

Health and Welfare Fund
6281 Youngstown-Warren Rd., Suite 240
Niles, Ohio 44446
330-652-3475
Toll Free 1-800-362-9354
Fax 330-652-3513



We are pleased to provide you with information about your prescription drug benefit. Medco is America's leading prescription drug benefit manager, with over 30 years of experience.

Your plan offers two convenient ways of getting your prescriptions:

- Through our award-winning mail-order pharmacy
- From a retail pharmacy that participates in our network

Here's how you can start getting the most from your benefit:

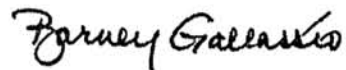
- 1. Begin using your new prescription benefit card on October 1, 2006.** Your card displays your member ID number, which your pharmacist needs to process your prescriptions. After October 1, 2006, please destroy your old card.
- 2. Have your long-term prescriptions sent by mail.** You may save time and money on medications you take regularly by ordering them through **Medco By Mail**, our mail-order pharmacy. Just fill out the enclosed order form and return it to us with your prescription in the envelope marked "Medco By Mail Order Center." Or have your doctor call us at 1 888 327-9791.
- 3. Register for online services.** Visit us at www.medco.com to register for the convenient, time-saving services our website offers. Registered members can order refills online, get information about their plan, and access health and wellness information 24 hours a day, 7 days a week.
- 4. Complete and return the Health, Allergy & Medication Questionnaire.** The information on this questionnaire will help us protect you against potentially harmful drug interactions. Please fill out the questionnaire and return it to us in the envelope marked "HMQ."
- 5. Find a participating retail pharmacy by visiting www.medco.com or by calling us toll-free at 1 800 716-2932.**



Under your plan, certain specialty medications may not be covered at a retail pharmacy. If you are currently taking a specialty medication (those normally administered by injection and often requiring refrigeration and special handling), call Medco's specialty care pharmacy, **Accredo Health Group**, toll-free at 1 800 716-2932.

Please review the enclosed handbook for more information about your prescription drug benefit. If you have any questions, please call us toll-free at 1 800 716-2932.

Sincerely,



Barney Gallassio
Vice President of Member Services
Medco

**Medco Health Solutions, Inc., manages your prescription drug benefit for
Ohio Carpenters Health and Welfare Fund.**



Medco By Mail pharmacies

Over 6 million members enjoy the convenience and savings of having their long-term medications (those taken for 3 months or more) delivered to their home or office. Medications are dispensed by Medco By Mail pharmacists through our network of mail-order pharmacies.

Medco By Mail advantages:

- **Get up to a 90-day supply** (compared with a typical 34-day supply at retail) of each covered medication for just one mail-order payment.
- **Registered pharmacists** are available 24 hours a day, 7 days a week.
- **Order refills** online, by mail, or by phone-anytime day or night. To order online, register at www.medco.com. Refills are usually delivered within 3 to 5 days after we receive your order.
- **Choose a convenient payment option**-Medco offers a safe, convenient method of paying for prescription orders. E-check is an electronic funds transfer system that automatically deducts payments from your checking account. You can also pay by money order, personal check, credit card, or through our automatic payment program. For more information, visit www.medco.com or call Member Services.
- **Standard shipping is free.**

How to start saving with Medco By Mail

1. When using **Medco By Mail**, be sure to ask your doctor to write a prescription for up to a 90-day supply of each medication (plus refills for up to 1 year, if appropriate).
2. Fill out the enclosed **Medco By Mail** order form.
3. Send the completed form, your prescription, and your payment option in the **Medco By Mail** envelope provided.

Your medication usually will be delivered within 8 days after we receive your order. If you are currently taking a medication, be sure to have at least a 14-day supply on hand when ordering. If you don't have enough, ask your doctor to give you a second prescription for a 14-day supply and fill it at a participating retail pharmacy while your mail-order prescription is being processed.

You may also have your doctor fax your prescriptions. Ask your doctor to call 1-888-327-9791 for faxing instructions.

Specialty care pharmacy

Some conditions, such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency, and rheumatoid arthritis, are treated with specialty medications. If you use specialty medications, you'll appreciate **Accredo Health Group** extras, including:

- Up to a 90-day supply of your specialty medication for just one payment
- Access to nurses who are trained in specialty medications
- Answers to your questions about specialty medications from a pharmacist 24 hours a day, 7 days a week
- Coordination of home care and other healthcare services

For more information, call **Accredo Health Group** at 1-800-716-2932.

Medco By Mail Order Form

Benefits provided by Ohio Carpenters Health and Welfare Fund



For New Prescriptions

Fill out one line of the Patient Information section for each new prescription you send. Be sure to include the patient's full name, date of birth, and address, along with the doctor's name and phone number.

For Refills

To order from our website: www.medco.com. Have your member ID number and prescription (Rx) number on hand. You can find your member ID below, and your 12-digit prescription or Rx number can be found on your refill slip.

To order by phone: Call 1 800 4REFILL (1 800 473-3455) to use the automated refill system. Have your member ID number and refill slip with the prescription information ready.

To order by mail: Include your refill slip(s) with this form. Do not complete the Patient Information section for refills.

For All Mail Orders

Place all prescriptions and refill slips together with this completed order form and your co-payment in the enclosed return envelope. Be sure to fold the form as indicated so the address on the bottom right shows through the window.

If You Need Additional Help

Call Member Services at 1 800 716-2932. The best time to call is in the afternoon, Tuesday through Friday.

See the back of this form for additional instructions.

Member Information

Member ID:

Group:

Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at:

_____@_____.

Shipping address if different from your mailing address

Check if Temporary Permanent

Daytime telephone

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Evening telephone

--	--	--	--	--	--	--	--	--	--	--	--

Patient Information—Complete one line for each new prescription (Do not complete for refills)

Patient name	Patient's relation to plan member (fill in one)	Sex	Birth date M/D/YYYY	Doctor name and phone number	Does patient have any other prescription plan
1	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No

Order Information

Total number of medications in this order (including all refills and new medications)

Subtotal of this order

\$

Optional expedited shipping \$9.00 (subject to change)

Total enclosed (do not send cash)

\$

Please be sure address is visible through window of envelope marked "Medco By Mail Order Center"

Paying by credit card? Visa MC Disc/NOVUS AmEx Diner

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CREDIT CARD NUMBER

M Y

EXPIRATION DATE

CARDHOLDER SIGNATURE

Check here to have all orders billed to your credit card.

By doing so, you authorize Medco to keep your card number on file and bill all future orders and any outstanding balances directly to your credit card. To enroll by phone, please call 1 800 948-8779.

Paying by check? Write your member ID number on your check or money order made payable to Medco Health Solutions, Inc.

MEDCO
PO BOX 30493
TAMPA FL 33630-3493



Please take a minute to make sure ...

- **You have included your doctor's signed prescription form and filled out the patient information on the front of the order form for each new prescription.**
- **You have either filled out the credit card section on the front of this order form or included a check or money order for the required co-payment.**
- **You have written your member ID number on any check or money order.**
- **The Medco address on the front shows through the window of the envelope marked "Medco By Mail Order Center."**
- **You have filled out the Health, Allergy & Medication Questionnaire. This information will help Medco better serve your prescription drug needs.**

Expedited shipping available

For an additional fee, your order will be shipped by an expedited service offered in your area. This option must be chosen when you make the order, and it cannot be applied after an order has already been processed.

Additional instructions

If you elect to have this and all future orders automatically charged to your credit card (by checking the box on the front or enrolling by phone), bear in mind that the automated payment plan feature will apply to all mail orders. Also note that we can only keep one credit card on record.

You may have a balance limit on your plan account. If so, once your unpaid balance exceeds that limit, no additional orders will be processed until the balance has been paid.

You can call 1 800 948-8779 anytime to enroll in our automated payment plan, change the credit card on file, check your account balance, or pay by phone using a credit card.

Get more information from our website

Visit us at www.medco.com.

To all Medicare beneficiaries whose private health plan has elected to be billed primary for Medicare Part B coverage:

By choosing the Medco mail-order pharmacy to fill your prescription, you are choosing to use the prescription drug coverage provided by your group health plan. Medco will process your prescription under your group health plan coverage, independent of the Medicare program, and no claim will be submitted to Medicare. If you believe that Medicare may also provide coverage and would like Medicare to pay for your prescription, you should go to a Medicare-participating pharmacy in your area. For a list of convenient Medicare-participating pharmacies, please call your local Medicare carrier or 1 800 MEDICARE. If you have any questions about the difference in coverage between your group health plan coverage and Medicare, please call **1 800 716-2932**.

Florida law requires pharmacists to substitute a less expensive, generically equivalent drug for certain brand-name drugs unless you or your physician directs otherwise.





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Health, Allergy & Medication Questionnaire (HMQ)

Your answers to the following questions will help us provide your prescription drug benefit services, including, for example, filling prescriptions and alerting your doctor about possible medication problems. To best serve you, we need to know whether you have any known allergies, conditions, or diseases.

- **Complete this questionnaire only for the person whose name is preprinted in Section 1.**
- Return the questionnaire in the self-addressed envelope marked "HMQ".
- **Do not include prescriptions with this questionnaire.**
- If you need more questionnaires, please call your toll-free Member Services number.
- Please fill in the response circles completely. The correct way to mark circles: ●

SECTION 1

This form is provided exclusively for:

Name:

Month/Year of Birth:

Gender:

This person's home
telephone number is:

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SECTION 2

Please fill in the circle **ONLY** if you've had an allergy or bad reaction to this medication in the past. If you've had an allergy to a medication not listed below, please print the name of that medication in the blank spaces at the bottom of this chart. Please use blue or black ink.


Penicillins/cephalosporins	Such as <i>Amoxil</i> [®] , amoxicillin, ampicillin, <i>Ceclor</i> [®] , <i>Ceftin</i> [®] , <i>Keflex</i> [®] , cephalexin	<input type="radio"/>
Tetracycline antibiotics		<input type="radio"/>
Erythromycin, <i>Biaxin</i>[®], <i>Zithromax</i>[®]		<input type="radio"/>
Codeine	Such as <i>Robitussin AC</i> [®] , <i>Tylenol #3</i> [®]	<input type="radio"/>
Non-steroidal anti-inflammatory drugs (NSAIDs)	Such as ibuprofen, <i>Advil</i> [®] , <i>Motrin</i> [®]	<input type="radio"/>
Aspirin (salicylates)		<input type="radio"/>
Sulfa drugs	Such as <i>Septra</i> [®] , <i>Bactrim</i> [®] , TMP/SMX	<input type="radio"/>
Iodine		<input type="radio"/>

If you have an allergy to a medication that is not listed above, please print the name of that medication in the spaces below. Example: *morphine*

Other:

Other:

Other:

Continue on the other side to tell us about any medical conditions. 

SECTION 3

Please respond to each question by filling the circle completely with the response that best describes the person identified in Section 1.

Has your doctor ever told you that you have any of the following conditions?

	YES	NO
Heart failure (weak heart)	<input type="radio"/>	<input type="radio"/>
High blood pressure (hypertension)	<input type="radio"/>	<input type="radio"/>
Heart attack or angina	<input type="radio"/>	<input type="radio"/>
High cholesterol (hypercholesterolemia)	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>
Chronic bronchitis or emphysema (COPD)	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>
Allergies, runny nose, hay fever (allergic rhinitis)	<input type="radio"/>	<input type="radio"/>
High blood sugar (diabetes)	<input type="radio"/>	<input type="radio"/>
Thyroid disease	<input type="radio"/>	<input type="radio"/>
Peptic, stomach, or duodenal ulcer	<input type="radio"/>	<input type="radio"/>
Gastric reflux, heartburn, or esophagitis (GERD)	<input type="radio"/>	<input type="radio"/>
Inflammatory bowel disease (colitis, Crohn's disease)	<input type="radio"/>	<input type="radio"/>
High pressure in the eyes (glaucoma)	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>
Poor circulation in the legs (peripheral vascular disease)	<input type="radio"/>	<input type="radio"/>
Trouble with blood not clotting properly	<input type="radio"/>	<input type="radio"/>
Enlarged prostate (benign prostatic hyperplasia, BPH)	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>
Migraine headache	<input type="radio"/>	<input type="radio"/>
Print other medical conditions not listed above in the spaces below. Example: <i>glaucoma</i>		

USING MEDCO BY MAIL? It's available to you at **NO EXTRA CHARGE, NO SIGN-UP.** Experience the convenience and savings millions of people are enjoying. Learn more by visiting us at www.medco.com.

Return ONLY the questionnaire in the preaddressed envelope marked "**HMQ**". If you do not have a preaddressed envelope, please return the questionnaire to:

Medco Health Solutions, Inc.
 100 Parsons Pond Drive
 MS F2-2 GT\SAMPPQ
 Franklin Lakes, NJ 07417-2603



Please do not include prescriptions or refill slips with this questionnaire.

Did you complete both sides? Thank you very much.



Coordination of Benefits / Direct Claim Form

See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.



Member/Subscriber Information *See your prescription drug ID card.*

Group no.

Member ID

Member name (first, last) _____

Street address _____

City State Zip

Patient Information

Patient name (first, last) _____

Patient date of birth (month/day/year)

Sex *Relation to plan member*
 Female 1 Self 5 Disabled dependent
 Male 2 Spouse 6 Dependent parent
 3 Eligible child 7 Other
 4 Dependent student 8 Nonspouse partner

Pharmacy Information

Name of pharmacy _____

Street address _____

City State Zip

Telephone (include area code)

Is this an on-site nursing home pharmacy? Yes No

Claim Receipts

Tape claim receipts or itemized bills on the back.

Do not staple!

Check the appropriate box if any of the receipts are for a medication that:

- Is a compound prescription.**
If so, make sure your pharmacist lists ALL the VALID 11-digit NDC numbers and ingredients and quantities on the receipt.
- Was purchased outside the United States.**
If so, please indicate:
Country _____
Currency used _____
- Is for treatment of an allergy.**

Coordination of Benefits

(Another health plan has paid a portion.)
Mark the appropriate box for your primary coverage method. See the back for more information.

Is this a coordination of benefits claim?

- Yes No
- 1 Another health plan paid and you are enclosing a statement that outlines how much you paid and how much the other carrier paid.
- 3 Card program
- 4 **Medco By Mail/mail-order pharmacy**

Acknowledgment

I certify that the medication(s) described above was/were received for use by the patient listed above and that I (and the patient, if not myself) am eligible for drug benefits. I also certify that the medication received was not for an on-the-job injury. I recognize that reimbursement will be paid directly to me and that assignment of these benefits to a pharmacy or any other party is void.

Signature of member

