Office and Professional Employees Locals 30 & 537
Health & Welfare and Retirement Trust Funds
Administered By: Benefit Programs Administration
Telephone • (800) 386-4350 • (562) 463-5065 • Facsimile (562) 908-7568 • www.opeiufunds.org

February 2022

Summary of Material Modifications

To: To: Participants in the OPEIU Locals 30 & 537 Health and Welfare Plan Who Are Not enrolled in Kaiser

PARTICIPANT NOTICE

This Participant notice will advise you of certain material modifications (plan changes) that have been made to the OPEIU Locals 30 & 537 Health and Welfare Plan (the Plan). This information is **very important** for you and your eligible dependents. Please take the time to read it carefully.

Unless otherwise indicated, these changes become effective on January 15, 2022.

Your Right to be Reimbursed for Over-the-Counter COVID-19 Tests

You now have the right to get eight (8) at-home, over-the-counter COVID-19 tests per month, at no cost to you, if the test is performed for diagnosis or treatment, and not for employment purposes.

Starting January 15, 2022, the Plan will cover the cost of over-the-counter, at-home COVID-19 diagnostic tests authorized by the FDA, with no cost to you, subject to the eight (8) count limit, as long is the test is intended for personal use, to diagnose or treat COVID-19. You do not need a referral from a doctor or a prior authorization from the Plan to be reimbursed for the cost of these tests.

The Plan will **not** cover the cost of tests purchased for employment purposes, such as a test your employer requires you to take before returning to work from a long weekend. The Plan will also not cover the costs of tests for surveillance purposes, such as tests taken to attend a social gathering or for travel.

If you are enrolled in Kaiser, please check with Kaiser regarding how you may obtain test kits and get reimbursed for them.

You can also obtain tests completely free through the Government COVID-19 at home testing website: https://www.covidtests.gov/.

What is the effective date of the change? The coverage applies only to tests purchased **on or after** January 15, 2022, and up until the end of the public health emergency period.

Must the test be purchased at any particular store, pharmacy, or online retailer to be eligible for reimbursement? No. You may purchase the over-the-counter test at any store,

pharmacy, or online retainer. The test, however, needs to be FDA-authorized. Please make sure to keep the receipt and the UPC code (i.e., the number next to the bar code on the box), as you will need it be reimbursed for the cost of the test. There currently is no preferred network of where to obtain the test.

If the Plan sets up a network of preferred stores, pharmacies, and online retailers at which you may obtain the COVID-19 test, you may still be reimbursed for the cost of an over-the-counter test you purchase outside the network, but only up to $12 per test (or the cost of the test, if less than $12). We will inform you if such a network is set up.

Is there a limit on how many at-home, over-the-counter COVID-19 tests will be reimbursed? Yes. Only eight (8) individual at-home, over-the-counter COVID-19 tests **per person** enrolled in the Plan per calendar month or 30-day period will be reimbursed. That means that if you have a family of four, all of whom are covered by the Plan, you may be reimbursed for 32 tests per month, as long as no more than eight tests are purchased for each person. If there are multiple tests within a kit that you purchase, each test counts toward the eight-count limit. The limit does **not** apply to tests administered or ordered by a health care professional after evaluating you (or the covered family member for whom the test is purchased) and determining there is a need for such a test.

What information will need to be submitted to the Plan to be reimbursed for the cost of the test? Please review the attached form to see which information you will need to submit to the Plan to be reimbursed for the cost of the test. You will need to provide your identifying and contact information; name, address, and phone number of the place where you purchased the test, the date of purchase and the brand name of the test (unless this information is shown on the receipt); the name of the person covered by the Plan for whom the test was purchased and their DOB; a copy of the receipt and the UPC code. You will also need to attest that the test was purchased for personal use, not for employment purposes or resale; that it has not and will not be reimbursed by another source, such as by someone else's insurance; and that the copy of the receipt you are submitting is unaltered. You must submit the claim to OPEIU Locals 30 & 537 Health and Welfare Plan Trust Office at 1200 Wilshire Blvd. 5th Floor Los Angeles, California 90017-1906 within 90 days from the date of purchase.

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If you have questions, please contact the Trust office at please contact the Trust office at (562) 463-5065 or the website at www.opeiufunds.org.

Sincerely,

THE BOARD OF TRUSTEES

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OPEIU LOCALS 30 & 537 HEALTH AND WELFARE PLAN
COVID-19 AT HOME TEST REIMBURSEMENT FORM

Use this form to be reimbursed for an at-home, over the counter COVID-19 test that was purchased on or after January 15, 2022. This form is **not** to be used when the test was ordered by a health care provider after evaluating the patient. You must provide a receipt along with this form. There is a limit of eight (8) tests per each eligible person per month for which you may be fully reimbursed by the Plan.

Note: A separate form is required for each family member for whom a test was purchased.

Member's Name: _____

Member's DOB: _____Member's last four of SSN:_____

Member's address:
_____

Member's phone number: _____

Name, address **and** phone number of the purchase location of the COVID-19 test (unless shown on the receipt): _____

_____

The brand name of the test (unless shown on the receipt) :_____

Date of purchase of the COVID-19 test (unless shown on the receipt): _____

Brand of the test (unless shown on the receipt):_____

Name of the person for whom the test was purchased: _____

DOB of the person for whom the test was purchased: _____

Please attach a copy of the receipt along with this form, and the UPC code.

I hereby attest that the test was purchased for personal use, that it was not purchased for employment purposes or resale, that it has not and will not be reimbursed by another source, and the copy of the receipt and UPC have been unaltered.

Signature:_____

Date: _____