Catastrophic Coverage Special Payments Reimbursement Request Form

OneExchange from Towers Watson

Mail: P.O. Box 981155, El Paso, TX 79998-1155 Fax to: 1-855-321-2605

① Former Employer Name | Total Number of Pages

Account Holder — Last Name | First Name | Middle Name

Social Security Number ___ - ___ - ____ | ZIP Code _____

② Covered Participant — Last Name | First Name | Middle Name

Social Security Number ___ - ___ - ____ | Relation to Account Holder (e.g., self, spouse)

③ **Step 1: Qualification Documentation**

To qualify for the catastrophic coverage special payments benefit, you must have reached the catastrophic coverage threshold as documented in the Explanation of Benefits (EOB) provided monthly by your Medicare prescription drug plan.

Catastrophic Coverage Threshold Qualification Date (MM/DD/YYYY):

Step 2: Reimbursement Documentation

Once you have qualified for the catastrophic coverage special payments benefit for the calendar year, you must submit a catastrophic coverage special payments reimbursement request form each time you incur a prescription expense. You will need to provide supporting documentation of your prescription drug expenses. Supporting documentation can be the EOB provided by your Medicare prescription drug plan or prescription drug receipts for prescription expenses incurred after the catastrophic coverage threshold qualification date. The EOB can be used for both qualification and reimbursement documentation.

④ Pharmacy Request Documentation (use additional pages if needed)

Date of Purchase	Amount Requested	Date of Purchase	Amount Requested
		Total Amount Requested	

⑤ By signing below, I certify that the information provided on this reimbursement form is correct, and that the expenses for which I am requesting reimbursement: a) were incurred for the covered participant while eligible under the plan on or after its effective date, b) have not been reimbursed in any other way from any other source, and c) will not be submitted for future reimbursement.

Account Holder Signature | Date

Catastrophic Coverage Special Payments Reimbursement Request Form Instructions

The catastrophic coverage special payments reimbursement request form is for participants with high prescription drug expenses. Use this form to request reimbursements for prescription expenses that exceed the catastrophic coverage threshold as documented in the Explanation of Benefits (EOB) statement from your Medicare prescription drug plan.

① Account Holder Information
The account holder is usually the retiree or the surviving spouse.

② Covered Participant Information
The covered participant is the person who incurred the prescription drug expense. Include the relationship to the account holder listed (e.g., self, spouse).

③ Step 1: Qualification Documentation
To qualify for catastrophic coverage special payments, you must have reached the catastrophic coverage threshold. The supporting documentation that shows you have reached this threshold is on the EOB provided by your Medicare prescription drug plan.

The EOB will show your year-to-date, true out-of-pocket costs (TrOOP) and total drug cost, and is the ONLY document that can be used to qualify for catastrophic coverage special payments.

Catastrophic Coverage Threshold Qualification Date
Each month you fill a prescription, your Medicare prescription drug plan carrier will send you an EOB statement. This EOB is a summary of your prescription drug and respective costs including the amount you have paid out of pocket.

Step 2: Reimbursement Documentation
Once you have qualified for the catastrophic coverage benefit for the calendar year, you must submit a catastrophic coverage special payment reimbursement request form each time you incur a prescription expense.

You will need to provide supporting documentation of your prescription drug expenses. Supporting documentation can be the EOB statement provided by your Medicare prescription drug plan or prescription drug receipts for prescription expenses incurred after the catastrophic coverage threshold qualification date.

Prescription discounts offered by some drug manufacturers may be indicated in your EOB, but not in your prescription drug receipts. These discounts may count toward your catastrophic coverage threshold. We encourage you to submit your monthly EOB as reimbursement documentation. The EOB may be used for coverage qualification and for requesting prescription reimbursement.

④ Expense Documentation
Medications not covered by your Medicare prescription drug plan are not eligible. Request reimbursement for only eligible prescription drug expenses listed on the EOB. For submitting large numbers of prescription drug requests, attach a separate sheet listing the prescriptions.

⑤ Certification
Carefully read the certification requirements before signing.

Additional Information
If you have lost a necessary document, contact your Medicare prescription drug plan carrier.

Reimbursement decisions will be made in accordance with the provisions of the plan. For more details refer to your Summary Plan Description.

Once your reimbursement request is approved, you will receive payment within 14 days of the request approval.