HAWAII ELECTRICIANS HEALTH & WELFARE FUND

1935 HAU STREET, ROOM 300 ● HONOLULU, HAWAII 96819-5003 ● PHONE (808) 841-6169 ● FAX (808) 847-4596

February 2022

To: All Active Employees, Non-Medicare Retirees, and Dependents, including Participants of the Oceanic Time Warner Retiree Plan and COBRA beneficiaries, of the Hawaii Electricians Health and Welfare Fund (HEHWF)

From: Travis Umemoto, Administrator

Re: New Pharmacy Benefits Manager (PBM) Express Scripts, Over the Counter (OTC) Covid-19 Test Benefits

New PBM Express Scripts

By now you should have received your Welcome Packet from the Fund's new PBM Express Scripts. The packet includes your new benefits cards as well as an application if you want to sign up to have your medication delivered to your home. If you did not receive a Welcome Packet yet, if you may have discarded the packet by mistake, or if you have any questions on Express Scripts, please contact our office at 808-841-6169, Option 1 or Option 2.

OTC Covid Test Benefit

Free COVID-19 Test Kits Under New Governmental Programs
Now you can get one set of four (4) at-home COVID-19 test kits for free. This is a government-sponsored program that's available to all residential households in the U.S. Simply visit **special.usps.com/testkits**, fill in and submit the form, and the kits will be mailed directly to your door.

You may also locate low or no cost COVID-19 tests in your community
via https://www.hhs.gov/coronavirus/community-based-testing-sites/index.html

Plan Coverage of COVID-19 Test Kits
In addition to the above governmental programs, the Fund also now provides coverage for COVID-19 test kits. Under this benefit, which applies to COVID-19 test kits purchased on or after January 15, 2022, and through the end of the Coronavirus public health emergency period, the Fund will provide coverage for up to eight (8) FDA-approved at-home COVID-19 test kits every 30 days for you and each eligible dependent that you purchase over the counter (OTC) for you or your family's personal use. For example, a family of four can receive coverage under this benefit for up to 32 OTC test kits every 30 days. You will not be required to get a doctor's order or an individualized clinical assessment. While the quantity limit applies to OTC at-home test kits purchased without the involvement of a health care provider, the Fund continues to cover COVID-19 tests performed by in-network health care providers without a quantity limit.

The best way to utilize this benefit is to purchase OTC COVID-19 test kits at an **Express Scripts network pharmacy**. When you do this, your eligible test kit purchases will be directly covered at point of sale with no cost to you. **Important Note! For this method, you must take the COVID-19 test kit to the pharmacy register and show them your new Express Scripts Benefit Card.** Alternatively, you can purchase OTC COVID-19 test kits at a non-network pharmacy. However, if you do this, you will need to pay the full cost up front out of pocket and then submit a claim for reimbursement to Express Scripts and the amount that you are eligible to be reimbursed for will be capped at $12 per test (see following pages for claim form to mail. If you registered for an account with Express Scripts, you may file a reimbursement claim online. See instructions on the following pages). **Please do not submit reimbursement claims to HWMG, as they will be rejected.** Any reimbursement claims for this benefit must be submitted to Express Scripts.

Please do not stockpile tests so that they will be more readily available for those who really need them. COVID-19 tests have expiration dates and stockpiling tests also may result in waste of unused tests.

Prescription Drug Reimbursement / Coordination of Benefits Claim Form

Did you know that you can now submit your prescription claims to us electronically?
Log in 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

NCPDP/NPI Required

Claim Receipts

Tape receipts or itemized bills on the back.
Check the appropriate box:

☐ **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.

☐ **Medication Purchased Outside of the United States**
Country _____
Currency used _____

☐ **Allergy Medication**

☐ **Covid Test Kit**
Kit Name _____
Kit Code (NDC/UPC) _____
Number of Kits _____
Tests per Kit _____
Purchase Date _____

This test was purchased by the customer for personal use or the use of a covered plan member and was not purchased for employment purposes. This test will not be reimbursed by another source nor placed for resale.

Coordination of Benefits

Mark the appropriate box for your primary coverage method.

Did another insurance pay for all/part of this claim?
☐ Yes ☐ No

Is an Explanation of Benefits included?
☐ Yes ☐ No

Is this a discount card claim?
☐ Yes ☐ No

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.†

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.

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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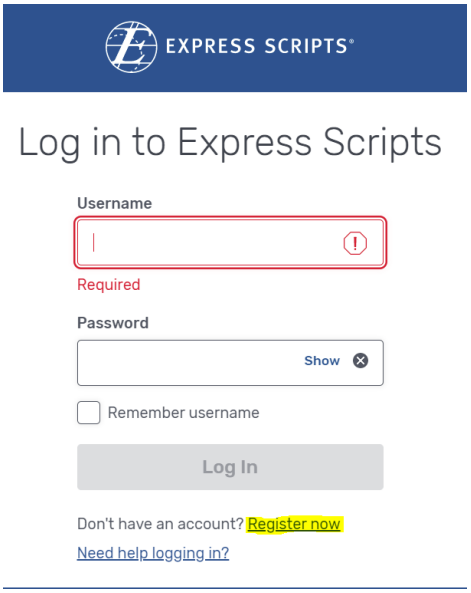
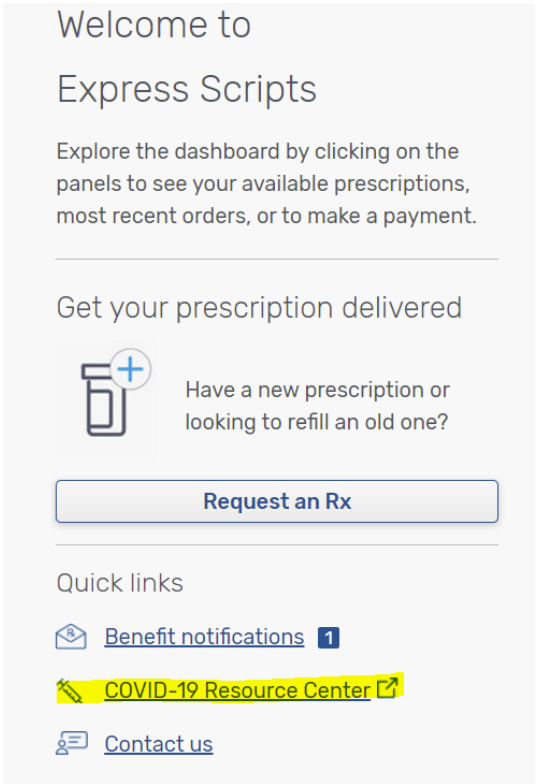
COVID-19 Over the Counter Online Reimbursement Instructions

1) **Log in to Express Scripts** at https://www.express-scripts.com/login

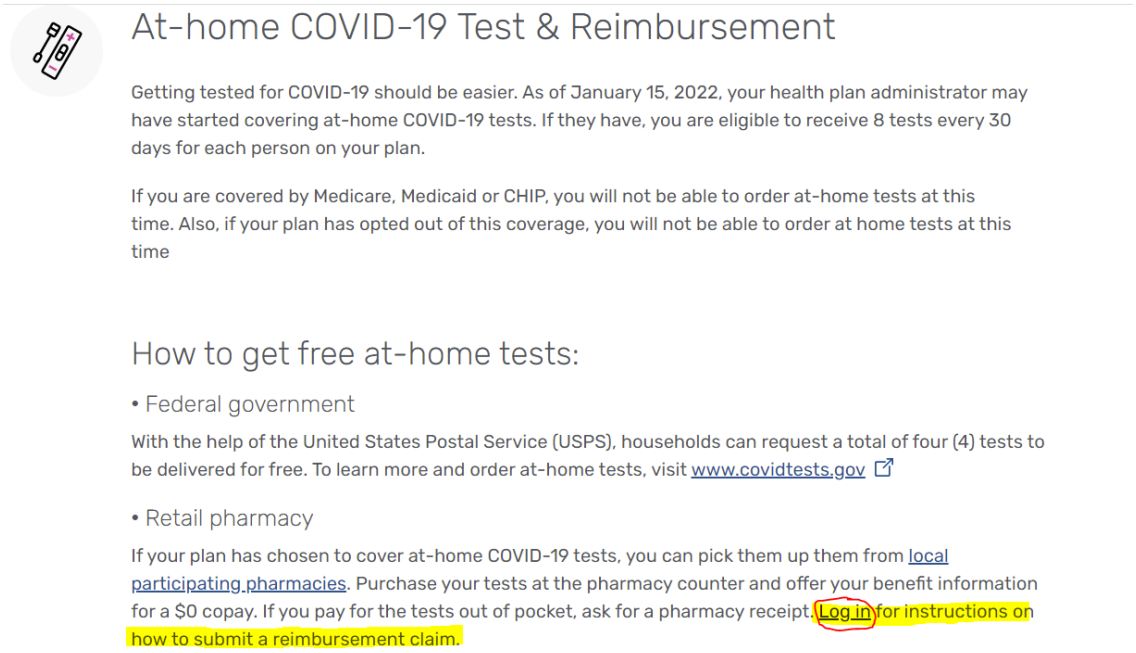
2) **Register to set up your account if you haven't already done so**



3) **Click on the COVID-19 Resource Center**



4) **Click on "Log in" to submit a reimbursement claim**



At-home COVID-19 Test & Reimbursement

Getting tested for COVID-19 should be easier. As of January 15, 2022, your health plan administrator may have started covering at-home COVID-19 tests. If they have, you are eligible to receive 8 tests every 30 days for each person on your plan.

If you are covered by Medicare, Medicaid or CHIP, you will not be able to order at-home tests at this time. Also, if your plan has opted out of this coverage, you will not be able to order at home tests at this time

How to get free at-home tests:

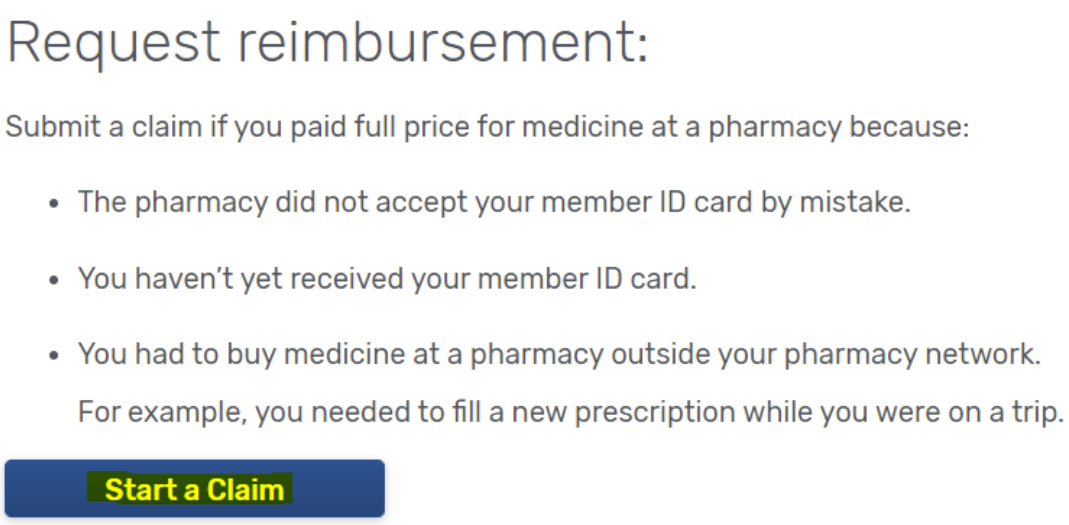
• Federal government

With the help of the United States Postal Service (USPS), households can request a total of four (4) tests to be delivered for free. To learn more and order at-home tests, visit www.covidtests.gov

• Retail pharmacy

If your plan has chosen to cover at-home COVID-19 tests, you can pick them up them from local participating pharmacies. Purchase your tests at the pharmacy counter and offer your benefit information for a $0 copay. If you pay for the tests out of pocket, ask for a pharmacy receipt. Log in for instructions on how to submit a reimbursement claim.

5) **Click on "Start a Claim"**



Request reimbursement:

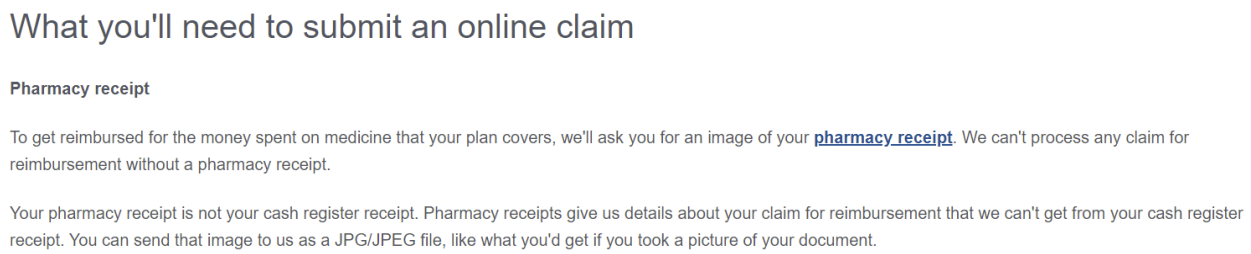
Submit a claim if you paid full price for medicine at a pharmacy because:

- The pharmacy did not accept your member ID card by mistake.
- You haven't yet received your member ID card.
- You had to buy medicine at a pharmacy outside your pharmacy network.

  For example, you needed to fill a new prescription while you were on a trip.

Start a Claim

6) **You will need to have an image of your receipt to upload**



What you'll need to submit an online claim

Pharmacy receipt

To get reimbursed for the money spent on medicine that your plan covers, we'll ask you for an image of your **pharmacy receipt**. We can't process any claim for reimbursement without a pharmacy receipt.

Your pharmacy receipt is not your cash register receipt. Pharmacy receipts give us details about your claim for reimbursement that we can't get from your cash register receipt. You can send that image to us as a JPG/JPEG file, like what you'd get if you took a picture of your document.

7) **Answer the questions that follow**