FABIAN & BYRN, LLC

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Roseland, NJ 07068

973-228-4200
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MEMORANDUM

To: **Eligible Participants of the Joint Welfare Fund of Local 164, IBEW**

Date: **February 1, 2022**

From: **Board of Trustees, IBEW Local Union No. 164 Welfare Fund**

Re: Summary of Material Modification to the Joint Welfare Fund of Local 164, IBEW
EIN: 22-1537766

Home Covid testing

Effective 1/15/22, Over the Counter (OTC) Covid-19 tests will be covered by the Fund under the Indirect Coverage Option. This will require eligible members and dependents to purchase OTC COVID-19 tests and then submit receipts for reimbursement by the plan. For in-network providers, reimbursement will be at 100% but will exclude tax and shipping which are non-covered charges. The Fund will reimburse for the cost of up to eight (8) tests per month per covered individual.

OTC COVID-19 tests are for self-use and are not to be used for employment or travel purposes. Tests may be purchased at retail and online pharmacies, and purchase from an in-network provider is strongly encouraged.

Members will need to complete the attached claim form and will be required to sign and date the attestation section confirming that OTC COVID-19 tests are for self-use and are not for employment or travel purposes. Receipts must be included with the claim form and the family member's name must be written on the receipt. Each family member will need to submit their receipts with their own claim form.

The federal government is also providing 4 free tests per address. These tests can be ordered through: www.covidtests.gov

Additionally, all covid testing, including PCR and rapid testing performed and billed by labs, doctor's offices or testing sites will require that a prescription accompany any request for reimbursement through the Plan. Claims submitted without a prescription will not be covered.

Joint Welfare Fund LU #164 OTC Covid Testing Claim Form

Fabian & Byrn, LLC T/P/A
Joint Welfare Fund LU #164 I.B.E.W
425 Eagle Rock Avenue, Suite 105
Roseland, NJ 07068
P: 877-228-4202
F: 973-228-4295
email: claims@fabianbyrn.com

Member's Name (print in full)	Group # 76132-	Member ID# ISC
Home Address	Date of Birth	Daytime Phone #
	Marital Status (circle one) Single Married Divorced Widowed	Work Status (Circle One) Active Disabled Retired Other (specify)

PATIENT INFORMATION		SPOUSE INFORMATION	
Name	Date of Birth	Name	Date of Birth
Relationship to Member Self Spouse Child Other (specify	Sex Male Female	Employer Name and Address	Employment Status Active Retired Unemployed

IF YOU OR ANY MEMBER OF YOUR FAMILY IS COVERED UNDER ANOTHER GROUP HEALTH PLAN, COMPLETE THE FOLLOWING SECTION

Covered Family Member (Circle One) Self Patient Spouse Other (specify name and relationship)			Name and address of Insurance Company
Policy or Plan No.	Insurance I.D #	Type of coverage individual Family	

ATTESTATION

*By signing below, I confirm that these tests are for self use and not for employment or travel purposes. I further acknowledge these tests will not be sold, distributed to or used by an individual who is not a dependent or family member enrolled in the Plan. Further, I agree that, if any benefit payments are paid by the Welfare Fund for myself or my eligible dependents, and I or my dependents recover money from any person or organization accepting responsibility for these costs, I will repay the Welfare Plan for the amount of the benefit payments. My failure to cooperate with the Welfare Fund by not repaying the Plan will be reason for the Welfare Plan to withhold further Welfare Fund benefits until such monies are recouped.

Member's Signature	Date	Patient's Signature	Date

*** Please attach this claim form to proof of payment. Patient's name must be written on receipt.**

*** Signatures in highlighted areas are required for reimbursement. Please make sure form is completed.**