

Benzie County Central Schools PRESCRIPTION CO-PAY REIMBURSEMENT PLAN CLAIM FORM EFFECTIVE 09/01/2009

NAME OF PARTICIPANT _____

Social Security # _____

Based on the following information, I hereby request Rx reimbursement for:

\$_____ **Co-pay portion of my prescription drug benefit**

- The reimbursable expenses relate to eligible Rx expenses incurred by me, my spouse, and/or my eligible dependents.
- The employee shall be reimbursed the difference for each prescription co-pay for the \$10/\$20 Rx plan as follows:

	2009-10 \$10/\$20 MESSA Rx Co-pay	Reimbursement Generic/Name
Up to 34 Day Supply	\$10.00/\$20.00	\$5.00/\$10.00
Up to 90 Day Supply	\$20.00/\$40.00	\$15.00/\$30.00
Up to 90 Day Supply - Mail Order	\$20.00/\$40.00	\$18.00/\$36.00

Note: Employee is to pay a minimum of \$5 per Rx/\$2 mail order Rx. If the drug cost is lower than \$10/\$20 Rx co-pay, employee shall be reimbursed the difference between the drug cost and minimum (\$5/\$2). For example, employee pays \$7 for a 30 day supply (generic/non mail order) the reimbursement will be \$2 (\$7 drug cost - \$5 minimum payment).

- I understand that Rx expenses are deemed to have been "incurred" when the services giving rise the claim rendered, regardless of when I am formally billed, charged or pay for the service.
- I have not received reimbursement under any insurance policy, federal or state health or accident plan, or any other plan for these expenses.
- I have attached to this claim such evidence of payment entitling me to a benefit under this plan.

I have read the note above, and the instructions on the reverse side of this form.

PARTICIPANT'S SIGNATURE

DATE

Submit form and receipts to:

**SET SEG
Medical Claims Department
415 W. Kalamazoo Street
Lansing, MI 48933
800-292-5421**

**INSURANCE REIMBURSEMENT FOR
PRESCRIPTION CO-PAYS**

The procedure to follow in order to receive reimbursement:

- ◆ You will be reimbursed for your co-pay expense for prescriptions only. You must file a Prescription Co-Pay Reimbursement Claim Form to receive this money.
- ◆ Attach the prescription print out from your pharmacy or photo copied sheets of pharmacy receipts to the Rx Co-Pay Reimbursement Claim Form. **Cash register receipts are not acceptable.** Keep copies for your records. Submit the claim form with attachments to:

SET SEG

Medical Claims Department
415 W. Kalamazoo Street
Lansing, MI 48933

- ◆ If you have any questions, please call SET SEG at 800-292-5421