
Prescription Drug Plan

This section is the Summary Plan Description for the Prescription Drug Plan and explains the key provisions of the Plan. For information about eligibility for benefits or when benefits may end, see the Eligibility and Enrollment section or call the Benefit Fund at the telephone numbers shown below. For information about appealing denied claims or about your rights (if any) to continue coverage after it ends under the Consolidated Omnibus Budget Reconciliation Act (COBRA), see the "Plan Information and Rights" section.

IMPORTANT TELEPHONE NUMBERS

THE BENEFIT FUND

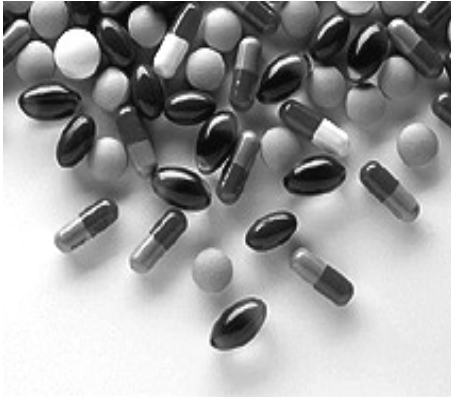
In Philadelphia	215-735-5720
Outside Philadelphia	1-800-531-1199

Prescription Drug Plan

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Prescription Drug Plan



Who Is Eligible and When

See the *Eligibility and Enrollment* section for eligibility requirements for you and your dependents.

Wage Class II and III members are not eligible for Prescription Drug Plan coverage.

Other Coverage

If your spouse or your dependents have primary coverage through another source, such as prescription drug coverage provided by your spouse's employer, your dependents must first submit claims to the other plan and then to this plan. Benefits paid by this Plan will be coordinated with your other coverage. When coordinating benefits with the Fund's plan, submit an Explanation of Benefits (EOB) statement from the other plan and a Benefit Fund claim form to:

The Benefit Fund
1319 Locust Street
Philadelphia, PA 19107

See "Coordination of Coverage" in the *Eligibility and Enrollment* section for more information.

Enrolling and Effective Date

You must fill out a Fund Enrollment Form and provide your dependent information (if any) before prescription drug coverage will take effect. Coverage will take effect as described in the *Eligibility and Enrollment* section. Forms are available from the Benefit Fund Office.

Identification Card

Once your enrollment is processed, you will receive one Prescription ID card from Medco Health (two for family coverage). You will need your ID card when you fill prescriptions at a retail pharmacy. If you use the mail order system to fill prescriptions, you will need the member number from the ID card to access the ordering system.

Changing Your Coverage

To keep your coverage up to date as required by Plan rules, you should call the Benefit Fund to make changes. See the *Eligibility and Enrollment* section of this booklet for a list of the events for which you must call the Benefit Fund.

How the Prescription Drug Plan Works

Benefits for prescription drugs are provided through Medco Health. There are two ways to receive prescriptions in this plan:

- **Retail Pharmacies**—For medications that you will take for 34 days or less, such as an antibiotic, use a participating Medco Health retail pharmacy.
- **Mail-order**—For medications over a 34-day supply that you take on an ongoing basis, such as high blood pressure medication, and for *all refills*, you **must** use the mail-order program.

***Prescriptions obtained from non-Medco Health pharmacies are not covered.
You are responsible for the full
cost of prescriptions at non-participating pharmacies.***

What You Pay

There are two forms of many prescription medications—the brand-name form and an equivalent, called the generic form. A generic drug is a prescription drug that is chemically equal to a brand-name drug, contains the same ingredients, and must pass similar testing requirements as the brand-name form. Yet, the generic form costs significantly less than the brand-name.

Under the Medco Health prescription drug plan, you pay a \$5 copayment for generic drugs and a \$10 copayment for brand-name drugs. The brand-name copay applies even if a generic is not available.

***If there is a generic form of your medication, and you request
the brand-name form, you will pay the difference in cost
between the generic cost and the brand-name cost.***

If You Require a Brand-Name Drug

If you or your covered dependent must take a brand-name drug that is medically necessary and prescribed by a licensed physician, you should submit a request for waiver of the generic requirement to the Benefit Fund. This form is available from the Benefit Fund Office.

The Plan Administrator will review your request. If it is approved, you will be granted a waiver, and you will not have to pay the difference in cost between the generic and the brand-name drug.

Using the Prescription Drug Plan

Covered Drugs

The Prescription Drug Plan covers legend drugs or medicines that require a prescription from a licensed medical physician, osteopathic physician, dentist, or podiatrist. The prescription drug must be for:

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- a United States federal legend drug (one for which U.S. Federal law requires a prescription),
 - a state restricted drug,
 - a prescription medication that requires compounding,
 - insulin or
 - oral contraceptives (Federal legend drugs only)

Using Retail Pharmacies

For short-term medications of 34 days or less, go to a participating Medco Health pharmacy. To find a pharmacy near you, simply call the member services number shown on your ID card. The Plan will not pay any benefits for prescriptions filled at pharmacies that **do not** participate in the Medco Health network.

Show the pharmacist your ID card, and the pharmacy will fill your prescription. If there is a generic form of your medication, you will receive it for the lower copayment of \$5. If you request the brand-name form, you will pay the difference in cost between the generic and the brand-name.

No benefits will be paid for prescriptions filled at pharmacies that do not participate in the Medco Health program. Also, you must use the mail-order program for prescriptions that you need to take for more than 34 days up to as many as 90 days and for all refills.

For Maximum Savings, Remember Your ID Card

If you forget your ID card, you must pay the **full cost** of the prescription (not the Medco Health discounted rate). After you submit a claim form and receipt to Medco Health, you will be reimbursed for the cost of the generic form (if available) at the Medco discounted rate. You are responsible for any charges above that amount. This means that you will pay more for each prescription if you forget your ID card—so be sure to keep it with you.

If you need to submit a claim, request a claim form from Medco at 1-800-711-0917 or online at www.medco.com.

The Medco Health mailing address to send itemized receipts and claims forms to is on your ID card.

Call 1-800-711-0917 or go online to www.medco.com if you need a claim form.

Using the Mail Order Program

Many members and their dependents need to take certain medications on an ongoing basis (such as medicine for high blood pressure, diabetes, allergies, or stomach problems). You must order these “maintenance medications” in up to a 90 day supply through the mail-order program.

All refills must be obtained through the mail-order program.

When you use the mail-order program, your prescriptions are delivered to your home at no additional cost to you. Make sure you have at least a 14-day supply of your medication on hand when you place an order for refills. Ask your doctor to write a new prescription for up to a 90-day supply plus refills for up to one year.

To refill a prescription, you have three options.

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1. By Telephone: Call 1-800-4REFILL and use the automated refill system. You will need your member ID number and credit card number for this.
 2. By Mail: Use the refill and order forms that will be in the packet in your initial prescription order.
 3. Online: Go to www.medco.com and, once you have registered, follow the online instructions to refill your prescription.

Filing Prescription Drug Claims

If you forget your ID card, you must pay the **full cost** of the prescription (not the Medco Health discounted rate). After you submit a claim form and receipt to Medco Health, you will be reimbursed for the cost of the generic form (if available) at the Medco discounted rate. You are responsible for any charges above that amount. This means that you will pay more for each prescription if you forget your ID card—so be sure to keep it with you.

If you need to submit a claim, request a claim form from Medco at 1-800-711-0917 or online at www.medco.com.

The Medco Health mailing address to send itemized receipts and claims forms to is on your ID card.

No benefits will be paid for prescriptions filled at pharmacies that do not participate in the Medco Health program.

Complaint and Grievance Procedures

If you feel that a prescription drug claim, or any portion of a claim, was not processed correctly, you have the right to appeal the claim decision and request that the Claims Service Administrator reconsider your claim. See “Claims Process, Denials, Appeals” below.

No legal action may be commenced against the Claims Service Administrator until the claims appeal process has been exhausted, nor may such action be taken more than two years after the services or supplies were performed or provided.

Claims Process, Denials, Appeals

Initial Claims

General Rules

The applicable Claims Service Administrator will be responsible for processing your medical claims and/or making benefit determinations. Benefit determinations will be made on a consistent basis, where circumstances are the same. Determinations will be made in accordance with the terms of the Prescription Drug Plan and any applicable internal practices or guidelines that are maintained under the Plan or by the applicable Claims Service Administrator.

The Plan will not charge for or otherwise unduly inhibit or hamper the filing or processing of a claim. Subject to reasonable verification procedures that the Plan may establish, a personal representative may act on a claimant’s behalf in filing and pursuing a claim.

Timing of Notifications

By law, your claims must be evaluated and processed within a time frame that depends on the nature of the claim. Different time frames apply depending on whether the claim is urgent, pre-service (but not urgent), or post-service.

A claim will be regarded as urgent if application of the ordinary pre-service time frame could seriously jeopardize your or your Dependent’s life, health, or ability to regain maximum function or, in the opinion of a Physician with knowledge of your claim, could subject you or your Dependent to pain that could not be controlled without the care or treatment that requires approval. If your Physician determines that the claim involves urgent care, it will be treated as urgent. Otherwise, urgency will be determined based on what a prudent person with average knowledge of health and science would have concluded.

Claims will be considered pre-service if the amount of the benefits payable to you depends on whether you obtain approval in advance of the medical care. Urgent claims are typically pre-service. A routine request for precertification is an example of a pre-service claim that is not urgent.

Post-service claims include claims that are filed after medical care has been received.

The time frames for each type of claim are set forth in the following chart.

Procedure	Nature of Claim		
	Urgent	Pre-Service Non-Urgent	Post-Service
Claims Service Administrator provides notice of incomplete filing	24 hours	5 days	N/A
Claims Service Administrator provides notice of initial determination (or need for an extension)	72 hours	15 days	30 days
Claimant provides additional information (where required)	48 hours	45 days	45 days
Claims Service Administrator provides notice of initial determination after extension begins or additional information received, as applicable	48 hours	15 days*	15 days*

The Claims Service Administrator will make determinations with respect to urgent claims as soon as possible within the maximum limits. It will make other determinations within a reasonable period that does not exceed the maximum.

* Except where more information is requested, the 15-day period may be increased by unused time from the period for providing notice of the need for extension. Where more information is requested, the determination will be made within 15 days of receipt. If the additional information is not provided on time, the determination will be made within 15 days of the end of the period for the information to be provided.

If you do not file an urgent or pre-service claim properly, you will receive a notice that directs you how to file it properly. However, this notice will be sent only if the claim is filed with the correct person or office and specifies the claimant's name, medical condition or symptom, and the treatment, service or procedure for which approval is sought. This notice will be provided within 24 hours of an urgent claim and within 5 days for any other pre-service claim. For urgent claims only, a need for more information will be regarded as an incomplete claim filing (and the need for more information will be communicated within 24 hours).

Denial Notice

If all or part of your claim is denied, you will receive a written Explanation of Benefits (EOB) Statement or other claim denial notice. In an urgent situation, you may be notified orally of a denial within the appropriate time frame, with written confirmation sent within three days.

All determinations will be final and binding to the extent they are not appealed in accordance with the standard appeals procedure.

Standard Appeals

Submitting the Appeal

If you disagree with a claim decision, you can apply for a claim review. You must send your request for review within 180 days after receiving the claim denial notice. You should state the reason(s) you believe your claim was improperly denied and submit all comments, documents, records, and other information relating to the claim that you believe is appropriate.

In deciding whether to appeal a denial, you may, on request and free of charge, obtain access to and copies of all documents, records or other information relevant to your claim from the applicable Claims Service Administrator.

To file an appeal, you must notify the claims service administrator below:

Member Appeals Department
Medco Health Solutions, Inc.
100 Parsons Pond Drive
Franklin Lakes, NJ 07417
1-800-336 5933

General Rules

Although certain aspects of the procedures may differ depending on your Claims Service Administrator, many of the basic rules will apply to all appeals.

The Plan will not charge or otherwise unduly inhibit or hamper submission or processing of an appeal. Subject to reasonable verification procedures, a personal representative may act on your behalf in filing or pursuing an appeal.

Claims will be reviewed fully and fairly, taking into account the comments and information you have submitted. The review will be conducted by one or more individuals who are not the same as, or subordinate to the individuals who made the initial determination (or any prior determination on appeal). The determination will be made independently, without deference to the initial claims determination. Determinations will be made on a consistent basis in like

circumstances. They will be made in accordance with the terms of the Plan and any applicable internal guidelines maintained by your Claims Service Administrator.

Where a determination requires medical judgment, the claims reviewer will consult a health care professional with appropriate experience and training in the applicable field of medicine. This consultant will not be, or be subordinate to, any consultant previously involved with the internal claim decision or any prior level of review. The Claims Service Administrator will provide for the identification of medical experts whom it consults, whether or not it relied on their judgments.

Timing and Notification

For all claims, there are two levels of appeal to the Claims Service Administrator. If your initial claim is denied, in whole or in part, notice of determination will be provided to you in writing, and you will have 60 days from the date you receive the denial notice to file for a second level of review by the Claims Service Administrator. The specific rules depend on the nature of the claim.

Urgent claims may be appealed orally or in writing, and necessary information, including the determination on appeal, may be transmitted by telephone, fax, or other expeditious methods. Urgent claim appeals will be decided as soon as possible, but in all cases within 72 hours of submission. If your appeal is denied, in whole or in part, and you appeal again, the Claims Service Administrator will conduct the second level of review in accordance with the voluntary appeal procedures described later in this section.

For pre-service claims, your Claims Service Administrator will make available two levels of standard appeals. These appeals will be decided within a reasonable period not to exceed 15 days at each level. If your claim is denied, in whole or in part, notice of the determination will be provided to you in writing.

For post-service claims, your Claims Service Administrator will make available two levels of standard appeals. These appeals will be decided within a reasonable period not to exceed 30 days at each level.

If your claim is denied, in whole or in part, notice of the determination will be provided to you in writing.

All decisions on appeal shall be final and binding to the extent they are not appealed to another level under these standard appeal processes.

The Bureau of Health Financing and Program Development is responsible for monitoring the Claims Service Administrator's compliance with these claims appeal procedures. Their address is:

Bureau of Health Financing and Program Development
Pennsylvania Department of Health
Room 1026, Health and Welfare Building
P.O. Box 90, Harrisburg, PA 17108-0090
717-787-5193

When Benefits May Be Limited or Not Paid

This section describes when prescription benefits may not be paid.

Your Responsibilities

You may forfeit your prescription benefits in two situations:

- **Reasonable Medical Examination**—If there is concern that the frequency, volume, or nature of medications prescribed to you or a dependent is not appropriate, the Plan has the right to ask that the patient have an independent medical examination. The Plan would choose the physician and pay the full cost of this examination. If you (or your dependent) refuse to comply with this process, benefits will be denied.
- **Fraud or Abuse**—If you or your eligible dependent uses the Prescription Drug Plan for any improper reason, coverage may be terminated, as described below.

Prescription Benefit Plan Abuse Policy

The following policy is designed to guard against abuse of the Prescription Drug Plan. This policy applies to all members and their eligible dependents. The policy covers minor abuse and flagrant abuse.

Minor Abuse

An example of minor abuse is obtaining the same drug on the same day from two different pharmacies. In the first instance of minor abuse, you will receive a letter from the Plan asking you to provide an explanation in writing.

If you do not respond, you will receive a second letter, and you will be billed for the second prescription. If you do not pay this bill, you will be notified that your prescription benefits have been terminated. The cost of the second prescription will be subtracted from any benefits paid for other claims. If you repay the Plan for the cost of the second prescription, your coverage will be reinstated.

Flagrant Abuse

You (or a dependent) will be considered to have committed flagrant abuse of your prescription benefits if:

- you forge a prescription,
- you obtain multiple prescriptions for the same medication from multiple doctors and/or from multiple pharmacies or
- you permit a non-covered person to use your prescription card.

If you (or a dependent) are suspected of flagrant abuse of your prescription drug benefits, the Director (or Director's representative) will suspend prescription drug benefits and will schedule a conference with you to review the situation. If the Director concludes that abuse has occurred, you must repay all benefits obtained fraudulently, and no other prescription benefits will be paid until the full amount has been repaid. A payment schedule may be established or the amount owed may be deducted from outstanding future benefit payments.

The Director will report all cases of flagrant abuse to the Trustees. The Trustees reserve the right not to restore prescription drug benefits even after repayment.

Prescription Charges Not Covered

The Prescription Drug Plan does not cover charges for:

- over-the-counter drugs or medications,
- prescriptions not filled within 3 weeks of the original date of the prescription,
- cosmetic medications, such as Rogaine, or Retin-A for anyone over age 25,
- prescriptions for hypodermic syringes and needles, devices such as, but not limited to, artificial appliances, therapeutic devices, diaphragms, or similar items,
- administration of a drug or insulin,
- immunization agents, biological sera, blood or plasma,
- quantities or refills in excess of those permitted under the plan,
- prescriptions that are not filled at a participating Medco Health pharmacy or through the mail-order program,
- prescriptions dispensed while your coverage is **not** in effect,
- prescriptions that could be covered by any other portion of the 1199C Benefit Fund program or any other agency,
- drugs obtained illegally or fraudulently,
- non-commercial injectable solutions for allergy treatments that are specially prepared by a physician or by a laboratory for administration to a specific patient,
- prescriptions filled without your prescription drug card if the claim form is submitted more than 6 months after the prescription was issued (or more than 14 months if this Plan has secondary responsibility for the claim),
- drugs or medicines dispensed and charged for by a physician or any person other than a registered pharmacist at a licensed pharmacy,
- drugs or medicines not legally dispensable under Federal and/or State law at a registered pharmacy, such as methadone, or drugs not covered by U.S. Food and Drug Administration regulations, such as certain foreign drugs,
- drugs not approved for use by the United States Food and Drug Administration,
- prescriptions covered without charge under Federal, State, or local programs including Workers' Compensation,
- investigational or experimental drugs, as defined in the Plan document,
- unauthorized refills,
- medication for a person confined to a rest home, nursing home, sanitarium, extended care facility, hospital, or similar institution,
- any charge above the usual and customary, advertised or posted price, whichever is less than the scheduled amount,

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- prescriptions not medically necessary to treat the injury or illness,
 - prescriptions dispensed that exceed the amount necessary to treat the illness or injury over the time period during which they were purchased or
 - drugs used for unlabeled or unapproved indications when such use has not been approved by the FDA.

When a Third Party Is Liable

If you or an eligible dependent incurs prescription drug expenses due to the fault of another party, that party is responsible for any expenses which may result. See “When a Third Party Is Liable” in the *Eligibility and Enrollment* section.

When Coverage Ends and Plan Information

The *Eligibility and Enrollment* section provides detailed information about when coverage ends and how benefits are affected by certain situations, such as disability.

See the *Plan Information and Rights* section for facts about how benefits are administered and your rights.

Continuing Your Coverage Through COBRA

If your coverage ends, you may be entitled to continue it (at your expense) for a limited time under COBRA (which stands for the Consolidated Omnibus Budget Reconciliation Act). See the *Plan Information and Rights* section of this handbook for details.