

Benzie County Central Schools PRESCRIPTION CO-PAY REIMBURSEMENT PLAN CLAIM FORM

NAME OF PARTICIPANT

Social Security #

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

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

- The reimbursable expenses relate to eligible medical care expenses incurred by me, my spouse, and/or my eligible dependents.
- The employee shall be reimbursed the difference between MESSA Preferred Rx co-pay and MESSA \$10 Rx co-pay:

	Old Plan MESSA Preferred Rx Co-pay	New Plan MESSA \$10 Rx Co-pay	Reimbursement
Up to 34 Day Supply	\$5.00	\$10.00	\$5.00
Up to 90 Day Supply	\$5.00	\$20.00	\$15.00
Up to 90 Day Supply - Mail Order	\$2.00	\$20.00	\$18.00

Note: If the drug cost is lower than MESSA \$10 Rx co-pay, employee shall be reimbursed the difference between the drug cost and MESSA Preferred Rx co-pay.
For example, employee pays \$17 for a 90 day supply (non mail order) the reimbursement will be \$12 (\$17 drug cost - \$5 Preferred Rx co-pay).

- I understand that medical care 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 Medical 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

REV (10/2008)