Northern Minnesota-Wisconsin Area Retail Clerks Fringe Benefit Funds

2002 London Road – Suite 300
Duluth, MN 55812

Wilson-McShane Corporation
Fund Administrators

Telephone: (218) 728-4231
Toll Free: (877) 752-3863 (FUND)

April 2022

TO: Northern Minnesota-Wisconsin Area Retail Food Health and Welfare Fund Participants

1. COVID-19 Tests Available Directly from the Government

The United States government is providing free at home COVID test kits. Please visit www.covidtests.gov or call 1-800-232-0233 (TTY 1-888-720-7489) to order up to two sets of four free tests per household. The test kits will ship through the USPS and are expected to ship out 7 to 12 days after the order date to most residential addresses.

2. Coverage of At-Home COVID-19 Tests On and After April 1, 2022

The Northern Minnesota-Wisconsin Area Retail Food Health and Welfare Fund ("Plan") will provide Plan participants and covered family members with coverage for at-home over-the-counter ("OTC") COVID-19 test kits. This section discusses the Plan's coverage of at-home OTC COVID-19 test kits purchased at a pharmacy or other retailer or ordered through the Elixir Mail Order Pharmacy on and after April 1, 2022 through the end of the COVID-19 Public Health Emergency declared by the Department of Health and Human Services. *(See section 3 below for information regarding coverage of at-home OTC COVID-19 test kits during the period from January 15, 2022 to March 31, 2022).*

- ***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.*** Please go to www.fda.gov to learn which tests are currently FDA approved or check the packaging on the test kit before purchasing.

- If purchased through the Elixir Mail Order Pharmacy or at an in-network pharmacy, the Plan will cover 100% of the cost (no Deductible or Copayment) for up to eight at-home OTC COVID-19 test kits per covered Eligible Person under the Plan per calendar month.

- Elixir Mail Order Pharmacy:

    - You can order eight at-home COVID-19 test kits per Eligible Person per calendar month from the Elixir Mail Order Pharmacy at no cost to you. A minimum of eight tests is required per order.

    - To order at-home COVID-19 test kits from the Elixir Mail Order Pharmacy, have your Plan Prescription card ready and call (866) 909-5170.

- In-Network Pharmacies:

    - You must purchase the OTC COVID-19 test kits at the pharmacy counter of a pharmacy in Elixir's 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 Elixir 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 a request for reimbursement to Elixir, following the reimbursement instructions at elixir.info/otc-guide.

- Out-of-Network Pharmacies and Other Retailers:
    - Plan reimbursement for at-home OTC COVID-19 test kits that you **do not purchase** at an Elixir in-network pharmacy will be limited to the cost of the test kit 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 Elixir pharmacy network or from any other retailer or supplier. For reimbursement (subject to these limitations), save your receipt of purchase and submit a request for reimbursement to Elixir, following the reimbursement instructions at elixir.info/otc-guide.

- The Plan will cover only OTC COVID-19 test kits for at-home medical use by you. 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.

3. **Coverage of At-Home COVID Tests Purchased Between January 15, 2022 and March 31, 2022**

The Plan covered 100% of the cost (no Deductible or Copayment) for up to eight at-home OTC COVID-19 test kits per Eligible Person under the Plan per calendar month that were purchased during the period from January 15, 2022 through March 31, 2022 subject to the following.

- ***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.*** Please go to www.fda.gov to learn which tests are currently FDA approved or check the packaging on the test kit.

- At-home OTC COVID-19 test kits purchased during this period are covered in full regardless of whether the test kit was purchased at an in-network pharmacy or an out-of-network pharmacy or other retailer.

- If you paid out-of-pocket for at-home OTC COVID-19 test kits during this period, the Plan will reimburse you for the entire cost of the at-home OTC COVID-19 test kits already purchased. In order to be reimbursed, submit your receipt and a separate claim form for each covered person to the Fund Office at the address listed on the form.

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

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, please call the Fund Office at (218) 728-4231 or (877) 752-3863.

5 Easy Ways to Get Your FREE At-Home, Rapid COVID-19 Tests

The federal government is encouraging Americans to get at-home COVID-19 tests for use if you have symptoms or suspect you've been exposed. Here are five easy ways you can get yours.

1 Free Tests from the Federal Government

Every U.S. household can order two sets of four free at-home tests, which are shipped directly to your home from the U.S. Postal Service. If you haven't taken advantage of this, visit **covidtests.gov** to get started.

2 Your Local Pharmacy Counter*

If your health plan is covering OTC COVID-19 tests **under the pharmacy benefit, you may be able to get** up to eight free tests per covered member per month.

All you have to do is:

- Go to the pharmacy counter (where you would normally purchase your prescription medications)
- Present your Member ID card
- Ask to have your OTC at-home COVID-19 tests submitted to your plan for coverage

3 Direct Coverage through Elixir Mail Order Pharmacy

If your health plan is covering OTC COVID-19 tests **under the pharmacy benefit, you may order tests from** Elixir Pharmacy at no cost to you. A minimum of eight tests is required per order.

All you have to do is:

- Have your pharmacy benefits Member ID card handy
- Call Elixir Pharmacy at 866-909-5170

4 Purchase from Elixir Mail Order Pharmacy and Request Reimbursement

If your health plan is covering OTC COVID-19 tests **under the medical benefit, you may purchase tests** from Elixir Pharmacy, but you'll have to pay up front and submit your receipts to your health insurance plan. The cost is $11 per test (minimum order of eight tests required) plus tax.

5 Pay Up Front at Other Locations and Request Reimbursement

Reimbursement from Elixir applies only if at-home COVID-19 tests are covered under your pharmacy **benefit rather than the medical benefit. For more** information, please contact your health plan or **benefits department.**

If you purchase tests at non-participating pharmacies or retailers, or if you purchase online, and your plan has chosen to have these tests paid under **the pharmacy benefit, you can submit receipts to** Elixir for up to eight tests per month for each covered person on the plan. See instructions in our reimbursement guide at **elixir.info/otc-guide**.

You will need to complete separate requests for each covered member.

Please allow up to 30 days for claims processing and payment to be issued.

Currently, only a few major pharmacy chains, such as Rite Aid (including Bartell's), Walmart, Sam's Club, Safeway/Albertsons, Price Chopper and Hy-Vee, are processing no-cost COVID-19 tests at the pharmacy counter. (This list of pharmacies is subject to change as more pharmacies develop the capability to process these purchases at no cost to you.)

PLEASE NOTE: The Office of the Inspector General (OIG) has issued a warning about scams involving fake and unauthorized at-home COVID-19 tests. Please be sure to purchase FDA-approved COVID-19 tests from legitimate providers. More information about COVID-19 scams is available on the OIG website at https://oig.hhs.gov/fraud/consumer-alerts/fraud-alert-covid-19-scams/.

elixir
CRAFTED Rx SOLUTIONS

Step-by-Step Guide to Requesting Reimbursement for Over-the-Counter COVID-19 Tests

NOTE: *This process applies only to members whose plans have chosen to have over-the-counter (OTC) COVID-19 tests paid under the pharmacy benefit. If your insurance plan reimburses these purchases under the medical benefit, you will have to submit your receipts to your health insurance plan.* ***Contact your benefits office or department to determine which option your plan has chosen.***

If you determine that your plan is reimbursing for OTC COVID-19 tests under the pharmacy benefit, please gather the following information for each covered member:

- Your Member ID card
- Itemized receipt(s), dated on or after January 15, 2022, showing the retail location where the tests were purchased as well as the date and cost of the tests. ***TIP: Circle the purchase price of the OTC COVID-19 tests.***
- UPC symbols from the tests purchased; see sample at right

You will need to complete separate requests for each covered member. You may submit your requests in one of several ways, depending on the BIN number on your Member ID card.

If the BIN number on the front of your Member ID card is **800004**, follow the directions below to submit your reimbursement request for OTC COVID-19 tests. **Members with <u>all other BIN numbers</u> should follow the instructions starting on page 2.**

1. Download the member reimbursement form for BIN number 800004. You can find it in the FORMS AND DOCUMENTS section at elixirsolutions.com/members.
2. Complete the top CARDHOLDER-PATIENT INFORMATION section.
3. In PRESCRIPTION INFORMATION section:
    a. Enter date the test(s) were purchased in the DATE FILLED box.
    b. Enter the number of tests purchased (for the individual named in the CARDHOLDER-PATIENT INFORMATION) in the METRIC QTY. DISPENSED box.
4. Submit this form along with copies or images of your receipt(s) and the UPC symbols from your test packages via one of the following methods:

    Email to keyedclaims@elixirsolutions.com (preferred method)

    Fax to (866) 552-8939

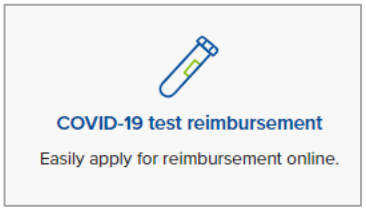
    Mail to Elixir Solutions, PO Box 619, Twinsburg, OH 44087

Please allow up to 30 days for claims processing and payment to be issued.

For all other BIN numbers (*NOT* 800004)

You may be able to submit reimbursement requests via your Member Portal account by following the instructions below. **NOTE: *You will need to complete separate requests for each covered member.***

1. Go to elixirsolutions.com and use the REGISTER OR LOGIN button to access your Member Portal account.
2. If it's visible, select the COVID-19 TEST REIMBURSEMENT icon on the Welcome screen. (If there is no COVID-19 TEST REIMBURSEMENT icon your screen, you will have to use one of the alternate methods indicated below.)



3. Follow the on-screen instructions to complete your request.
NOTE: You can request reimbursement for up to 8 tests per month for each covered person on the plan, but separate requests are required for each covered member.

   To complete your request, you will need:

   - Itemized receipt of COVID-19 tests showing the date or purchase, location of purchase and cost of tests

   (TIP: Circle the tests and purchase price on the receipt and ensure that the location, date of purchase and OTC COVID-19 test price are all visible.)

   - Original or photocopy of UPC (Universal Product Code) symbols from purchased products; see sample at right
   - Number of tests purchased for each covered person

You may also submit your reimbursement requests via mail or fax.

1. Download the member reimbursement form. You can find it in the FORMS AND DOCUMENTS section at elixirsolutions.com/members.
2. Complete the top CARDHOLDER INFORMATION section, and select the NO box in answer to the question, IS THIS A COORDINATION OF BENEFITS CLAIM?
3. In the MEDICATION section:
   a. Enter date the test(s) were purchased in the FILL DATE box.
   b. Enter the number of tests purchased (for the individual named in the CARDHOLDER INFORMATION section) in the QUANTITY/DAYS SUPPLY box.

4. Submit this form along with copies or images of your receipt(s) and UPC symbols via one of the following methods:

   Fax to (866) 646-1403 - Attn: DMR Department

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

Please allow up to 30 days for claims processing and payment to be issued.

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

elixir

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

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: (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:	

Additional Medication		Additional Medication	
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:	

For additional medications, attach a separate page.

NORTHERN MINNESOTA-WISCONSIN AREA RETAIL FOOD HEALTH & WELFARE FUND

COVID-19 OVER THE COUNTER AT-HOME TESTING REIMBURSEMENT FORM

Please use this form to request reimbursement of your COVID-19 Over the Counter (OTC) at-home test purchased between January 15,2022 and March 31, 2022.

To be eligible, the following criteria must apply:

- The at-home test must be approved for use under the Emergency Use Authority (EUA) of the FDA.
- Only for COVID-19 OTC tests purchased on or after 1/15/2022 and through 3/31/2022.
- Reimbursement is limited to eight (8) tests per participant under the Plan in a calendar month.

Participant information:		
Last Name:	First Name:	Birthdate:
Social Security Number:		Phone Number:
Is testing for employment purposes:	Yes □	No □
Total number of tests purchased:*		
Street address:		
City:	State	Zip Code:

How to submit your claim:

1. Complete all applicable blanks on the form.
2. Attach a copy of the itemized receipt. The itemized receipt must include:
   - Name of vendor the test was purchased from,
   - UPC – the Universal Product Code or UPC is usually found on the back of the product,
   - Date(s) of purchase,
   - Number of tests purchased, and
   - Individual charge for each COVID-19 OTC test (or set of tests) purchased.*
3. If you have other health care coverage primary to your Northern Minnesota-Wisconsin Area Retail Food Health & Welfare Fund coverage, submit a claim to your primary plan first. Then, when you submit this claim, include a copy of the Explanation of Health Care Benefits you received from your primary coverage.

Mail this form to: Northern Minnesota-Wisconsin Area Retail Food Health & Welfare Fund
2002 London Road, Suite 300
Duluth, MN 55812
Fax: (218) 728-4231

I certify that the COVID-19 OTC test(s) I am requesting reimbursement for are for personal use, are not for employment purposes, have not been (and will not be) reimbursed by another source, and are not for resale. I attest that the statements provided by me are correct and acknowledge that I will refund the Northern Minnesota-Wisconsin Area Retail Food Health & Welfare Fund duplicate payments to myself (if any) because of coordination of benefits.

Signature: _____ Date signed _____

*Many test kits are only available for purchase in sets of two. Please note the number of individual tests above. For example, if you buy two boxes that each contain two test kits, put “4” in the “Total number of tests purchased” box above.