Minneapolis Retail Meat Cutters & Food Handlers Health and Welfare Fund

UFCW a VOICE for working America Local 663 Preparing today for a secure future.

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TO: Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Plan Participants

COVID-19 Tests Available Directly from the Government

The United States government is also providing free at home COVID test kits. Please visit www.covidtests.gov to order up to 4 free tests per household. The tests kits will ship through the USPS and are expected to ship out 7 to 12 days to most residential addresses.

Coverage of At-Home COVID-19 Tests as of January 15, 2022

The Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Plan ("Plan") will provide coverage for at-home over-the-counter ("OTC") COVID-19 test kits purchased on and after January 15, 2022 subject to the following provisions.

- ***The Plan will only cover COVID-19 test kits available "over the counter" that have been approved by the FDA for use at home or elsewhere without involvement of a health care provider*** purchased January 15, 2022 through the end of the COVID-19 Public Health Emergency that was declared by the Department of Health and Human Services. Please go to www.fda.gov to learn which tests are currently FDA approved or check the packaging on the test kit before purchasing.

- The Plan will cover 100% of the cost (no Deductible or Copay) for up to eight (8) at-home OTC COVID-19 test kits per Covered Person under the Plan every 30 days.

    - You must purchase the OTC COVID-19 test at the pharmacy counter of a pharmacy in the Express Scripts Choice Plus network and present your Plan Prescription card at the time of purchase. If the in-network pharmacy is set up to process test kits in the same manner as a prescription, you will not pay any amount for the OTC COVID-19 test kits at the time of purchase.

    - Some pharmacies in the Express Scripts Choice Plus network are not set up to process at-home OTC COVID-19 test kits in the same manner as a prescription. You must pay 100% of the cost for at-home OTC COVID-19 test kits you purchase at one of these pharmacies. The Plan will reimburse you for the entire cost of these at-home OTC COVID-19 test kits if you save your receipt of purchase and submit the receipt along with the "*Over-The-Counter (OTC) COVID-19 Test Kit Claim Reimbursement Request"* form to Express Scripts at their address noted on the reimbursement request form. Reimbursement request forms are available at www.express-scripts.com. A sample claim form is also attached to this Notice.

- Plan reimbursement for at-home OTC COVID-19 test kits that you **do not purchase** at an Express Scripts Choice Plus in-network pharmacy will be limited to the cost of the test or $12, whichever is less. You are responsible for any amount that you pay in excess of $12 for an at-home OTC COVID-19 test kit purchased at a pharmacy that is not in the Express Scripts Choice Plus network, or any other retailer or supplier. The Plan will not count these costs towards your Prescription Drug Benefit Annual Out-of-Pocket Maximum.

- Save your receipt of purchase and submit the receipt along with the "*Over-The-Counter (OTC) COVID-19 Test Kit Claim Reimbursement Request"* form to Express Scripts at their address noted on the reimbursement request form. Reimbursement request forms are available at www.express-scripts.com.

- The Plan will cover only OTC COVID-19 test kits for at-home medical use by you or your covered household family members. Tests for employment purposes or resale will not be covered or reimbursed under this program.

The above provisions only apply to at-home OTC COVID-19 test kits and do not affect previous Plan provisions regarding coverage of non-at-home OTC COVID-19 test kits.

Questions

Federal and state agencies are frequently releasing new information and guidance about COVID-19. This means the information above is subject to change. If you have any questions about the Plan's coverage of at-home COVID-19 test kits or your pharmacy benefits in general, please call the Fund Office at (952) 851-5797 or toll-free at (844) 468-5917 or at www.663benefits.com.

Prescription Drug Reimbursement / Coordination of Benefits Claim Form

Did you know that you can now submit your prescription claims to us electronically?
Login to express-scripts.com and select Benefits ➔ Forms & Cards

EXPRESS SCRIPTS®

›› Cardholder 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

- ☐ Female
- ☐ Male

Relationship to Plan Member

- ☐ 1 Self
- ☐ 2 Spouse
- ☐ 3 Eligible Child
- ☐ 4 Dependent Student
- ☐ 5 Disabled Dependent
- ☐ 6 Dependent Parent
- ☐ 7 Non-spouse Partner
- ☐ 8 Other

›› Pharmacy Information

Name of Pharmacy

Street Address

City State ZIP

Telephone (include area code) - -

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

I hereby certify that the charge(s) shown for the medication(s) prescribed is correct and agree to provide Express Scripts or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the plan member and assignment of these benefits to a pharmacy or any other party is void.

X _____
Signature of Pharmacist or Representative **(Required)**

NCPDP/NPI Required

›› Claim Receipts

Tape receipts or itemized bills on the back.
See back for details.
Check the appropriate box if any receipts or bills are for a:

☐ **Compound prescription**
Make sure your pharmacist lists ALL the VALID NDC numbers, cost and quantities for each ingredient on the back of this form and attach receipts. Claim will be returned if incomplete.
ONE CLAIM FORM PER COMPOUND SUBMISSION

☐ **Medication purchased outside of the United States**
Please indicate:
Country _____
Currency used _____

☐ **Allergy medication**

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

☐ Another Health Plan paid and you are enclosing a statement that outlines how much you paid and how much the other carrier paid (1)

☐ Card Program (3)

☐ Express Scripts Mail Order (4)

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any materially false, deceptive, incomplete, or misleading information pertaining to such claim may be committing a fraudulent insurance act, which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment or denial of benefits.†

Please tape receipts on the back of this page.

›› Acknowledgment

I certify that the medication(s) described was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I certify that the medication(s) described were not for an on-the-job injury. *By completing this form, 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.**

X _____ _____
Signature of Member Date

*If allowed by law, you may assign the payment of this claim to your pharmacy. If your pharmacy is willing to accept assignment, do not complete this form. Please request that your pharmacy contact Pharmacy Services at 800.922.1557 for assistance.

Claim Receipts

Please tape your receipts here. **Do not staple!** If you have additional receipts, tape them on a separate piece of paper

Tape receipt for prescription 1 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and day supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

Tape receipt for prescription 2 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and day supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

COMPOUND PRESCRIPTIONS ONLY

- List the VALID 11-digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- For each NDC number, indicate cost per ingredient.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

Rx # ☐☐☐☐☐☐☐☐☐☐☐☐

Date Filled ☐☐/☐☐/☐☐☐☐ Day Supply ☐☐☐ Quantity ☐☐☐☐☐

Valid 11-digit Ingredient NDC	Metric Quantity	Ingredient Cost
	Total charge	

Instructions Read carefully before completing this form.

1. Always present your prescription drug ID card at the participating retail pharmacy.
2. Use this form when you have paid full price for a prescription drug at a retail pharmacy or need to submit claims under Coordination of Benefits rules:
3. **You must complete a separate claim form for each pharmacy used and for each patient.**
4. You must submit claims within 1 year of date of purchase or as required by your plan.
5. **Be sure your receipts are complete.**

   In order for your request to be processed, all receipts must contain the information listed at the top of this page. Your pharmacist can provide the necessary information if your claim or bill is not itemized.
6. The plan member should read the acknowledgment carefully, and then sign and date this form.
7. **Return the completed form and receipt(s)** to:
   Express Scripts
   ATTN: Commercial Claims
   P.O. Box. 14711
   Lexington, KY 40512-4711
8. You may also **fax your claim form to: 608.741.5475.**

Please use one claim form per fax. Do not combine claims for different members in the same fax submission.

Additional Coordination of Benefits Instructions

Another Health Plan Paid

You must first submit the claim to the primary insurance carrier. Once the statement from the primary plan is received from the primary carrier, complete this form, tape the original prescription receipts in the spaces provided at the top of this page, and attach the statement from the primary plan, which clearly indicates the cost of the prescription and what was paid by the primary plan.

Prescription Drug Programs or HMO Plans

Retail pharmacies

If the primary plan is one in which a copayment or coinsurance is paid at a retail pharmacy, then no EOB is needed. Just complete this form and attach the prescription receipt(s) that shows the copayment or coinsurance amount paid at the pharmacy. The receipt(s) will serve as the EOB.

The Express Scripts Pharmacy

If the primary plan is mail order, complete this form and attach either the prescription receipt(s) that shows the copayment or coinsurance amount paid to the mail-order pharmacy or the statement of benefits you receive from the mail-order pharmacy.

† **California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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