TOWNSHIP OF MONROE
INSTRUCTIONS FOR SUBMITTING A
RETIREE MEDICAL/PRESCRIPTION REIMBURSEMENT CLAIM

These instructions will explain the procedure for an eligible Retiree to submit a claim for reimbursement of out-of-pocket expenses incurred for certain medical/prescription expenses that occurred on or after **April 1, 2016** (the date the Township of Monroe switched medical/prescription coverage from Horizon Blue Cross & Blue Shield (BCBS) Direct Access Health Plan(s) Subgroups 02, 03, 05 and 06 to the New Jersey State Health Benefit Program (SHBP) NJ Direct 10**,** the current applicable Plan.

As fully explained below, an eligible Retiree/Dependent whose claim is approved will receive reimbursement from the Township of Monroe for the difference in the benefit of those medical/prescription expenses covered under the prior Health Plan(s) with the Township of Monroe and those medical/prescription benefits that have increased under the current New Jersey State Health Benefit Program (SHBP) NJ Direct 10 Plan.

1. Retired Employee

- **a.** Eligible Retiree/Dependent MUST have previously been receiving or eligible to receive medical/prescription coverage under the Township of Monroe's Health Plan(s) prior to April 1, 2016**.**

2. Eligible Expenses

- **a.** To be eligible for reimbursement, the eligible medical/prescription expense must have occurred on or after April 1, 2016.
- **b.** The medical/prescription expenses must be one that was covered under the Township of Monroe's previous Health/Prescription Plan(s) but is now considered at a different benefit level under the Township of Monroe's current New Jersey State Health Benefit Program (SHBP) NJ Direct 10 Plan
- **c.** Medical expenses that were not covered under the Township of Monroe's previous Health Plan(s) will not be eligible for reimbursement nor any amounts that exceed the normal reasonable and customary (R & C).
- **d.** The purpose of this "coverage" is to provide the differences in the benefit provisions for medical and prescription expenses from the old Health Plan(s) to the current Health Plan(s) for any increases in copayment(s), deductible(s) or coinsurance.

3. Procedure for Submitting a Claim

- **a.** All claims submitted to Insurance Design Administrators (IDA) must be submitted with a completed Medical/Prescription Reimbursement Claim Form and appropriate documentation.
- **b.** The Medical/Prescription Reimbursement Claim Form must be filled out completely and signed and dated by the eligible Retiree and submitted for payment.
- **c.** The following documents must be submitted at a minimum **(Monthly)** to Insurance Design Administrators (IDA) along with the Medical/Prescription Reimbursement Claim Form. Claim submission can be made at the discretion of the claimant for periods exceeding monthly.
- **d.** Claims submitted by the 10th day of the month will be processed in that month's end-of month check run. Claims submitted after 10th day of the month will be processed in the following month's end-of month check run.

MEDICAL CLAIMS (See example 1)

1. A copy of the **Horizon Blue Cross Blue Shield (BCBS) NJ Direct** "Explanation of Benefits (EOB) form associated with the service that includes the following:

SUBSCRIBER NAME SUBSCRIBER ID

Summary Information

- **a.** Patient Name
- **b.** Relation
- **c.** Claim Number
- **d.** Group Number
- **e.** Total Charge
- **f.** Horizon Paid

Detail Information

- **a.** Date of Service
- **b.** Provider/Type of Service
- **c.** Billed Amt
- **d.** Allowed Amt
- **e.** Your Coins/Copay
- **f.** Your Deductible Amt
- **g.** Other Carrier Payment Amt
- **h.** Not Cov Amt
- **i.** Horizon Paid Amt
- **j.** Subscriber Responsibility****

*******For any amounts reflected under Subscriber Responsibility, other than Copay, proof of payment is required. Proof of Payment (cancelled check, credit card statement or receipt of payment).***

PRESCRIPTION CLAIMS – (See Examples 2, 3 and 4)

There are (2) forms of documentation you may provide as supporting documentation for prescription reimbursement:

1. For retail purchases, a copy of your "Customer Receipt" (stapled to your prescription bag) that includes the following:

- **a.** Name
- **b.** Address
- **c.** Prescription Name
- **d.** Date
- **e.** RX number
- **f.** Insurance Payment Amount
- **g.** Your Payment Amount

1. A copy of your Express Scripts Invoice that you receive with your "Mail-In" Order that includes the following:

- **a.** Invoice Number
- **b.** Plan Member Name
- **c.** Order process date
- **d.** Prescription Name
- **e.** RX Number
- **f.** Your Payment Amount

2. A copy of the **Express Scripts <u>"Claims & Balances"</u>** report associated with the service that includes the following:

PATIENT NAME DATE OF BIRTH

CLAIMS - Detail Information

- **a.** Rx Number
- **b.** Date of Service
- **c.** Drug Information
- **d.** Filled at:

AMOUNT APPLIED TO:

- **e.** Deductible
- **f.** Out-of-pocket maximum
- **g.** Total Cost
- **h.** You Paid

Please note that the Express Scripts "Claims & Balances" Report reflects both retail purchases and mail-in purchases.

e. Once the Medical/Prescription Reimbursement Claim Form and proper documentation are collected by the eligible Retiree requesting payment **(minimum monthly)**, the documents must be submitted directly to the following.

Insurance Design Administrators
P.O. Box 690
Oakland, NJ 07436
Attention: XXXXXX
or
Fax to – (201) 337-1391

Claim Questions can be directed to Customer Service at (800) 225-1345

f. The eligible Retiree should retain a copy of all documentation for his/her records.

g. Please note that cash register receipts will not be accepted.

h. Payment will be issued to the eligible Retiree.

i. If a claim is denied, the Retiree will receive notification of the denial. Based on the reasons for the denial, the eligible Retiree may submit additional documentation to support the payment of the claim. If the claim is still denied the Retiree will have the right to appeal the decision with the Township of Monroe. Any notification of denial received by the Retiree should be forwarded within a reasonable timeframe (60 days) to the following:

Township of Monroe
Attn: Human Resources Officer
125 Virginia Ave
Williamstown, NJ 08094

Or call – (856) 729 – 9800 Ext. 205

(TOMGC)

TOWNSHIP OF MONROE
RETIREE MEDICAL/PRESCRIPTION REIMBURSEMENT CLAIM FORM

RETIREE INFORMATION					
NAME:	LAST	FIRST	MIDDLE	HOME PHONE NUMBER	
ADDRESS:	STREET	APARTMENT#	CITY	STATE	ZIP CODE
SS# / ID#:	HORIZON DIRECT 10 SUBSCRIBER ID:				

DEPENDENT INFORMATION				
NAME:	LAST	FIRST	MIDDLE	RELATIONSHIP
NAME:	LAST	FIRST	MIDDLE	RELATIONSHIP :
NAME:	LAST	FIRST	MIDDLE	RELATIONSHIP

INSTRUCTIONS

1) For Medical/Prescription Reimbursement Claims, attach copies of the Explanation of Benefits (EOB) issued by Horizon Blue Cross Blue Shield (BCBS) NJ Direct and/or Retail Pharmacy Customer Receipt, and/or Invoices or Claims & Balances Report issued by Express Scripts to establish amount(s) paid and eligible for Plan Difference reimbursement.

2) Submit This Form To:
   INSURANCE DESIGN ADMINISTRATORS
   P.O. BOX 690
   OAKLAND, NJ 07436
   CUSTOMER SERVICE # - (800) 225-1345
   FAX # - (201) 337-1391

EXPENSES			
MEDICAL/PRESCRIPTION PROVIDER	DATE RANGE EXPENSES INCURRED	AMOUNT PAID	AMOUNT OF CLAIM
		TOTAL AMOUNT	$

A. I am submitting this Form with the required documentation, Horizon Blue Cross Blue Shield (BCBS) NJ Direct EOB, Proof of Payment and/or Retail Pharmacy Customer Receipt and/or Express Scripts Invoices or Claims & Balances Report.

RETIREE CERTIFICATION AND SIGNATURE

I Hereby Certify That:

1. The amount of the Claim is the difference between the current Horizon Blue Cross Blue Shield (BCBS) NJ Direct and/or Express Scripts, whichever is applicable, and the prior Township of Monroe Plan, minus the Retiree responsibility, is owed to me, and

2. I have not received, and am not eligible to receive, any type of reimbursement or payment other than the amount noted as the difference in Plan provisions noted above, if any.

I CERTIFY THAT THE FOREGOING STATEMENTS ARE TRUE. I AM AWARE THAT IF ANY OF THE FOREGOING STATEMENTS MADE BY ME ARE WILLFULLY FALSE, I AM SUBJECT TO PUNISHMENT.

SIGNATURE____ **DATE**____________________