFT Welfare Fund/Medco Prescription Drug Identification (ID) Card; **or**
- the prescription is for a non-listed dependent; **or**
- you use a non-participating pharmacy.

In these cases, the pharmacist is allowed to charge the store's regular price.

How am I reimbursed?

In order to receive any reimbursement, you must submit a UFT Welfare Fund *"Prescription Drug Reimbursement Form for In-Service Members"*. The form is available at the UFT Welfare Fund website www.uftwf.org or by calling the UFT Welfare Fund Forms Hotline at 212-539-0539. You must complete and sign the form and attach detailed paid pharmacy receipts, showing the name, strength, and quantity of drug.

The completed form should be mailed to the UFT Welfare Fund at the address preprinted on the form, within ninety (90) days from the date the drug was dispensed.

Reimbursement will be made in accordance with the schedule of allowances limited to the same quantity and

package rules, less the co-payment that is applicable to participating pharmacies. This will most likely result in an out-of-pocket expense to you, which is in addition to the co-payment.

Reimbursement for Controlled Substances is limited to the quantities mandated by federal, state, or local laws for controlled substances in the jurisdiction in which the prescription is written.

What is the diabetes program?

In 1994, a mandatory diabetes program was legislated by New York State law. The law states that all basic health carriers must cover all drugs, ancillary devices and have a diabetes management educational program for all patients. Since the Welfare Fund supplements your basic city health plan, it was no longer necessary for the Fund to cover these items.

The Welfare Fund has instituted a procedure to reimburse you for the difference in drug co-payments between your basic health carrier and the UFT Welfare Fund.

For reimbursements, you should submit a *“Prescription Drug Reimbursement Form for In-Service Members”* completely filled out with all pharmacy receipts attached and/or a statement from your basic health carrier that they have paid or denied the claims. The form is available at the UFT Welfare Fund website **www.uftwf.org** or by calling the UFT Welfare Fund Forms Hotline at 212-539-0539.

Members will only be reimbursed for co-payment amounts over the applicable UFT Welfare Fund co-payment.

What is the NYC PICA program?

Due to a negotiated citywide health benefit agreement, the PICA Drug Program, rather than the UFT Welfare Fund, covers two (2) categories of drugs, Injectible and Chemotherapy. For more information regarding this program call Express Scripts, their administrator, at 800-467-2006 or visit the UFT Welfare Fund website **www.uftwf.org**.

What is meant by Enteral Formula Coverage?

Enteral formulas are liquid food products that are specially formulated and designed to increase the amount of various food elements and nutrients that will maintain proper physiological function of the body process. They may also be used to correct an existing deficiency.

The New York State law regarding coverage of enteral formulas is not applicable to the Welfare Fund. However, we will cover these formulas providing the following guidelines are met:

1. Members requesting access to these formulas will be subject to the Fund's prior approval process, **which must be renewed every January.**
2. The formulas are for ORAL home use and has been prescribed by a physician or other legally authorized health care provider. These formulas are distinguished from nutritional supplements taken electively. They are not covered if they are administered via nasogastric tube, via feeding gastrostomy or via needle-catheter jejunostomy since the patient's health insurance plan usually covers it with prior authorization. The patient should contact their health plan.
3. The patient's physician must send a letter of medical necessity to the Welfare Fund's Pharmacy program that states that the enteral formula is clearly medically necessary. This means that the formula has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic disability, mental retardation, or death.
4. The formulas must be for specific diseases, which include, but are not limited to:
 - inherited diseases of amino-acid or organic acid metabolism;
 - Crohn's disease;
 - gastroesophageal reflux with failure to thrive;
 - disorders of gastrointestinal motility such as chronic intestinal pseudoobstruction;
 - multiple severe food allergies.
5. Coverage for a calendar year for any insured individual shall not exceed two thousand five hundred dollars (\$2,500.00).
6. Quantities are limited to 30-day supplies per dispensing and are considered non-preferred brand (Tier 3) for co-payment purposes. (See chart under Drug Program Design).

Cost Care Program

What is the Cost Care Program?

The Cost Care Program allows members and their dependents to obtain medication in a cost-effective manner, while maximizing the resources available to the Fund.

Who is enrolled in the Cost Care Program?

Families whose combined prescription drug claim benefits totaled in excess of \$1,200 during the past twelve (12) months (December through November) will be enrolled in this program. For members and their in-service spouse/domestic partner who are also members (SCOB), this total is \$2,400. These members must notify the Fund of this relationship in order for the \$2,400 total to be applied.

How do I verify the costs of my prescription drugs?

Your utilization is reflected on the PBR explained previously. The dates used to determine your eligibility in the Cost Care Program are the dates listed in the column headed "Prescription Date".

How long will I be in the Cost Care program?

That all depends on your drug expenditures. The Welfare Fund will review your claim experience every twelve (12) months. If your costs fall below \$1,200.00 (or \$2,400.00 if your spouse/domestic partner is also an in-service member) you will be re-enrolled in the regular prescription drug plan.

How is the Cost Care Program different?

The program differs in two (2) ways:

1. You will receive a Prescription Drug ID card that will have the words "Cost Care Program" printed on the front.
2. Mandatory Generic Price Provision - When a brand name prescription drug has an approved generic equivalent, you can still get the brand name drug. However, you will be responsible for the difference between the cost of that brand name drug and the cost of the generic equivalent. This is known as an "ancillary" charge. This charge is in addition to the applicable co-payment. Therefore, in order to avoid this ancillary charge, ask your prescriber to write prescriptions generically whenever possible.

What is a generic drug?

A generic drug is one that is defined by its official chemical name, rather than its advertised brand name. Generic

equivalent drugs must meet the same U.S. Food and Drug Administration (FDA) regulations for purity, strength, and safety as brand name drugs; they just cost less.

What if my prescriber insists on a brand name drug?

The Fund has established a procedure whereby members may seek a waiver to its Mandatory Generic Price Provision. Any member seeking such an exception may do so by having a “*Generic Price Waiver Form*” completed in full by the member and his or her physician. The form is available at the UFT Welfare Fund website www.uftwf.org or by calling the UFT Welfare Fund Forms Hotline at 212-539-0539. (In lieu of the form, a physician’s letter will suffice.)

The Fund’s Pharmacist and Medical Advisor, whose decision will be based upon specific medical criteria, other available medications, and other pertinent information, will review each request. Members will be notified by mail as to whether an exception can be made to have the Fund pay for a brand name drug where a generic equivalent exists.

If there is a generic drug available, how will I be charged if I obtain a brand name at a pharmacy?

The Welfare Fund pays only for the cost of the generic drug. You are responsible for the difference (known as an “ancillary” charge) between the generic’s price and the brand name’s price, plus the co-payment. Medco determines this “ancillary” charge, according to their contractual arrangement with the pharmacies.

Drug Plan Design

There are three “tiers” of drugs in the plan. What does that mean?

Every drug is classified as either a generic drug (Tier 1), a preferred brand drug (Tier 2) or a non-preferred brand drug (Tier 3).

Are the co-payments different for each tier?

Yes. Here is a chart showing the co-payments for each tier:

Category	Tier #	Retail Pharmacy Co-payment (30 day supply)	Medco By Mail Pharmacy Co-payment (90 day supply)	Retail Maintenance Pharmacy Co-payment (90 day supply at a local network pharmacy)
Generic	1	\$5	\$10	\$10
Preferred Brand (Formulary)	2	\$15	\$30	\$40
Non-Preferred Brand (Not on Formulary)	3	\$35	\$70	\$80

Is there an annual maximum for co-payments?

Yes. There is a maximum out-of-pocket expense of \$1,000.00. After a family has reached the \$1,000.00 in co-payments, no further co-payments will be collected except for those drugs obtained in Tier 3 where you are responsible for the appropriate co-payment.

Please note: if you were in the Cost Care program, you would also be responsible for the ancillary charges as explained above.

What is a preferred brand (formulary) drug?

A formulary is a list of approved medications created by a committee of doctors and other health care professionals for your pharmacy benefit plan. The formulary includes all generic drugs and select brand-name medications.

There is a preferred brand drug (Tier 2) for most medical conditions. If your physician prescribes a brand-name drug for your particular condition — either because there is no generic or there is a special reason your physician wants to use the branded drug — and if it is on this list, then you will pay the Tier 2 co-payment.

What is a non-preferred (non-formulary) brand drug?

Any brand-name drug not listed on the formulary is considered a non-preferred drug (Tier 3). Your co-payments are higher since there are more cost-effective alternatives that are on the formulary to treat your condition. You would continue to pay co-payments after you reached the \$1,000.00 maximum out-of-pocket if your physician prescribes Tier 3 drugs.

If I am currently using a non-preferred brand drug, how can I switch to a preferred or a generic drug?

Speak to your doctor about your medication and discuss the options. Then your doctor can choose a brand or generic from the preferred formulary list and either call-in or write you a new prescription.

Participating Retail Pharmacy Program

In order for you to obtain prescription drugs at a participating pharmacy, simply present the prescription and your UFT Welfare Fund/Medco Prescription Drug Identification (ID) Card to the pharmacist. You will be required to make an out-of-pocket payment (co-payment) toward the cost of the drug. The co-payments are listed in the table above.

Please note: You must always pay the co-payment or the calculated fee schedule, **whichever is less**. For example, if the calculated fee schedule price of your preferred brand prescription is \$12.57, then you will pay \$12.57 instead of \$15.00 (the usual co-payment).

Refills authorized on the original prescription can be obtained (subject to the quantity and time period limitations described below) by presenting your prescription ID card together with the Rx number to the participating pharmacy that filled the original prescription. However, another co-payment will be necessary.

In both cases mentioned above, you must sign, where mandated by law, either a logbook, *or* an electronic signature log verifying the receipt of medication.

Participating pharmacies have both an agreement with, and a computerized link to Medco. If you need to locate a participating pharmacy, you may call 800-723-9182 or obtain the information from their website at **www.medco.com**. There are over 56,000 participating pharmacies located throughout the U.S.

What quantities are permitted at a participating pharmacy?

Participating pharmacies are authorized to dispense, when permitted by law, up to a 30-day supply or 100 unit doses, whichever is less. In addition, if permitted by law, the participating pharmacies are authorized to dispense a **maximum** of two (2) refills, if indicated on the prescription, within one (1) year *from the date the prescription is written, regardless of the number of refills indicated by the prescriber.*

Medco By Mail
Medco Health Solutions of Fort Worth
P.O. Box 650322
Dallas, Texas 75265-0322
800-723-9182

Mandatory Maintenance Drug Program

Maintenance medications (those taken regularly over an extended period) cannot be filled in monthly quantities after they have been filled three (3) times (original prescription plus two (2) refills), regardless of the number of refills indicated on the prescription. After the second refill, to continue using the drug, you must use either of the following options:

- Medco By Mail Pharmacy **or**
- The Retail Maintenance Network Providers. (The co-payments are higher for brand name drugs if you use this option rather than sending away to the Medco By Mail Pharmacy.)

Examples of maintenance drugs are drugs prescribed for high blood pressure, birth control, high cholesterol, anxiety, arthritis, asthma, and depression.

How is this requirement going to save me money?

The Medco By Mail Pharmacy program is designed, through bulk buying discounts and rebates, to provide substantial savings to the Fund and the convenience of receiving prescription drugs at home for a lower co-payment to the member. Look at the following example:

If you take one pill per day of a preferred brand-name formulary drug (Tier 2), you can get a one-month supply at a retail pharmacy for \$15. Filled three times, for 90-days worth of drugs, your cost is \$45.

By utilizing the Medco By Mail pharmacy, your cost for the same medication for the same 90 days is \$30.

By utilizing the retail maintenance network option, your cost for the same medication for the same 90 days is \$40.

Not only is either option more convenient, it also saves you money in every instance.

How does the Medco By Mail program work?

It is very simple. Just mail original prescriptions in the postage paid envelope along with a completed Order

Form to the Medco By Mail Pharmacy. Both are available from your Chapter Leader, the Welfare Fund, or Medco.

Must I use the Medco By Mail Order Form to send in prescriptions?

The Order Form is provided only as a convenience, however it will expedite your order. If you choose not to use the form (which is available on the www.uftwf.org and www.medco.com websites), you must indicate your ID number and group number copied from the UFT Welfare Fund/Medco Prescription Drug Identification (ID) Card.

Must I use the Medco By Mail Pharmacy postage-paid envelope to send in prescriptions?

The envelope is provided only as a convenience. Whether you use it or your own, what must be clear to Medco By Mail Pharmacy is the address where you would like the drugs to be sent. If you do not indicate an address, your prescriptions will be sent to the address listed on the Welfare Fund's database.

How much time should I allow for my prescriptions to be delivered and what will be included with my order?

Prescriptions are filled within 48 hours; however, you must allow delivery time both ways. Your medication will be delivered to your home or to any location you request within 10-14 business days by first class mail or United Parcel Service (UPS).

Accompanying your medication will be:

- a Medco By Mail Order Form and envelope to order your refill(s) and/or future prescription(s); **and**
- a "Product Information" sheet, which has useful information regarding your medication(s); **and**
- an invoice that can be used as a paid receipt; **and**
- a Doctor Fax Form if you have no refills left and your physician would like to continue to prescribe the same medication.

Is there a limit to the number of prescriptions I can send in?

No. There is no limit to the number of prescriptions that can be included in one envelope.

What do I have to pay for my medications?

You will be required to make an out-of-pocket payment (co-payment) toward the cost of the drug until you reach the annual \$1,000.00 maximum out-of-pocket expense limit. The co-payments are:

- \$10.00 for Generic drugs (Tier 1)
- \$30.00 for Preferred Brand drugs (Tier 2)
- \$70.00 for Non-Preferred Brand drugs (Tier 3)

After you reach \$1,000.00 in co-payments, no further co-payments will be collected, except for those drugs obtained in Tier 3 where you are responsible for the appropriate co-payment of \$70.00.

Please note: If you were in the Cost Care program, you would also be responsible for the ancillary charges.

You must always pay the co-payment or the calculated fee schedule, **whichever is less**. For example, if the calculated fee schedule price of your Preferred Brand prescription is \$23.00, then you will pay \$23.00 instead of \$30.00 (the usual co-payment).

I have prescriptions on file at my local pharmacy. Can they be transferred?

No. Prescriptions on file at a local retail pharmacy cannot be transferred. In addition, telephone prescriptions and photocopies cannot be accepted.

What quantities are permitted through the Medco By Mail Pharmacy?

Medco By Mail Pharmacy is authorized to dispense up to a 90-day supply, 100 unit doses, or multiple package sizes, whichever is greater, with up to three (3) refills regardless of the number of refills indicated on the prescription by the physician, within one (1) year from the date the prescription was written. If further medication is necessary, a new prescription must be obtained from the patient's prescriber.

Can I use Medco By Mail Pharmacy for drugs in all three tiers?

Yes, if they are maintenance drugs. Medco By Mail Pharmacy program fills prescriptions for maintenance drugs for members for any generic or brand name drugs — Tiers 1, 2 or 3 — through the mail. The telephone number is 800-723-9182 and the Web site is www.medco.com.

When should I not use Medco By Mail Pharmacy?

Drugs used for short periods and/or drugs that must be started immediately. These are called acute drugs. Examples include antibiotics and drugs used in emergencies.

NOTE: CONTROLLED SUBSTANCES OR OTHER MEDICATIONS, WHEN MANDATED BY LAW OR THE FDA, WHICH YOUR PHYSICIAN MUST ORDER MONTHLY, SHOULD BE ORDERED FROM YOUR LOCAL PHARMACY AND NOT AT THE MEDCO BY MAIL PHARMACY.

I only use brand name drugs. Can I get them through this service?

Yes. However, members who belong to the Cost Care Program must pay the difference between the cost of the brand name drug and the generic (known as the ancillary charge), if one is available, in addition to the applicable co-payment.

I have many prescriptions. How do I know how much to make my check out for?

The formulary list can be used as a guide to determine how much your co-payment will be for Medco By Mail.

- Medications that are listed in lower case letters are generic medications and have the lowest co-payment (Tier 1).
- Medications that are listed in capital letters are preferred brand medications and have the middle co-payment (Tier 2).

If your medication does not appear on the formulary, or you have any questions or concerns, call Medco's Customer Service at 800-723-9182. A representative will verify your co-payment. You can also check your co-payments on-line at www.medco.com.

Since I am in the Cost Care program, how will I be charged for a brand name drug ordered through the mail when a generic is available?

You will receive a bill for the difference between the brand name and its generic equivalent when you receive your prescription(s). It is important that this bill be paid to Medco By Mail Pharmacy within ten (10) days of receipt.

Does Medco By Mail Pharmacy accept credit cards?

Yes. In fact, if you wish, the company will keep your credit card information on file to make payment easier.

Suppose I have questions about an interaction with other medication(s) that I am taking, or possible reactions to the medication itself?

Your doctor should alert you to possible reactions and should know other medications you are taking for possible interactions. However, if you ever have a question of that nature, Medco By Mail Pharmacy always has a pharmacist on duty 24 hours a day/seven days a week.

You may also visit www.medco.com for information about interactions and side effects.

How do I get an Order Form and/or postage-paid envelope?

You will receive one every time you receive an order from the Medco By Mail Pharmacy. The forms and envelopes are also available:

- from your chapter leader; **or**
- by calling the Welfare Fund's Hotline at 212-539-0539, which operates 24 hours a day, seven days a week; **or**
- by calling the Welfare Fund during business hours at 212-539-0500; **or**
- by calling the Medco hotline at 800-723-9182 — also open 24 hours a day, seven days a week.

Can I have my drugs shipped anywhere?

Anywhere in the U.S., but due to different rules and regulations in other countries, medications cannot be shipped abroad. You can have the medication shipped to your place of business, your spouse's/domestic partner's place of business, your dependent's college dorm, etc., as long as it is in the United States.

Just be sure to clearly indicate the address where you want the medications to go when you send in your prescriptions or refill form. If you do not indicate an address, your prescriptions will be sent to the address listed on the Welfare Fund's database.

I was just prescribed a new medication that my physician wants me to start right away and I will be using it for a length of time. How can I best utilize the program?

Ask your physician for two prescriptions. The first should be written for a 30-day supply and should be taken to your local pharmacy, where you will use your drug ID card. The second prescription should be written for a 90-day supply, or 100 unit doses, whichever is larger, and you should immediately mail it to Medco By Mail.

How can I be sure that I will not run out of a medication before my refill arrives?

While you receive a three-month supply of medication, refills may be ordered after two months. Therefore, if at the start of the third month you reorder your medication(s), you will be sure not to run out.

How do I order refills?

This can be done three different ways:

- 1- The fastest way is by using the Medco Web site (www.medco.com); **or**
- 2- The next fastest way is to use the automated touch-tone refill system by calling 800-473-3455 and follow the instructions; **or**
- 3- You may also put the refill slip that came attached to your statement along with a check (or fill in the credit card information) into the postage-paid envelope — or any stamped envelope — and mail it.

Is the Medco By Mail Pharmacy unionized?

Yes. In the Texas Medco By Mail Pharmacy, the pharmacists and other employees are members of the United Steel Workers union.

Retail Maintenance Network Pharmacy Program

This is an added benefit requested by many members. At a local pharmacy that has elected to participate in this retail maintenance network program, you will be able to fill a prescription of a maintenance drug for a 90-day supply or 100 dosage units, whichever is greater. You may bring in your prescription or your physician may call it in.

How can I tell if my local pharmacy participates in this Retail Maintenance Network Program?

On the Medco website (www.medco.com), after you log in, on the left side of the screen under “Prescriptions & Benefits” there is a link to “Locate Pharmacy”. All you have to enter is your zip code or city and state. The UFT Welfare Fund’s website (www.uftwf.org) includes a listing of pharmacies for the metropolitan area. However, this list is constantly being updated and the best way to find out if your particular pharmacy participates would be to call the toll free Medco number 800-723-9182 to inquire.

What quantities are permitted at a participating Retail Maintenance Network Pharmacy?

A participating Retail Maintenance Network Pharmacy is authorized to dispense up to a 90-day supply, 100 unit doses, or multiple package sizes, whichever is greater, with up to three (3) refills regardless of the number of refills indicated on the prescription by the physician, within one (1) year from the date the prescription was written. If further medication is necessary, a new prescription must be obtained from the patient's prescriber.

Can I use a participating Retail Maintenance Network Pharmacy for drugs in all three tiers?

Yes, as long as they are maintenance drugs.

I only use brand name drugs. Can I get them through this program?

Yes. However, members who belong to the Cost Care Program must pay the difference between the cost of the brand name drug and the generic, if one is available, in addition to the applicable co-payment.

Prior Authorization Program

What exactly is the Prior Authorization Program?

This program covers certain drugs that require special action by your physician before you can have a prescription for them filled through the Welfare Fund. These drugs

all have **[PA]** next to them on the formulary list. For any of these “PA” drugs, your physician should call Medco and may be asked to mail or fax both a Letter of Medical Necessity and a diagnosis to Medco.

Step Therapy Program

What is Step Therapy?

This is a program that encourages the use of the best medication for your condition. It applies to **first-time users** of drugs in certain categories. Some examples of these categories include psychotropic, asthma, PPI (heartburn and ulcer), hypertension, and cholesterol.

Under this program, when you start on one of these medications you must first try a well-established treatment that is known to be safe and effective. This is called “first-line therapy,” and it is the preferred therapy for most people. It also usually has the lowest co-payment.

If your doctor has found the first-line drug has not been very successful for you, he or she may request a second-line therapy. However, no second-line therapy will be approved unless the first-line therapy has been tried.

How do I know which medications require Step Therapy?

All Preferred medications that have an indication of **[STP]** next to them on the formulary list will require Step Therapy.

Accredo Health Group, Inc. Medco’s Specialty Pharmacy

What is Accredo?

Accredo is Medco’s specialty pharmacy. The list of medications subject to this specialty drug program may change, and you should check the list before you fill a prescription for a specialty medication. Due to the special handling of these medications, a Patient Care Advocate (PCA) will assist you with expedited, scheduled delivery at no additional charge.

What are the quantities allowed and the co-payments?

Due to the nature of these specialty medications, Accredo will only dispense a 30-day supply with the following co-payments:

- Tier 1 – \$10
- Tier 2 – \$30
- Tier 3 – \$70

Accredo will contact you after the first one of these medications has been filled at your retail pharmacy in order to co-ordinate future refills on that medication.

How do I know which medications will be handled by Accredo?

All Preferred medications that have an indication of **[AC]** next to them on the formulary list will be handled by Accredo.

If I have any additional questions, where can I get them answered?

- You can call the Medco Customer Service number at 800-723-9182 24 hours a day, seven days a week.
- You can call the Welfare Fund office at 212-539-0500 during business hours.
- In addition, information is also available at **www.uftwf.org** and **www.medco.com**.

What is not covered under the Prescription Drug Plan?

- Legend drugs that are also available over-the-counter, regardless of strength variations.
- Drugs, including vitamins, foods, diet and nutritional supplements, homeopathic and natural medicines, etc. which legally can be purchased without a prescription, even if a written prescription is obtained from a prescriber.
- Drugs used for cosmetic purposes.
- Drugs used for hair growth.
- Drugs covered under the NYC PICA program (Injectible and Chemotherapy medications for members with a NYC health plan.)
- Drugs used for the treatment of diabetes.
- Appliances, devices and other companion implements used in the administration of drugs.*
- Prescriptions not dispensed by licensed pharmacists in a retail pharmacy unless authorized by the Fund.
- Experimental or investigational drugs.
- Legend drugs for unapproved (unlabeled) uses(s).
- Immunization agents**, biological sera, blood or plasma unless authorized by the Fund.

- Diagnostic drugs.
 - Prescriptions covered without charge under federal, state, or local programs, including Worker's Compensation.
 - Any charge for the administration of a drug.
 - Unauthorized refills.
 - Medication for an eligible person confined to a rest home, nursing home, sanitarium, extended care facility, or similar entry, unless preauthorized by the Fund.
 - Drugs filled in a foreign country, unless required by an eligible person in an emergency, and the drug would otherwise be a legend drug in the US, covered by the Fund, and payment is approved by the Fund.
 - Direct claims if they are presented for payment later than ninety- (90) days from the date on which the drug was dispensed unless authorized by the Fund.
 - Direct claims for enteral formulas if bought at a non-pharmacy and/or bought before prior approval was obtained.
- * The Welfare Fund's Prescription Appliance Benefit covers many of these items for HIP PRIME and HIP PRIME POS enrollees. GHI-CBP and all other health plans cover many of these items in their basic coverage. Check with your individual plan for details.
- ** Your basic carrier covers Immunizations for dependents up to the age of 19. Check with your individual plan for details.

Is there COB under the Prescription Drug Program?

Yes. If the primary coverage of the spouse/domestic partner of the Fund member is under another prescription drug plan (which must be used first), then the spouse/domestic partner may submit for reimbursement of his/her co-payment or any other out-of-pocket co-insurance required by his/her primary carrier. Here too, all plan parameters will apply, i.e., members will only be reimbursed for co-payment amounts over the applicable UFT Welfare Fund co-payment. Computer printouts, computerized paid receipts from pharmacies, direct reimbursement forms showing proof of other carrier payment, or other similarly marked "coordination of benefits" should be sent to the Fund office.

In the event the primary plan of the spouse/domestic partner does not cover a prescription drug, which is otherwise covered by the UFT Welfare Fund, then the Fund will reimburse the UFTWF member for the spouse/domestic

partner prescription, up to a maximum of the UFTWF Prescription Drug Program Schedule of Allowances.

SCOB (Special Coordination of Benefits)

SCOB for prescription drugs is only available to in-service members and their in-service spouse/domestic partner.

Under Special Coordination of Benefits, the maximum annual benefit per family per calendar year is \$200,000.00, provided both members are in-service.

For Cost Care determination, \$2,400.00 is used instead of \$1,200.00.

How do I obtain claim forms or additional information?

Call or write to the United Federation of Teachers Welfare Fund. For forms, call the Forms Hotline, 212-539-0539. For other information, call 212-539-0500. Information and most forms are available on our website at www.uftwf.org.

The UFT Welfare Fund will take appropriate action to recover from the member, any monies paid out on behalf of or to, members/dependents for prescriptions obtained after eligibility terminates and for drugs used for non-approved or unlabeled uses.

