COPAY / COINSURANCE REIMBURSEMENT CLAIM PROCESS

As part of the regional settlement negotiations, the Rensselaer-Columbia-Greene Health Insurance Trust (the “Trust”) agreed to establish and administer a “Make Whole” fund of $50,000, from which members who incurred higher out-of-pocket costs (i.e., copay or coinsurance) due to the formulary change in September 2016 can seek reimbursement of those higher out-of-pocket costs. This document outlines the claims process that has been established.

Claims for higher out-of-pocket costs incurred as a result of purchasing a prescription drug during the period from September 1, 2016 through December 31, 2016 can be submitted to the Trust for reimbursement in accordance with this process.

Eligibility Criteria:

To have a reimbursement claim paid, a member must meet ALL of the following eligibility criteria:

- Was a participant or had a dependent who was a participant in the Trust’s Blue Shield pharmacy benefit plan on August 31, 2016.
- Was a participant or had a dependent who was a participant in the Trust’s CVS pharmacy benefit plan in the period from September 1, 2016 through December 31, 2016.
- Had a prescription for a drug or had a dependent who had a prescription for a drug that was being covered by the Blue Shield plan on August 31, 2016 and can establish proof of the member’s/dependent’s actual out-of-pocket cost for that drug as filled by Blue Shield.
- Renewed a prescription for the same drug under the CVS plan in the period from September 1, 2016 through December 31, 2016 and can establish proof that the member’s/dependent’s out-of-pocket cost for that drug was higher than the member/dependent paid when the prescription was covered by Blue Shield.
- Claims not supported with submitted proof of higher cost will not be processed.

Affected members can make a one-time claim for a payment towards ALL of their out-of-pocket costs. ALL claims MUST be filed on the attached form, with all supporting documentation attached, no later than May 19, 2017. Members should use a different claim form for each drug on which they submit a claim, but all claims must be submitted at the same time. Only a member may submit a claim on behalf of their dependent(s).

Acceptable Forms of Proof:

- Pharmacy receipt(s);
- Pharmacy statement(s);
- Mail order pharmacy receipt(s);
• Written confirmation from Blue Shield and/or CVS that confirms that a prescription was filled;
• Written confirmation from Blue Shield and/or CVS that confirms the amount of a copay or the amount of coinsurance paid for a prescription.
• It is not likely that any other form of proof will be considered acceptable by the Trust.

Initial Reimbursement Limit:

Initially, reimbursement will be limited to $150 for each covered person. Nevertheless, if you or your dependent have a claim or claim(s) that exceed(s) $150 during the period from September 1 to December 31, 2016, you MUST include the claim forms and documentation for your entire out-of-pocket expense in your submission to have it reviewed for potential payment in excess of the initial limit.

Potential for Payments in Excess of the $150 per person Cap:

If, after all claims filed by the May 19, 2017 deadline have been processed and approved up to their face amount (or the $150 cap), there remains money in the Make Whole Fund, the Trust will reevaluate those claims that were not paid in full due to the $150 cap. It will then distribute any remaining funds, proportionally, to those members whose timely claims exceeded $150 per person, up to the face amount of those claims, or until the Make Whole Fund is exhausted.

It is anticipated that payments from the Make Whole Fund will be made after June 16, 2017 and no later than July 31, 2017.

EACH CLAIM FORM MUST BE COMPLETED IN FULL. SUPPORTING DOCUMENTATION MUST BE ATTACHED TO THE FORM TO PROVE THAT A PRESCRIPTION WAS FILLED, FIRST BY BLUE SHIELD AND THEN FOR EACH SUBSEQUENT FILL BY CVS. PROOF OF ACTUAL OUT-OF-POCKET COST MUST ALSO BE ATTACHED FOR EACH FILL. IF MATERIAL IS MISSING, THE CLAIM WILL NOT BE PROCESSED. YOU MUST SUBMIT SEPARATE CLAIM FORMS FOR EACH PRESCRIPTION FOR WHICH YOU MAKE A CLAIM.

All claims must be submitted by mail to the following address and post-marked not later than May 19, 2017:

Copay / Coinsurance Reimbursement Fund  
Rensselaer-Columbia-Green Health Insurance Trust  
c/o Questar III BOCES  
P.O. Box 208  
East Schodack, New York 12063

Questions regarding this process or how to obtain prescription receipts can be posed to Benetech at (888) 411-4398.
COPAY / COINSURANCE REIMBURSEMENT CLAIM FORM

THIS FORM MUST BE COMPLETED IN FULL; SUBMIT SEPARATE FORMS FOR EACH PRESCRIPTION FOR WHICH YOU MAKE A CLAIM; SUPPORTING DOCUMENTATION MUST BE ATTACHED TO THIS FORM TO PROVE THAT A PRESCRIPTION WAS FILLED, FIRST BY BLUE SHIELD AND THEN FOR EACH SUBSEQUENT FILL BY CVS; PROOF OF ACTUAL OUT-OF-POCKET COST MUST ALSO BE ATTACHED FOR EACH FILL. IF MATERIAL IS MISSING, THE CLAIM WILL NOT BE PROCESSED.

Member Name: ___________________________ Date of Birth: ________________

(Last) (First)

Address: _____________________________________________________________

(Street / P.O. Box) (Town) (State) (ZIP)

Blue Shield Member ID: ___________________________ CVS Member ID: ___________________________

Name of Employer: ___________________________ Employment Status: Employee or Retiree? (circle one)

Employer’s (School District) Bargaining Unit: ___________________________

Is this a claim on your own behalf or on behalf of a dependent? ______ Self ______ Dependent

(check one of above)

If this is a claim on behalf of a dependent, please provide the following information:

Dependent’s Name: ___________________________ Date of Birth: ________________

(Last) (First)

Dependent’s Blue Shield Member ID: ___________________________

Dependent’s CVS Member ID: ___________________________

Name and Strength of Prescription Drug: ___________________________

Please list all CVS Fill Date(s) between 9/1 and 12/31:

Cost of Prescription Drug Copay / Coinsurance under Blue Shield (per fill): ___________________________

Cost of Prescription Drug Copay / Coinsurance under CVS (per fill): ___________________________

Last Blue Shield Fill Date: ___________________________

How many times did you fill this prescription from September 1 through December 31, 2016? ___________________________

Difference in Cost between CVS and Blue Shield: ___________________________

What is the total claim for which you are seeking reimbursement on this prescription? ___________________________

Signature: ___________________________ Date ___________________________

(Member’s Signature) Date

NOTE: The total amount of your claim for this prescription cannot exceed the Difference in Cost times the number of fills by CVS in the time period from 9/1 through 12/31.)