ELECTRICAL WORKERS HEALTH AND WELFARE FUND

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

A SEPARATE CLAIM FORM MUST BE SUBMITTED FOR EACH PERSON COVERED UNDER THE PLAN

Please use this form to request reimbursement of your COVID-19 Over the Counter (OTC) At-Home Test.

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 the end of the COVID-19 Federal Public Health Emergency (PHE), as determined by the Secretary of Health and Human Services.
- Reimbursement is limited to eight (8) tests per participant or dependent under the Plan in a thirty-day period, with the initial thirty-day period beginning on 1/15/22. Each covered participant or dependent must submit a separate claim form to receive reimbursement. If you receive tests with a $0 copay from a Prime Therapeutics in-network pharmacy it counts against the eight (8) test limit.
- Reimbursement is limited to the lesser of the actual cost of the test or $12.00 for tests purchased out-of-network (*i.e.*, tests that are not purchased through the Prime Therapeutics pharmacy network).

Participant information:		
Last Name:	First Name:	Birthdate:
Participant: □	Dependent: □	
Is testing for employment purposes:	Yes □	No □
Street address:	City:	State and Zip Code:
Phone No:	E-Mail:	

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 purchased.
3. If you have other health care coverage primary to your Electrical Workers Health and 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.

Note: There will be delays of up to 45 days in sending out reimbursement checks due to Wilson-McShane Corporation coordinating with in-network pharmacies to ensure that no more than eight (8) tests per 30 days are covered.

Mail this form to: Wilson-McShane Corporation
2002 London Road, Suite 300
Duluth, MN 55812

Fax: 218-728-4773

Email: ibew242.294@wilson-mcshane.com

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 Electrical Workers Health and Welfare Fund duplicate payments to myself (if any) because of coordination of benefits.

Signature: _____ Date signed _____