Support Staff Benefit Program Changes
Frequently Asked Questions

This list of frequently asked questions and answers was prepared by the Support Staff Benefits Committee to provide you information about the changes to the Support Staff Benefits Plan that begin January 1, 2016.

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OVERVIEW

1. What benefits are changing?

- **Prior Authorization for Biologic & Speciality Drugs**
  - Effective January 1, 2016, reimbursements for biologic and speciality drugs are subject to the Sun Life Prior Authorization program. The program covers a number of health conditions as referenced on the Sun Life Prior Authorization website.
  - Members with prescriptions for prior authorization drugs reimbursed in the 120 days prior to implementation will be grandfathered with individual DIN exceptions for 100% of the cost of the medication covered (subject to the existing plan limitations).
  - Changes to drug treatment protocols will be subject to the Prior Authorization program and require prior authorization.
  - Any member prescribed a biologic or speciality drug covered by the prior authorization program after January 1, 2016 is required to have their physician complete and submit the appropriate prior authorization form.

- **DFFL (Dispensing Fee Frequency Limit)**
  - Effective January 1, 2016, support staff with prescriptions on the maintenance medications list are covered for a maximum of five (5) dispensing fees per calendar year per certificate for each maintenance medication. Maintenance medications are those used to treat chronic, long-term conditions. If members choose to have prescriptions filled more frequently, only the cost of the drug itself will be covered, subject to any other plan restrictions.
  - If a drug is defined as acute, it will not be part of the DFFL program and all prescription dispensing fees will be covered.
  - If prescribed medications are only dispensed in less than 90/100 day supplies requiring more than five (5) prescriptions per year, members will be required to complete and submit the Sun Life Exemption form for each affected drug.
  - The University of Alberta will inform members early in the year about the DFFL restriction and the exemption process.

- **Mandatory Generic Substitution / Lowest Priced Equivalent**
  - Effective January 1, 2016, claims for prescription drugs with a generic substitution, including those where “no-substitution” is identified on the prescription, are reimbursed at the rate of the lowest-priced equivalent.
  - If there is a medically supported reason why an alternative generic drug cannot be used, a member may have their physician complete the Sun Life Drug Exemption form and submit it to Sun Life for review.
  - If a covered member chooses to purchase a brand name drug, the difference between the lowest price generic drug and the brand name will be the member's expense.

- **Over-the-counter (OTC) Medications**
  - Effective January 1, 2016, reimbursement for over-the-counter (OTC) drug products is not permitted under the support staff benefit plan.
  - Life sustaining OT Cs (such as insulin, diabetic supplies, Epi-Pen) and a small number of non-life sustaining OT Cs that are injectable OT Cs (i.e. injectable vitamins) are included in the plan and covered.
  - No grandfathering or exceptions apply to this restriction.
• **MAC (Maximum Allowable Cost) / Reference Based Pricing**
  o Effective January 1, 2016, prescriptions for drugs within the following therapeutic drug classes are subject to Maximum Allowable Cost pricing.
  o The support staff drug plan applies a maximum dollar amount to the therapeutic class of drugs (Column 2) based on the most cost-effective drug within the class (the reference drug) as shown in Column 4 of Table 1 below.
  o Prescriptions for drugs within these classes (Column 3) are reimbursed at the maximum allowable cost. Members do not have to be prescribed an alternative drug within the MAC program to be reimbursed at the maximum allowable cost.
  o Members with prescriptions for drugs in these therapeutic drug classes that were reimbursed in the 120 days prior to January 1, 2016 are not grandfathered.
  o MAC pricing applies to all drug claims in the therapeutic drug classes listed in Table 1.
  o Exceptions to the MAC pricing are permitted only if the member can provide a physician's medical evidence that the MAC drug cannot be used. The [Sun Life Drug Exemption form](#) must be completed and submitted for review in that case. Members will only be reimbursed for the maximum allowable price of the drugs listed within Column 4 unless an exception is approved.

*Table 1*

<table>
<thead>
<tr>
<th>Health Condition</th>
<th>Therapeutic Drug Class</th>
<th>Specific Drug (including generics above MAC)</th>
<th>Drugs within MAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>High blood pressure</td>
<td>Angiotensin converting enzyme inhibitors</td>
<td>Mavik (Trandolarpril) Accupril (Quinapril)</td>
<td>Altace (Ramipril)</td>
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<td>Conversyl (Perindopril) Monopril (Fosinopril)</td>
<td>Zestril, Prinivil</td>
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<td>Vasotec (Enalpril) Inhibace (Cilazapril)</td>
<td>(Lisinopril)</td>
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<tr>
<td></td>
<td></td>
<td>Lotensin (Benazepril)</td>
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<tr>
<td>High blood pressure</td>
<td>Angiotensin II receptor blockers</td>
<td>Cozaar (Losartan) Olmetec (Olemesartan)</td>
<td>Diovan (Valsartan)</td>
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<tr>
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<td>Teveten (Eprosartan) Avapro (Irbesartan)</td>
<td>Atacant (Candesartan)</td>
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<tr>
<td></td>
<td></td>
<td>Edarbi (Azilsartan)</td>
<td>Micardis (Telmisartan)</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Dihydropyridine calcium channel blockers</td>
<td>Plendil, Renidil (Felodipine) Adalat XL (Nifedipine)</td>
<td>Norvac (Amlodipine)</td>
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<tr>
<td>Cholesterol</td>
<td>HMG-CoA reductase inhibitors</td>
<td>Lipitor (Atorvastatin) Zocor (Simvastatin)</td>
<td>Crestor (Rosuvastatin)</td>
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<td></td>
<td>Mevacor (Lovastatin) Pravachol (Pravastatin)</td>
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<td>Lescol (Fluvastatin)</td>
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</table>
2016 Support Staff Benefit Program Changes - FAQ

<table>
<thead>
<tr>
<th>Health Condition</th>
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<th>Specific Drug (including generics above MAC)</th>
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</thead>
<tbody>
<tr>
<td>Stomach Hyperacidity</td>
<td>Proton pump inhibitors</td>
<td>Pantoloc (Pantaprazole sodium) DEXILANT (Dexlansoprazole) PREVACID (Lansoprazole) LOSEC (Omeprazole) TECTA (Pantoprazole magnesium)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pariet (Rabeprazole)</td>
</tr>
</tbody>
</table>

2. Why are you changing our benefits plan?

The Support Staff Benefits Committee, comprised of an equal number of members from both NASA and the University, has a role to ensure that the benefit plan meets (as best as it can) the needs of employees within agreed budget targets and that our benefits program is managed efficiently and responsibly to support both individual and organizational health. Equally important to the committee is to ensure the benefits plan is meeting the benefit needs of plan members in a way that is efficient and cost effective, and is able to be sustained into the future.

With a mandate to manage fixed resources for the benefit of all covered members and their dependants, the committee is focused on evidence-based coverage that can appreciably improve health and quality of life outcomes. The priorities are health initiatives and health products or services that demonstrate a high value for members and their dependants at a reasonable plan cost.

As drug plan costs continue to rise, especially due to the escalating costs of speciality and biologic drugs, the committee determined it was best to implement changes to the plan that aligned with industry best practice and ensure the plan can be sustainable into the future. The changes implemented impact a small number of total employees however impact high cost drug claims.

3. Who do these changes apply to?

The changes to the prescription drug benefit implemented January 1, 2016 apply to all members (and their dependents) of the Non-Academic Staff Association (NASA) that are eligible for extended health plan coverage.

4. What are maintenance medications?

Maintenance medications are those used to treat chronic, long-term conditions. If members choose to have prescriptions filled more frequently, only the cost of the drug itself will be covered, subject to any other plan restrictions. If a drug is defined as acute, it will not be part of the dispensing fee frequency limit (DFFL) program and all prescription dispensing fees will be covered.
5. How many times per year can I get my maintenance medication prescription filled?

Support staff with prescriptions on the maintenance medications list are covered for a maximum of five (5) dispensing fees per calendar year for each maintenance medication. If you fill a maintenance medication prescription for the same medication more than five times per year, the plan pays the cost of the drug (subject to the lowest priced equivalent pricing) but won’t pay any additional dispensing fees. Any additional dispensing fees are an out-of-pocket expense you will have to pay yourself. These fees are an eligible expense under the health spending account.

Medications that are defined as acute (ie. Narcotics) are not included in the dispensing fee limit program. If your prescriptions are not available in 90-100 day quantities, please consult your physician and/or pharmacist to confirm and submit a Sun Life Drug Exception form to gain approval of additional dispensing fees. Please ensure you submit this form early in the year to avoid unnecessary delays.

6. Why limit the number of times the plan will pay dispensing fees for my maintenance medication prescriptions?

A large portion of each total prescription cost is the dispensing fee that is charged by the pharmacist to fill your prescription. The dispensing fee could be up to $12.30 of the total cost.

OVER-THE-COUNTER (OTC) MEDICATIONS

7. What over-the-counter medications are affected by the January 1, 2016 changes?

The support staff benefits plan does not provide coverage for ALL non-life-sustaining over-the-counter medications. Examples of non-life-sustaining over-the-counter medications include (not a complete list):

- Low-dose aspirin
- Sudafed
- Imodium

To determine what drugs are eligible for coverage by your benefits, please refer to the Sun Life Drug Inquiry Tool available at http://mysunlife.ca or from the Sun Life Mobile App for your Apple, Android or Blackberry mobile device. Learn more about the Mobile App options available at https://goo.gl/yC74X8.

8. Why did the Support Staff Benefits Plan stop providing coverage for these medications?

In order to comply with Canada Revenue Agency guidelines, the benefit plan has removed coverage for all non-life-sustaining over-the-counter medications.
9. **What over-the-counter medications does the benefits plan cover?**

The benefits plan provides coverage for life-sustaining over-the-counter medications. Examples of these medications include:

- Insulin and diabetic supplies
- EpiPens
- Nitroglycerin products for treatment of angina
- Potassium supplements (supplement must be *just* potassium, not a multivitamin or other supplement that simply contains potassium)

To determine what drugs are eligible for coverage by your benefits, please refer to the Sun Life Drug Inquiry Tool available at [http://mysunlife.ca](http://mysunlife.ca) or from the Sun Life Mobile App for your Apple, Android or Blackberry mobile device. Learn more about the Mobile App options available at [https://goo.gl/yC74X8](https://goo.gl/yC74X8).

10. **Are there prescription medications that I can purchase and won’t have to pay out of pocket?**

   It is possible that there may be prescription drug equivalents for some non-life-sustaining over-the-counter medications. You should discuss possible alternatives with your physician and/or pharmacist.

11. **If the over-the-counter (OTC) drug doesn’t have the same dosage as my prescription, will my prescription still be paid for?**

    When a prescribed product is available as an over-the-counter (OTC) drug, several elements are considered to determine if the prescribed drug is the same as the OTC drug including: the strength, the formulation, and route of administration. Your pharmacist will be able to tell you if your exact prescription is available as an OTC and if it is, then it will not be covered.

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**PRIOR AUTHORIZATION PROCESS**

12. **Why is the Support Staff Benefits Plan introducing the prior authorization process?**

    Helping our covered members manage their health, no matter where they are on their health journey, is something the University of Alberta takes pride in. The prior authorization process now aligns more closely with the University’s holistic health approach, providing the opportunity for the Support Staff Benefits Committee (SSBC) to engage members more in the process.

    It’s also vitally important for the benefits plan to manage the increasing cost of specialty drugs in a way that doesn’t jeopardize the health and well-being of our covered members. Our goal is to ensure that all covered members and their dependants have access to the health resources they need, when they need them.

    The prior authorization process allows the benefits plan to review available treatment options for an applicable health condition and assess it based on the covered member’s individual situation before a coverage decision is made. Putting the focus on the covered member and their health allows for more accurate reviews of requests for specialty drugs, while providing the benefits plan with the opportunity to take all clinical information, government guidelines and product research into consideration. For example, if
two drugs are deemed to be clinically similar, offering the same level of effectiveness, and the covered member is eligible for both treatments, but one is offered at a lower cost, the lower cost product will be deemed a preferred product and will be approved for use by the covered member. If the lower cost drug is a treatment that a covered member has tried before, but wasn’t able to tolerate, Sun Life will approve the more expensive drug for the covered member. Handling prior authorizations in this way will ensure both the covered member and the support staff benefits plan are getting the most value from the benefit.

The process also allows us to be more fluid with our prior authorization decisions. If product pricing changes over time, or new treatment options become available, we’re able to adjust our adjudication process around these changes. Having this flexibility provides better coverage for our covered members and better cost management for the plan.

13. Why is the new process only in effect for certain health conditions?

The prior authorization process is in effect for health conditions that are very costly to treat with biologic or specialty drugs. These health conditions are also chronic in nature, meaning once medications are prescribed, in most cases, they will continue to be prescribed for the rest of the covered member’s life (the type of medication may change throughout the course of treatment). Due to the high benefit utilization nature of these health conditions, the Support Staff Benefits Committee identified there is an opportunity to engage more with these covered members by providing additional resources available to them through their benefits, as well as extra support through the prior authorization process.

14. What are the key health conditions for which the prior authorization process applies?

Effective January 1, 2016, reimbursements for biologic and specialty drugs are subject to the Sun Life Prior Authorization program. The program covers a number of health conditions as referenced on the Sun Life Prior Authorization website. Sun Life will render coverage decisions for these health conditions.

15. I was granted approval for a specialty drug prior to January 1, 2016, how does this new process affect me?

Beginning January 1, 2016, any support staff or their dependents that were taking one of the medications on the prior authorization list in the 120 days prior are grandfathered and no permission is required. Prior authorization is only required if the treatment begins after January 1 and the drug is on the list or if you and your physician decide to change your medication or if you develop one of the other key health conditions.

You can view the list of drug treatments requiring prior authorization at http://www.sunlife.ca/Canada/sponsor/Group+benefits/Forms/Prior+Authorization+Drug+List+and+Forms?grpcontract=0&vgnLocale=en_CA. There is also a link to that information on our website at http://hrs.ualberta.ca/Benefits/Overview/SupportStaffBenefitsPlanChanges.aspx
16. What happens if I am previously had approval for a specialty drug and my renewal is after January 1, 2016?

If you had approval for a special authorization drug for one of the key health conditions prior to January 1, 2016, and have been actively taking this medication, you will not be affected by this change, even for renewals. You will only have to follow the new process if you and your physician decide to change your medication, or if you develop one of the other key health conditions.

17. If I had approval for a medication prior to January 1, 2016, but my physician decides to change my medication because it’s no longer working, which process do I use?

If you and your physician decide to change your medication, even if you previously had approval for a specialty drug used to treat one of the key health conditions, you will need to follow the prior authorization process for the new medication. Your previous medication history and the reason for changing your treatment therapy will be taken into account during the review process.

18. My doctor and I have been discussing treatment options for one of the health conditions outlined in the prior authorization process. What do I need to do?

We understand that choosing a treatment option is a big decision. When you start these discussions with your physician, we encourage you to contact Sun Life using the Prior Authorization Notification form available on the Sun Life website at http://www.sunlife.ca/Canada/sponsor/Group+beneﬁts/Forms/Prior+Authorization+Drug+List+and+Forms?grpcontract=0&vgLocale=en_CA or http://www.sunlife.ca/priorauthorization. Enter contract number 025379 when prompted.

You can also make this notification by contacting the Sun Life Customer Care Centre at 1-800-361-6212. Once Sun Life receives notification, they will reach out to you to provide the Prior Authorization Request form and to share resources available to you through your benefits that may be able to assist you with managing your health condition. The Prior Authorization Request form will need to be completed by your physician.

19. I don’t have one of the listed health conditions, but require a specialty drug. What do I do?

If you do not have one of the key health conditions list, it may still be possible that prior authorization applies. Follow the prior authorization process and your physician will complete the required form on your behalf. Your physician will be familiar with this process and will have access to all of the necessary forms.

20. I require specialty drugs for two health conditions—one of the key health conditions and a second condition that is not one of the key health conditions. What do I do?

For the specialty drug that is used to treat one of the key health conditions, you will need to follow the prior authorization process (complete a notification form or call Sun Life – they will provide the applicable prior authorization form, physician will complete the request form and submit to Sun Life).
For the specialty drug that will treat the health condition that isn’t covered by the prior authorization process, your physician will start this process on your behalf. Sun Life may also provide forms for this process. Your physician will be familiar with this process and will have access to all of the necessary forms.

21. I was previously covered under my spouse’s benefits for Extended Health Care, but have recently enrolled in the support staff benefit plan coverage due to loss of coverage. I was granted approval for a prior authorization drug under my spouse’s plan and need to refill my prescription after January 1, 2016. What do I do?

Since your previous approval was through another benefits provider, you will need to request prior authorization for your medication using the Sun Life prior authorization process. Your current treatment and past medication history will be taken into account during the review process.

The Support Staff Benefits Committee understands the importance of continuing a drug therapy that is currently working for you and will take all possible steps to ensure your treatment is not disrupted.

22. My spouse has coverage through his employer, but is also covered under my University Extended Health Care plan. If his benefits provider approves his request for a specialty drug used to treat one of the listed health conditions, but only up to 80%, what process do I follow to request the University support staff benefits plan to cover the rest?

Although the University’s support staff benefit plan will be the second payer for your spouse’s claim, we will still require you to submit your request through the prior authorization process. Our plan may have different eligibility criteria than your spouse’s benefits provider, so we need to ensure a fair and consistent process is followed for each claim, whether our plan is the first or second payer.

It is possible that your spouse’s request may be declined for coverage through your benefits plan if it does not meet our eligibility requirements.

23. Where can I find the form I need to use to notify Sun Life of my desire to seek approval for a specialty drug for one of the health conditions?


24. What happens if my physician doesn’t use the new Prior Authorization Request form to submit my request?

If your physician does not use one of the prior authorization forms created for the approval process, Sun Life will follow up with your physician to request any information that may not have been collected on the form submitted. The forms have been developed to capture all applicable medical history and health condition information that will allow Sun Life to properly adjudicate your request.
25. Why are there preferred products?

There are a number of medication options available to treat the key health conditions. Typically, these drugs offer the same level of efficacy when it comes to treating these conditions; however, their pricing may vary widely due to a number of factors (profit margins determined by pharmaceutical manufacturers, ingredients, availability, dosage frequency and delivery method, how long the drug has been on the market, etc.).

As a way for the Support Staff Benefits Plan to manage these varying costs, Sun Life has established preferred products. A product is deemed a preferred product by working with medical and other industry experts to review clinical data, medical and other research on the product and governmental guidelines.

26. How are preferred products decided on?

Preferred products are established by working with medical and other industry experts to review clinical data, medical and other research on the product and governmental guidelines. Preferred products will evolve over time as pricing changes, new drugs come on the market and changes to existing therapies take place.

27. Does the Support Staff Benefits Plan receive any compensation from drug companies to have their product listed as a preferred product?

No, the University does not receive any compensation from drug companies when their product is deemed a preferred product. Preferred products have been established to provide the best possible treatment options for our covered members, while managing the financial sustainability of the benefit plan as a whole.

28. What are the preferred products for my health condition?

To learn more about which drugs are preferred products, log in to your http://MySunLife.ca account or use the Sun Life Mobile App and visit the Drug Coverage section to view the Drug Inquiry Tool. The Drug Inquiry Tool allows you to search for any medication and find out if it is covered by your benefits plan, whether generic or least cost alternatives are available, if prior authorization is required or if it is a preferred product. It also provides information about the drug’s common uses.

LOWEST PRICED EQUIVALENT / LOWEST COST ALTERNATIVE (LCA) PRICING

29. What is lowest priced equivalent or lowest cost alternative pricing?

Lowest priced equivalent / lowest cost alternative (LCA) pricing applies to the maximum amount the plan will reimburse for generic drugs. Effective January 1, 2016, claims for prescription drugs with a generic substitution, including those where “no-substitution” is identified on the prescription, are reimbursed at the rate of the lowest-priced equivalent. If there is a medically supported reason why an alternative generic drug cannot be used, a member may have their physician complete the Sun Life Drug Exemption form and submit it to Sun Life for review. If a covered member chooses to purchase a brand name drug, the difference between the lowest price generic drug and the brand name will be the member's expense.

Prior to January 1, 2016, if an employee was prescribed a brand name drug, the plan normally required a generic substitution to be covered for the entire cost of the prescription however physicians could override the generic drug by indicating that the brand name drug is required on the prescription. Brand name drugs
are always much more expensive that the cost of the generic equivalent drug even though they have the same active ingredients to treat the same condition.

Beginning January 1, 2016, the plan only pays the lowest cost of the generic drug equivalent, even if a patient or physician prescribes a higher cost alternative or brand name drug. Additional costs will need to be paid by the patient however can be submitted through the Health Spending Account for reimbursement if enough credits are available.

30. What if I can’t take the generic version of the brand name drug?

For some patients, ingredients in a generic drug may cause side effects requiring a physician to make a substitution. Exceptions to the mandatory LCA pricing will only be considered with the submission of medical evidence to Sun Life to substantiate a drug other than the lowest cost alternative. Your physician will be required to complete the Drug Exception form from Sun Life.

MAC (MAXIMUM ALLOWABLE COST) / REFERENCE BASED PRICING

31. What is maximum allowable cost or reference based pricing?

There are a number of drug products that have therapeutic alternatives (drugs with different active ingredients) which treat the same condition and are considered equally safe and effective. For various reasons however, the price of those drugs can drastically differ even though they all treat the same condition. Reference based pricing is a standard practice of drug plans paying for the cost of the lowest priced drug (maximum allowable cost) in a therapeutic drug class.

Beginning January 1, 2016, the support staff benefits plan introduced alternative reference pricing in several therapeutic classes used to treat stomach hyperacidity, high blood pressure, and cholesterol. The benefits plan will pay the price of the lowest cost alternative drug in the class, whether a patient chooses that product or another in the same class. Patients may choose to switch to a preferred product (maximum allowable cost drug) in order to not incur out-of-pocket expenses.

For example, if you were taking medication to treat stomach hyperacidity, there are many different medications available ranging from $0.24 per pill to $2.39 per pill. Beginning January 1, 2016, the support staff benefits plan pays the lowest cost or $0.24 per pill.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Price per Pill</th>
<th>Amount Paid by Drug Plan Per Pill**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dexilant (brand)</td>
<td>$2.39</td>
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<tr>
<td>Nexium (brand)</td>
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<tr>
<td>Rabeprazol (generic Pariet) *</td>
<td>0.24</td>
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</tr>
</tbody>
</table>

* Preferred (maximum) allowable cost

** Additional costs may be submitted to HSA account if credits are available.
32. What drugs are covered within the maximum allowable cost program?

The support staff drug plan applies a maximum dollar amount to the therapeutic class of drugs (Column 2) based on the most cost-effective drug within the class (the reference drug) as shown in Column 4 of Table 1 below. Prescriptions for drugs within these classes (Column 3) are reimbursed at the maximum allowable cost. Members do not have to be prescribed an alternative drug within the MAC program to be reimbursed at the maximum allowable cost.

Members with prescriptions for drugs in these therapeutic drug classes that were reimbursed in the 120 days prior to January 1, 2016 will not be grandfathered.

No exceptions are permitted in this program. Members will only be reimbursed for the maximum allowable price of the drugs listed within Column 4.

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<thead>
<tr>
<th>Health Condition</th>
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<tbody>
<tr>
<td>High blood pressure</td>
<td>Angiotensin converting enzyme inhibitors</td>
<td>Mavik (Trandolapril) Accupril (Quinapril) Conversyl (Perindopril) Monopril (Fosinopril) Vasotec (Enalapril) Inhibace (Cilazapril) Lotensin (Benazepril)</td>
<td>Altace (Ramipril) Zestril, Prinivil (Lisinopril)</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Angiotensin II receptor blockers</td>
<td>Cozaar (Losartan) Olmetec (Olemesartan) Teveten (Eprosartan) Avapro (Irbesartan) Edarbi (Azilsartan)</td>
<td>Diovan (Valsartan) Atacant (Candesartan) Micardis (Telmisartan)</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Dihydropyridine calcium channel blockers</td>
<td>Plendil, Renedil (Felodipine) Adalat XL (Nifedipine)</td>
<td>Norvasc (Amlodipine)</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>HMG-CoA reductase inhibitors</td>
<td>Lipitor (Atorvastatin) Zocor (Simvastatin) Mevacor (Lovastatin) Pravachol (Pravastatin) Lescol (Fluvastatin)</td>
<td>Crestor (Rosuvastatin)</td>
</tr>
<tr>
<td>Stomach Hyperacidity</td>
<td>Proton pump inhibitors</td>
<td>Pantoloc (Pantaprazole sodium) Dexilant (Dexlansoprazole) Prevacid (Lansoprazole) Losec (Omeprazole) Tecta (Pantoprazole magnesium)</td>
<td>Pariet (Rabeprazole)</td>
</tr>
</tbody>
</table>
33. How can I learn more about these changes?

To review the upcoming changes in more detail and access other information about your extended health, drug and dental plan benefits, please visit The Support Staff Benefits section of the Human Resource Services website at [http://www.hrs.ualberta.ca/Benefits/Overview/SupportStaffBenefitsPlanChanges.aspx](http://www.hrs.ualberta.ca/Benefits/Overview/SupportStaffBenefitsPlanChanges.aspx).

We encourage you to go to the Sun Life website at www.mysunlife.ca and review resources available to you as a plan member. If you have any questions, please contact Payroll and Benefit Services at benefits@ualberta.ca or by phone at 780-492-4555.

34. Who is on the Support Staff Benefits Committee?

The Support Staff Benefits Committee (SSBC) is a joint committee with representatives from both NASA and the University. The members are committed to managing the support staff benefits plan in accordance with the terms of reference outlined in Appendix B1 of the Common Provisions in the NASA collective agreement. The committee is co-chaired by NASA and Human Resource Services. The current members are: Joy Correia (NASA), Nancy Furlong (NASA), Elizabeth Johansson (NASA), Brian Pearson (Human Resource Services), Wayne Patterson (Human Resource Services), Martin Coutts (Financial Services).

35. How do I contact the Support Staff Benefits Committee?

Please visit [nasa.ualberta.ca](http://nasa.ualberta.ca) for contact information on the NASA members or use the University Directory available at [http://webapps.srv.ualberta.ca/search/](http://webapps.srv.ualberta.ca/search/) for the University members.