LOCAL 891 INTERNATIONAL UNION OF OPERATING ENGINEERS
WELFARE FUND BENEFITS PROGRAM

PRESCRIPTION CLAIM FORM

MAIL CLAIMS TO:
LOCAL 891 WELFARE FUND C/O DANIEL H. COOK ASSOCIATES
253 WEST 35TH STREET 12TH FLOOR, NEW YORK NY 10007
(212) 505-5050 ext. 229

CLAIM #
RETURNED FOR

MEMBER: FIRST MIDDLE LAST	STATUS – ACTIVE / RETIRED /COBRA
MEMBER ADDRESS NUMBER AND STREET	SOCIAL SECURITY-MEMBER ID
	HOME PHONE
CITY STATE ZIP-CODE	WORK PHONE

	DATE PURCHASED			FIRST NAME	RELATION SHIP	PRESCRIPTION NO.	NAME OF PHARMACY	NAME OF DRUG	NAME OF DOCTOR	COST	CO-PAY AMOUNT
1											
2											
3											
4											
5											
6											
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8											
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24											
25											

PHARMACY DRUG PRINTOUTS MAY BE USED IN FILLING OUT INDIVIDUAL PRESCRIPTION LINES PROVIDING THAT THE PATIENTS NAME, DATE OF PURCHASE, PRESCRIPTION NUMBER, NAME OF DRUG, PRESCRIBING DOCTOR'S NAME, DISPENSING PHARMACY AND THE COST OF THE PRESCRIPTION TO THE PATIENT IS ENTERED.
IF MORE SPACE IS NEEDED ATTACH ADDITIONAL CLAIM FORMS.

TOTAL AMOUNT MUST BE ENTERED TO RECEIVE PAYMENT. $ _____

I CERTIFY THAT THE ABOVE CHARGES WERE FOR THE BENEFIT OF MY ELIGIBLE FAMILY MEMBERS LISTED. I AUTHORIZE THE RELEASE OF ANY INFORMATION CONCERNING THESE PRESCRIPTIONS TO THE BENEFIT FUND OR THEIR REPRESENTATIVES FOR PURPOSE OF AUDIT OR VERIFICATION.

MEMBER SIGNATURE: _____ DATE: _____

PRESCRIPTION DRUG REIMBURSEMENT BENEFIT

WHO IS ELIGIBLE……
MEMBER CLAIMING FOR SELF AND/OR DEPENDENTS

WHAT IS THE BENEFIT…….
Once annually, up to a maximum of $400.+ 1% of each individual script thereafter. The Fund reimburses to a member the *co-payment* costs which have been paid within the calendar year for drugs prescribed by a medical doctor, osteopath or dentist. Prescription must be dispensed by a licensed pharmacist.

Prescription services which are covered include:

- Prescriptions which require compounding;
- Prescriptions for legend drugs (drugs which cannot be dispensed by a pharmacist without a prescription);
- Insulin on prescription;
- Allergenic solutions or extracts normally purchased at a pharmacy authorized by a doctor;
- Prescribed vitamins;
- Prescribed birth control drugs.

DESCRIPTION OF BENEFIT
Active member and retiree benefits under this plan have been made available by the Trustees and are always subject to modification or termination in the exercise of the prudent discretion of the Trustees.

RESTRICTIONS …….

- Only one claim per family per year is eligible.
- Individual prescriptions not accompanied by a pharmacy printout or copy of receipt. Do not submit original receipts. **The Fund is not responsible for loss if originals are submitted.**
- The Fund prescription drug coverage is secondary to you primary prescription drug coverage (e.g. – GHI, HIP, or spouse's coverage).
- No coverage is provided for "over the counter" drugs, vitamins, diet supplements, etc. which even though prescribed by a physician, can be legally purchased without a prescription.
- Allergy prescriptions unable to be filled at a licensed pharmacy
- Drugs prescribed for cosmetic purposes.

CLAIMING….
Obtain a prescription drug claim form from the Fund office. The entire form must be completed in order to be eligible for payment. However pharmacy drug printouts may be used in lieu of filling out individual prescription line providing that the patient's name, date of purchase, prescription number, name of drug, prescribing doctors name, dispensing pharmacy and the cost of the prescription to the patient must be entered. The co-payment MUST be indicated on either the claim form or the pharmacy's printout. All claim forms MUST contain a total dollar amount on the bottom of the claim or it will be returned to you without payment. All items listed will be subject to verification.

Submit your completed and signed form only after you have accumulated a minimum total of $400. or more for prescription drugs. If you do not meet the minimum prior to the end of the year, submit your claim for whatever the amount below that figure after the last day of that calendar year. In order to be eligible for coverage, your prescription drug claim MUST be submitted no later than of the year following the year charges were incurred. (e.g. – Covered expenses incurred from 01/01/15 through 12/31/15 can be claimed between 01/01/16 and 12/31/16.

PRESCRIPTION DRUG CLAIM MAY ONLY BE SUBMITTED ONCE ANNUALLY

NOTE……
The same rules and regulations governing your primary prescription drug plan apply. The Fund does not cover prescription costs incurred by members beyond the amount payable by you primary prescription drug plan. If for some reason you had to pay the full price for a prescription (perhaps your card was unavailable, or you were out-of-state), you MUST first submit the costs to your primary prescription plan prior to claiming. Do not submit your claim to the Fund unless all costs are backed by proof. Submissions at a later date will NOT be reconsidered for payment.

"ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD THE FUND OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING THE FACTUAL MATERIAL THERETO, COMMITS A FRAUD WHICH IS A CRIME."