NECA/IBEW FAMILY MEDICAL CARE PLAN
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IMPORTANT NOTICE

NEW PRESCRIPTION DRUG CO-PAYS EFFECTIVE FEBRUARY 1, 2010

January 2010

To All Participants in Plans 1, 2, 3, 4, 5, 10, S, T and U:

The fastest growing part of medical cost comes from prescription drugs. In order to keep from increasing the Plan's contribution rate any more than necessary, the Trustees have made some changes to the prescription drug benefit starting February 1, 2010. Those changes are described in the box on the back of this page, but there are some key points for you to remember.

- First, if you use generic drugs, your benefit is still 100% and you will have no out-of-pocket cost.
- Second, if there is not a generic drug for your condition, there is now a formulary list of the most effective brand name drugs. If you use a formulary drug, your co-pay is still 20%.
- Third, if you use a non-formulary brand name drug, your co-pay will be 30%.
- Fourth, if there is not a generic drug for your condition, your 20% or 30% co-pay will be capped at $1,000 per person per year.
- Last, if you select a brand name drug when a generic drug is available, you must pay the difference between the cost of the brand name drug and the generic drug, and that cost difference is not subject to the $1,000 out-of-pocket limit.

These changes have been made as part of the Plan's ongoing commitment to provide the best possible benefits, while controlling the cost of the Plan that ultimately comes out of your pocket in the form of higher contributions.

In order to reduce or completely eliminate your out-of-pocket cost, please ask your doctor to prescribe generic drugs whenever possible. If a brand name drug is necessary, make sure that your doctor is aware of the Plan's formulary.

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PRESCRIPTION DRUG PROGRAM – RETAIL AND MAIL

EFFECTIVE FEBRUARY 1, 2010

Co-pays:	
Generic	0%
Formulary brand	20%
Non-formulary brand	30% Minimum $40 retail, $80 mail
Co-pay out-of-pocket limit per year	$1,000
Brand/generic differential	If you decline a generic substitution, you must pay the cost difference between the brand and generic. The difference does not apply to your out-of-pocket limit and must be paid even after your out-of-pocket limit has been met. Example: If you take a brand prescription for $80 when a $20 generic is available, you will have to pay the $60 difference, and that $60 will not apply to your out-of-pocket limit.

"Formulary" brands are medications that have been evaluated by physicians and pharmacists, and have been determined to be the most effective treatments for most patients. These drugs are also reasonably priced. For the most recent information about the formulary or the status of a specific drug, contact Sav-Rx at 1-866-233-IBEW (4239) or go to www.savrx.com.

"Generic drugs" are those with more than two manufacturers. You will have to pay the 20% or 30% co-pay for a drug sold by only one or two companies, even if it is called a 'generic.'

When your co-pay out-of-pocket limit has been met, your co-pay will usually be $0 for the remainder of that calendar year. This applies to all generic, formulary and non-formulary drugs. However, you will still be responsible for paying the cost difference between the brand and generic versions of a drug if you decline a generic substitution.

You will reduce your out-of-pocket costs by talking to your doctor about whether a generic equivalent or a formulary brand would be appropriate for you. Your doctor can also make sure you have a new prescription, if necessary. Please remember that you and your doctor have free choice in deciding which prescription drug is best for your medical situation. However, your co-pay will be based on whether or not the drug is a generic, formulary brand or non-formulary brand.