High-Cost Rx Program:
Submission Rules and Claim Form Instructions

Please read a complete description of the High-Cost Rx Program on the Fund website at psccunywf.org *before submitting a claim. This page is strictly guidance for completing the form.* Claims for out-of-pocket prescription reimbursement may be submitted quarterly, four times per calendar year, **when the individual annual out-of-pocket deductible of $2,500 (of eligible costs*) has been exceeded**. Claims and Deductibles are individual-only. Maximum annual reimbursement is $25,000.

- Submit the **High-Cost Rx Program Form** with copies of your **prescription package receipts AND cashier receipts showing amount paid** or **mail order/invoice receipts for every prescription fill.**** *(Retain your original receipts for your records.)* Complete the **Prescription Information** section with name of drug, number of fills and cost.
- Receipts must include the member's (patient's) name, name of drug, date of service, and amount paid. **CVS/Caremark member portal printouts will not be accepted.**
- Reimbursement claims will not be accepted until 15 days following the end of the quarter. See the examples below:

  1st quarter claims (Jan. 1 - Mar. 31) may be filed on or after April 15.
  2nd quarter claims (Jan. 1 - June 30) may be filed on or after July 15.
  3rd quarter claims (Jan. 1 - Sept. 30) may be filed on or after Oct. 15.
  4th quarter claims (Jan. 1 – Dec. 31) may be filed on or after Jan. 15.
- Claims must be submitted to ASO no later than March 31st of the following year for claims with a date of service in the prior plan year.
- *Brand name or dispensing penalties are ineligible costs & do not count towards the deductible.
- *Any copay costs in the following categories are ineligible costs & do not count towards the deductible:
  - PICA drugs (See NYC PICA injectable and chemo program, 212-306-7464)
  - Non-formulary drugs
  - Excluded drugs
  - New-to-Market drugs
  - Erectile Dysfunction drug coverage exceeding the Fund's annual $500 maximum
  - Drugs covered by any provider other than PSC-CUNY Welfare Fund Prescription Plan
- Partipants in the PSC-CUNY Welfare Fund Catastrophe Major Medical (CMM) Plan and NYSUT Catastrophe Major Medical Plan are required to file reimbursement claims with the CMM plans before submitting High-Cost Rx Plan claims. CMM plan Explanation Of Benefits (EOB) must be included with the High-Cost Rx Program Reimbursement Claim Form.
- No claims will be accepted after March 31 for service in the prior plan year. The "Plan Year" is the calendar year (January 1 – December 31) or for a newly eligible member, any remaining portion thereof.

**To see examples of eligible pharmacy and mail order receipts, go to the Fund website, psccunywf.org

High-Cost Rx Program - Reimbursement Claim Form

PSC-CUNY Welfare Fund - Administrative Services Only, Inc.
P.O. Box 9009, Department # 178
Lynbrook, NY 11563-9009
1-877-362-2869

Pre-Requisite

I am covered by the PSC-CUNY Welfare Fund Catastrophe Major Medical Plan. ☐ Yes ☐ No

If Yes, Certificate # _____

I am covered by the NYSUT Catastrophe Major Medical Plan: ☐ Yes ☐ No

If Yes, Certificate # _____

IMPORTANT: If you answered YES and are covered by either of the plans above, an Explanation of Benefits (EOB) from the insurer MUST be included in your High-Cost Rx Plan reimbursement claim.

Member

Name (First, MI, Last) _____ Member SSN: _____

Date of Birth: _____ ☐ Active Employee ☐ Non-Medicare Retiree

Address: _____

City: _____ State: _____ Zipcode: _____

Preferred Email: _____ Preferred Telephone #: _____

If your current mailing address is different from the permanent address on file with the Welfare Fund, please inform ASO by registering as a member at ***asonet.com*** . Use your legal name. Your password is your Social Security number.

Patient Information

Patient Name *(First, MI, Last*) _____ Relationship to Member: _____

Patient DOB: _____ Patient SSN: _____

Preferred Email: Preferred Telephone #:

Other Insurance

Please indicate **other** health insurance available for this patient ONLY.

Name of Employer _____ Insurance Carrier _____ Contract # _____

With this Application for Benefits under the PSC-CUNY Welfare Fund I hereby certify that I am eligible for Benefits and that all statements are true and accurate. I authorize the release of any necessary medical, employment or insurance information by service providers, insurers, employers, attorneys, or benefit administrators to Administrative Services Only, Inc. (ASO) for the purpose of evaluating and adjudicating this claim. I understand that I have a right to receive a copy of this authorization on request. I agree that a true image of this authorization is as valid as the original.

I have not applied for or received any other prescription drug reimbursement and/or copay assistance related to these claims from any other insurance plan.

Signature _____ Today's Date _____

Prescription Information

1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
January thru March	*April thru June*	*July thru September*	*October thru December*
X			

Fill Date	Drug Name	Copay Amount
1/15/2019	ARNUITY ELPT INHALER	$124.26
2/23/2019	AZELASTINE SPRAY	$33.92
3/7/2019	BREO ELLIPTA INHALER	$356.28

***Please include prescription receipts for each prescription fill. Limit of one (1) submission per quarter. List each prescription fill separately.**

1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
January thru March	*April thru June*	*July thru September*	*October thru December*
☐	☐	☐	☐

Fill Date	Drug Name	Copay Amount

Page Total =

Grand Total =