# SHEET METAL WORKERS' LOCAL UNION NO. 80
# FRINGE BENEFIT FUNDS

P.O. Box 1408 / Troy, MI 48099-1408 / (248) 641-4980 (800) 400-7710


*January 24, 2022*

To: All Eligible Active PPO Participants and Non-Medicare Eligible Retirees in the Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund

From: Board of Trustees
Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund

RE: **OVER-THE-COUNTER (OTC) COVID-19 TESTS**

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The federal government now requires group health plans – like the Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund (Fund) – to cover the entire cost of FDA-authorized, OTC COVID-19 tests without a prescription so you can receive them without any cost to you for purchases made on and after January 15, 2022 for the duration of the national public health emergency. Below, we describe important limitations and restrictions about this new and temporary benefit.

Although the government has mandated that you receive OTC COVID-19 tests without any cost to you, the Fund will cover the entire cost of you and your family's OTC COVID-19 tests. That is, the government is <u>not</u> paying for any portion of the costs associated with OTC COVID-19 tests.

For this reason, the Trustees ask that you only purchase OTC COVID-19 tests you and your family need and not stockpile unneeded tests. In addition, the federal mandate does not require the Fund to provide coverage of testing (including OTC COVID-19 tests) that is purchased for employment purposes, so any test paid for or reimbursed by the Fund should not be used for that purpose.

The Trustees have chosen to have OTC COVID-19 test claims processed as pharmacy benefits through the Fund's pharmacy benefits manager, Elixir Pharmacy, instead of medical benefits through Blue Cross Blue Shield of Michigan. ***As such, please present your Rx card (Elixir) and not your medical card (BCBSM) at the pharmacy counter when you purchase your OTC COVID-19 tests.***

The Trustees encourage you to purchase tests at participating in-network pharmacies, which are the same places you would typically fill your prescription medications like Kroger, Walgreens, CVS, Rite Aid, or Meijer. If you purchase a test at a participating in-network pharmacy, it should be processed with $0 cost-sharing at the point-of-sale, meaning that you should be able to leave the pharmacy with the OTC COVID-19 test without having to pay anything out-of-pocket.

If you purchase an OTC COVID-19 test at an out-of-network pharmacy or other retailer or if you have issues at the pharmacy counter at a participating in-network pharmacy, you will pay up front for the cost of the test(s), but you may submit your receipt for reimbursement at a rate of up to $12 per test (if the cost of the test was less than $12, you will be reimbursed the actual amount of the test). To request reimbursement, you must complete and mail the enclosed reimbursement form to Elixir, including a receipt that indicates the amount you paid, the date of purchase and where you purchased the test. Additional forms are available to download at www.elixirsolutions.com/members (under Member Resources - Forms and Documents, entitled Reimbursement Form).

Each covered individual *(i.e.,* you, your spouse, and each of your children) who is not eligible for Medicare may buy up to eight tests per month with no cost sharing regardless of whether the tests are purchased at one time or at separate times. Please note this is the total number of tests, not boxes. If your OTC COVID-19 purchase contains two tests per box, you will be limited to four boxes per month.

Medicare beneficiaries are not covered by this mandate.

Please contact Elixir Pharmacy customer care to find out if tests are available for shipping.

The FDA-authorized tests covered by the mandate as of the date of this notice are:

1. BinaxNow COVID-19 Antigen Self-Test
2. BinaxNow COVID-19 Ag Card 2 Home Test
3. COVID-19 At-Home Test (SD Biosensor, Inc.)
4. CLINITEST Rapid COVID-19 Antigen Self-Test
5. iHealth COVID-19 Antigen Rapid Test
6. CareStart COVID-19 Antigen Home Test
7. BD Veritor At-Home COVID-19 Test
8. SCoV-2 Ag Detect Rapid Self-Test
9. InteliSwab COVID-19 Rapid Test
10. Celltrion Dia Trust COVID-19 Ag Home Test
11. QuickVue At-Home OTC COVID-19 Test
12. Flowflex COVID-19 Antigen Home Test
13. Ellume COVID-19 Home Test
14. Detect COVID-19 Test
15. Lucira CHECK-IT COVID-19 Test Kit
16. Cue COVID-19 Test for Home and Over The Counter Use

This Notice contains important information about the Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund Plan changes. Please keep this notice for future reference.

Sincerely,
*Board of Trustees*
*Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund*

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**USE THIS FORM TO REQUEST REIMBURSEMENT FOR CLAIMS THAT YOUR PHARMACY DIDN'T PROCESS UNDER YOUR INSURANCE.**

Cardholder Name: _____ Cardholder ID: _____

Patient Name: _____ Patient DOB: _____

Cardholder Address: _____ City/State: _____ ZIP Code _____

Phone Number: _____

Is this a Coordination of Benefits Claim? ☐ Yes ☐ No

**Internal Use Only: Episode Number:**

**Please include a pharmacy receipt for each medication to avoid denial and/or delays in processing your case.**
**A cash register receipt alone cannot be used to process your claims.**

**All information in the below boxes must be completed in order to avoid delay or denial of your claim.**

| | **Medication #1** | | **Medication #2** | |
|---|---|---|---|---|
| Pharmacy NABP: (Obtain from pharmacy) | | | Pharmacy NABP: (Obtain from pharmacy) | |
| Fill Date: | | | Fill Date: | |
| RX #: | | | RX #: | |
| National Drug Code (NDC) (11 Digits) | | | National Drug Code (NDC) (11 Digits) | |
| Medication Name: | | | Medication Name: | |
| Medication Strength: | | | Medication Strength: | |
| Physician Name: | | | Physician Name: | |
| Physician NPI: (Obtain from physician) | | | Physician NPI: (Obtain from physician) | |
| Quantity/Day Supply: | | | Quantity/Day Supply: | |
| Patient Paid: | | | Patient Paid: | |

Please provide a brief explanation regarding why you paid out of pocket for your medication(s). (Attach a separate sheet if additional space is required)

This form can be faxed to: 866-646-1403 OR This form can be mailed to:

Elixir – DMR
8935 Darrow Rd
P.O. Box 1208
Twinsburg, OH 44087

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**All information in the below boxes must be completed in order to avoid delay or denial of your claim.**

| Additional Medication | | Additional Medication | |
|---|---|---|---|
| Pharmacy NABP:<br>(Obtain from Pharmacy) | | Pharmacy NABP:<br>(Obtain from Pharmacy) | |
| Fill Date: | | Fill Date: | |
| RX #: | | RX #: | |
| National Drug Code<br>(NDC) (11 Digits) | | National Drug Code<br>(NDC) (11 Digits) | |
| Medication Name: | | Medication Name: | |
| Medication Strength: | | Medication Strength: | |
| Physician Name: | | Physician Name: | |
| Physician NPI:<br>(Obtain from Physician) | | Physician NPI:<br>(Obtain from Physician) | |
| Quantity/Day Supply: | | Quantity/Day Supply: | |
| Patient Paid: | | Patient Paid: | |

| Additional Medication | | Additional Medication | |
|---|---|---|---|
| Pharmacy NABP:<br>(Obtain from Pharmacy) | | Pharmacy NABP:<br>(Obtain from Pharmacy) | |
| Fill Date: | | Fill Date: | |
| RX #: | | RX #: | |
| National Drug Code<br>(NDC) (11 Digits) | | National Drug Code<br>(NDC) (11 Digits) | |
| Medication Name: | | Medication Name: | |
| Medication Strength: | | Medication Strength: | |
| Physician Name: | | Physician Name: | |
| Physician NPI:<br>(Obtain from physician) | | Physician NPI:<br>(Obtain from physician) | |
| Quantity/Day Supply: | | Quantity/Day Supply: | |
| Patient Paid: | | Patient Paid: | |

For additional medications, attach a separate page.

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# INSTRUCTIONS

## A. WHEN TO USE THIS FORM

1. This claim form is to be used only when it has been necessary to purchase prescriptions because your participating pharmacy did not honor your identification card or was unable to directly submit your claim. It should also be used when it was necessary to have your prescriptions filled at a non-participating pharmacy.
2. Submit this form to the address below as soon as you have your prescription(s) filled in order to receive prompt payment. IT IS NOT necessary to keep the form until completely filled.

## B. HOW TO COMPLETE THIS FORM

1. Complete the upper portion of the claim form under **Cardholder Information.** Transfer the Cardholder Identification Number, Member Number (if applicable) and Group Number from your identification card.
2. A separate claim form must be completed for each **patient.**
3. Have your pharmacist complete the **PRESCRIPTION INFORMATION** section for each prescription filled and the **PHARMACY INFORMATION** section. If you are unable to have the form completed by your pharmacist, most of the information needed in these sections can be copied from the prescription label and/or your receipt.
4. **IMPORTANT:** The drug quantity, drug name and strength **or** eleven digit National Drug Code (NDC) is required and **must** appear on your submitted claim(s) or receipt(s).
5. **The original paid pharmacy receipt(s) must accompany this form. A cash register receipt is not satisfactory proof of purchase.**
6. **FOR COMPOUNDED PRESCRIPTIONS ONLY:** Ask your pharmacist for assistance. The NDC number appearing on the claim should be that of the most expensive prescription ingredient. Should you have more than one compounded prescription, please use additional claim forms.
7. Claim forms submitted without the required information can cause payment delays and result in the information being returned for completion.

## C. WHERE TO MAIL THIS FORM

1. Mail this form and your original paid pharmacy receipt(s) to: Your Benefit Manager at your company or:

   Elixir – DMR
   8935 Darrow Rd
   P.O. Box 1208
   Twinsburg, OH 44087

2. Or you can fax this form and your receipts to 866-646-1403 Attn: DMR Department.
3. Please allow up to four weeks for processing and payment of your claims. For Part D claims, please allow up to 14 days for processing and payment of your claims.
4. You may call 1-800-361-4542 between 8:00 AM and 9:00 PM (Eastern Time) for questions or problems concerning your submitted claims.

**CLAIMS WITH MISSING OR ILLEGIBLE INFORMATION WILL BE RETURNED**