Kalamazoo RESA

Enhancing your school and community

Make your health care choice **Blue**

Enrollment Information

Dear KRESA Employee:

Blue Cross Blue Shield of Michigan is pleased to be the health care claims administrator for your group. Enclosed you will find information regarding your health care coverage and claims filing. We have also enclosed customer service information, in case you have questions about your coverage or claims.

The *Power of Blue* section contains information to help you better understand your coverage, such as *Preferred Provider Organizational (PPO) information, ID Card information, Your Emergency Benefits, 5 Good Reasons Why You Should Use a Participating Physician and Home is where your BlueCard is.* Other forms and information included in this booklet:

- ***Benefit Summary*** – A general description of the health care benefits you have.
- ***BlueHealthConnection*** – Provides information on our integrated health care management program.
- ***Quit the Nic*** – Provides information on our stop-smoking telephone-based program.
- ***Health Care Benefits Online*** – Describes the BCBS Web site where you can view your claim status, out-of-pocket costs, benefit limitations, eligibility and search for providers.
- ***Automated Servicing Systems*** – Describes the Interactive Voice Response System (IVR) and the Health Care Benefits Online (HCBO) Web site.
- ***Understanding Your Explanation of Benefits*** – Explains your Explanation of Benefits (EOB) statement.
- ***Urgent Care Reminders*** – A brief explanation of your urgent care benefits.
- ***Prescription Drug Information*** – Includes information on our prescription drug program as well as information on generic drugs and prescription drug advertising.
- ***Vision Information***– Includes information on your vision program.
- ***Dental Information*** – Includes information on your dental program.
- ***Coordination of Benefits Information*** – Use this form if you or your family members have other insurance carriers that need to be reported.
- ***Prescription Drug Reimbursement Form*** – If you need to file a drug claim.
- ***Subscriber Submitted Claim Form*** – If you need to file a medical claim.
- ***Medco Health Mail Order Form, Return Envelope & Questionnaire*** – Use these forms if you want to order medications from the mail service pharmacy.
- ***Customer Service Number, 877-671-2583*** – Keep this number handy in case you have questions about claims or coverage.

We wish you the best of health and encourage you to take full advantage of your benefits when needed.

Sincerely,

Blue Cross Blue Shield of Michigan

Simply Blue[SM] PPO HSA – Plan 1250/0% Medical Coverage with Prescription Drug Coverage Benefits-at-a-Glance

The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This BAAG is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

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	In-network	Out-of-network *
Member's responsibility (deductibles, copays, coinsurance and dollar maximums)		
Note: If a PPO provider refers you to a non-network provider, all covered services obtained from that non-network provider will be subject to applicable out-of-network cost-sharing.		
Deductibles **Note:** Your deductible **combines** deductible amounts paid under your Simply Blue HSA medical coverage **and** your Simply Blue prescription drug coverage. **Note:** The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract.	$1,250 for a one-person contract or $2,500 for a family contract (2 or more members) each calendar year (**no 4th quarter carry-over**) Deductibles are based on amounts defined annually by the federal government for Simply Blue HSA-related health plans. Please call your customer service center for an annual update.	$2,500 for a one-person contract or $5,000 for a family contract (2 or more members) each calendar year (**no 4th quarter carry-over**)
Fixed dollar copays	Based on prescription drug copay rider selected	Based on prescription drug copay rider selected
Coinsurance amounts **Note:** Coinsurance amounts apply once the deductible has been met.	None	20% of approved amount
Annual coinsurance/copay dollar maximums **Note:** Your coinsurance/copay dollar maximum **combines** coinsurance/copay amounts paid under your Simply Blue HSA medical coverage **and** your Simply Blue prescription drug coverage.	$1,000 for a one-person contract or $2,000 for a family contract (2 or more members) each calendar year – applies to prescription drug copays	$2,000 for a one-person contract or $4,000 for a family contract (2 or more members) each calendar year
Lifetime dollar maximum	None	
Preventive care services		
Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered

***** Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

	In-network	Out-of-network *
Preventive care services, *continued*		
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	80% after out-of-network deductible **Note:** Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
	One per member per calendar year	
Routine screening colonoscopy	100% (no deductible or copay/coinsurance) for routine colonoscopy **Note:** Medically necessary colonoscopies are subject to your deductible and coinsurance.	80% after out-of-network deductible
	One routine colonoscopy per member per calendar year	
Physician office services		
Office visits	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits	100% after in-network deductible	80% after out-of-network deductible
Office consultations	100% after in-network deductible	80% after out-of-network deductible
Urgent care visits	100% after in-network deductible	80% after out-of-network deductible
Emergency medical care		
Hospital emergency room	100% after in-network deductible	100% after in-network deductible
Ambulance services – must be medically necessary	100% after in-network deductible	100% after in-network deductible
Diagnostic services		
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% after out-of-network deductible

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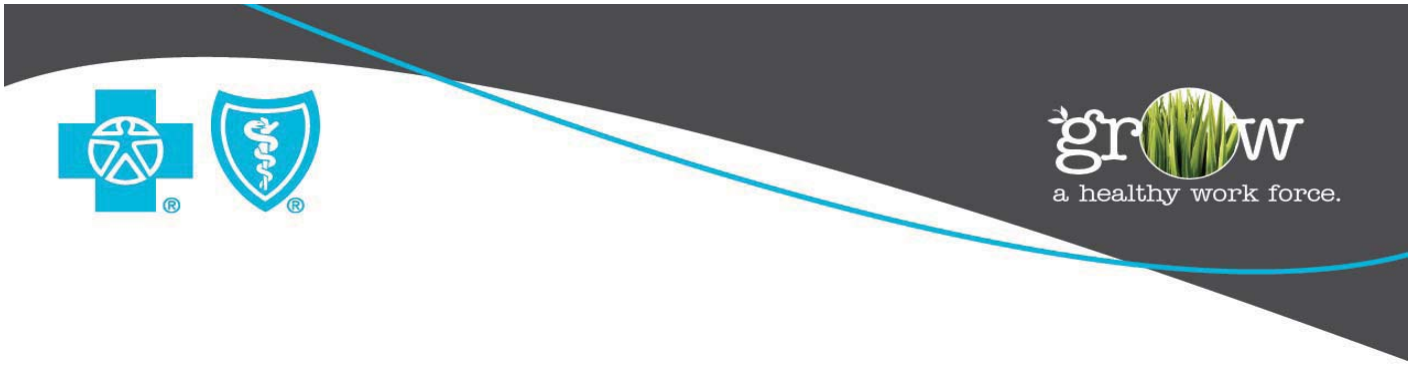

	In-network	Out-of-network *
Maternity services provided by a physician		
Prenatal and postnatal care	100% after in-network deductible	80% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	100% after in-network deductible	80% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% after out-of-network deductible
Alternatives to hospital care		
Skilled nursing care – must be in a **participating** skilled nursing facility	100% after in-network deductible	100% after in-network deductible
	Limited to a maximum of 90 days per member per calendar year	
Hospice care – must be provided through a **participating** hospice program	100% after in-network deductible	100% after in-network deductible
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care – must be medically necessary and provided by a **participating** home health care agency	100% after in-network deductible	100% after in-network deductible
Home infusion therapy – must be medically necessary and given by **participating** home infusion therapy providers	100% after in-network deductible	100% after in-network deductible
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization	100% after in-network deductible	80% after out-of-network deductible
Human organ transplants		
Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	100% after in-network deductible – in designated facilities **only**
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials	100% after in-network deductible	80% after out-of-network deductible
Kidney, cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

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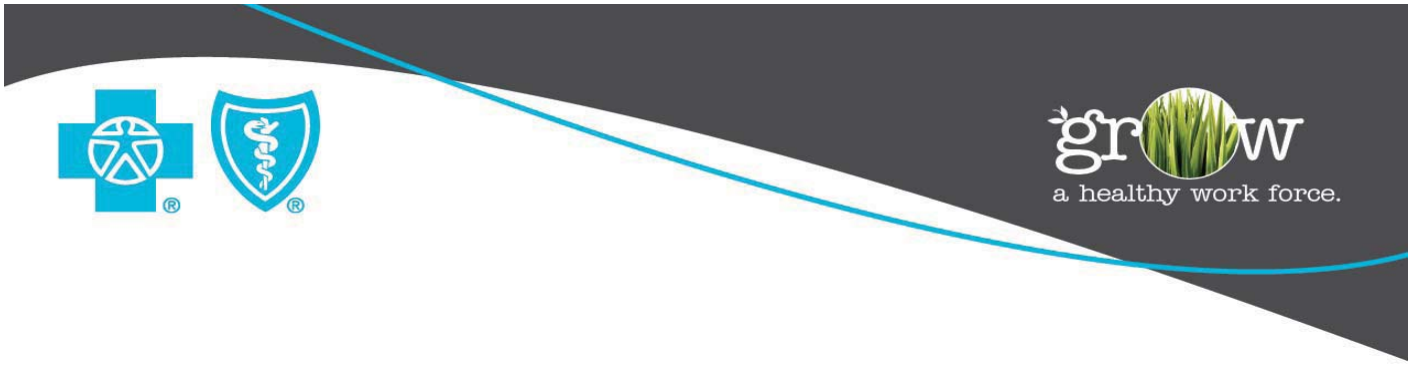

	In-network	Out-of-network *

Mental health care and substance abuse treatment

Note: If your employer has **51 or more** employees (including seasonal and part-time) and is subject to the MHP law, covered mental health and substance abuse services are subject to the following coinsurance amounts. Mental health and substance abuse coinsurance amounts are included in the annual coinsurance maximums for all covered services. See "Annual coinsurance maximums" section for this amount. If you receive your health care benefits through a collectively bargained agreement, please contact your employer and/or union to determine when or if this benefit level applies to your plan.

Inpatient mental health care and inpatient substance abuse treatment	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Outpatient mental health care: • Facility and clinic	100% after in-network deductible	100% after in-network deductible, in participating facilities **only**
• Physician's office	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities **only**	100% after in-network deductible	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Other covered services

Outpatient Diabetes Management Program (ODMP) **Note:** Effective July 1, 2011, when you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	100% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay/coinsurance) for diabetes self-management training	80% after out-of-network deductible
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% after in-network deductible	80% after out-of-network deductible
	Limited to a **combined** maximum of 12 visits per member per calendar year	
Outpatient physical, speech and occupational therapy – provided for rehabilitation	100% after in-network deductible	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** maximum of 30 visits per member per calendar year	
Durable medical equipment	100% after in-network deductible	100% after in-network deductible
Prosthetic and orthotic appliances	100% after in-network deductible	100% after in-network deductible
Private duty nursing	100% after in-network deductible	100% after in-network deductible

Simply Blue[SM] PPO HSA – Prescription Drug Coverage with $10 Generic / $40 Formulary (Preferred) Brand / $80 Nonformulary (Nonpreferred) Brand Triple-Tier Copay Open Formulary

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Specialty Drugs – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com**. Log in under *I am a Member*. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

Member's responsibility (copays)

Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and same annual coinsurance/copay dollar maximum required under your Simply Blue HSA medical coverage. Benefits are not payable until after you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are required to pay applicable prescription drug fixed dollar copays which are subject to your annual coinsurance/copay dollar maximums.

Note: Fixed dollar copays apply once the deductible has been met.

		90-day retail network pharmacy	* Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
Tier 1 – Generic or prescribed over-the-counter drugs	1 to 30-day period	$10 copay	$10 copay	$10 copay	$10 copay ***plus*** an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	$20 copay	No coverage	No coverage
	84 to 90-day period	$20 copay	$20 copay	No coverage	No coverage
Tier 2 – Formulary (preferred) brand-name drugs	1 to 30-day period	$40 copay	$40 copay	$40 copay	$40 copay ***plus*** an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	$80 copay	No coverage	No coverage
	84 to 90-day period	$80 copay	$80 copay	No coverage	No coverage
Tier 3 – Nonformulary (nonpreferred) brand-name drugs	1 to 30-day period	$80 copay	$80 copay	$80 copay	$80 copay ***plus*** an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	$160 copay	No coverage	No coverage
	84 to 90-day period	$160 copay	$160 copay	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.

***** BCBSM will not pay for drugs obtained from non-network mail order providers, including Internet providers.

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Covered services

	90-day retail network pharmacy	* Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
FDA-approved drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay ***plus*** an additional 20% prescription drug out-of-network copay **
Prescribed over-the-counter drugs – when covered by BCBSM	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay ***plus*** an additional 20% prescription drug out-of-network copay **
State-controlled drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay ***plus*** an additional 20% prescription drug out-of-network copay **
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay.	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug ***plus*** an additional 20% prescription drug out-of-network copay **
Rider CI, contraceptive injections **Rider PCD**, prescription contraceptive devices **Rider PD-CM**, prescription contraceptive medications	Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and intrauterine devices, and FDA-approved oral, or self-injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered). **Note:** These riders are only available as part of a prescription drug package. Riders CI and PCD are part of your medical-surgical coverage, subject to the same deductible and copay, if any, you pay for medical-surgical services. (Rider PCD waives the copay for services provided by a network provider.) Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.			

***** BCBSM will not pay for drugs obtained from non-network mail order providers, including Internet providers.

****** The 20% prescription drug out-of-network copay will not be applied toward your Simply Blue HSA deductible or annual coinsurance/copay dollar maximum.

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Custom Traditional Plus Dental Coverage
Benefits-at-a-Glance

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With Traditional Plus Dental, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Dental Network of America (DNoA) Preferred Network of PPO dentists.

DNoA Preferred Network – Blue Dental members have unmatched access to PPO dentists through the DNoA Preferred Network, which offers nearly 200,000 dentist access points* nationwide. DNoA Preferred Network dentists agree to accept our approved amount as payment in full and participate on all claims. Members also receive discounts on noncovered services when they use PPO dentists. To find a DNoA Preferred Network dentist near you, please visit **BCBSM.com/bluedental** or call 1-888-826-8152.

** A dentist access point is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two locations would be two access points.*

Blue Par Select℠ arrangement– Most dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services — members pay only applicable copays and deductibles, along with any fees for noncovered services. To find a dentist who may participate with BCBSM, please visit **BCBSM.com/bluedental**.

Note: Members who go to nonparticipating dentists may be billed for any difference between our approved amount and the dentist's charge.

Member's responsibility (copays and dollar maximums)

Copays	
• Class I services	25% of approved amount
• Class II services	25% of approved amount
• Class III services	50% of approved amount
• Class IV services	50% of approved amount
Dollar maximums	
• Annual maximum (for Class I, II and III services)	$1,000 per member
• Lifetime maximum (for Class IV services)	$1,500 per member

Class I services

Oral exams	75% of approved amount, twice per calendar year
A set (up to 4 films) of bitewing x-rays	75% of approved amount, twice per calendar year
Full-mouth and panoramic x-rays	75% of approved amount, once every 60 months
Dental prophylaxis (teeth cleaning)	75% of approved amount, twice per calendar year
Pit and fissure sealants – for members age 19 or under	75% of approved amount, once per tooth every 36 months when applied to the first and second permanent molars
Palliative (emergency) treatment	75% of approved amount
Fluoride treatment	75% of approved amount, two per calendar year
Space maintainers – missing posterior (back) primary teeth – for members under age 19	75% of approved amount, once per quadrant per lifetime

Class II services

Fillings – permanent (adult) teeth	75% of approved amount, replacement fillings covered after 24 months or more after initial filling
Fillings – primary (baby) teeth	75% of approved amount, replacement fillings covered after 12 months or more after initial filling
Onlays, crowns and veneer fillings – permanent teeth – for members age 12 or older	75% of approved amount, once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	75% of approved amount, three times per tooth per calendar year after six months from original restoration
Oral surgery including extractions	75% of approved amount
Root canal treatment – permanent tooth	75% of approved amount, once every 12 months for tooth with one or more canals
Scaling and root planing	75% of approved amount, once every 24 months per quadrant
Limited occlusal adjustments	75% of approved amount, **limited** occlusal adjustments covered up to five times in a 60-month period
Occlusal biteguards	75% of approved amount, once every 12 months
General anesthesia or IV sedation	75% of approved amount, when medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	75% of approved amount, six months or more after it is delivered
Relining or rebasing of a partial or complete denture	75% of approved amount, once every 36 months per arch
Tissue conditioning	75% of approved amount, once every 36 months per arch

Class III services

Removable dentures (complete and partial)	50% of approved amount, once every 60 months
Bridges (fixed partial dentures) – for members age 16 or older	50% of approved amount, once every 60 months after original was delivered
Endosteal implants – for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount, once per tooth in a member lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services – Orthodontic services for dependents under age 19

Minor treatment for tooth guidance appliances	50% of approved amount
Minor treatment to control harmful habits	50% of approved amount
Interceptive and comprehensive orthodontic treatment	50% of approved amount
Post-treatment stabilization	50% of approved amount
Cephalometric film (skull) and diagnostic photos	50% of approved amount

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.

Blue Vision

Benefits-at-a-Glance

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. There are more than 1,100 VSP provider locations in Michigan and 24,000 locations nationwide. To find a VSP provider, call 1-800-877-7195 or visit VSP's Web site at www.vsp.com.

	VSP Provider	Out-of-Network Provider
Eye exams		
Covers a complete eye exam by an ophthalmologist or optometrists. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	Covered – $10 copay	Reimbursement up to $35 less a $10 copay
	Once every 12 months	
Eyeglass Frames		
Covers standard eyeglass frames. A wide selection of quality frames is fully covered by VSP up to the frame allowance. Members should ask their doctor which frames are covered in full. Members may select a more expensive frame and pay a cost controlled price difference.	Covered – $25 copay(one copay applies to both lenses and frames)	Reimbursement up to predetermined amount based on lense type after copay
	One frame every 12 months	
Eyeglass Lenses		
Single vision, bifocal, trifocal or lenticular lenses in glass or plastic. Note: Additional pairs of prescription glasses and non-covered lens options are discounted when purchased from a VSP provider.	Covered – $25 copay (one copay applies to both lenses and frames)	Reimbursement up to predetermined amount based on lense type after copay
	One pair every 12 months	
Contact Lenses: Members may obtain either eyeglasses or contact lenses, but not both.		
Elective contact lenses (prescribed, but **not** medically necessary) may be chosen instead of spectacle lenses and a frame	Covered – $130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	Covered – $105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Once every 12 months	
Therapeutic contact lenses (medically necessary)	Covered – $25 copay	Reimbursement up to $210 after a $10 copay (member responsible for difference)
	Once every 12 months	
Copays/Coinsurance		
• Eye exam	$10 copay	$105 copay applies to charge
• Frames and/or lenses or medically necessary contact lenses	A combined $25 copay applies to charge	Member responsible for difference between approved amount and provider's charge, less a $25 copay

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-At-A-Glance and any applicable plan document, the plan document will control.

The Most Recognized Coverage in Health Care

The Most Accepted

The Most Trusted

The Most Experienced

Blue Cross
Blue Shield

Put the Cross and Shield to Work for You

Don't settle for less when it comes to your health care. Choose the security of the Blues, the most widely recognized health care coverage in the world. Join the 97 million members — one in three Americans — who look to us for peace of mind with their health care needs.

Blues economics

As a leader in the health care field, with over 70 years of experience and a strong financial standing, you know we'll be here for you today and tomorrow. We're committed to making sure you receive the best value and best service for your hard-earned health care dollar.

BCBSM's health care fraud investigation unit has saved or recovered nearly $277 million since it first began operation nearly 30 years ago. Rest assured the Blues are determined to make sure your money goes towards your health care plan.

We find new solutions rather than limiting or reducing your benefits. For example, we offer managed care programs to control health care costs. We have nearly 30 years of experience with managed care programs, more than any other health care plan.

And you save whenever you need care through special discounts we have arranged with providers close to you — dedicated professionals who have met our high standards and share our commitment to providing you with high quality, stress-free health care.

Blues providers

Blue Cross Blue Shield provides you access to more than 90 percent of hospitals and 80 percent of doctors in the U.S. — more than any other insurer.

Using Blues providers means no unexpected costs or paperwork. That's because Blues providers accept our payment as payment in full for covered services, less any copayments, coinsurances or deductibles. In most instances, your doctor, hospital or health care professional will send bills directly to Blue Cross Blue Shield for payment. You don't have to file a claim or complete any complicated paperwork. It's simple, just show your Blues ID card.

If your doctor is a nonparticipating provider, just mail the claim information to us, and we'll take care of the rest. You'll receive an easy-to-read explanation of your treatment costs and what the Blues paid for the claim.

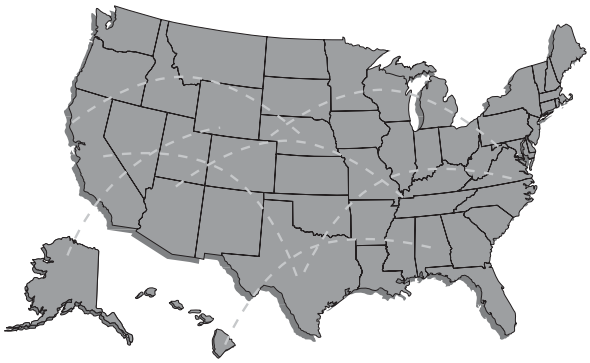
Your Blues neighbor

We're just around the corner, not 200 miles away. There are Blues service centers across the nation. We're servicing our neighbors, friends, business partners, local physicians and hospitals. Need assistance? A dedicated, experienced customer service representative is a toll-free phone call away. Our Customer Service centers are ready to provide any assistance you need with your health care.

The nation is Blue

Whether you're vacationing in sunny California or visiting family in New York, we've got you covered. The Blues have the largest participating provider network in the health care industry. The BlueCard® program links your health care provider to an electronic system that quickly delivers your benefit information anywhere in the country. Members also have access to a network of health care providers around the world through BlueCard. This means that wherever you go, you receive the same comfort and convenience to which you're accustomed.

Your Blues ID card links health care providers to an electronic data system that quickly delivers your benefit information anywhere in the country.



More reasons to choose Blue

Blue Cross Blue Shield is a recognized leader in designing innovative health care programs. We create happier, healthier members by providing free access to the following programs:

Online benefit information — Gives members access to claim status, eligibility information, benefit information and provider information through a private, easy-to-access website, **bcbsm.com**.

***Living Healthy* magazine** — This Blue Cross Blue Shield publication features articles on prevention, nutrition and exercise.

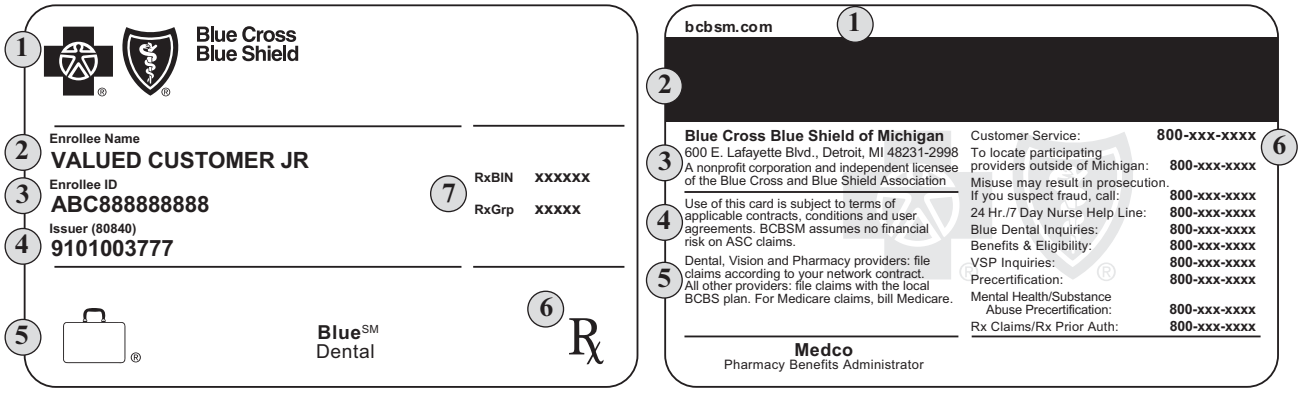
BlueHealthConnection® — An integrated health care management program designed to provide members with the information, tools and assistance needed to make the most informed health care choices.

Healthcare Advisor™ — This online resource allows members to research treatment costs, learn about medications and find out more about doctors and hospitals they may be considering.

Only one health care plan gives you the combination of personal choice, universal recognition and access to quality health care.

Your Blue Cross Blue Shield ID Card

Your identification card will contain some or all of the following information:



The front of the ID card

1. This is the Blue Cross Blue Shield logo. The Blue Cross Blue Shield logo is recognized worldwide, ensuring that no matter where you go, your health care needs are covered.
2. The name of the subscriber is listed here. Names of eligible dependents are listed on Blue Cross Blue Shield records, but not on the identification card.
3. The Enrollee ID number identifies the subscriber. The alpha prefix, ABC, is a sample national Blue Cross Blue Shield identifier.
4. The Issuer code (80840) identifies that Blue Cross Blue Shield is a health insurance carrier, and the number (9101003777) identifies BCBSM as the issuer of the card.
5. This suitcase shows that you belong to our BlueCard program, which means you're covered where you live and where you travel.
6. This logo shows that your prescription drug benefits are administered by Blue Cross Blue Shield and your drug claims are processed by Medco Health Prescription Solutions, Inc.
7. These numbers help the pharmacist administer your prescription drug claims.

The back of the ID card

1. The **bcbsm.com** website provides information about participating providers and other health care issues.
2. This magnetic stripe contains key subscriber information. It contains information from the front of the card and the subscriber's birth date. It doesn't contain any benefit or health information.
3. This language explains the relationship of Blue Cross Blue Shield of Michigan to the Blue Cross and Blue Shield Association.
4. This information explains the use and penalties of misuse of a Blue Cross Blue Shield ID card.
5. This is information for your providers regarding claim submission.
6. These important telephone numbers are for members to ask questions about their health care coverage or to locate doctors and hospitals outside of their plan area.

Preferred Provider Organization

These programs provide your health care through a vast list of preferred providers. Blue Cross Blue Shield offers one of the country's most extensive networks of hospitals, physicians, tertiary-care facilities and ancillary providers. Of course, you always have the choice to seek care from a non-network or nonparticipating provider, although there may be additional costs.

Note: If you have an exclusive provider network health care plan, services received from non-network or nonparticipating providers are not covered.

Community care

Our nationwide provider network gives you access to some of the most respected hospitals and physicians in the United States. Our network is so extensive, chances are that your current physician and community hospital are already Blues preferred providers. To ensure the highest standards of care, Blue Cross Blue Shield has established rigorous standards for participating providers in areas such as access to their services, the quality of care they provide, and how referrals are processed.

Comprehensive care

This plan covers a wide range of care, including hospitalization, medical and surgical care, maternity care and diagnostic services.

Emergency care

You're covered anywhere, anytime — including the emergency room and physician's office. Just remember to see a preferred provider for any additional or follow-up care you may need.

Referral care

From orthopedists to cardiologists, from pediatric oncologists to geriatric specialists, we've designed our network to handle all your family's health care needs. If your preferred physician feels you require treatment from a specialist that is not a part of our network, he or she will coordinate your care.

No unexpected costs

When your preferred physician refers you to a specialist, your costs are covered in full, except for any deductible, coinsurance or copayment that may be required by your specific plan.

Limited non-network costs

When you refer yourself to a provider outside of the preferred provider network, just remember to use Blues participating providers. They will only bill you for your out-of-network deductible, coinsurance or copayments. Only Blue Cross Blue Shield saves you money with this type of out-of-network agreement.

Your Ambulance and Emergency Benefits

Blue Cross Blue Shield's Ambulance and Emergency Room Benefits are designed to help you when you truly need it. We're providing coverage information, including limitations and restrictions, to help minimize your out-of-pocket charges and avoid rising health care costs.

What's covered

Your benefits include:

- Ambulance services
- Emergency room treatment

Note: Charges for physician services or ambulances are not covered for every situation or by all plans. Contact your local Customer Service office for benefit details.

When an ambulance is needed

Air and ground ambulance services are only used for a sudden onset of a medical emergency or an accidental injury, with signs and symptoms of severity, including:

- Severe pain, such that the absence of immediate medical attention could seriously jeopardize a patient's health or pregnancy
- Serious impairment to bodily functions
- Serious dysfunction of bodily organs or parts

Air ambulance transport is only approved when provided by a licensed air ambulance carrier and one of the following conditions exists:

- Patient's condition requires transport by air (rather than ground)
- No other means of transportation is available

When ER treatment is needed

ER treatment is only covered if it meets BCBS-approved criteria. It's important to know what defines an accidental injury or medical emergency.

Accidental injury

Any physical damage caused by an action, object or substance outside the body. This may include:

- Allergic reactions, caused by an outside force (e.g., bee stings, insect bites)
- Attempted suicide
- Bruises, burns or cuts
- Drug overdose
- Frostbite
- Poisoning
- Strains or sprains
- Sunburn or sunstroke
- Toxic inhalation (e.g., carbon monoxide, fumes, smoke)

Medical emergency

A condition that occurs suddenly and unexpectedly, and could result in serious bodily harm or threaten life, if not treated immediately. This includes:

- Bleeding (severe)
- Chest pain (severe)
- Convulsion or seizure

Avoiding the emergency room

Medical records are not available to an ER doctor if a patient is not part of that hospital's system.

The ER staff does not work on a first-come, first-serve basis. During busy times, people with minor illnesses may wait for hours to receive care.

Always remember:

- Never assume all medical conditions require immediate attention (e.g., low back pain, sore throat, diarrhea).
- ER service fees may not be covered if a condition is not due to an accidental injury or medical emergency.
- ER service fees are two to three times more costly than a doctor's office fees.

What's not covered

It's important to know the following services are not covered by your plan.

Nonpatient fees

Ambulance transportation is not covered for anyone other than the patient.

Nonambulance vehicles

- Cabs
- Commercial air carriers (e.g., airlines)
- Emergency transport providers (e.g., fire department, rescue squads)

General medical care

Nonurgent services (usually provided in a physician's office) are not covered in the ER.

Examples:

- Routine medical care
- Treatment of chronic conditions
- ER follow-up visits

Emergency preparations

Before your next ER trip, you should develop a personal plan:

- Map-out the fastest routes to local ERs (e.g., from home, school, office)
- Locate ERs near places you often visit (e.g., family, friends, vacation spots)
- Contact each potential ER:
  - Ask if they have a triage system
  - Get familiar with their process (e.g., initial check-in, patient's status, visitation rules)
- Keep important lists easily accessible:
  - Phone numbers (e.g., doctors, police, ambulances, firefighters, hospitals, poison control centers)
  - Allergies (for each family member)
  - Medications and dosages (for each family member)

Knowing what qualifies as an emergency and the scope of your emergency room coverage saves you money.

Five Good Reasons Why You Should Use a Participating Physician

A physician is considered to be either a **participating** physician or a **nonparticipating** physician. This depends on whether he or she signed an agreement to "participate" with Blue Cross Blue Shield.

Here are five good reasons why you should choose a participating physician.

1. Your out-of-pocket costs are minimized because participating physicians accept BCBS's payment as payment in full.

Participating physicians have signed agreements with BCBS to accept our approved amount as payment in full for covered services. When you use participating physicians, you limit your out-of-pocket costs.

Nonparticipating physicians have not signed agreements with BCBS. They may choose not to accept BCBS's payment as payment in full. This means you are responsible for any charges over what BCBS reimburses you.

2. You are not asked for full payment at the time of service.

For services covered under your health care program, just present your BCBS identification card only to your participating physician. You will be asked for payment to cover any deductibles, coinsurances, copayments or services not covered by your contract.

Nonparticipating physicians may require you to pay the bill at the time you receive services. This can be very costly when the payment is for services during a hospital stay or surgery. Remember, in order to avoid any unnessesary out-of-pocket costs, please always ask your provider if he or she participates with your BCBS health plan.

3. Your claims are filed for you.

When you use a participating physician for your health care needs, all you have to do is show your BCBS identification card. Your participating physician will file a claim for you. Your physician then receives payment directly from us.

If you are treated by a nonparticipating physician, you may have to fill out and submit your own claims to BCBS. We will then send the payment directly to you.

4. You take an active part in holding down health care costs.

Participating physicians have chosen to work closely with BCBS to help hold down rising medical costs. When you choose a participating physician, you support our cost containment efforts.

5. You can always find a BCBS participating physician.

Participating physicians are easily recognized because they usually display the BCBS logo in their windows or offices.

BCBS also publishes a "Participating Provider Directory." You can find participating providers by searching our provider directory at **bcbsm.com** or by calling 1-800-810-BLUE (2583).

You can locate providers based on a particular medical speciality (e.g., internist, obstetrician, pediatrician) or geographic location.

If you already have a physician who does not participate, you may ask if he or she will accept BCBS's payment for services. This is called participating on a "per claim" basis. Knowing the difference between a participating and nonparticipating physician may save you money. By using participating physicians, you also help keep health care affordable.

If you have questions about participating physicians, please call the Customer Service phone number on the back of your Blues ID card. Our knowledgeable representatives will be glad to help you.

Home is Where Your BlueCard® is.

When you're a Blue Cross Blue Shield plan member, you take your health care benefits with you — across the country and around the world. The BlueCard program gives you access to doctors and hospitals almost everywhere, giving you peace of mind that you'll be able to find the health care provider you need.

You have the freedom of choice

As a Blue Cross Blue Shield plan member, you have more freedom to choose the doctors and hospitals that best suit you and your family. Your membership gives you a world of choices. Within the United States, you're covered whether you need care in urban or rural areas. Outside the United States, you have access to doctors and hospitals in more than 200 countries and territories around the world.

With the BlueCard program, you can locate doctors and hospitals quickly and easily. With your Blue Cross Blue Shield plan ID card handy, do the following:

- Visit the BlueCard Doctor and Hospital Finder at **bcbs.com** to locate doctors and hospitals, along with maps and directions to find them.

— OR —

- Call BlueCard Access® at 1-800-810-BLUE (2583) for the names and addresses of doctors and hospitals in the area where you or a covered dependent need care.

If you're a PPO member, always use a BlueCard PPO doctor or hospital to make sure you receive the highest level of benefits.

Designed to save you money

In most cases, when you travel or live outside your Blue Cross Blue Shield plan's service area, you can take advantage of savings the local Blues plan has negotiated with doctors and hospitals in the area. For covered services, you should not have to pay any amount above these negotiated rates.

Take charge of your health, wherever you are

Within the United States:

1. Always carry your current Blue Cross Blue Shield plan ID card.
2. In an emergency, go directly to the nearest hospital.
3. To find nearby doctors and hospitals, call BlueCard Access at 1-800-810-BLUE (2583) or visit the BlueCard Doctor and Hospital Finder at **bcbs.com**.
4. Call your Blue plan for precertification or prior authorization, if necessary. The phone number is located on your Blues plan ID card. ***Note: This phone number is different from the BlueCard Access number mentioned above.***
5. When you arrive at the participating doctor's office or hospital, show the provider your ID card. The provider will identify your benefits through one of these symbols:


Traditional/ Indemnity Benefits

PPO Benefits

After you receive care, in most cases, you should:

- Not have to complete any claim forms
- Not have to pay up-front for medical services, except for the usual out-of-pocket expenses (noncovered services, deductible, copayment and coinsurance)
- Receive an explanation of benefits statement from your Blues plan

Around the world

1. Verify your international benefits with your Blue plan before leaving the United States. Coverage may be different outside the country.
2. Always carry your Blues ID card.
3. In an emergency, go directly to the nearest hospital.
4. Call the BlueCard Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week for information on doctors, hospitals, and other health care professionals or to receive medical assistance services around the world. An assistance coordinator, in conjunction with a medical professional, will help arrange a doctor's appointment or hospitalization, if necessary.
5. If you need to be hospitalized, call your Blues plan for precertification or preauthorization. You can find the phone number on your Blues plan ID card. ***Note: This phone number is different from the number listed above.***
6. Call the BlueCard Service Center when you need inpatient care. In most cases, you should not need to pay up-front for inpatient care at participating hospitals except for the usual out-of-pocket expenses. The hospital should submit your claim on your behalf.
7. You will need to pay up-front for care received from a doctor or nonparticipating hospital. Then, complete an international claim form and send it with the bill(s) to the BlueCard Service Center (the address is on the form). The claim form is available from your Blue plan, the BlueCard Service Center, or online at **bcbs.com/bluecardworldwide**.

Questions?

Don't let questions keep you from making the right choice. If you would like additional information, just call one of our Customer Service representatives, visit our website at **bcbsm.com**, or speak with the benefits coordinator at your company. We're here to help you make your choice Blue.

The Value of Blue

BlueHealthConnection®...

personal health management when it's needed most

Do you need help with your health —

managing a chronic condition, such as diabetes, asthma, heart disease or other illness — so you can improve your quality of life?

Do you want answers to questions about your treatment options to help you make decisions about what's best for you?

Do you want to learn about nutrition, fitness and living a healthy lifestyle?

Then BlueHealthConnection can help.

Through BlueHealthConnection, the Blues' personal health management program, a team of registered nurse "health coaches" can help you stay healthy, get better or improve your quality of life while living with an illness.

Think of BlueHealthConnection as your personal health care partner, someone who's there to help you help yourself.

How does the program work?

BlueHealthConnection is designed to educate and empower you to take a proactive role in managing your health.

At the same time, we encourage you to discuss your condition with your doctor or other health care provider in order to make decisions that are right for you.

In addition, by simply registering online, you can take our health assessment. This questionnaire, developed by doctors and leading health researchers, helps you pinpoint your specific health issues and risks. From there, BlueHealthConnection takes over, driving health news, tips, tools and information important for your health to a personal home page called the health dashboard.

What other help can we provide?

- Written materials or videos to assist you in your decision-making
- Our *Quit the Nic* smoking cessation program
- Disease and case management programs for those with a serious illness or disease

How do I contact BlueHealthConnection?

If you have a question about your health, you can contact BlueHealthConnection at our toll-free number.

Your doctor, hospital or other health care professional may also refer you to BlueHealthConnection for help.

Blue Cross members call 1-800-775-BLUE (2583) or go to **bcbsm.com**.

Please have your Blue Cross Blue Shield ID card handy.

Quit the Nic Smoking Cessation Program

Cigarette smoke contains more than 4,800 chemicals, 69 of which are known to cause cancer. Smoking is directly responsible for approximately 80 percent to 90 percent of deaths caused by emphysema and chronic bronchitis.

Blue Cross Blue Shield has a program that can help you quit smoking called *Quit the Nic*.

How it works:

If you want to stop using tobacco, call *Quit the Nic* at 1-800-775-BLUE (2583). *Quit the Nic* is a telephone-based program you can use to support your effort to quit.

- During your first call, a nurse health coach will discuss your readiness to quit using tobacco.
- In subsequent calls, the nurse health coach will guide you through a series of topics to help you through the quitting process. Each phone session is designed to help you overcome the urge to use tobacco.
- Together, you'll map out an action plan to gradually stop using tobacco and set a quit date when you're ready.

Why quit smoking?

Did you know that 20 minutes after you stop smoking, your body begins to heal?

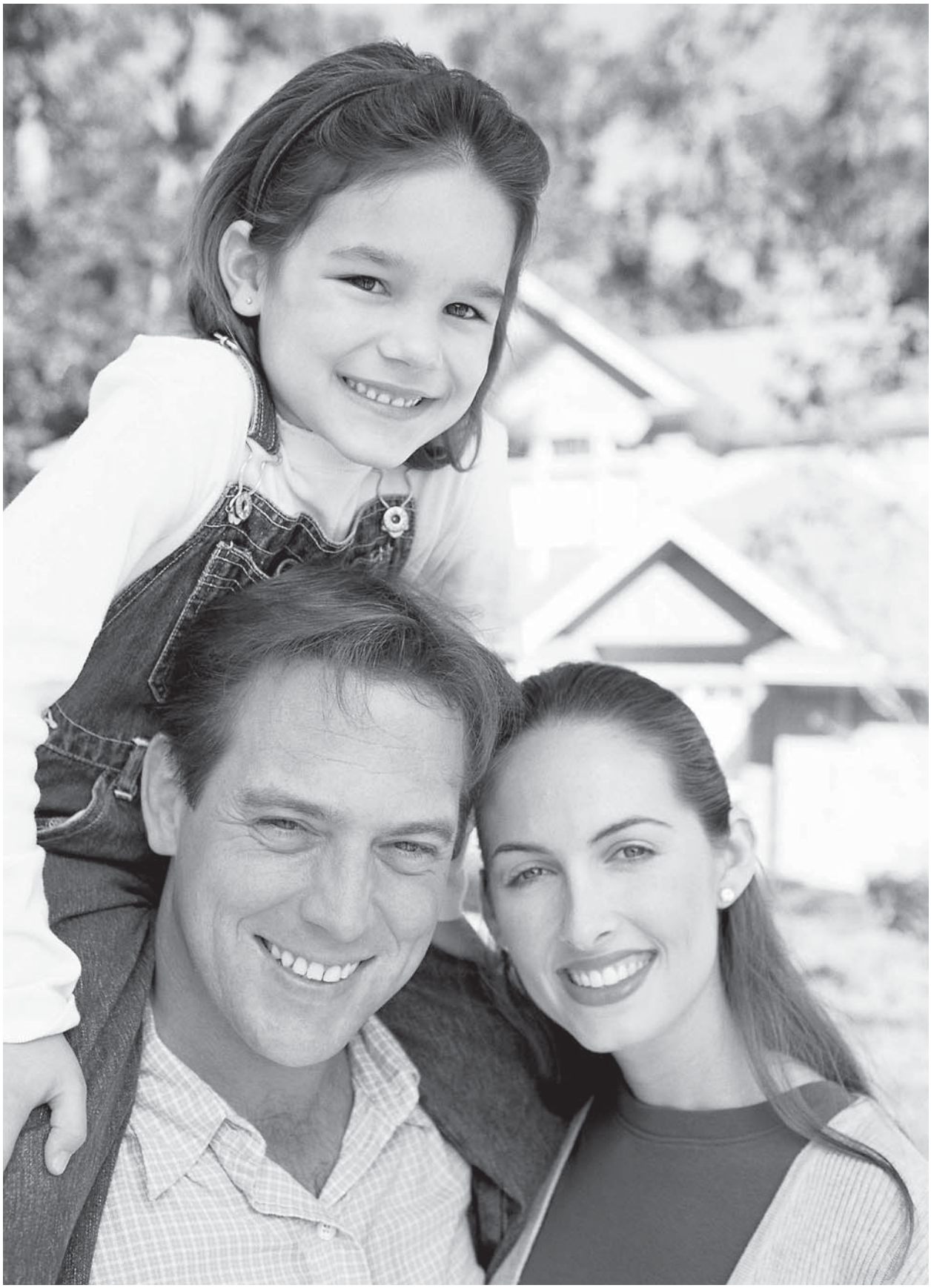
- After 20 minutes, your heart rate has a favorable response.
- After 8 hours, the carbon monoxide level in your blood drops to normal.
- After two weeks to three months, circulation and lung function improve.
- After one to nine months, coughing and shortness of breath decrease.
- After one year, your risk of coronary artery disease is half that of a smoker's.
- After five to 15 years, your stroke risk is reduced to that of a nonsmoker.
- After 10 years, your risk of lung cancer is about half that of a continuing smoker. Your risks of mouth, throat, esophagus, bladder, cervix and pancreas cancer also decrease.
- After 15 years, your risk of coronary heart disease is similar to that of someone who has never smoked.

Here are some reasons why people want to quit using tobacco:

- I want to feel better and enjoy a healthier lifestyle.
- I want to set a good example for my children.
- I want to save money.
- I want my clothes and hair to smell better.
- I want to decrease my risk of getting cancer, heart disease and lung disease.
- I want whiter teeth and fresher breath.

Why do *you* want to stop using tobacco?

Call *Quit the Nic* today!
1-800-775-BLUE (2583)
bcbsm.com/quitsmoking



View and manage your health and health plan online at **bcbsm.com**

Visit **bcbsm.com** and register for *Member Secured Services* so you can access all of our online services.

Registering is easy. Here's how:

- Visit **bcbsm.com**.
- Click on the *Member* tab.
- Click *Register*.
- Follow the registration steps that appear on the screen.
- If you have any problems or questions, call the Web Help Desk at **1-888-417-3479**. This number is located at the bottom of our Web pages for your convenience.

If you're registering for the first time, please note that we require a one-time PIN registration before you're able to access personalized online services that contain protected health information. We'll mail your PIN to the postal address we have on file for you. Delivery takes three to five business days. While you're waiting for your PIN, you can take your health assessment online. After you receive your PIN, please log back into *Member Secured Services* and complete your registration by entering this PIN.

Once you register you'll be able to:

- "Go green" and receive your *Explanation of Benefits* Payments statements online*
- View detailed claim and benefit information
- Access your pharmacy information
- Take an interactive health assessment and receive a lifestyle score and tailored action plan
- Participate in online health coaching programs so you can achieve health goals identified by your health assessment
- Access extensive, up-to-date health content, including multimedia components like podcasts and videos
- Find and compare doctors and hospitals based on factors most important to you, like cost and quality
- Save money on the healthy products and services you use everyday through our member savings programs, Healthy Blue Xtras℠ and Blue365®.

All features may not be available, depending on your group's participation.

*This feature is only available to the subscriber of the contract.

Online health care benefits at **bcbsm.com**

At **bcbsm.com** you have completely secure, password-protected access to the personal health benefits information that you need most. You can create your own account and obtain real-time access to information on your claims, eligibility, deductibles, local providers and more. Plus, it's easy.

Some of the website features include:

- **Claims** — View your claim status, including current and previous claims for the past two years. You can also view claim payment information, claim summary and claim details.
- **Eligibility** — View the coverages you are eligible for under your contract.
- **Deductibles and maximums** — View your out-of-pocket costs and benefit limitations.
- **Provider Lookup** — View and find participating Blue Cross Blue Shield doctors and hospitals, no matter where you live or travel.

- **ID cards** — Request a replacement ID card to be sent to your home.
- **Downloads** — View, print or download forms and documents related to your health care coverage.
- **Coordination of benefits** — Allows you to update additional health care coverage for each member on the contract.
- **BlueHealthConnection®** — Offers personal health and wellness information all custom tailored to meet your individual needs. The site also includes a health assessment, a health dashboard and a personal health record.
- **Healthcare Advisor™** — Allows you to estimate the costs of health care services, research hospitals and physicians, compare drug treatment options and forecast your family's out-of-pocket costs.
- **Explanation of benefits** — View and print your explanation of benefits statements for the past two years.
- **Benefit information** — View and print a summary of your benefits.

At **bcbsm.com**, you'll have member-level security that is password protected. You view only the information you are authorized to see; you cannot access information for your spouse or adult dependents. Spouses and adult dependents (aged 18 years or older) can access only their own information. You can rest assured that your privacy is protected.

We recognize how important information concerning your health care benefits is to you. You will find online health care benefits at **bcbsm.com** to be is a very valuable resource tool for you and your family.

Information at your fingertips

Finding answers to your health care questions is now a simple mouse click away at **bcbsm.com**.

Automated Servicing Systems

For quick answers about your Blue Cross Blue Shield coverage.

Online information at your fingertips

Finding answers to your health care questions is now a simple mouse click away.

"Member Secured Services," at **bcbsm.com**, offers completely secure, password-protected access to the personal health benefits information you need most. You can create your own account and access up-to-date information on your claims, eligibility, deductibles, providers and more. Plus, it's easy.

The website's features include:

- Claims history
- Eligibility
- Deductibles and maximums
- Provider directory
- ID cards
- Downloadable forms
- Coordination of benefits information (enrollee only)
- BlueHealthConnection® (includes a health assessment)
- Healthcare Advisor™
- Explanation of benefits statements
- Benefit information

We recognize how important information concerning your health care benefits is to you. You will find that **bcbsm.com** is a very valuable resource tool for you and your family.

Easy. Quick. Convenient.

When you need to know about claims, coverage information, deductibles, maximums, updating your account, requesting ID cards or participating provider information, you can get answers quickly and easily. When you dial the customer service telephone number on the back of your ID card, you're immediately connected to the Interactive Voice Response System.

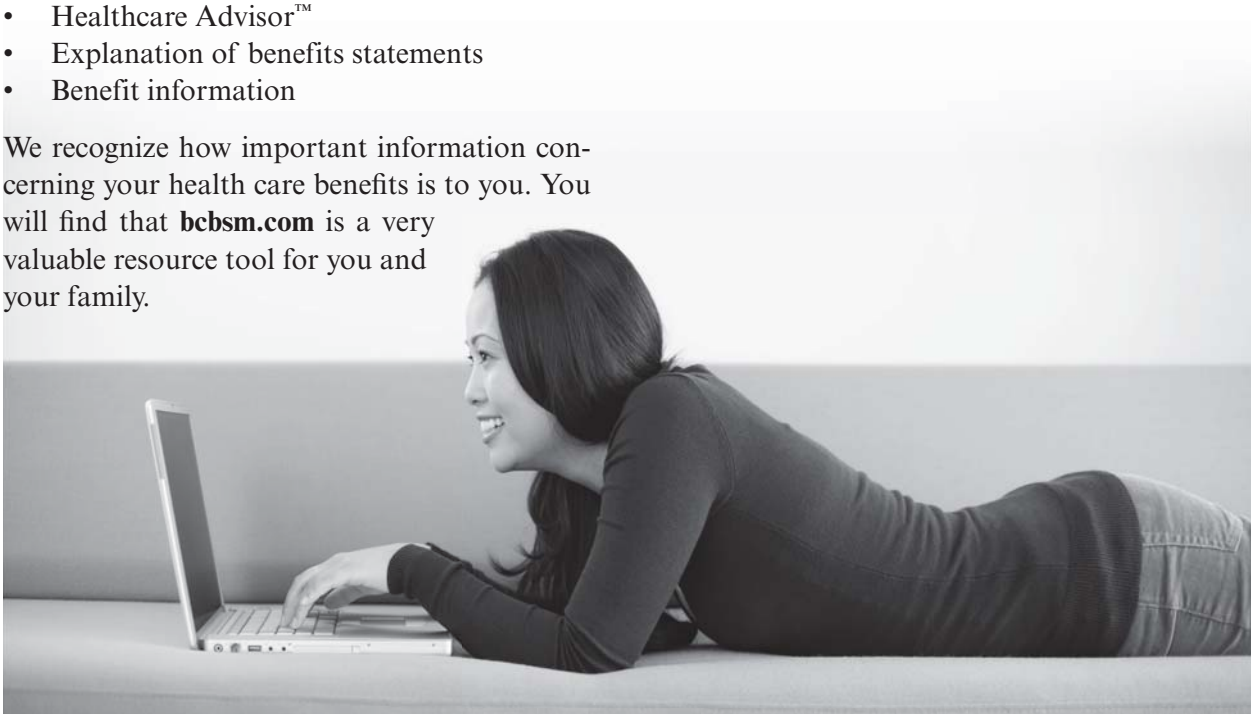
Extended hours of operation let you call at your convenience (all times are EST).

Monday – Friday	6 a.m. to 11 p.m.
Saturday	7 a.m. to 6 p.m.
Sunday	9 a.m. to 4 p.m.

Live service is available:
Monday – Friday from 8 a.m. to 8 p.m.

Monday – Thursday from 8 a.m. to 8 p.m. and Friday from 8 a.m. to 5 p.m. (West Michigan accounts only)

Verification of eligibility does not guarantee payment by BCBS. Questions about specific situations should be directed to a BCBS Customer Service representative.



Before you dial

Be sure you have:

- Your BCBS contract number/enrollee ID
- Dates of service, if checking claims
- Patient's birth date, if checking claims or deductible and maximum amounts

After the system answers

You will be asked to identify yourself as a member and offered main menu options. The options are:

- Claims
- Coverage information
- Deductibles and maximums
- Update your account
- Order ID cards
- Find a provider
- Something else

You may speak your response or use your telephone keypad to enter your responses.

If you choose to speak your responses, background noises may impact the effectiveness of the speech option.

When you hear the option you want, you can make the selection without listening to the entire message.

Example 1

Q. What is the family deductible for your medical plan?

A. Make the following selections:

- Say "deductibles and maximums" or press 3 on the main menu
- Say or enter your contract number or enrollee ID
- Say "this calendar year" "last year" or "before that"
- Say "medical"
- Say "family"

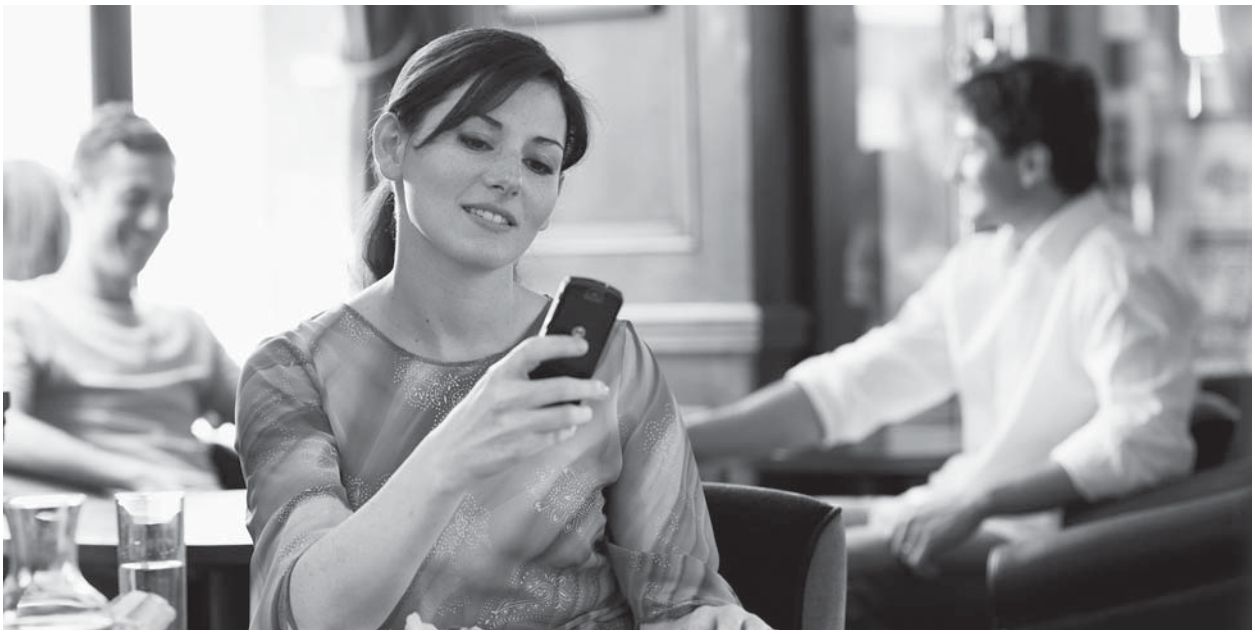
The System will provide your family deductible amount.

Example 2

Q. How do I order ID cards?

A. Make the following selections:

- Say "ID cards" or press 5 on the main menu
- Say or enter your contract number or enrollee ID
- The system will confirm your ID card order and provide a confirmation number for the request.



Online EOBs

You'll benefit from online EOBs

In the past, the BCBS explanation of benefits statements you received in the mail after doctor or hospital visits have proven to be a good way to keep track of your medical care while helping us hold down costs.

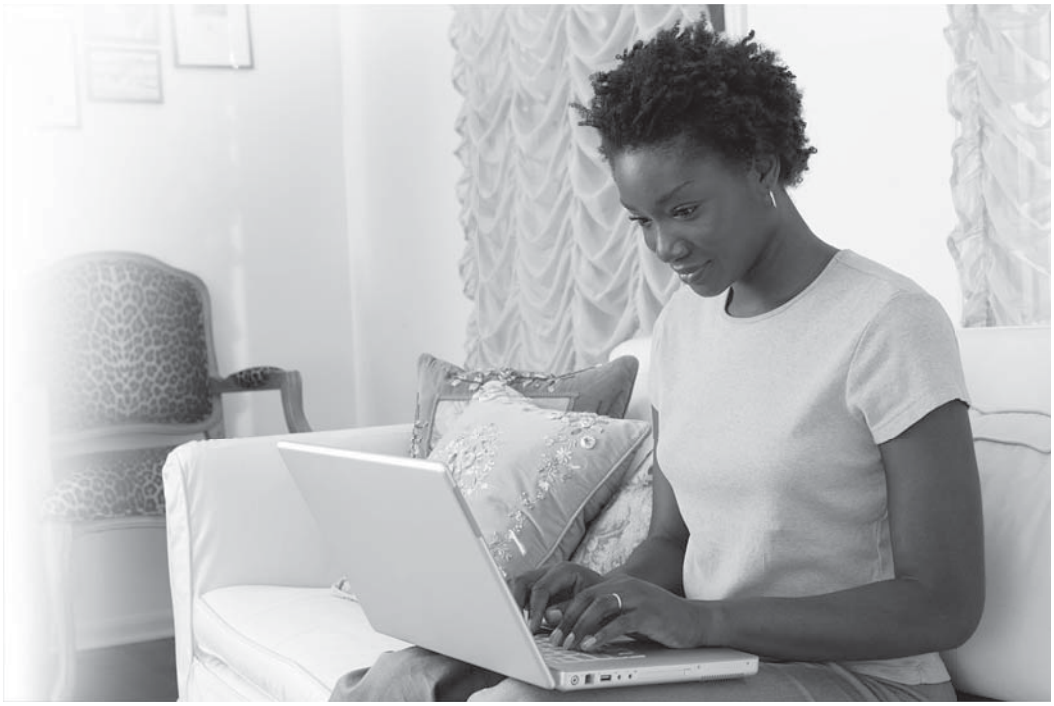
Well, what was once good has become even better.

Through Blues innovation, your EOBs are now available to you online, as handy as your computer and as fast as your Internet connection allows. Using just your keyboard, Web access and a few quick clicks, you can now keep an eye on your health care information in the easiest and most convenient way possible.

When you discontinue the delivery of your paper EOBs and use online EOBs, you have at your fingertips a way to securely track your BCBS claims while helping reduce paper use, cut down on clutter and save dollars on printing and mailing costs. Perhaps best of all, you can conveniently view, print or save only those benefit statements you need.

Viewing EOBs is easy

- At **bcbsm.com**, sign in at the left using your user name and password.
- Choose *Search for EOBs* on the left navigation bar and click *View All* to view all EOBs covered by your policy, or enter the service date ranges you are looking for.
- Click *Search* and one or more EOB document numbers will be displayed. Select the *Document Number* of the EOB you want to look at, and your EOB will appear in a new window.
- Another option is to click *Claims Status* on the left navigation bar, choose the service date (or *View All Claims*), then click *View EOB*.
- To discontinue the delivery of the paper version, in which case you will receive an email notification when a new EOB is ready for viewing, click on the link called *Click here to update your delivery options for your Explanation of Benefits (EOB) documents* on the *Search for EOBs* or *Claims Status* screens.



Understanding Your Explanation of Benefits Statement

What to look for on your EOB statement

You will receive an explanation of benefits statement after we process your claim. The EOB statement shows you what services have been paid by Blue Cross and what you may owe through deductibles and copayments. The EOB will also show noncovered services for which we did not make payment.

Always check your EOB statement closely to make sure that you received the services listed. It is very important that you notify Blue Cross Blue Shield if you did not receive the services or there are any discrepancies.

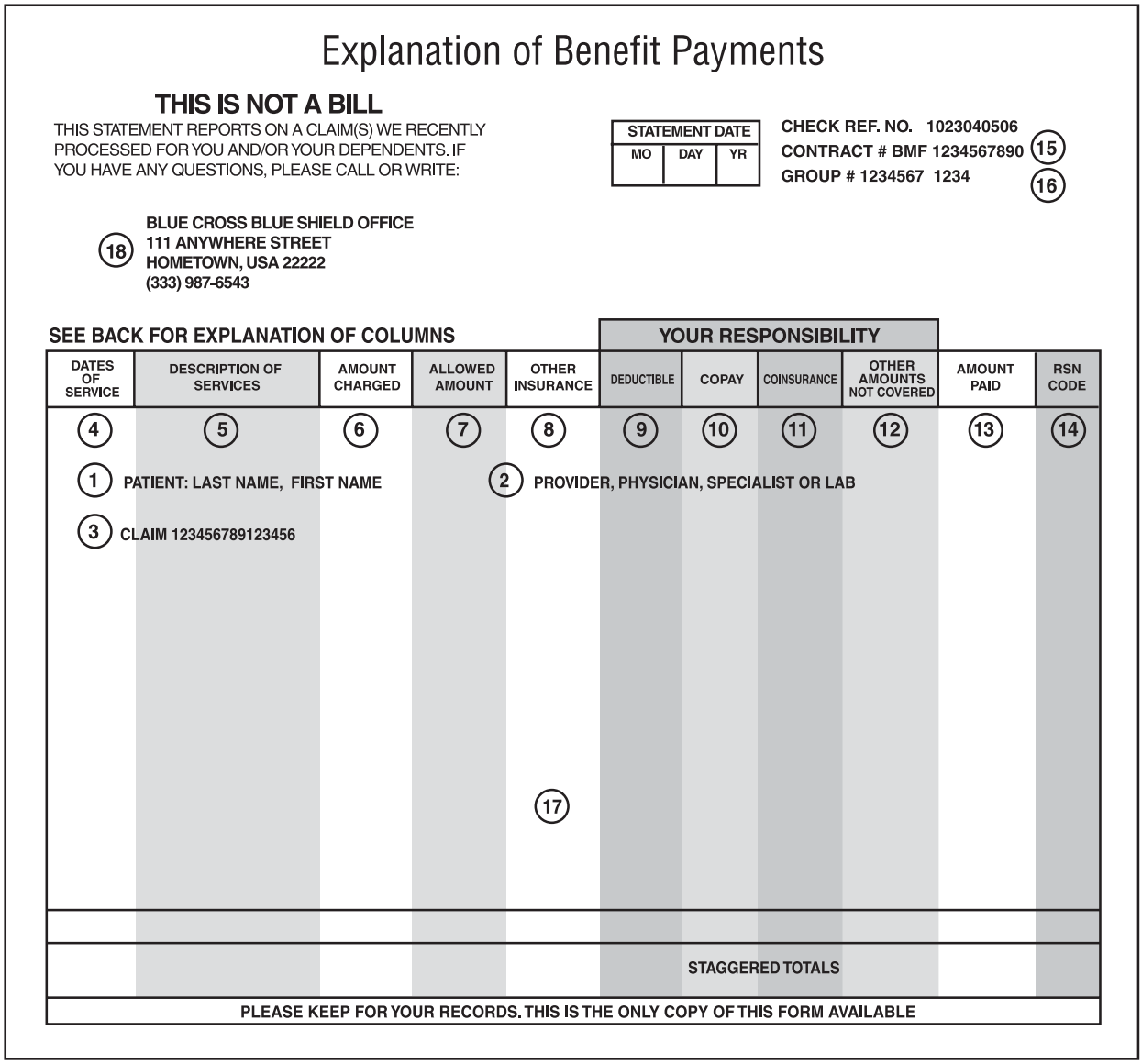
If you have questions about your EOB statement, please call your Blue Cross Blue Shield Customer Service office listed on the back of your ID card.

We hope your EOB statement will meet your needs for clear and complete information about your claims.

Please remember these important tips when viewing your EOB statement:

- Review the contract information section to determine which family member the statement is for and then verify that the information is correct.
- Review the "Patient's Name" section to determine the patient who accepted services.
- Review the "Deductibles" and "Copays" sections to determine the dollar amount covered for health care expenses and the amounts you are responsible for specified by your contractual benefits.
- Match the information in the "Description of Services" section with your doctor or hospital bills to verify that all services listed are services you or a family member received.
- Follow the step-by-step payment calculators in the "Description of Services" section to see how we arrived at our payment and how much you may owe for each service.
- Review "Other Amounts Not Covered" section to establish the amount of expenses enclosed with your benefits.
- Read the "Messages" and "Address and Phone" sections to view any applicable messages or to reach a Blue Cross Blue Shield Customer Service representative with questions or inquiries.

You can now view your EOB statement online. Simply access the website listed on the back of your ID card.



Explanation of Benefit Payments

THIS IS NOT A BILL

THIS STATEMENT REPORTS ON A CLAIM(S) WE RECENTLY PROCESSED FOR YOU AND/OR YOUR DEPENDENTS. IF YOU HAVE ANY QUESTIONS, PLEASE CALL OR WRITE:

STATEMENT DATE		
MO	DAY	YR

CHECK REF. NO. 1023040506
CONTRACT # BMF 1234567890 (15)
GROUP # 1234567 1234 (16)

(18) BLUE CROSS BLUE SHIELD OFFICE
111 ANYWHERE STREET
HOMETOWN, USA 22222
(333) 987-6543

SEE BACK FOR EXPLANATION OF COLUMNS

					YOUR RESPONSIBILITY					
DATES OF SERVICE	DESCRIPTION OF SERVICES	AMOUNT CHARGED	ALLOWED AMOUNT	OTHER INSURANCE	DEDUCTIBLE	COPAY	COINSURANCE	OTHER AMOUNTS NOT COVERED	AMOUNT PAID	RSN CODE
(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
(1) PATIENT: LAST NAME, FIRST NAME				(2) PROVIDER, PHYSICIAN, SPECIALIST OR LAB						
(3) CLAIM 123456789123456										
				(17)						
					STAGGERED TOTALS					

PLEASE KEEP FOR YOUR RECORDS. THIS IS THE ONLY COPY OF THIS FORM AVAILABLE

1. **Patient's Name:** the name of the patient who received services.
2. **Provider Name:** the name of the provider (e.g., physician, hospital or lab) who performed the services for the patient. The provider name shown may be different than your physician's name because services such as tests, X-rays and consultations may be provided by other health care professionals or facilities as directed by your physician. ***Note: If payment was directed to a provider, the message "Payment was made to provider" will appear.***
3. **Claim Number:** the number assigned to that patient's claim.
4. **Dates of Service:** the dates reported to each service performed for the patient.
5. **Description of Services:** a brief description of each service.
6. **Amount Charged:** the amount billed by your physician, pharmacy, hospital, lab or other health care professional who performed each service. ***Note: If Medicare Supplemental services are involved, the amount in the column will represent the amount billed to Medicare.***

7. **Allowed Amount:** the amount we have approved for payment prior to deductibles, coinsurance or other member expenses (if any).
8. **Other Insurance:** the amount paid by other insurance, including Medicare.
9. **Deductible:** a fixed dollar amount that you must pay for covered health care expenses before your benefits are provided. You are responsible for this amount.
10. **Copay:** a predetermined amount specified by your contractual benefits. You are responsible for this amount.
11. **Coinsurance:** a percentage of the cost (allowable charge) for which you are responsible as defined by your covered benefits.
12. **Other Amounts Not Covered:** This amount represents expenses not covered or in excess of your benefits. You may be responsible for this amount to your health care provider.
13. **Amount Paid:** the total amount paid to you or your provider for the services performed.
14. **Reason Code:** Codes shown in this column refer to specific messages below each claim. These messages clarify a payment situation or explain why you may be responsible for a service.
15. **Contract Number:** This is the identification number of the subscriber/employee. It is also the number printed on your Blue Cross Blue Shield ID card. Please reference this number if you call or write with questions.
16. **Group Number:** This is the number used to identify the account in which you are enrolled.
17. **Messages:** Additional messages, if applicable, will appear in this section.
18. **Address and Phone:** the Blue Cross Blue Shield office where all questions should be directed. A Customer Service representative will assist you with your inquiries.

Urgent Care Reminders

One advantage of your PPO health plan is access to urgent care when your regular physician is not available. However, it's sometimes difficult to know if the physician on call is a PPO physician, which limits your copayment to a fixed dollar amount.

Some members tell us they pay more than the fixed dollar amount at some urgent care locations. This may be because a PPO physician at the urgent care location does not see them. Therefore, we recommend that before you go to any urgent care center, you call first and ask if:

- You will be seen by a PPO physician
- The center can provide the type of care you'll need

By calling first, you will avoid having to pay higher out-of-network costs because the physician you saw was not part of our PPO network.

To locate a participating physician or urgent care center in your area, you can call 1-800-810-BLUE (2583) or log onto **bcbs.com**.

Please remember…if you feel you have a life threatening medical condition or injury, you should seek care at the nearest emergency room so you don't delay necessary treatment. Your PPO plan covers medical emergencies and emergency first aid at your in-network level of benefits.

We hope this brief explanation of your urgent care benefits makes it a little easier for you and your family.

Health Savings Account

Tax-free, long-term

Basics

A health savings account, or HSA, is an account you can use to pay for current health care expenses and to save for future qualified medical and retiree health expenses on a tax-free basis. It's like a 401(k) account for your health care.

Here's how it works

You and your employer may make tax-free contributions to your HSA. You can use the account to cover your deductible requirements for services covered through your health care plan. You can also use money in the account to pay for eligible health care expenses. Money in your account will automatically rollover from year to year and can earn interest and be invested once the balance reaches a specific dollar amount. If you leave your employer, the money accumulated in your HSA is yours to take with you.

HSA benefits

More control over your health care dollars

You're in charge of your health … shouldn't you be in charge of how you spend your health care dollars, too? With an HSA, you are. Your HSA works in conjunction with a compatible high deductible health plan. You decide how much money (up to certain limits) you want to contribute each year. Allowable catch-up contributions, portability, and the ability to save money for future health care expenses make the HSA more flexible than other tax-advantaged accounts, such as medical savings accounts, flexible spending accounts and health reimbursement arrangements.

Tax savings

Who doesn't appreciate a tax-free way to pay — and save? With an HSA, your contributions, earnings and withdrawals for qualified medical expenses are all tax-free. You must keep supporting receipts and records to show the Internal Revenue Service you used the funds to pay qualified medical expenses, in the event of an audit.

Long-term savings

An HSA covers more than your health expenses today … it helps you plan for the future, too. Just like an IRA or 401(k), you have the opportunity to make your HSA grow by earning interest on your balance and by investing your contributions in your choice of investment funds. You can choose from a variety of mutual fund investment options — from conservative to aggressive — to match your personal financial goals and investment style. Best of all, your unused account balance rolls over from year to year.

Ownership

No one knows what your family's future may bring — job changes, new health plans, perhaps an out-of-state move. With an HSA, you don't have to worry — your account is entirely owned by you. Your account balance is yours to take with you wherever you go.

Convenience

Need new eyeglasses? Need to visit your health care provider for a sports injury? From doctor visits to prescription drugs, you can use the money in your HSA to pay for a variety of health care expenses.

How does an HSA work?

Consider the following examples[1]:

Ben enrolled in a high-deductible health plan in January with family coverage for himself, his wife and his two children. Ben decides to contribute $5,000 to his HSA.

Ben's health plan features:	
Family coverage:	$5,000 deductible
Maximum out-of-pocket (including deductible):	$10,000

Ben's coverage:	**In-network**	**Out-of-network**
Coinsurance coverage:	80%	60%
Employee pays:	20%	40%
Preventive care:	100% coverage (deductible does not apply)	
Pharmacy coverage:	subject to deductible	

Ben	**Amount in Ben's HSA**	**Amount Ben pays from his HSA**	**Amount paid by Ben's health plan**	**Ben's remaining out-of-pocket expense**	**Amount left in Ben's HSA to carry over to next year**
Scenario 1 During the year, Ben and his family have in-network health care expenses of $6,000 that are not considered preventive care. Ben chooses to pay these expenses from the balance in his HSA. Because his deductible is $5,000, the health plan covers 80 percent of the remaining $1,000, or $800. This leaves $200 (20 percent) as Ben's out-of-pocket expense.					
	$5,000	$5,000	$800	$200	$0
Scenario 2 During the year, Ben and his family have in-network health care expenses of $1,200 that are not considered preventive care. Since his total expenses are less than his deductible, Ben is responsible for all the expenses. Ben chooses to pay these expenses from the balance in his HSA.					
	$5,000	$1,200	$0	$0	$3,800 (plus earnings)

Alicia enrolled in a high-deductible health plan in January with individual coverage for herself. Her deductible is $2,500. Alicia decides to contribute $2,500 on a pretax basis from her paychecks into her HSA.

Alicia's health plan features:	
Individual coverage:	$2,500 deductible
Maximum out-of-pocket (including deductible):	$5,000

Alicia's coverage:	**In-network**	**Out-of-network**
Coinsurance coverage:	80%	60%
Employee pays:	20%	40%
Preventive care:	100% coverage (deductible does not apply)	
Pharmacy coverage:	subject to deductible	

Alicia	**Amount in Alicia's HSA**	**Amount Alicia pays from her HSA**	**Amount paid by Alicia's health plan**	**Alicia's remaining out-of-pocket expense**	**Amount left in Alicia's HSA to carry over to next year**
Scenario 1 During the year, Alicia has in-network health care expenses of $1,000 that are not considered preventive care. Because her deductible is $2,500, Alicia is responsible for all of these costs. She chooses to pay only $600 of these expenses from the balance in her HSA because she wants to start saving for her future health care needs.					
	$2,500	$600	$0	$400	$1,900 (plus earnings)
Scenario 2 Alicia is very healthy during the year and has no health care expenses except for regular checkups and screenings, which are all considered preventive care. Since her plan covers preventive care at 100% and it does not apply to her deductible, Alicia is able to carry over her entire $2,500 HSA balance into the next year.					
	$2,500	$0	$0	$0	$2,500 (plus earnings)

[1] These examples are for illustrative purposes only. Individual situations will vary depending on the specifics of your high-deductible health plan and your individual contributions.

Using your HSA

When you pick up a prescription or need to pay for other qualified medical expenses, simply use your HSA debit card. As long as you have the necessary funds in your account, there's no need to pay copayments or other expenses out-of-pocket. If you choose not to use the card, you can reimburse yourself for out-of-pocket expenses,by transferring funds from your HSA to your personal checking account online. Online account management allows you to review your account information 24 hours a day, seven days a week. Also, an experienced Customer Service representative is a toll-free phone call away.

Qualified medical expenses

The money in your HSA can be used to pay for qualified medical expenses for you, your spouse or your dependent children, even if your spouse and dependents are not covered by the same high-deductible health plan. Qualified medical expenses include copayments and deductibles at doctors, pharmacies, medical labs, dentists and orthodontists, medical supply stores, chiropractors, hospitals, vision centers, podiatrists and more.

You can also use HSA funds for eyeglasses and contact lenses, mail order prescriptions, online prescriptions, eligible over-the-counter medications and bills from providers for "Patient Balance Due" amounts.* You can find a complete list of qualified medical expenses in IRS Publication 502, Medical and Dental Expenses, Catalog Number 15002Q, available at **irs.gov**.

Best of all, the money in your HSA can be used to pay for eligible out-of-pocket health care expenses now — or in the future. The choice is yours — for each expense, you can pay from your HSA or save the money in your account for future health care expenses.

Note: If you use funds from your HSA to pay for something other than a qualified health care expense, you will be required to pay income tax and a 20 percent additional tax on that amount unless you are disabled or age 65 or older. You will need to include that amount as regular income when you file your taxes.

Frequently asked questions

What is a health savings account?

A health savings account is an employee- or employer-funded account that allows employees to set aside pretax dollars to pay for eligible medical expenses.

Who is eligible for an HSA?

To be eligible for an HSA you must be covered by a high-deductible health care plan, must not be covered by other health care plan unless a high-deductible health care plan (does not apply to specific injury insurance and accident, disability, dental care, vision care and long-term care), must not be eligible and enrolled in Medicare, must not be claimed as a dependent on someone else's tax return, and must not be enrolled or covered by Healthcare FSA or Full HRA.

What is a high-deductible health care plan?

A high-deductible health care plan has the following deductible requirements:

- Minimum deductibles:
  - — $1,200 for individual-only coverage
  - — $2,400 for family coverage (two or more members) Annual out-of-pocket (including deductibles and coinsurances) cannot exceed $6,050 for individual-only coverage and $12,000 for family coverage (two or more members). These are 2012 amounts. The federal government can change deductible and out-of-pocket maximum requirements annually, based on increases in the Consumer Price Index.

Qualified high-deductible health plans generally have no deductible requirements for preventive care and higher out-of-pocket costs for out-of-network services.

*Effective Jan. 1, 2011, a physician prescription is required for over-the-counter (OTC) drugs, medicines and biologicals (products found in medicines) to be considered eligible for reimbursement against an HSA.
You can continue to use your HSA funds to purchase eligible OTC items that are not considered medicine or a drug, or for bandages, contact lens solution, etc.)
You may be required to submit a copy of the prescription along with required receipts when seeking reimbursement.

How much can I contribute to an HSA?

The current maximum contribution allowed is $3,150 for individuals or $6,250 for family coverage. These dollar limits are for 2012 and are adjusted annually. If you are 55 or older you can make additional catchup contributions each year until you enroll in Medicare. The catch-up contribution is $1,000 for 2009 and after.

Do HSA funds roll over from year to year?

Yes, money invested in an HSA can roll over from year to year. Accounts earn interest and once the account meets a minimum threshold, the additional dollars can be invested in longer-term investment vehicles. The level of risk in your investment is up to you. There are a wide range of investment options available.

What happens to the money in my HSA after I turn 65?

Once you reach age 65, you can use your HSA to pay eligible health care expenses and certain insurance premiums like Medicare Part A and B, Medicare HMO and your share of retiree medical insurance premiums. Money cannot be used to purchase a Medigap policy, but can be used for certain other expenses. Amounts used for eligible health care expenses are tax-free. Money used for any other expenses are taxable.

Can I roll an HSA over into an IRA?

No, you are not allowed to roll an HSA into an IRA, but you can make a one time transfer from an IRA into an HSA, up to certain dollar limits.

How can I use distributions from my HSA?

You can distribute the amounts for either eligible health care expenses or other expenses. If the amount distributed is used for eligible health care expenses, the distribution is tax-free. If the amount distributed is used for expenses other than eligible health care expenses, the amount distributed will be taxed and subject to a 20 percent tax penalty for individuals who are not disabled or age 65 or older.

What if I change jobs?

HSAs are permanent and portable. You can take your HSA to your next job. You can continue to grow the dollars in your account through interest or investments or use the money for eligible health care expenses. However, in order to actively contribute to your HSA, you must be covered by a high-deductible health plan either through your new employer or through an individual policy. HSAs can also be rolled into a similar HSA at a different bank if desired.

Qualified medical expenses

According to the Internal Revenue Service, health savings accounts can be used to pay for:

1. Eligible medical expenses including over-the-counter medicines and drugs**
2. Health insurance premiums under COBRA continuation coverage
3. Health insurance premiums while receiving unemployment compensation
4. Medicare Part A or Part B premiums for individuals enrolled in Medicare
5. Qualified long-term care insurance premiums

Eligible medical expenses for HSAs are defined in Section 213(d) of the Internal Revenue Code. A complete list is available from the IRS in Publication 502 Medical and Dental Expenses by visiting irs.gov*. Below is a reference list that may help you determine whether a medical expense is eligible for HSA reimbursement. This reference list is provided only as a guide. Please consult Publication 502 Medical and Dental Expenses from the IRS or a professional legal or tax advisor regarding the eligibility of a medical expense.

Eligible HSA medical expenses (not fully inclusive)

- Acupuncture
- Alcoholism treatment
- Ambulance
- Anesthetist
- Artificial limbs
- Autoette (used for relief of sickness or disability)
- Blood tests
- Blood transfusions
- Braces
- Breast pumps and lactation supplies
- Chiropractor
- Christian Science Practitioner
- Contact lenses
- Convalescent home (medical treatment only)
- Crutches
- Dental treatment
- Dental X-rays
- Dentures
- Dermatologist
- Diagnostic fees
- Diathermy
- Drug addiction therapy
- Drugs (prescription or over-the-counter)**
- Elastic hosiery (prescription)
- Eyeglasses
- Fees paid to doctor-prescribed health institute
- FICA and FUTA tax (paid for medical services)
- Fluoridation unit
- Guide dog
- Gum treatment
- Gynecologist
- Healing services
- Hearing aids and batteries
- Hospital services
- Hydrotherapy
- Insulin treatments
- Lab tests
- Lead-based paint removal
- Lodging (away from home for health care)
- Metabolism tests
- Neurologist
- Obstetrician
- Operating room costs
- Ophthalmologist

*Blue Cross Blue Shield of Michigan does not control this website or endorse its general content.
**After December 31, 2010, a prescription from a physician will be required.

- Optician
- Optometrist
- Oral surgery
- Organ transplant (including doctor's expenses)
- Orthopedic shoes
- Orthopedics
- Osteopath
- Oxygen and oxygen equipment
- Pediatrician
- Physician
- Physiotherapist
- Podiatrist
- Postnatal treatments
- Practical nurse for medical services
- Prenatal care
- Psychiatrist
- Psychoanalyst
- Psychologist
- Psychotherapy
- Radium therapy
- Registered nurse
- Special school costs for the handicapped
- Spinal fluid test
- Splints
- Sterilization
- Stop smoking programs
- Surgeon
- Telephone or TV equipment to assist the hard of hearing
- Therapy
- Transportation expenses (for health care)
- Ultraviolet ray treatment
- Vaccines
- Vasectomy
- Vitamins (if prescribed)
- Wheelchair
- X-rays

Ineligible HSA medical expenses (not fully inclusive)

- Advance payment for services to be rendered next year
- Athletic club memberships
- Automobile insurance premium allocable to medical coverage
- Boarding school fees
- Bottled water
- Commuting expenses of a disabled person
- Cosmetic surgery and procedures
- Cosmetics, hygiene products and similar items
- Diaper service
- Domestic help
- Funeral, cremation or burial expenses
- Health club dues
- Health programs offered by resort hotels, health clubs and gyms
- Illegal operations and treatments
- Illegally procured drugs
- Insurance premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits
- Maternity clothes
- Scientology counseling
- Social activities
- Special food or beverages
- Specialty designed car for the handicapped other than an Autoette or special equipment
- Swimming pool
- Travel for general health improvements
- Tuition and travel expenses for a problem child to a particular school

Flexible Spending Account

Manage expenses and lower your taxes

A flexible spending account, or FSA, is an employee benefit plan that allows you to set aside money, on a pretax basis, for certain health and dependent care expenses.

FSA Options

Multiple FSA options are offered. Check with your employer to find out which of the following options are available to you:

- **Healthcare FSA** — This option allows you to use pre-tax money in your account to pay for miscellaneous medical, dental, vision or hearing expenses, including deductibles, coinsurance amounts and copayments. See partial list on the page after next.
- **Limited-purpose FSA** — Before health plan deductible is met: The limited purpose FSA funds are available only for dental or vision, or both expenses only.

  After health plan deductible is met: The member may get reimbursed for all FSA qualified health care expenses. Once the deductible is met, your limited health care FSA may work like a standard health care FSA.
- **Dependent care FSA** — This option allows you to use pre-tax money in your account to pay for child or elder care services that help you maintain or look for employment. Your spouse must also work, be looking for work or attend school full-time, unless he or she is the dependent receiving care. This FSA option reimburses you for expenses incurred for care given to a child who is younger than 13 or an older relative who is incapable of self-care and lives in your home at least eight hours each day. For example, a young son or daughter or an elderly parent living with you would be considered an eligible dependent.

If you have questions about eligible expenses, you may call our Customer Service center at the phone number on the back of your Blues ID card or visit **bcbsm.com**.

Accessing your FSA funds

Your FSA dollars are accessible by several methods. Check with your employer to find out which of the following methods are available to you:

- **The FSA debit card** enables you to access your FSA funds at any point of service (provider or merchant) that accepts debit cards as a method of payment for qualified expenses. This option is determined by your employer-based specific plan.
- **Auto Reimbursement** – Any Blue Cross submitted claims will be sent directly to your FSA for reimbursement processing. Reimbursement is sent to you via check, or deposited into any personal checking account.
- **Manual submission of claims** – A copy of your Explanation of Benefits or copies of your receipts prescriptions or non-covered health-related expenses must be included in your request for reimbursement. Reimbursement is sent to you via check or deposited into any personal checking account.

Documentation from your provider, merchant or insurance carrier is important to satisfy the Internal Revenue Service's substantiation requirement. It is important for you to retain this documentation for at least 18 months. If you receive a request for substantiation of your claim, please send the appropriate documentation.

Use it or lose it

To be eligible for reimbursement, an expense must be incurred during the plan year. Submitted reimbursement claims are required by the end of the extended time frame of the plan contract which is determined by the employer. The Internal Revenue Code does not allow the plan to return unused contributions to you. You cannot transfer your contributions from one account to another or roll them into the next plan year. For this reason, it is very important that you carefully estimate your expected expenses. All funds remaining in your account following the grace period will be forfeited.

Important reminders

- To help you determine whether an expense qualifies under your FSA, remember the IRS has stated that eligible expenses must be made for "medical care." This is defined as amounts paid for the "diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body."
- Items that are merely beneficial to an individual's general good health, such as vitamins or dietary supplements, are not eligible expenses and therefore are not reimbursable with pretax dollars.
- Your employer may restrict reimbursement of expenses under your particular plan. Your employer will communicate this to you if applicable.
- Effective Jan. 1, 2011, a physician prescription is required for over-the-counter (OTC) drugs, medicines and biologicals (products found in medicines) to be considered eligible for reimbursement against an FSA.

  You may be required to submit a copy of the prescription along with required receipts when seeking reimbursement.
- Drugs must be purchased legally.
- Your doctor may recommend a treatment that will be good for your health, but it still may be considered ineligible, such as a vacation.

Frequently asked questions

What are the tax advantages of an FSA?

You can contribute pretax earnings to your health care and dependent care FSA. The amount you deposit into any FSA will not have federal income and Social Security taxes deducted but could have state and local taxes withheld.

Am I eligible to participate in a dependent care FSA?

You are eligible for this benefit if you have a dependent (whose expenses are eligible) who requires care to enable you to work. In addition, you must meet one of the following eligibility criteria:

- You are unmarried.
- Your spouse works, is a full-time student, is actively seeking work or is disabled (incapable of self-care).
- You are divorced or legally separated and have custody of your child even though your former spouse may claim the child for income tax purposes. Your dependent care FSA can be used to pay for child care services provided during the period the child resides with you

How is my account funded? How much can I contribute?

You can designate the amount to contribute up to a maximum set by your employer. Your employer may also make contributions to your account. You should contribute the amount of money you expect to pay out-of-pocket for eligible expenses during the plan period.

Your employer will identify the maximum amount you can contribute to your health care FSA.

How do I access the funds in my account?

You can access the funds in your account by using your FSA debit card or by spending your own funds and submitting a reimbursement form and receipts for reimbursement. When you use your reimbursement card to pay for eligible expenses, you don't need to submit a claim form. The merchant or provider is paid when you present your card at the point of service and the transaction amount is deducted from your account.

Keep all of your itemized receipts and be prepared to provide them if you are requested to do so.

If you are filing a reimbursement form, please submit it along with the applicable receipts that document the type, amount and date of the expenses incurred. Once approved, you'll receive reimbursement according to your employer's scheduled reimbursement dates.

What happens if I don't use all the money in my account by the end of the plan year?

Federal law governing flexible spending accounts specifies that any money remaining in your account at the end of the plan year will be forfeited. This is more commonly known as the "use-it-or-lose-it" rule. Your employer may use forfeitures to offset the administrative costs of operating the plan.

What happens to my FSA if I leave my job?

Participation in the FSA ends if you terminate employment. This means only expenses incurred prior to the date of your participation in the plan ends are eligible for reimbursement. Claims for expenses incurred prior to the plan termination date must be submitted within the "run out" period.

Can I transfer an account balance from one account to the other?

No, the health care, dependent care and limited purpose FSAs are separate plans that may be offered by your employer under separate terms and conditions.

Can I be reimbursed for my dependents' medical expenses under my FSA?

Yes, as long as the dependent meets the IRS definition of a dependent and is included in your employer's plan.

What happens if the amount I request for reimbursement is larger than my available account balance?

Reimbursement requests that exceed your account balance will be reimbursed up to the amount available in the account.

Can I change my election amount during the plan year?

Once you make an election for an FSA, you cannot change the amount unless there is an appropriate change in status. If you have a qualifying event or family status change, such as a marriage, divorce, birth or adoption, change of job or loss of a covered dependent, you can change your election amount.

Can I have both a health savings account and an FSA?

Federal regulations prohibit you from participating in both an HSA and a health care FSA. However, you can participate in an HSA with Limited Purpose FSA, an HSA with Dependent Care FSA or an HSA with both Limited Purpose FSA and Dependent Care FSA .

Healthcare FSA qualified medical expenses

The money in your FSA can be used for qualified medical expenses for you, your spouse or your dependent children. Qualified medical expenses may vary by the plan offered by your employer. Please contact your employer to see which expenses can be paid from your FSA. Qualified medical expenses include copayments and deductibles at doctors' offices, pharmacies, medical labs, dentists and orthodontists, medical supply stores, chiropractors, hospitals, vision centers, podiatrists and more. A partial list of qualified and ineligible expenses is below. Not all items listed below may be eligible under your employer's benefit plan. You can find a complete list of qualified medical expenses in IRS Publication 502, Medical and Dental Expenses, Catalog Number 15002Q, available at **irs.gov**.*

Examples of qualified medical expenses

- Acupuncture (excluding remedies and treatments prescribed by an acupuncturist)
- Alcoholism treatment
- Ambulance
- Artificial limbs and teeth
- Chiropractors
- Christian Science practitioner fees
- Contact lenses and solutions
- Copayments
- Costs for physical or mental illness confinement
- Crutches
- Deductibles
- Dental treatment
- Drug and medical supplies (e.g., syringes, needles, etc.)
- Eyeglasses
- Eye examination fees
- Eye surgery (cataracts, LASIK, etc.)
- Hearing devices and batteries
- Hospital services
- Insulin
- Laboratory fees
- Laser eye surgery
- Obstetrical expenses
- Oral surgery
- Orthodontic fees
- Orthopedic shoes
- Over-the-counter drugs* and medications for medical care
- Oxygen
- Physician fees
- Prescribed medicines
- Psychiatric care
- Psychologist fees
- Routine physicals and other nondiagnostic services or treatments
- Smoking cessation programs (includes over-the-counter patches, medications and gums)
- Surgical fees
- Wheelchair
- X-rays

Health care expenses that do not qualify for reimbursement

- Cosmetic surgery and procedures
- Dental bleaching
- Marriage and family counseling
- Over-the-counter drugs and medications for general health (including vitamins, toiletries and other personal items)
- Weight-loss programs — unless directed by a physician (A letter of medical necessity is required)

*BCBS does not control this website or endorse its general content.

**After January 1,2011, a prescription from a physician will be required.

Flexible Spending Account Dependent Care

Qualified Medical Expenses

A dependent care flexible spending account can be used to pay for qualified dependent care expenses. However, eligible expenses may vary by plan. Please contact your employer too see which expenses can be paid from your FSA.

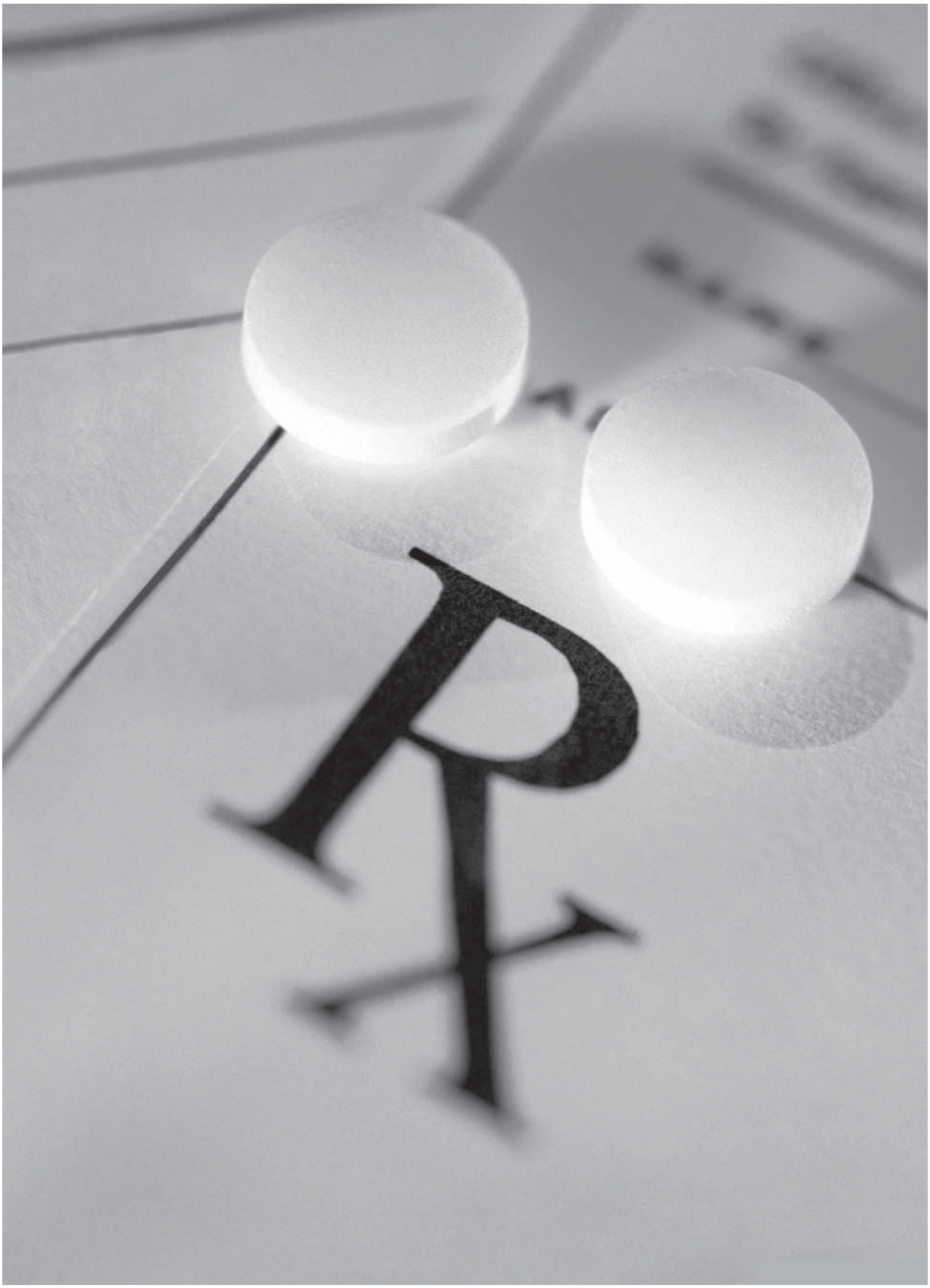
Eligible expenses

Eligible dependent care expenses must be employment-related.

- Day camp for the primary purpose of custodial care, not educational in nature
- Dependent care expenses that are necessary for you and your spouse to work, actively look for work or attend school full-time.
- Overnight childcare when one parent is working and the other is sleeping
- Dependent care for a child under age 13
- FICA and FUTA taxes of day care provider
- Late pick up-fees
- Nanny expenses attributed to dependent care
- Nursery school (preschool)
- Registration fees when allocated to dependent care services that have been provided
- Elderly care

Ineligible expenses

- Activity fees and supplies
- Disabled dependent living outside of employee's home
- Educational expenses
- Field trips
- Food
- Kindergarten
- Late fees
- Overnight camp
- Placement fees
- Transportation
- Fees paid to provider not reporting the income to the IRS



Prescription Drugs

Pharmacy Program

This innovative program provides a national network of pharmacies that will fill your prescriptions and help identify potential prescription drug interaction problems. As with most prescription programs, you receive your prescriptions with only a coinsurance or copayment for each prescription.

Participating pharmacies

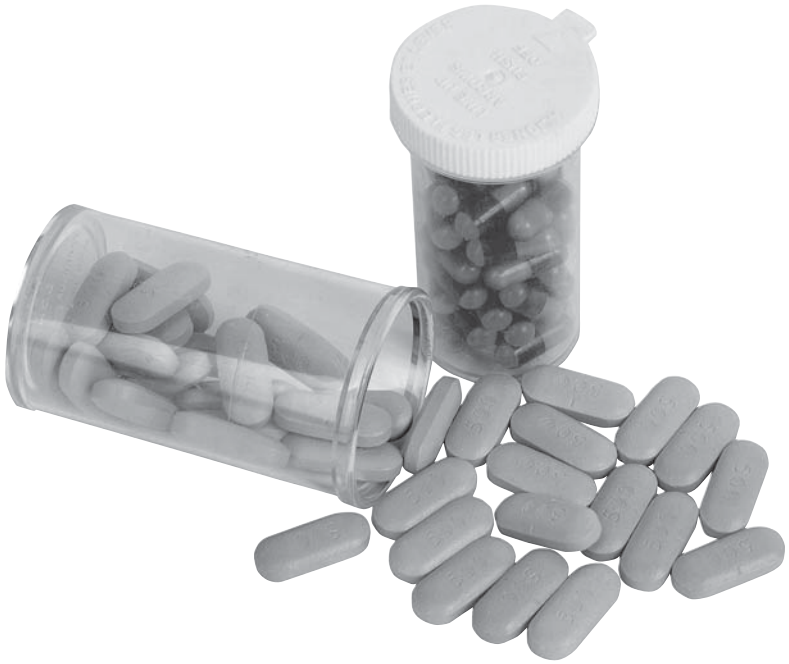
A participating pharmacy is sure to be conveniently located near your home, whether you live in a metropolitan area or a less-populated area. Most of the major drugstore chains and many independent pharmacies participate — about 59,000 pharmacies across the nation. Just present your Blues ID card when you fill your prescription — it's that simple. You don't have to fill out any claim forms.

Quality assured

Participating pharmacies must meet high standards for quality, cost and hours of service.

Watching out for you

Participating pharmacies use a special computer system that helps alert the pharmacist to possible interactions with other prescriptions you may be taking and to known medical conditions. Potential allergic reactions are also identified for you and your doctor. This process is designed to help identify complications that could happen if you are taking more than one prescription or are taking a prescription that may affect you if you have an existing medical condition.



Brand-Name vs. Generic Drug Costs

These 25 drugs represent Blue Cross Blue Shield of Michigan's most prescribed brand-name drugs that have available generic equivalents.

This price list for generic drugs is based on the BCBSM maximum allowable cost. Those with other insurance coverage or no insurance should expect to pay more for medications, as pharmacies may charge a dispensing fee or service fee in addition to the cost of the drug. These additional costs may vary among pharmacies.

Brand Name and Strength*	Commonly Prescribed Quantity for a 30 Day Supply	Brand Name Cost **	Generic Cost***	Generic Name	Generic Savings
Adderall 20 mg	60	$185.40	$24.00	Amphetamine Mixture	$161.40
Altace® 10 mg	30	$64.64	$18.10	Ramipril	$46.54
Ambien® 10 mg	30	$160.09	$3.00	Zolpidem Tartrate	$157.09
Coreg® 25 mg	60	$148.16	$9.00	Carvedilol	$139.16
Coumadin® 5 mg	30	$33.06	$5.10	Warfarin Sodium	$27.96
Dyazide® 37.5 mg / 25 mg	30	$33.66	$2.70	Triamterene/Hydrochlorothiazide	$30.96
Glucophage® XR 500 mg	90	$106.96	$11.70	Metformin Hcl	$95.26
Imitrex® 100 mg^	12	$335.28	$228.60	Sumatriptan Succinate	$106.68
Klonopin® 0.5 mg	60	$94.52	$6.00	Clonazepam	$88.52
Lotrel® 10 mg / 20 mg	30	$133.71	$65.40	Amlodipine Besylate/Benazepril	$68.31
Norvasc® 5 mg	30	$82.22	$6.00	Amlodipine Besylate	$76.22
Paxil CR® 25 mg	30	$119.00	$80.21	Paroxetine Hcl	$38.79
Prilosec® 40 mg	30	$261.34	$166.41	Omeprazole	$94.93
Protonix® 40 mg	30	$152.62	$85.80	Pantoprazole Sodium	$66.82
Razadyne® ER 16 mg^	30	$212.18	$143.14	Galantamine Hydrobromide	$69.04
Requip® 1 mg^	60	$182.78	$31.64	Ropinirole Hcl	$151.13
Risperdal® 1 mg	60	$333.45	$204.75	Risperidone	$128.70
Ritalin® 20 mg	90	$126.82	$25.71	Methylphenidate Hcl	$101.11
Tenormin® 50 mg	30	$58.97	$3.00	Atenolol	$55.97
Valium® 5 mg	60	$177.77	$1.82	Diazepam	$175.94
Vicodin ES® 7.5 mg / 750 mg	120	$177.48	$7.20	Hydrocodone Bitartrate/Acetaminophen	$170.28
Wellbutrin XL® 150 mg	30	$189.53	$94.80	Bupropion Hcl	$94.73
Xanax® 0.5 mg	90	$158.58	$4.50	Alprazolam	$154.08
Zocor® 40 mg	30	$150.79	$7.50	Simvastatin	$143.29
Zoloft® 100 mg	30	$120.80	$7.50	Sertraline Hcl	$113.30

* Most Common strength dispensed for BCBSM members.
**Brand name cost based on Average Wholesale Price (AWP) obtained from various data sources. (February 25, 2009)
***Generic cost based on BCBSM Maximum Allowable Cost (MAC) schedule or discounted AWP. (February 27, 2009)
^ Newly available generic medication

For more information about generic drugs, go to **theunadvertisedbrand.com**.

The Generic Advantage

Did you know that 69 percent of all prescriptions in the U.S. today are filled using generic drugs?[1] More patients and doctors are turning to generic drugs because they can save as much as 80 percent over the cost of brand-name medications. Generic drugs are an option you may want to consider as a way to receive highquality medication at considerably lower prices. Depending on your prescription drug plan, you may have a lower copayment when you choose generic drugs. And choosing generic drugs can help contain costs, which may in turn help keep monthly premiums and out-of-pocket cost sharing from rising too quickly.

Blue Cross Blue Shield of Michigan and Blue Care Network of Michigan believe you should know all the facts about generic drugs before deciding to try them. Remember to ask your doctor or pharmacist if generics are the right option for you.

Fact 1

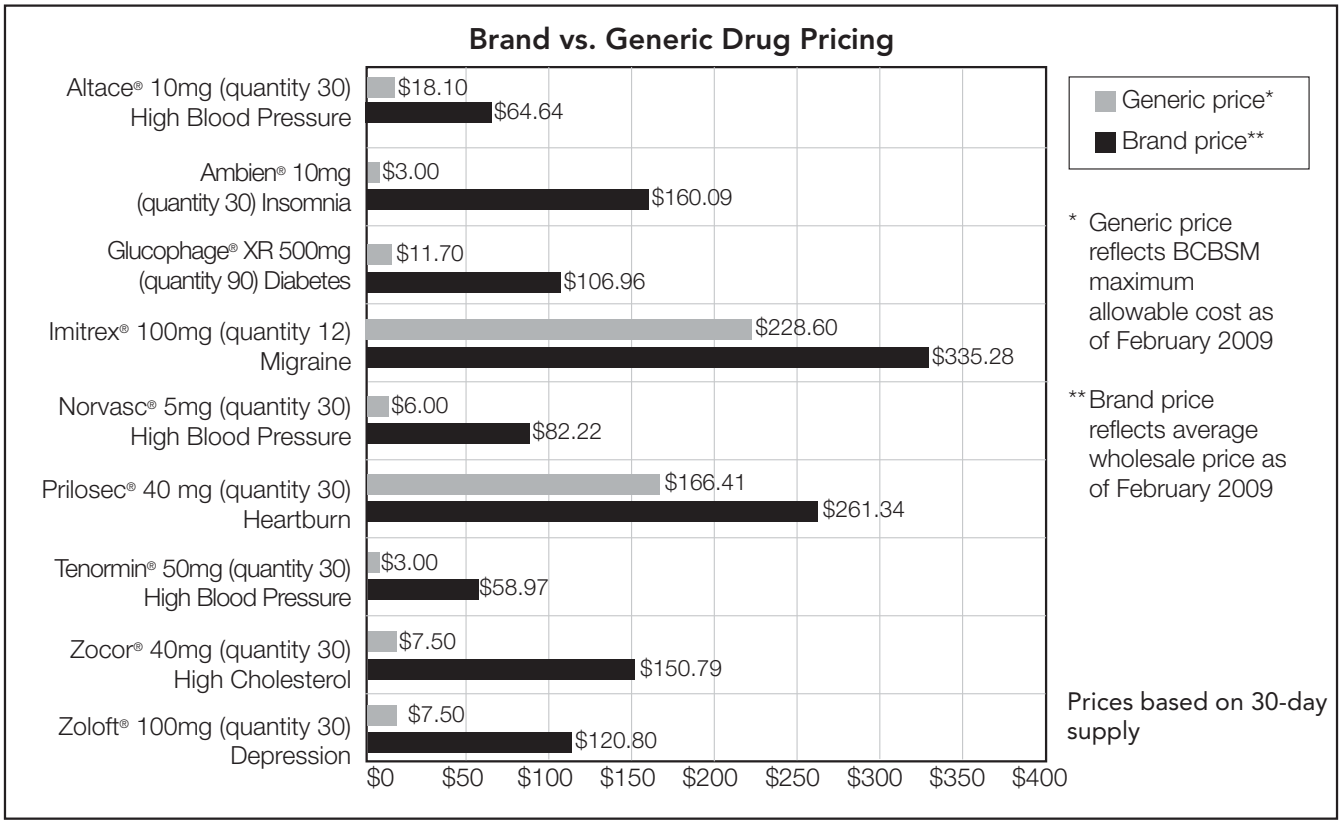
A generic drug is made with the same active ingredients and is available in the same strength and dosage form as the equivalent brand-name product.

Generic drugs produce the same effects in the body as brand-name drugs because both contain identical active ingredients. The difference is in the name. The brand name is the name under which the product is sold and is protected by a patent for up to 20 years. When the patent expires, other manufacturers can produce the generic equivalent of the brand and sell it under its generic name.

Fact 2

The manufacturing process of all drugs, including generics, is strictly regulated by the U.S. government and the same standards are met by all manufacturers.

The Food and Drug Administration requires all drug manufacturers to comply with FDA Good Manufacturing Practices and inspects plants to ensure compliance. If the FDA identifies a manufacturer that does not meet these high standards, they work with the firm to stop production and, if appropriate, recall the product.



Fact 3

A generic drug meets the same stringent performance and bioequivalence standards set by the U.S. government as the brand-name drug.

Each generic drug is laboratory-tested to ensure that the same amount of drug will be absorbed into the bloodstream as with the brand-name drug. Since 1984, no generic drug has been approved in the U.S. unless it has been shown to have the same rate and amount of active drug absorbed as the brand-name drug.

Fact 4

A generic drug is as safe and provides the same therapeutic effects as the brand-name product for patients of all ages.

As a group, generic drugs have no proven age-related side effects that are different from brand-name drugs. Generics have been shown to be as safe as brand-name drugs and work no differently in children or the elderly.

Fact 5

Many of the generic drugs approved by the FDA are manufactured by companies that also make brand-name drugs.

Many more generic drugs will become available as brand-name drugs lose their patent protection. More commonly, brand manufacturers are making generic drugs when they lose brand patent protection to compete directly with other generic makers and their branded product.

Fact 6

Health care professionals strongly support the use of generic drugs.

The American Medical Association, the largest organization of medical doctors, states that generic drug products are acceptable for use by the American public. Most hospitals routinely use generic drugs for treatment of their patients.

Fact 7

Of the top 10 prescription drugs sold in 2009, nine were generics.

In fact, the top prescription sold in 2008 was the generic version of Vicodin®.[2]

Fact 8

The American public spent $227 billion on prescription drugs in 2007.[3]

With the price of generic drugs averaging 30 to 80 percent less than the cost of brand-name drugs, the American public can save billions of dollars by using generic drugs. Overall, these savings can help control the cost of health care in the U.S. without reducing the quality offered to patients.

Fact 9

Everyone can lower their prescription costs with generics, especially people over age 65.

People over age 65 represent 13 percent of the U.S. population, and they account for 24 percent of the nation's prescription medication used each year.[4] Considerable savings can be gained through the use of generic drugs, which is great news for people over 65 who are the largest users of prescription drugs and often have fixed incomes.

Fact 10

The decision to use generic medications is ultimately made through the cooperation of your physician, your pharmacist and you.

Ask your physician or pharmacist if any of the prescription medications you are currently taking can be filled with a generic alternative. Once you begin using generic drugs whenever possible, you can start to reduce prescription drug costs while maintaining the same strength, dosage and quality as the brand-name drug.

[1] IMS Health, **imshealth.com**

[2] Drug Topics, *Top 200 Generic and Brand Drugs by Units in 2008*, **drugtopics.com**

[3] Office of the Actuary, Centers for Medicare and Medicaid Services, *Health Spending Projections Through 2018: Recession Effects Add Uncertainty to the Outlook*, Health Affairs 28, no. 2 (2009): w346-w357

[4] U.S. Department of Health and Human Services, Health, United States, 2008, **cdc.gov/nchs/data/hus/hus08.pdf**

Custom Formulary Quick Guide for Members

To ensure the quality and cost effectiveness of medications, your employer, sponsor, health plan administrator or retirement group has selected a prescription drug plan with a formulary. A formulary is a list of drugs approved by the Food and Drug Administration that your doctor refers to when prescribing your medications.

This guide can help you be a more informed patient. It is not intended to take the place of your doctor's advice; please talk to your doctor about your drug options.

Generic drugs offer the best value

Prescription drugs can be costly, but many are now available as generics. Generic drugs work the same as brand-name drugs, but cost less. Depending on your drug benefit, using generic drugs may lower your copayment. The FDA requires that generic drugs have the identical active ingredients as the equivalent brand-name drugs, but they may differ from brand-name drugs in color and shape. Since the major difference between brand-name and generic drugs is price, your prescription will be filled with the generic equivalent when medically appropriate.

Guide lists most commonly prescribed drugs

Our formulary lists medications available to BCBS members who have a triple-tier formulary benefit. The formulary represents the clinical judgment of physicians, pharmacists and other experts in the diagnosis and treatment of disease and promotion of health.

This guide lists drugs most commonly prescribed for BCBSM members; it is not a complete listing of drugs in our formulary. A complete list can be found at **bcbsm.com**. It encourages you and your doctor to select drugs recognized as the safest and most effective. Referring to this guide can help you understand how your drug copayment works and save money on your prescriptions.

Tier 1 – Generic

Tier 1 drugs are generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same ways as equivalent brand-name drugs. Generic drugs have a proven record of effectiveness. They also require the lowest copayment, making them the most cost-effective option for treatment. Look for these drugs under "Tier 1 – Generic" in this guide. Please note that the generics are listed according to their better-known brand-names.

Tier 2 – Formulary brand

Tier 2 drugs are brand-name drugs included in the formulary. Tier 2 drugs are also safe and effective but require a higher copayment than Tier 1 drugs. Look for these drugs under "Tier 2 – Formulary Brand" in this guide.

Tier 3 – Nonformulary brand

Tier 3 drugs are brand-name drugs not included in the formulary. If you have a triple-tier benefit, you will pay the highest copayment for these drugs. If you have a closed formulary benefit, these drugs will not be covered. However, generic equivalents and similar drugs with generic equivalents or formulary brand-name alternatives are available for many of these drugs. If you wish to know if it is possible to have your prescription changed to one of the products with a lower copayment, consult with your physician to see if a change is appropriate for you. Look for these drugs under "Tier 3 – Nonformulary Brand" in this guide.

The following chart shows how the copayments work within each tier:

Tier	Triple-tier plan
Tier 1 – Generic	Lowest copayment
Tier 2 – Formulary brand	Higher copayment
Tier 3 – Nonformulary brand	Highest copayment

Allergy, asthma, and respiratory

Tier 1 — Generic
Accuneb (g)
Alupent Solution, Syrup, Tab (g)
Atrovent Nasal, Solution (g)
Brethine (g)
DuoNeb (g)
Flonase (g)
Nasalide (g)
Nasarel (g)
Intal Solution (g)
Mucomyst (g)
Proventil/Ventolin Solution, Tab (g)
Uniphyl (g)
Vospire ER (g)

Tier 2 — Formulary brand
Accolate (QL)
Advair Diskus, HFA
Asmanex
Astelin
Atrovent Inhaler
Azmacort
Combivent
Flovent Inhaler
Foradil
Intal Inhaler
Maxair Autohaler
Nasacort AQ (ST)
Proair Inhaler
Proventil Inhaler
Pulmicort, Respules
Pulmozyme (s)
QVAR
Serevent Diskus
Singulair (PA) (QL)
Spiriva
Symbicort
Theo-24
Ventolin HFA

Tier 3 — Nonformulary brand
Aerobid, M
Alvesco
Beconase AQ (ST)
Brovana
Nasonex (ST)
Omnaris (ST)
Perforomist
Quibron-T
Rhinocort Aqua (ST)
Veramyst (ST)

Allergy, asthma, and respiratory *continued*

Xopenex, HFA
Zyflo, CR (QL)

Antidepressants

Tier 1 — Generic
Anafranil (g)
Asendin (g)
Celexa (g)
Desyrel (g)
Effexor (g)
Elavil (g)
Etrafon (g)
Limbitrol, DS (g)
Ludiomil (g)
Luvox (g)
Norpramin (g)
Pamelor/Aventyl (g)
Parnate (g)
Paxil, CR (g)
Prozac (g)
Remeron, Soltab (g)
Sarafem (g)
Sinequan/Adapin (g)
Surmontil (g)
Tofranil, PM (g)
Vivactil (g)
Wellbutrin, SR, XL (g)
Zoloft (g)

Tier 2 — Formulary brand
Effexor XR (ST)
Lexapro (ST)
Nardil
Surmontil 100mg
Venlafaxine ER (ST)

Tier 3 — Nonformulary brand
Cymbalta (PA)
Emsam
Luvox CR (ST)
Marplan
Pexeva (ST)
Pristiq (ST)
Prozac Weekly (ST) (QL)

Antifungals

Tier 1 — Generic
Diflucan (g)
Grifulvin V Susp (g)
Lamisil Tabs (g)
Mycelex Troche (g)
Nizoral (g)
Nystatin (g)
Sporanox Caps (g)

Antifungals *continued*

Tier 2 — Formulary brand
Ancobon
Grifulvin V 500mg
Gris-Peg
Noxafil
Sporanox Solution
Vfend

Tier 3 — Nonformulary brand
Lamisil Granules

Antihistamines and decongestants

Tier 1 — Generic
Allegra (g)
Atarax/Vistaril (g)
Benadryl (g)
Bromfed, PD (g)
Claritin, D, Alavert (OTC) (g)
Deconamine, SR, Syrup (g)
Entex PSE (g)
Periactin (g)
Phenergan, VC (g)
Polaramine (g)
Rondec (g)
Rynatan, Suspension (g)
Tavist-RX (g)
Zyrtec, D (g) (OTC)

Tier 2 — Formulary brand
Allegra D (ST) (QL)
Astelin Nasal Spray

Tier 3 — Nonformulary brand
Allegra Susp (ST)
Clarinex, Reditabs, D (ST) (QL)
Patanase
Semprex-D
Xyzal (ST) (QL)

Anti-infectives

Tier 1 — Generic
Adoxa (g)
Amoxil (g)
Augmentin, ES (g)
Bactrim, DS/Septra, DS (g)
Biaxin, XL (g)
Ceclor, ER (g)
Ceftin (g)
Cefzil (g)
Cipro, XR (g)
Cleocin (g)
Dicloxacillin (g)
Duricef (g)
Erythromycin (g)
Floxin (g)

Anti-infectives *continued*

Hiprex/Urex (g)
Keflex (g)
Macrobid (g)
Macrodantin (g)
Minocin/Dynacin (g)
Monodox (g)
Omnicef (g)
Pediazole (g)
Penicillin VK (g)
Periostat (g)
Principen (g)
Pyridium (g)
Sulfadiazine (g)
Sumycin (g)
Trimethoprim (g)
Vantin (g)
Vibramycin/Vibratabs (g)
Zithromax (g)

Tier 2 — Formulary brand
Avelox, ABC
Gantrisin Susp
Zyvox

Tier 3 — Nonformulary brand
Adoxa CK, TT
Augmentin XR
Cedax
Doryx
Factive
Keflex 750mg
Ketek
Levaquin
Maxaquin
Monurol
Moxatag
Noroxin
Oracea
Oraxyl
PCE
Proquin XR
Raniclor
Solodyn
Spectracef
Suprax
Xifaxan
Zmax

Cardiovascular (heart and high blood pressure)

Tier 1 — Generic
Accupril/Accuretic (g)
Aldactone/Aldactazide (g)
Aldomet/Aldoril (g)
Altace (g)

(PA) — Prior authorization may be required; clinical criteria must be met
(ST) — Step therapy may be required
(g) — Drug is available as generic equivalent but is listed by its brand-name
(QL) — Quantity limits may apply
(s) — Specialty drug

(OTC) — Over-the-counter product may be covered as Tier 1 (generic) copayment
Should a Tier 2 formulary brand-name drug lose its patent and generic versions become available, the generic versions are added to Tier 1 and the brand version may become a Tier 3 nonformulary brand

Cardiovascular (heart and high blood pressure) *continued*

Betapace, AF (g)
Blocadren (g)
Bumex (g)
Calan/Isoptin, SR (g)
Capoten/Capozide (g)
Cardene (g)
Cardizem, SR, CD (g)
Cardura (g)
Catapress (g)
Cordarone (g)
Coreg (g)
Corgard (g)
Corzide (g)
Coumadin (g)
Demadex (g)
Diamox (g)
Digoxin Tabs (g)
Diuril (g)
Dynacirc (g)
Hygroton, Thalitone (g)
Hytrin (g)
Inderal, LA/Inderide (g)
Inspra (g)
Ismo/Imdur (g)
Isordil (g)
Kerlone (g)
Lasix (g)
Lopressor, HCT (g)
Lotensin, HCT (g)
Lotrel (g)
Lozol (g)
Mavik (g)
Maxzide/Dyazide (g)
Microzide (g)
Midamor (g)
Minipress (g)
Moduretic (g)
Monopril, HCT (g)
Nitroglycerin Oral, Patch (g)
Normodyne (g)
Norvasc (g)
Persantine (g)
Pindolol (g)
Plendil (g)
Pletal (g)
Prinivil/Zestril (g)
Prinzide/Zestoretic (g)
Procardia, XL/Adalat CC (g)
Rythmol (g)
Sectral (g)
Sular 20, 30, 40mg (g)

Cardiovascular (heart and high blood pressure) *continued*

Tenormin/Tenoretic (g)
Tiazac (g)
Ticlid (g)
Toprol XL (g)
Trental (g)
Univasc/Uniretic (g)
Vasotec/Vaseretic (g)
Verelan, PM (g)
Zaroxolyn (g)
Zebeta (g)
Ziac (g)

Tier 2 — Formulary brand
Benicar, HCT (ST)
Bidil
Catapres-TTS
Covera-HS
Cozaar/Hyzaar (ST)
Edecrin
Dilatrate-SR
Dyrenium
Digoxin Elixir
Lotrel 5/40, 10/40
Lovenox (s)
Nitro-Bid
Nitrolingual spray
Plavix

Tier 3 — Nonformulary brand
Aceon
Aggrenox
Arixtra (s)
Atacand, HCT (ST)
Avapro/Avalide (ST)
Azor
Bystolic (ST)
Caduet (QL)
Cardene SR
Cardizem LA
Coreg CR
Diovan, HCT (ST)
Dynacirc CR
Exforge
Fragmin (s)
Innohep (s)
Innopran XL
Inversine
Levatol
Miacardis, HCT (ST)
Naturetin-5
Ranexa
Rythmol SR

Cardiovascular (heart and high blood pressure) *continued*

Sular 8.5, 10, 17, 25.5, 34mg
Tarka
Tekturna, HCT (PA)
Teveten, HCT (ST)

Central nervous system

Tier 1 — Generic
Adderall (g)
Chlorpromazine (g)
Clozaril (g)
Dexedrine (g)
Eskalith, CR/Lithobid (g)
Focalin (g)
Haldol, Decanoate (g)
Lithium Citrate (g)
Loxitane (g)
Mellaril (g)
Navane (g)
Nimotop (g)
Perphenazine (g)
Prolixin, Decanoate (g)
Razadyne, ER (g)
Requip (g)
Risperdal (g)
Ritalin, SR/Methylin, ER (g)
Stelazine (g)
Thorazine (g)

Tier 2 — Formulary brand
Abilify, Discmelt
Adderall XR
Aricept, ODT
Concerta
Desoxyn
Exelon
Geodon
Metadate CD
Moban
Namenda
Orap
Provigil
Razadyne Solution
Seroquel
Zyprexa, Zydis

Tier 3 — Nonformulary brand
Cognex
Daytrana
Equetro
Fazaclo
Focalin XR
Invega (QL)
Liquadd

Central nervous system *continued*

Methylin Chew, Solution
Requip XL
Risperdal M-Tab
Ritalin LA
Seroquel XR (QL)
Strattera (PA)
Symbyax
Vyvanse (PA)

Cholesterol — lowering

Tier 1 — Generic
Colestid (g)
Fenofibrate (g)
Lofibra (g)
Lopid (g)
Mevacor (g) (QL)
Pravachol (g) (QL)
Questran, Light (g)
Zocor (g) (QL)

Tier 2 — Formulary brand
Crestor (ST) (QL)
Niaspan
Tricor
Welchol
Zetia (PA) (QL)

Tier 3 — Nonformulary brand
Advicor (ST)
Altoprev (ST) (QL)
Antara
Caduet (QL)
Colestid Flavored
Fenoglide
Lescol, XL (ST) (QL)
Lipitor (ST) (QL)
Lipofen
Lovaza
Simcor (ST)
Triglide
Vytorin (ST) (QL)

Diabetes treatment

Tier 1 — Generic
Amaryl (g)
Diabinese (g)
Glucophage, XR (g)
Glucotrol, XL (g)
Glucovance (g)
Glynase (g)
Metaglip (g)
Micronase/Diabeta (g)
Orinase (g)
Precose (g)
Tolinase (g)

(PA) — Prior authorization may be required; clinical criteria must be met
(ST) — Step therapy may be required
(g) — Drug is available as generic equivalent but is listed by its brand-name
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(s) — Specialty drug

(OTC) — Over-the-counter product may be covered as Tier 1 (generic) copayment
Should a Tier 2 formulary brand-name drug lose its patent and generic versions become available, the generic versions are added to Tier 1 and the brand version may become a Tier 3 nonformulary brand

Diabetes treatment *continued*

Tier 2 — Formulary brand
Actos (ST)
Apidra
Avandia (ST)
Insulin (all)
Lantus
Levemir
Prandin

Tier 3 — Nonformulary brand
Actoplus Met (PA)
Avandamet (PA)
Avandaryl (PA)
Byetta (PA)
Duetact (PA)
Fortamet
Glumetza
Glyset
Janumet (PA)
Januvia (PA)
Riomet
Starlix
Symlin

Gastrointestinal agents

Tier 1 — Generic
Axid (g)
Carafate Tabs (g)
Cytotec (g)
Pepcid (g)
Prilosec (g)
Prilosec (OTC) (g)
Protonix (g)
Tagamet (g)
Zantac (g)

Tier 2 — Formulary brand
Carafate Suspension
Helidac
Prevacid, Solutab
Prevpac

Tier 3 — Nonformulary brand
Aciphex (ST)
Nexium (ST)
Protonix Suspension
Pylera
Zantac Granules, Efferdose
Zegerid (ST)

Hormones and birth control

Tier 1 — Generic
Alesse, Levlite (g)
Androxy 10mg (g)
Aygestin (g)
Climara (g) (QL)
Cyclessa (g)
Danocrine (g)
Demulen (g)
Depo Provera (150mg) (g)
Depo-Testosterone (g)
Desogen, Ortho-Cept (g)
Estrace (g)
Estratest, HS (g)
Estrostep Fe (g)
Lo/Ovral (g)
Loestrin, Fe (g)
Mircette (g)
Modicon (g)
Necon 10/11 (g)
Nordette, Levlen (g)
Norinyl, Ortho-Novum Necon 1/50 (g)
Ogen, Ortho-Est (g)
Ortho Micronor, Nor-QD (g)
Ortho Tri-Cyclen (g)
Ortho-Cyclen (g)
Ortho-Novum 7/7/7, 10/11 (g)
Ovcon-35 (g)
Ovral (g)
Oxandrin (g) (PA)
Provera (g)
Seasonale (g) (QL)
Tri-Norinyl (g)
Triphasil, Trilevlen (g)
Yasmin (g)

Tier 2 — Formulary brand
Alora (QL)
Androderm (QL)
Crinone
Delatestryl
Depo-SubQ Provera 104
Endometrin
Estraderm (QL)
Estring (QL)
Femhrt
Lybrel
Ortho Evra (QL)
Ortho Tri-Cyclen Lo
Plan B
Premarin, Low Dose
Premphase

Hormones and birth control *continued*

Prempro, Low Dose
Prochieve
Prometrium
Vivelle-DOT (QL)
Yaz

Tier 3 — Nonformulary brand
Activella
Anadrol-50 (PA)
Androgel (QL)
Angeliq
Cenestin
Climara Pro (QL)
Combipatch (QL)
Divigel
Elestrin
Enjuvia
Estrace Vaginal Cream
Estrasorb (QL)
Estrogel (QL)
Evamist
Femcon Fe
Femring (QL)
Femtrace
Loestrin 24 Fe
Menest
Menostar (QL)
Methitest, Testred
Nuvaring (QL)
Ortho-Prefest
Ovcon-50, Fe
Seasonique (QL)
Striant (QL)
Testim (QL)
Vagifem

Migraine

Tier 1 — Generic
Cafergot (g)
D.H.E. 45 (g)
Fioricet/Esgic, Plus, Zebutal (g)
Fiorinal, w/ codeine (g)
Imitrex Tab, Injection (g) (QL)
Midrin (g)
Phrenilin, Forte, Axocet (g)
Stadol NS (g)

Migraine *continued*

Tier 2 — Formulary brand
Ergomar
Imitrex Nasal Spray (QL)
Maxalt, MLT (QL)
Migranal (QL)
Zomig, ZMT, Nasal Spray (QL)

Tier 3 — Nonformulary brand
Amerge (QL)
Axert (QL)
Frova (QL)
Relpax (QL)
Treximet (PA) (QL)

Osteoporosis

Tier 1 — Generic
Didronel (g) (QL)
Estrogens (See Hormones and Birth Control)
Fosamax, Weekly (g) (QL)
Miacalcin (g)

Tier 2 — Formulary brand
Estrogens (See Hormones and Birth Control)
Actonel, Weekly, Plus Calcium (ST) (QL)
Evista
Fortical

Tier 3 — Nonformulary brand
Boniva (ST) (QL)
Forteo (PA) (QL) (s)
Fosamax Plus D (QL)

Pain and arthritis

Tier 1 — Generic
Anaprox, DS (g)
Ansaid (g)
Cataflam (g)
Clinoril (g)
Daypro (g)
Feldene (g)
Indocin, SR (g)
Lodine, XL (g)
Meclomen (g)
Mobic (g)
Motrin (g)
Naprelan 500mg (g)
Naprosyn, EC (g)
Orudis KT, Oruvail (g)
Relafen (g)
Tolectin, DS (g)
Toradol (g) (QL)
Voltaren, XR (g)

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Pain and arthritis *continued*

Tier 2 — Formulary brand
Ponstel

Tier 3 — Nonformulary brand
Arthrotec
Celebrex (PA)
Flector (PA)
Naprelan 375mg
Prevacid Naprapac
Voltaren Gel

Sleep and anxiety

Tier 1 — Generic
Ambien (g) (QL)
Ativan (g)
Buspar (g)
Chloral hydrate (g)
Dalmane (g) (QL)
Halcion (g) (QL)
Librium (g)
Miltown (g)
ProSom (g) (QL)
Restoril (g) (QL)
Serax (g)
Sonata (g) (QL)
Tranxene (g)
Valium (g)
Xanax, XR (g)

Tier 2 — Formulary brand
None

Tier 3 — Nonformulary brand
Ambien CR (ST) (QL)
Butisol Sodium
Doral (QL)
Libritabs
Lunesta (ST) (QL)
Niravam
Rozerem (ST) (QL)
Tranxene SD
Xyrem

Additional Tier 3 — Nonformulary brand
Acular, LS, PF
Aczone
Akne-Mycin
Alamast
Aldara
Altabax
Amitiza (ST) (PA)
Amrix
Anzemet
Aphthasol
Aranesp (PA) (s)
AVC
Avinza
Avodart
Azasite
Azelex
Azilect
Beconase AQ
Benzaclin
Benzashave, Brevoxyl-4, 8 Pack
Betaseron (s)
Betimol
Carbatrol
Campral (PA)
Cardura XL
Carmol HC
Cesamet
Clarifoam EF
Cleocin Vaginal Ovules
Clindesse
Clinac BPO
Clobex
Combigan
Cultivate Lotion
Darvon-N
Denavir
Depen
Derma-Smoothe/FS
Desonate
Dipentum
Duac CS
Edex (QL)
Efudex Occlusion (QL)
Elestat
Eligard (s)
Emadine
Enablex
Entocort EC
Epogen (PA) (s)
Equetro
Ertaczo

Additional Tier 3 — Nonformulary brand *continued*
Evoclin Foam
Evoxac
Exelderm
Exjade (s)
Fentora (PA)
Fexmid
Finacea
Flomax
Follistim AQ (s)
Fosrenol
Genotropin (PA) (s)
Gynazole-1
Halflytely
Halog, E
Hectorol
Humatrope (PA) (s)
Increlex (s)
Iopidine
Iquix
Kadian
Keppra XR
Kineret (PA) (s)
Levitra (QL)
Lialda
Lidoderm Patch
Locoid Lipocream
Loprox Shampoo
Lotronex (PA)
Luveris (s)
Luxiq
Lyrica (PA)
Magnacet
Megace ES (s)
Menopur (s)
Mentax
Meridia
Moviprep
Myfortic (s)
Naftin
Nasonex
Neulasta (QL) (s)
Nevanac
Nicotrol, Inhaler, Nasal Spray
Norditropin (PA) (s)
Noritate
Numorphan
Olux
Omnaris
Omnitrope (PA) (s)
Opana, ER

Additional Tier 3 — Nonformulary brand *continued*
Optivar
Orapred ODT
Osmoprep
Oxistat
Oxycontin
Oxytrol (QL)
Pandel
Pataday
Patanese
Peranex HC
Pramosone Lotion, Ointment
Protopic
Quixin
Raptiva (s)
Regranex
Requip XL
Revlimid (s)
Rhinocort Aqua
Sanctura, XR
Sancuso
Santyl
Serostim (PA) (s)
Solaraze
Soltamox
Soma 250
Taclonex, Scalp
Targretin Gel (s)
Tasmar
Tev-Tropin (PA) (s)
Ultram ER
Ultravate PAC
Vanos Cream
Veramyst
Verdeso
Vesicare
Visicol
Vusion
Xalatan
Xenical
Xibrom
Xodol
Xolegel
Zacare
Zavesca (s)
Zelapar
Ziana Gel
Zemplar
Zorbtive (PA) (s)
Zydone
Zymar

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Filling your prescription

There are two ways to fill your prescription:

- **At a retail pharmacy** — Over 59,000 retail pharmacies participate with BCBS. You may fill prescriptions at any participating pharmacy.
- **Mail order (home delivery)** — If you are enrolled in a mail order program, you can receive your prescriptions through one of our mail order vendors. The type of medication you take determines which mail order vendor you use:
  - Specialty drugs should be ordered through Walgreens Specialty Pharmacy. Specialty drugs are prescription medications used to treat complex conditions and require special handling, administration or monitoring.
  - All other drugs should be ordered through Medco by Mail®.

If you have questions about which mail order vendor you should use to order your drug, or if you would like to request a mail order kit, please contact the Customer Service phone number on the back of your BCBS ID card.

Call if you need more information

If you have questions about your prescription drug benefit, please call the Blue Cross Blue Shield Customer Service number on the back of your BCBS ID card.

Take advantage of our website

Visit **bcbsm.com** for more information on your prescription drug coverage.
Click on "I am a Member" and then click on "Prescription Drugs."
From there you can learn about:

- Custom and Clinical Formularies
- Prior Authorization and Step Therapy
- Generic drugs, the unadvertised brand
- 90-day retail prescription program
- Mail order prescriptions
- Specialty drugs
- Medication Guides
- Pharmacy initiatives
- Once your coverage begins, register on **Medco.com** for the following features:
  1. **Benefit highlights** – view your current copayment amounts and other pharmacy information
  2. **Formulary lookup** – determine drug coverage and obtain a cost estimate for a selected medication.
  3. **Pharmacy Locator** – Find a participating pharmacy near your location.
  4. **PersonalHealth Rx** – Print your prescription history for a physician visit or tax reporting.

Your Prescription Drug Program

The Blue Cross Blue Shield of Michigan Prescription Drug Program:

Whether you take medication on an ongoing basis or simply need a prescription filled from time to time, your Blue Cross Blue Shield of Michigan Prescription Drug Program offers important benefits, service and savings for you and your eligible dependents in these important ways:

- A network of pharmacies throughout Michigan
- A national network of participating pharmacies for prescriptions filled outside Michigan
- Mail-order prescription drug programs that provide savings and convenient delivery of your long-term prescription drugs and specialty prescription drugs

Your prescription drug program is administered by Blue Cross Blue Shield of Michigan. Medco by Mail is the mail-order provider of long-term prescriptions, and Walgreens Specialty Pharmacy provides specialty drugs by mail.

If you or an eligible family member needs to take a prescription drug on a short-term basis (for example, an antibiotic to treat strep throat), have the prescription filled at a participating pharmacy. Just present your Blue Cross Blue Shield of Michigan ID card and prescription(s) to the pharmacist. You'll be charged a single copayment (or coinsurance amount, depending on your plan) for each covered prescription order or refill. You do not have to submit a claim form when you use a participating pharmacy.

To locate a participating pharmacy near you, call your toll-free Blue Cross Blue Shield of Michigan Customer Service number on the back of your ID card, or visit **bcbsm.com**.

Out-of-state pharmacies

The out-of-state pharmacy network includes the majority of the major chain pharmacies, as well as thousands of independently owned pharmacies. To locate a pharmacy while traveling outside Michigan, call your toll-free Blue Cross Blue Shield of Michigan Customer Service number on the back of your ID card.

How to use the retail pharmacy program

At participating retail pharmacies in or outside Michigan:

- You must present your Blue Cross Blue Shield of Michigan ID card and prescription(s) to the pharmacist.
- You must provide the pharmacist with the patient's full name, date of birth (month, day and year), and his or her relationship to the subscriber.
- The pharmacist will use a computerized system to confirm your eligibility for benefits and tell you the correct amount to pay.

You will not have to file any claim forms for prescriptions filled at a participating retail pharmacy.

At nonparticipating pharmacies:

Pay the full price of the prescription and obtain a prescription drug receipt. Fill out a claim form, attach the receipt, make a copy of your claim and receipt for your records, and mail them to Attn:

Medco Health Solutions, Inc.
P.O. Box 14711
Lexington, KY 40512

To obtain claim forms, call your toll-free Blue Cross Blue Shield of Michigan Customer Service number on the back of your ID card.

Please note that your cost will usually be higher when you use a nonparticipating pharmacy.

Mail Order Prescription Drugs

The mail order prescription drug plan is available for long-term and ongoing prescription drug needs. If you are taking medication on a regular basis, you can purchase your prescriptions through mail order.

When you order your prescription from Medco by Mail, you can receive up to a 90-day supply of medications when authorized by your doctor. Medco by Mail is to be used for all your prescriptions except for specialty drugs.

How to use Medco By Mail

The simple way to use mail order

If you're taking medication on an ongoing basis, such as to reduce blood pressure or treat asthma, diabetes, or any other chronic health condition, you could be using Medco By Mail.

With mail order

- You can be assured we follow strict quality and safety controls for every prescription filled.
- Medco pharmacies are staffed with highly trained, registered pharmacists.
- A registered pharmacist is available for emergency consultation 24 hours a day, seven days a week.
- Ordering new prescriptions and refills is easy.

Here's how

1. **Ordering new prescriptions:** Ask your doctor to prescribe needed medication for up to the number of days permitted by your plan, plus refills, if appropriate. Mail your prescription and correct copayment in the mail-order envelope. Your doctor can also fax your prescription to Medco by Mail. If you need to order additional Medco by Mail envelopes, visit **bcbsm.com** or call 1-800-903-8346 and the requested materials will be sent to you.

   You can download a prescription order form at **bcbsm.com**. Click on " I am a Member," then click on "Prescription Drugs" and then "Mail Order Prescriptions Drug Program."

2. **Refilling your medication:** To be sure you never run short of your prescription medication, you should reorder on or after the refill date indicated on the refill slip, or at least two weeks before your current supply runs out.

   To order online: Log on to **medco.com**. Have your member ID number, the prescription number (the 12-digit number on your refill slip), and your credit card ready.

   To order by phone: Call 1-800-778-0735 and use the automated refill system. Have your member ID number and refill slip with the prescription information ready.

   To order by mail: Simply mail your refill slip and copayment in the mail-order envelope.

3. **Delivering your medication:** Your order will be processed promptly upon receipt by the pharmacy, and your medication will be sent to you via U.S. mail or UPS, along with instructions for future refills, if applicable. Allow up to 14 days for delivery.

4. **Paying for your medication:** Choose a convenient payment option — You can pay by credit card, personal check, money order, debit card, e-check or by automatic payment.

Specialty Pharmacy

Specialty drugs are prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions including:

- Rheumatoid Arthritis
- Cancer
- Kidney failure
- Hepatitis C
- HIV
- Infertility
- Multiple sclerosis
- Organ Transplants
- Osteoporosis
- Psoriasis

Specialty Drug Guide

Members can receive these drugs through the mail from Walgreens Specialty Pharmacy (1-866-515-1355) or get them at a retail specialty network pharmacy. They are not available through Medco By Mail. Medications in bold are available as generics for the lowest copayment.

Anticoagulants
- Arixtra®
- Fragmin®
- Heparin
- Innohep®
- Lovenox®

Antineoplastics (Cancer Drugs)
- Afinitor® (pa)
- Arimidex® (pa)
- Aromasin® (pa)
- **Casodex® (bicalutamide)**
- Eligard®
- Femara® (pa)
- Gleevec®
- Hycamtin® (pa)
- Intron – A® (pa)
- Iressa® (pa)
- **Lupron® (leuprolide)**
- Lupron Depot®
- Nexavar® (pa)
- Oforta™
- Revlimid® (pa)
- **Sandostatin® (pa) (octreotide)**
- Sandostatin LAR® (pa)
- Sprycel® (pa)
- Sutent® (pa)
- Tarceva® (pa)
- Targretin®
- Tasigna®
- Temodar®
- Thalomid®
- Trelstar Depot®
- Trelstar LA®
- Tykerb® (pa)
- Votrient™ (pa)
- Xeloda®
- Zoladex®
- Zolinza® (pa)

Antivirus/Hepatitis
- Baraclude®
- **Copegus® (pa) (ribavirin tablets)**
- Hepsera®
- Infergen® (pa)
- Intron A® (pa)
- Pegasys® (pa)
- PEG-Intron® (pa)
- **Rebetol® (pa) (ribavirin capsules)**
- Rebetron™ (pa)
- **Ribasphere® (pa) (ribavirin capsules)**
- **Ribapak® (pa) (ribavirin tablets)**
- Tyzeka®

Chemotherapy/Cancer Support Medications
- Aranesp® (pa)
- Leukine®
- Neulasta®
- Neumega®
- Neupogen®
- Procrit® (pa)

Chronic Kidney Failure/ Dialysis
- Aranesp® (pa)
- Epogen® (pa)
- Sensipar®

Cystic Fibrosis
- Pulmozyme®
- Tobi®

Growth Disorders
- Genotropin® (pa)
- Humatrope® (pa)
- Increlex® (pa)
- Norditropin® (all forms) (pa)
- Nutropin® (all forms) (pa)

Growth Disorders (cont.)
- Omnitrope® (pa)
- Saizen® (pa)
- **Sandostatin® (pa) (octreotide)**
- Sandostatin LAR® (pa)
- Somatuline® Depot
- Serostim® (pa)
- Tev-Tropin® (pa)
- Zorbtive® (pa)

HIV/AIDS
- Fuzeon®

Immune Globulin
- Vivaglobin® *
- Hizentra™ *

Infertility
- Bravelle® (pa)
- Cetrotide® (pa)
- Fertinex® (pa)
- Follistim/Follistim AQ® (pa)
- Ganirelex acetate® (pa)
- Gonal-F® (pa)
- **Lupron® (leuprolide)**
- Luveris® (pa)
- Menopur® (pa)
- Novarel® (pa)
- Ovidrel® (pa)
- Pregnyl® (pa)
- Profasi® (pa)
- Repronex® (pa)

Miscellaneous
- Acthar®*
- Actimmune®
- Promacta® (pa)
- Samsca™
- Supprelin®*
- Syprine®

Multiple Sclerosis
- Avonex®
- Ampyra™ (pa)
- Betaseron® (pa)
- Copaxone®
- Extavia®
- Rebif®

Organ Transplant/ Antirejection
- Cellcept® (mycophenolate)
- **Cyclosporine (oral)**
- **Gengraf® (cyclosporine)**
- Myfortic®
- **Neoral® (cyclosporine)**
- **Prograf® (tacrolimus anhydrous)**
- Rapamune®
- **Sandimmune® (cyclosporine)**
- Zortress®

Osteoporosis
- Forteo™ (pa)

Psoriasis
- Enbrel® (pa)
- Humira® (pa)

Pulmonary Arterial Hypertension (PAH)
- Adcirca™(pa)
- Letairis™ (pa)
- Remodulin®
- Revatio™ (pa) (LD)
- Tracleer® (pa)
- Tyvaso™ (pa) (LD)
- Ventavis® (pa) (LD)

Rheumatoid Arthritis
- Cimzia® (pa)
- Enbrel® (pa)
- Humira® (pa)
- Kineret® (pa)
- Simponi™ (pa)

Limited Distribution Drugs – Billed through the *pharmacy benefit*
Must be ordered through Accredo Specialty Pharmacy at (800) 803-2523

- Apokyn®
- Arcalyst® (pa)
- Exjade® (pa)
- Kuvan® (pa)
- Orfadin®
- Remodulin®
- Sabril®
- Somavert®
- Tyvaso™
- Ventavis® (pa)
- Xenazine® (pa)

*Not covered under the BCN pharmacy benefit. (pa) May require prior authorization. (LD) Limited Distribution drug.

How do I obtain specialty drugs?

If your medication is included in the specialty drug list available on the next page you can:

- Get your prescription drugs delivered to your home by mail ordering them through Walgreens Specialty Pharmacy, our specialty drug vendor. Download the Walgreens Specialty Pharmacy order form from **bcbsm.com** or call Walgreens Specialty Pharmacy at 1-866-515-1355.
- Fill your prescription at a retail pharmacy. Not all pharmacies will dispense specialty drugs, so call your pharmacy first to verify that they will fill your prescription.

Case management

Walgreens Specialty Pharmacy provides focused processing to ensure appropriate utilization and optimal outcomes from drug therapy. Activities may include:

- Prior Authorization
- Verification/Assignment of Benefit
- Statement of Medical Necessity processing
- Utilization review
- Formulary Alignment
- Compliance interventions and consultations
- Access to Patient Assistance Programs

Standardized patient education materials are sent with the product regarding drug information, storage and administration.

The member education materials are guideline-based, drug specific and/or disease specific. The material is sent by mail, but if the member needs extensive education, a direct patient visit is available. A 24/7 helpline is available: the clinical team consists of a registered nurse and pharmacist.

Patients are contacted at least monthly to assess their response to therapy and compliance with the regimen.

Support services are designed to address clinical needs of patients ranging from complex condition management to medication adherence.

All pharmacy claims, including specialty pharmacy claims are subject to BCBSM's comprehensive drug utilization review to ensure proper drug usage.

Drug Utilization Review: Safe and Appropriate Use of Medications

Under this program, you and your covered dependents benefit from a comprehensive medication safety review. When your prescriptions are filled through mail order or at a participating retail pharmacy, they are reviewed for any potential drug interactions based on your personal medication profile. This is especially important if you take many different medications or see more than one doctor. If there is a question about your prescription, your pharmacist may contact your doctor before dispensing the medication.

Pharmacy Cost-Saving Programs (Pharmacy Initiative/Preferred Therapy)

The BCBSM pharmacy initiatives are a series of cost-saving programs that provide additional ways to reduce drug costs. The following is a summary:

Member Education Therapeutic Interchange educates about generic drugs and over-the-counter equivalents of expensive brand-name drugs. If you switch to the formulary generic or over-the-counter drugs, the generic copay will be waived for the first fill only.

Dose Optimization encourages the use of select prescription drugs in once-daily dosage regimens at a lower cost rather than higher cost multiple daily doses.

Brand to Alternate Generic Interchange encourages the interchange of brand-name drugs with less costly generic alternatives.

Generic Copay Waiver is offered when you switch to a generic equivalent of a multi-source brand. It targets brand-name drugs that have a generic equivalent already on the market. When you agree to switch, you'll receive a one-time free copay for the generic drug.

> **Note**: If your plan has a deductible and your deductible has not been met, there will be no copay to waive.

Three-Month Generic Copay Holiday waives your first three retail or mail-order prescription copays if you switch from a targeted, **cholesterol-lowering** brand-name drug, to a generic equivalent or generic alternative.

Brand-to-Brand Therapeutic Interchange promotes the exchange of high-cost brand name drugs for lower-cost brand medicines that are equal in strength and efficacy.

Quantity Limits restrict the dispensing of targeted drugs in quantities inconsistent with FDA-approved labeling for the drugs. Medical necessity authorization is required to dispense quantities that exceed the limit.

Exclude Off-Label Coverage ensures you are using medication as recommended by the FDA. Prior authorization is required for growth hormone prescriptions **unless** the prescription is written by a pediatric endocrinologist

High Utilization Management and Polypharmacy identifies and monitors potential misuses and excessive utilization of prescription drugs. Polypharmacy refers to the use of multiple medications by a member, usually from multiple physicians. Targeted members are those who are on more than 10 chronic medications or who are seeing three or more physicians within a three-month period. BCBSM will work to identify situations resulting from poorly coordinated care, drug abuse and/or prescription fraud

Expanding Aggressive Maximum Allowable Cost adds more drugs to the MAC list.

Preferred Therapy Component
Step therapy for first time users of targeted drugs within the program.

Medications requiring review under the Pharmacy Initiative Preferred Therapy program are reviewed by BCBSM pharmacists. Your doctor should call 1-800-437-3803, Option 1, to initiative a review or they can obtain a copy of the Prior Authorization review form from Web-DENIS.

Other important features

Your program has been designed to provide you with the quality of care you expect and the service you deserve. Whether it's keeping a profile of your medication history, providing a toll-free number to speak with a pharmacist, or advising you of any program changes in a timely manner.

BCBSM administers your prescription drug benefit by using health and prescription information about you and your dependents. BCBSM uses information gathered from claims submitted nationwide for reporting and analysis without identifying individual patients.

Member Services

Protecting your safety

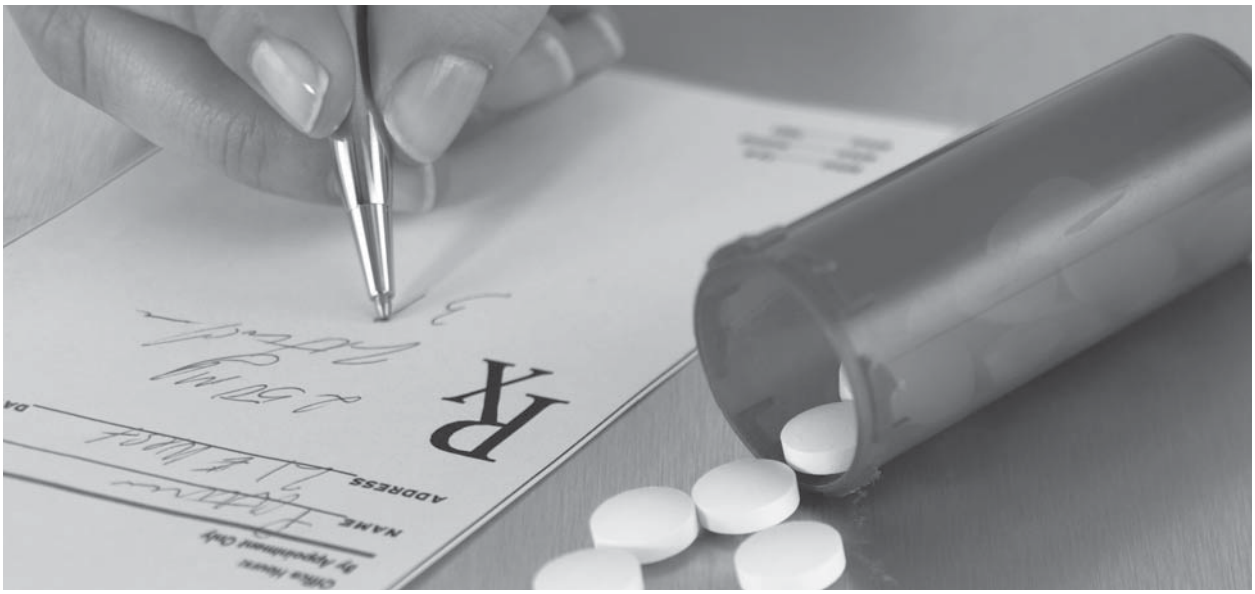
The risks associated with drug-to-drug interactions and drug allergies can be very serious. You and your covered dependents benefit from a comprehensive medication safety review. To protect your safety, prescriptions are reviewed for any potential interactions and allergies based on your personal medication profile. This is especially important if you take many different medications or see more than one doctor. If there is a question about your prescription, the pharmacist may contact your doctor before dispensing the medication.

Your plan may have coverage limits

Your plan may have certain coverage limits. For example, prescription drugs used for cosmetic purposes may not be covered or a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period. If you submit a prescription for a drug that has coverage limits, your pharmacist will tell you that approval is needed before the prescription can be filled. When a coverage limit is triggered, more information is needed to determine whether your use of the medication meets your plan's coverage conditions. BCBSM will notify you and your doctor of the decision in writing. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal.

Your doctor may be contacted about your prescription

If you are prescribed a drug that is not on your plan's covered list, yet an alternate drug exists, the pharmacy may contact your doctor to ask whether that drug would be appropriate for you. If your doctor agrees to use a preferred drug, you will never pay more and will usually pay less.



Answers to your questions

Q: How do I find a participating pharmacy?

A: Contact Blue Cross Blue Shield of Michigan Customer Service at the number on the back of your BCBSM ID card.

Q: Is it safe to order my medication through Medco By Mail?

A: Yes. Every prescription you order is reviewed by a team of licensed pharmacists, who carefully check the prescription against your drug history profile. The prescription is verified by the Medco By Mail quality control department to make sure it is accurate in product, quantity and strength.

Q: How do I know if my medication is covered under the program?

A: Call the Customer Service number on the back of your BCBSM ID card.

Q: If my plan covers insulin and insulin syringes, can I order them through the mail?

A: Yes. Insulin and insulin syringes are available through Medco By Mail. For safety in shipping, Medco by Mail packages insulin according the manufacturer's guidelines. The Medco By Mail pharmacy also allows for changes in climate by using special insulated packaging and cold packs when necessary.

Q: How can I be sure of getting a 90-day supply through Medco By Mail?

A: Simply have your doctor write the prescription for a 90-day supply plus refills. The prescription should include the exact quantity to be dispensed, the doctor's DEA number and name, dosing directions, drug name and strength and the exact number of refills.

Note: Certain controlled substances may be subject to other dispensing limitations and the professional judgment of the pharmacist. If you have any questions about your medication, please call 1-800-903-8346.

Q: What if I send in the wrong copayment?

A: If there is a balance due, an invoice will be included with your prescription order. If you overpaid, your account will be credited. Remember to send your payment with your prescription order.

Q: Are there differences between brand and generic drugs?

A: The brand-name of a drug is the product name under which it is advertised and sold. Generic medications contain the same active ingredients and are subject to the same rigid FDA standards for quality, strength and purity as their brand-name equivalents. Generally, generic drugs are less expensive than brand-name drugs.

Vision

Blue Vision℠: Our Focus is on Your Health

Regular eye exams are crucial to a person's overall health. That's why the Blue Vision plan, administered by VSP®, places great importance on maintaining good vision and ensuring that taking care of your eyes is a relatively simple task.

Blue Vision promotes eye health through the preventive care that comes with regular and thorough eye exams and early corrective treatment.

These thorough eye exams also can provide you with peace of mind. According to the American Academy of Ophthalmology, more than 30 medical problems, including diabetes, brain tumors and high blood pressure, can be detected during an eye exam. When detected early, some of these diseases can be cured or treated to prevent other major health consequences.

Among the additional benefits Blue Vision members receive are:

Accessibility

Provider network — Blue Vision members have access to more than 26,000 eye doctors across the United States. VSP has established a network of eye doctors who are dedicated to quality, safety and accessibility. These network doctors are fully credentialed private-practice doctors.

Vision coverage wherever you go — When you're a Blue Vision member, you take your vision care benefits with you across the country. Blue Vision provides you with access to VSP network doctors in all 50 states, giving you the peace of mind that you'll be able to find an eye doctor when you need services.

Convenience

One card — Blue Vision members use a single Blues ID card to obtain medical and vision services.

Top-notch customer service — With Blue Vision, members can easily verify coverage or obtain benefit information via the Internet at **vsp.com** or by phoning VSP Member Services at 1-800-877-7195.

No paperwork — Blue Vision members don't complete any paperwork, including claim forms, when they see a VSP network doctor. VSP network doctors contact VSP directly to verify member eligibility and plan coverage and to obtain authorization for services. They also submit the claim to VSP for processing.

Choice

Wide selection of frames and lenses — Blue Vision members can choose from a wide selection of eyeglass frames to complement their lifestyles. All single vision, bifocal and trifocal lenses are covered in full.

Value-added

Discounts — Blue Vision members also receive special discounts on items such as prescription sunglasses, progressive lenses, ultraviolet screening, scratch guard coating, LASIK, Custom LASIK and polycarbonates.

Simple to use

Using Blue Vision coverage is as easy as 1, 2, 3.

1. You can find a VSP network doctor online at **vsp.com** or by phoning VSP Member Services at 1-800-877-7195.
2. When you make an appointment with a VSP network doctor, tell the doctor you are a VSP member.
3. Your doctor and VSP will handle the rest.

Blue Vision is more than just glasses and eye exams. It's a plan designed to give you value and choice.

Dental

Reasons to Choose a Blues Dental Plan

- We've got you covered with the DenteMax network of more than 2,800 access points in Michigan and more than 83,000 access points nationwide.
- With our dental plan, you can see any dentist not in the network. Non-network dentists can choose to participate with us on a per-claim basis (always ask first).
- If you travel outside of Michigan and see a DenteMax dentist, you'll only pay your usual deductible and copay and receive the same dental benefits as you would at home.
- There's no paperwork if you see a participating or network dentist.

Welcome to Traditional Plus

Traditional Plus is the Blues dental plan that promotes preventive care, so little dental problems don't become big ones. We're sure you'll agree that life is better when dental care isn't a major concern. Plus, our plan is easy to use.

How your Traditional Plus plan works:

You choose

Traditional Plus gives you three options for choosing a dentist. The main difference among them is the amount you pay out of pocket. You can choose the same or a different option each time you see a dentist. Your three options are:

Network dentist

Blue Cross Blue Shield has contracted with the DenteMax dental network to offer you a choice of more than 2,800 Michigan access points as well as more than 83,000 access points across the country. When you receive services from a DenteMax network dentist, you will usually have the lowest out-of-pocket costs because your copayments are based on a discounted fee. DenteMax dentists will also file all claims for you and will receive payment directly from us. You'll only be responsible for paying your deductible and copays and any fees for noncovered services.

Blues participating dentist

Dentists who aren't in the network can choose to participate with Blue Cross Blue Shield on a "per-claim" basis. If your dentist participates, it means he or she accepts our approved amount plus any required deductible or copay from you as payment in full for covered services. Because your out-of-pocket costs are limited to just deductible and copays, this option offers you the next lowest out-of-pocket costs. Participating dentists will file your claims for you and receive payment directly from us. You'll only be responsible for paying your deductible and copays and any fees for noncovered services.

Nonparticipating dentist

If your dentist chooses not to participate with Blue Cross Blue Shield, you are responsible for any difference between our approved amount and your dentist's charges. This amount is in addition to any deductible or copay. You usually have the highest out-of-pocket costs with this option. Nonparticipating dentists may often file your claims for you, but the claims are submitted as "pay subscriber," which means you receive the payment directly from us. You are responsible for paying the dentist, plus any balance above what we pay and your deductible, copay and fees for noncovered services.

It's important to find out if your dentist is in the network. If your dentist is not in the network, it is important to see if he or she will participate with Blue Cross Blue Shield.

What does this mean for you?

Let's take a look at what your out-of-pocket costs would be under each option if you had a dental procedure that costs $600. The following example is based on a 25 percent copay:

	DenteMax dentist	Participating dentist	Nonparticipating dentist
Dentist's fee	$600	$600	$600
We approve	$400	$500	$500
Your copay (25%)	$100	$125	$125
We pay (75%)	$300	$375	$375
Your total out-of-pocket cost	$100 copay only	$125 copay only	$225 ($125 copay, plus $100 difference between dentist's fee and our approved amount)

You save money when you choose a participating dentist. It's always your choice.

Remember, your copay is the same in or out of network and whether you see a participating dentist or nonparticipating dentist. But if you see a DenteMax dentist, that copay is based on a lower fee schedule.

Important things for you to know

The Blues ID card

Our ID card is the most widely recognized health card there is. Dentists recognize it without question. Always remember to present your card at the time you receive services.

Predetermination

When you need dental treatment, the last thing you want is to be surprised with unexpected expenses. That's why predetermination can be done for all nonurgent, complex or expensive procedures (e.g., porcelain veneers, crowns, etc.) or when there are alternative courses of treatment.

Alternative treatment plans

Sometimes your dental problem can be treated more than one way. If more than one procedure meets accepted standards of dental care for

your condition, your benefits will be based on the least costly alternative. Of course, you don't need to choose the treatment we recommend, but the most we pay is the amount allowed for that treatment. That amount can be applied to the treatment you select. We encourage you to discuss alternative treatments with your dentist so you fully understand what your total out-of-pocket costs will be.

Deductible

Your plan may include a deductible, which is a specific dollar amount you must pay each calendar year before your dental plan begins to pay for covered services.

Copays

A copay is the percentage of our approved amount you're required to pay for covered services.

Annual and lifetime benefit dollar maximums

This is the total amount we pay for each eligible person per year and per lifetime.

Calendar year

Payment of benefits, your deductible and annual dollar maximums are based on a calendar year beginning Jan. 1 and ending Dec. 31.

What's not covered

- Services available through a government program or under workers' compensation laws
- Charges for completing insurance forms
- Charges for missed dental appointments
- Services that are experimental, investigational or do not meet standards of the profession
- Services provided or started before the effective date
- Charges for lost, missing or stolen dental appliances
- Services for solely cosmetic or personal preferences, such as bleaching of teeth
- Instruction in oral hygiene, diet, plaque control programs and dental sealants
- The more costly treatment when two or more methods are available to treat the condition
- Services by a student at a dental or medical school
- Charges for premedication, local anesthetic or analgesic billed as a separate service
- Restorations to adjust or restore missing tooth structure due to abrasion, attrition or erosion; to stabilize the teeth or to correct the vertical dimension, to strengthen a tooth, prevent a future problem or close a space
- Services provided after coverage ends, except for a crown, bridge or denture if it's ordered before coverage ends and is completed within 60 days of the coverage end date
- Surgery, anesthesia and diagnostic services covered by your health care program
- Artificial and endodontic implants and related services
- Repair and maintenance of implants and surrounding tissues
- Dental services related to an accident

Frequently asked questions

Q. How do I know if my dentist is a DenteMax network dentist?

A. You can locate DenteMax network dentists by asking your dentist, going to the DenteMax Web site, **dentemax.com** or by calling our Customer Service department toll-free. Remember, your copay amount will usually be lower if you select a network dentist.

Q. How do I know if my dentist is a participating dentist or a nonparticipating dentist?

A. Because dentists participate with us on a "per-claim" basis, you will need to ask your dentist if he or she participates with us. Your copay amount will be lower if your dentist participates, since it will be based on a lower fee schedule. Remember to ask your dentist if he or she participates each time you see your dentist. A DenteMax provider will always participate with us.

Q. How will I know ahead of time what my copay amount will be?

A. Your dentist can let you know before your scheduled treatment so that you will be prepared.

Q. If I choose a network dentist, can I switch to another dentist?

A. Yes. At any time, you can choose a different DenteMax network dentist or switch to a dentist who isn't in the network. The choice is yours. We do not need to be notified when you change dentists.

Q. How do I know if my planned dental work is a covered service?

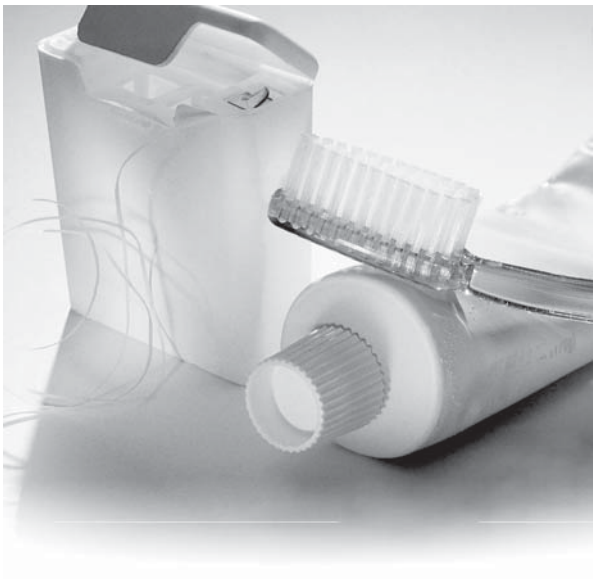
A. You can check your benefit booklet, call our Customer Service department or ask your dentist to submit a predetermination to us before you receive treatment. Your dentist can request predetermination for any nonurgent, complex or expensive procedures. This way both you and your dentist will know what's covered and what your out-of-pocket costs will be before treatment begins.

Q. How do I know if my planned treatment has a less expensive alternative treatment available?

A. If your dentist requests predetermination, we let him or her know if there's a less costly method we've approved and what your options are. We encourage you to discuss your options with your dentist so you can choose what is best for you.

Q. Where can I call if I have more questions?

A. Call our toll-free Customer Service department at the telephone number listed on the back of your ID card.



Your Blue Dental℠ also covers you abroad!

For dental services performed outside the U.S.A.:

The dentist can submit your claim

- or -

You can send your dental claims or receipts directly to BCBSM:

BCBSM
P.O. Box 49
Detroit, MI 48231-0049

bcbsm.com/bluedental

smile, you're covered

Forms

You can find the forms you are looking for in this section.

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

COORDINATION OF BENEFITS INFORMATION

Your prompt response will ensure that your claims are paid timely and accurately

PLEASE PRINT

☐ If new address, check here.

Name of Subscriber (First & Last)		
Subscriber's Address		
City	State	Zip
Subscriber's Social Security No.		
Subscriber's Group Number		

Complete this section when BCBSM is the only insurance for you and your dependents.

PART I :

Subscriber's name (first & last) _____

Subscriber's Social Security number _____ Birth date _____

Spouse's name (first & last) _____

Spouse's Social Security number _____ Birth date _____

Subscriber's signature _____ Today's date _____

Did you previously have non-Blue Cross Blue Shield health coverage that was cancelled? Yes ☐ No ☐

If yes, indicate date cancelled _____

Complete this section if you or any dependents are also covered by another health insurance policy. This includes another Blue Cross and Blue Shield policy.

PART II: OTHER HEALTH INSURANCE POLICY (NON MEDICARE)

Subscriber name with other insurance policy _____ Birth date _____

Social Security number _____ Is this person actively employed? _____ Retired? _____

Name of other health insurance policy _____ Effective date of coverage _____

Street address _____

City _____ State _____ Zip code _____ Phone _____

Policy number _____ Group number _____ ID number _____

Type of coverage (check one): Single ☐ Family ☐ Type of plan: Hospital ☐ Medical ☐ Both ☐

Employer providing coverage _____

Street address _____

City _____ State _____ Zip code _____

List family members covered by other plan:

Name (first & last)	Relationship to this subscriber	Relationship to BCBSM subscriber
1.		
2.		
3.		
4.		

Over please

Complete this section if you are divorced or separated and have dependent children on your BCBSM contract.

If responsibility is determined by a court order, please attach a copy of the sections of that order that deal specifically with custody and health care responsibility.

PART III : IF YOU ARE DIVORCED OR SEPARATED WITH DEPENDENT CHILDREN

(**Complete this section even if it duplicates information reported in Part II of this form.)**

Children's first and last names and Who has physical custody

1. _____ and _____
2. _____ and _____
3. _____ and _____
4. _____ and _____
5. _____ and _____

Individual responsible for children's coverage:

Name _____ Relationship to child _____

Social Security number _____ Birth date _____

Name of health insurance carrier providing child's coverage _____

Street address _____

City _____ State _____ Zip code _____ Phone _____

Policy number _____ Group number _____ ID number _____

Effective date of coverage _____ Type of plan: Hospital ☐ Medical ☐ Both ☐

Please note: If other dependent children are covered by another individual's health care coverage, or the above children are covered under a third health care policy, we need the same type of information (requested above) for each health care policy. (If additional space is needed, please attach a separate sheet.)

PART IV : MEDICARE INFORMATION

Name of member covered by Medicare		Name of spouse/dependent covered by Medicare	
Health insurance claim number	Sex M ☐ F ☐	Spouse's/dependent's health insurance claim number	Sex M ☐ F ☐
Effective date of medicare hospital insurance	Effective date of Medicare medical insurance	Effective date of Medicare hospital insurance	Effective date of Medicare medical insurance

Mail to: Special Claims Center-NCOB Mail Code B484
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-9942

Coordination of benefits information can also be updated through HCBO.com in the Coordination of Benefits menu option or by calling the automated COB response number at 866-263-9494

Blue Cross Blue Shield

Administered by Blue Cross Blue Shield of Michigan, a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

CHECK APPLICABLE BOX

☐ ENROLLMENT	☐ REINSTATEMENT	☐ TRANSFER
☐ ADDRESS CHANGE	☐ CONTRACT CHANGE	☐ RETIREMENT
☐ TERMINATION	☐ COBRA	☐ DEATH OF SUBSCRIBER
☐ WAIVED COVERAGE		

NASCO-NATIONAL ACCOUNTS

BLUE CROSS BLUE SHIELD BENEFIT ENROLLMENT/CHANGE FORM

SHADED AREA IS FOR EMPLOYER USE ONLY

Subscriber Information

SEC. 1

Subscriber Social Security #	Subscriber Last Name ☐ Check if Name Change	Subscriber First Name	Group Number	Group Section	Department Number	Effective Date
						/ /

Street Address ☐ Check if new	City	State	Zip Code	Package Code	Date of Birth	Date of Hire	Plan Code
					/ /	/ /	

SEC. 2

List all persons to be enrolled / terminated:

	Circle One	LAST NAME	FIRST NAME	MI	SEX	DATE OF BIRTH MMDDYYYY	* RECOLDE	SOCIAL SECURITY #	Indicate type of Coverage for Dependents listed in Section 2: Med	Dental	Vision	Drugs	Are you or your spouse or any dependents in Section 2 Medicare eligible? ☐Yes ☐No If Yes Complete below. ⬇ Med. **A** Eff. Date	Med. **B** Eff. Date	HIB#
Subscriber													/ /	/ /	
Spouse	Add Delete												/ /	/ /	
Dep-1	Add Delete												/ /	/ /	
Dep-2	Add Delete												/ /	/ /	
Dep-3	Add Delete												/ /	/ /	
Dep-4	Add Delete												/ /	/ /	
Dep-5	Add Delete												/ /	/ /	
Dep-6	Add Delete												/ /	/ /	

* Relationship Code

N - Natural/Adopted Child
S - Stepchild
F - Family Continuation 19+
P - Principal Support-Attached Documentation
A - Child Adoption in Process-Attached Documentation
L - Legal Guardianship-Attached Documentation
SD - Sponsored Dependent-Attached Documentation
C - Court Order Coverage (QMSCO)-Attach Court Order
D - Disabled Child (PA 275)-Attached Physician Statement

If the permanent address of spouse or dependent is different address in section one, please complete information below:

Spouse/Dependent (Full Name)	Street Address	City	State	Zip Code

Other Coverage

SEC. 3

Do you, your spouse or dependent(s) maintain other health care coverage? ☐ Yes ☐ NO

If you checked YES, you must complete the **Enrollment Application Coordination of Benefits Health Coverage** form (XN 0249 APR 04) and attach it to this form . You must also submit any needed documentation (court orders, divorce decree, etc.).

If you checked NO, proceed to Section 4 of this form.

Signature

SEC. 4

The information I have submitted is full, complete and true to the best of my knowledge. I understand that any false statements may result in the loss of this coverage. In addition, I authorize deductions from my earnings of the required contributions, if any, towards the cost of coverage.

Subscriber Signature	Date

Return completed form to: Blue Cross Blue Shield of Michigan, 600 E. Lafayette Blvd. M.C. B340, Detroit, MI 48226. Please keep a copy for your records.

Please read the following information before completing the other side of this application.

THE INFORMATION ON THIS FORM AND THE FOLLOWING CONDITIONS ARE PART OF MY CONTRACT WITH BLUE CROSS BLUE SHIELD OF MICHIGAN (BCBSM).

I am applying for coverage under my group or association's contract with BCBSM. Coverage begins on the date determined by BCBSM. When BCBSM accepts my application. I and covered members of my family are bound by the terms of the policy and this application, I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my enrollment or retroactive termination of my coverage.

Proof of eligibility: I agree to provide proof of my dependent's eligibility for coverage when requested by BCBSM.

Authorization: I appoint my group or association to handle all matters of coverage. They may forward any agreed deductions for coverage from my wages. I am responsible for giving notice to my group or association of changes in my status and/or my family's status that affect coverage, such as marriage, divorce, births, or deaths of anyone covered under my policy. I authorize BCBSM to obtain the medical records relating to me and my enrolled family members necessary for the coordination of our medical care, administration of my coverage with BCBSM and for other purposes necessary for BCBSM to fulfill its contractual and statutory obligations.

Release of information: BCBSM does not require your Social Security number; however, your group or association, Medicare, Medicaid and others do require it. BCBSM will release information about you only when:

- You authorize it in writing
- When it must be released to process a claim (e.g., to another insurance company).

Upon your request, BCBSM will tell you where the information was sent.

Prescription Drug Reimbursement Form

Blue Cross Blue Shield of Michigan
A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

medco®

See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.

Member/Subscriber Information *See your BCBS ID card.*

Group No. B C B S M A N

Contract/ Enrollee ID#

Enter your 9 digit numeric Contract/Enrollee ID# only; do not include the alpha prefix. The Contract/Enrollee ID# is found on your BCBSM ID card.

Contract/Enrollee Name (First, Last)

Street Address

City

State/Province

Zip/Postal Code

Country

Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year)

Sex
- ☐ Female
- ☐ Male

Relationship to Plan Member
- ☐ 1 Self
- ☐ 2 Spouse
- ☐ 3 Eligible Child
- ☐ 4 Dependent Student
- ☐ 5 Disabled Dependent
- ☐ 6 Dependent Parent
- ☐ 7 Nonspouse Partner
- ☐ 8 Other

Pharmacy Information

Name of Pharmacy

Street Address

City State Zip

Telephone (include area code)

Is this an on-site nursing home pharmacy? ☐Yes ☐No

Claim Receipts

Tape receipts or itemized bills on the back. **See back for details.**

Check the appropriate box if any receipts or bills are for a:

☐ **Compound prescription**
Make sure your pharmacist lists ALL the VALID 11 digit NDC numbers and ingredients and quantities on the receipt or bill.

☐ **Medication purchased outside of the United States**
Please indicate:
Country _____
Currency used _____

☐ **Allergy medication**

☐ **Coordination of Benefits**
Please indicate:
Primary insurance carrier _____
Primary prescription drug program _____

See back for more information

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*

Please tape receipts on the back. Keep a copy for your records.

Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X _____
Signature of Member

Claim Receipts

Please tape your receipts here. **Do not staple!** If you have additional receipts, tape them on a separate piece of paper.

Tape receipt for prescription 1 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

Tape receipt for prescription 2 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

PHARMACY INFORMATION (For Compound Prescriptions ONLY)

- List the VALID 11 digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

RX#		Date Filled		Days Supply	

VALID 11 digit NDC#	Quantity
Total Quantity	
Total Charge	

General Instructions

Read carefully before completing this form

1. You must complete a **separate** claim form for each pharmacy used and for each patient.
2. You must submit claims within 1 year of date of purchase or as required by your plan.
3. **Be sure your receipts are complete.** In order for your request to be processed all receipts must contain the information listed above. Your pharmacist can provide the necessary information if your claim or bill is not itemized.
4. The plan member should read the acknowledgment carefully, then sign and date this form.
5. Return the completed form and receipts to:

Medco Health Solutions, Inc.
P.O. Box 14711
Lexington, KY 40512

Coordination of Benefits Special Instructions

Primary Insurance carrier

You must first submit the claim to the primary insurance carrier. Once you receive the statement or explanation of benefits (EOB) from the primary carrier, complete this form, tape the prescription receipts above, and attach the statement or EOB from the primary carrier, which clearly indicates the cost of the prescription and what was paid by the primary carrier.

Primary Prescription Drug Program

Retail and Mail Order Pharmacy: If the primary carrier is a prescription drug program, one in which a co-payment or coinsurance is paid to the pharmacy, then no EOB is needed. Just complete this form and attach the prescription receipts or statement of benefits that show the co-payment or coinsurance amount paid to the pharmacy. The receipts will serve as the EOB.

* California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

* Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Any questions, call your current Blue Cross Blue Shield of Michigan customer service number. Visit us at **www.medco.com**.

CF904347

[redacted]

SUBSCRIBER SUBMITTED

Blue Cross Blue Shield of Michigan

YOU MAY NOT NEED TO FILE THIS CLAIM FORM. ASK THE PROVIDER OR HOSPITAL TO BILL THEIR LOCAL BLUE CROSS AND BLUE SHIELD PLAN DIRECTLY.
MEDICARE: YOU MAY NOT NEED TO FILE THIS CLAIM FORM. ASK THE PROVIDER OR HOSPITAL IF THEY HAVE BILLED MEDICARE OR BLUE CROSS AND BLUE SHIELD DIRECTLY OR IF THE PROVIDER ACCEPTED MEDICARE ASSIGNMENT FOR THESE SERVICES.

INSTRUCTIONS (Please turn over for examples)
1. Please print or type a separate form for each patient.
2. Attach to each form an itemized statement, bill or receipt which includes: provider's name and address, primary enrollee's contract number, full name of patient, date and description of each service, diagnosis/nature of illness, and amount charged. If you paid for service, please attach a copy of your receipt or cancelled check. Also attach copies of any relevant Explanation of Benefit forms or check vouchers (if you have Medicare, attach the Explanation of Medicare Benefits or Medicare voucher.)
3. Save copies of all items you submit. All materials submitted will be kept for our files. (Please submit the original claim form, not the copy.)
4. Send to the appropriate address shown on the back of this form.

1. SUBSCRIBER LAST NAME | 2. FIRST NAME

3. STREET ADDRESS | CITY

STATE | ZIP CODE | THIS INFORMATION APPEARS ON YOUR ID CARD → | PREFIX | 4. CONTRACT NUMBER | 5.GROUP NUMBER

6. PATIENT LAST NAME | FIRST NAME | DATE OF BIRTH | MO | DAY | YEAR

7. IS PATIENT ENROLLED WITH MEDICARE? ☐ YES ☐ NO | 8. MEDICARE H.I.B. NUMBER | 9. IS PATIENT COVERED BY OTHER HEALTH INSURANCE? ☐ YES ☐ NO | **BCBS USE ONLY**

10. NAME OF OTHER INSURANCE CARRIER

11. CITY | STATE | ZIP CODE

12. NAME OF POLICY HOLDER | 12a. POLICY NUMBER | 13. POLICY HOLDER'S DATE OF BIRTH

(If you received partial payment from another company, please attach a copy of their check voucher or Explanation of Benefits form.)

14. Relationship to Primary Enrollee ☐ Self ☐ Spouse ☐ Dependent

15. Sex ☐ Male ☐ Female

16. Were Injuries or Illness related to patient's employment? ☐ Yes ☐ No

17. Were Injuries the result of an auto accident? ☐ Yes ☐ No

18. Date of accident MO. DAY YR.

19. If patient was hospitalized, give dates below. Date of Admission MO. DAY YR. Date of Discharge MO. DAY YR.

20. PROVIDER'S NAME | 21. STREET ADDRESS

22. CITY | STATE | ZIP CODE | TAX I.D. (FOR PROVIDER USE ONLY)

CERTIFICATION STATEMENT
I certify that the above information is true, the attached material is correct and unaltered, and that the expenses were incurred by the above named patient. I understand all material submitted becomes the property of Blue Cross and Blue shield and may not be returned. I realize false receipts or fraudulent alterations of these materials may result in civil or criminal prosecution. I authorize the release of any information necessary to process or review this claim.

CLAIM NUMBER (FOR BCBSM USE ONLY)

SUBSCRIBER'S SIGNATURE

DATE | TELEPHONE NUMBER

SUBSCRIBER'S CLAIM FORM INSTRUCTIONS

PLEASE READ AND FOLLOW INSTRUCTIONS LISTED BELOW

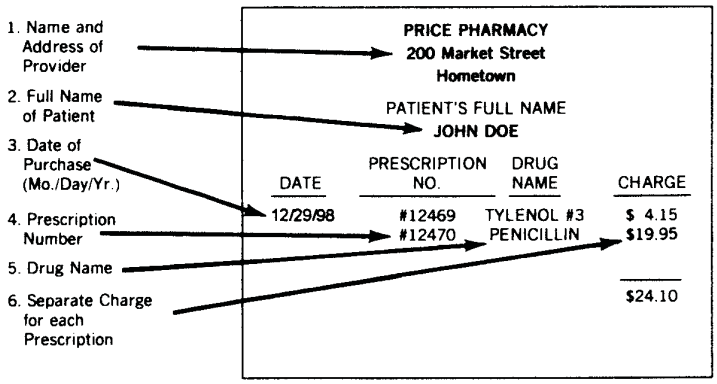
HOW TO FILE CLAIMS: IF YOUR PHYSICIAN DOES NOT ELECT TO BILL DIRECTLY AND GIVES YOU AN ITEMIZED BILLING, COMPLETE THE TOP PORTION ONLY. COMPLETE A SEPARATE CLAIM FORM FOR EACH ELIGIBLE FAMILY MEMBER.

- ITEMS 1 & 2-COMPLETE ITEMS 1 & 2 EXACTLY AS THEY APPEAR ON YOUR BLUE CROSS AND BLUE SHIELD I.D. CARD.
- ITEM 3-ENTER YOUR STREET ADDRESS, CITY, STATE AND ZIP CODE.
- ITEMS 4 & 5-COMPLETE EXACTLY AS IT APPEARS ON YOUR BLUE CROSS AND BLUE SHIELD I.D. CARD.
- ITEM 6-ENTER THE PATIENT'S NAME AND DATE OF BIRTH.
- ITEM 7-YOU MUST CHECK EITHER "YES" OR "NO".
- ITEM 8-IF YOUR PROVIDER DID NOT ACCEPT MEDICARE ASSIGNMENT, ENTER THE COMPLETE MEDICARE IDENTIFICATION NUMBER AND LETTER. IF YOU HAVE ALREADY RECEIVED THE MEDICARE PAYMENT AND ARE REQUESTING COMPLEMENTARY COVERAGE PAYMENT ONLY, BE SURE TO ATTACH THE EXPLANATION OF MEDICARE BENEFITS (E.O.M.B.) THAT WAS SENT TO THE PATIENT, EXPLAINING CHARGES PAID OR DENIED BY MEDICARE.
- ITEMS 9-13-YOU MUST CHECK EITHER "YES" OR "NO" FOR ITEM 9. IF YOU CHECK "YES" COMPLETE 10-13. GIVE CARRIER NAME, POLICY NUMBER, POLICY HOLDER'S NAME AND INSURANCE CO. ADDRESS. IF YOU RECEIVED PARTIAL PAYMENT FROM ANOTHER INSURANCE CARRIER, YOU MUST ATTACH A COPY OF THE CHECK VOUCHER OR EXPLANATION OF BENEFITS FORM THAT WAS SUPPLIED BY THE CARRIER.
- ITEM 14-RELATIONSHIP TO THE SUBSCRIBER.
- ITEM 15-ENTER THE PATIENT'S SEX.
- ITEM 16-IF THE ILLNESS OR INJURY WAS CONNECTED WITH THE PATIENT'S EMPLOYMENT, CHECK "YES". IF NOT, CHECK "NO".
- ITEM 17-CHECK "YES" IF THE INJURIES WERE THE RESULT OF AN AUTO ACCIDENT, IF NOT, CHECK "NO".
- ITEM18-IF ITEM 17 ABOVE WAS CHECKED "YES", PLEASE GIVE DATE OF AUTO ACCIDENT.
- ITEM 19-IF ANY OF THE BILLS ARE FOR HOSPITAL EXPENSES, ENTER THE ADMISSION AND DISCHARGE DATES.
- ITEMS 20-22-ENTER THE NAME AND ADDRESS OF THE PHYSICIAN WHO PERFORMED THE SERVICES YOU ARE REPORTING. IF YOU ARE ATTACHING RECEIPTS FROM MORE THAN ONE PHYSICIAN, DO **NOT** COMPLETE THIS PORTION.

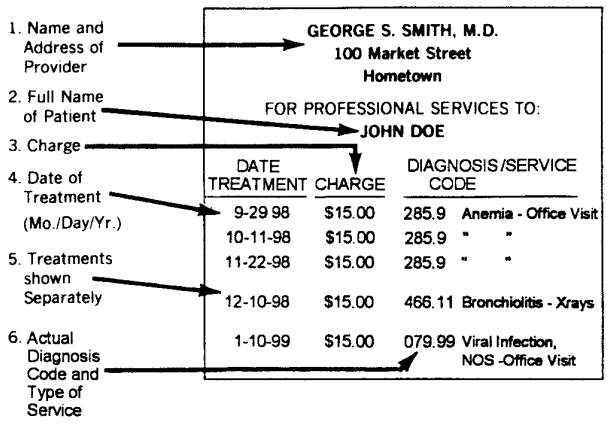
MAKE ANY NEEDED COPIES OF THE CLAIM FORM AND RECEIPTS FOR YOUR USE BEFORE MAILING THE ORIGINALS. DO NOT MAIL XEROX COPIES. MATERIALS SUBMITTED WILL BE RETAINED FOR OUR FILES.

EXAMPLES OF PROPERLY ITEMIZED RECEIPTS

PHARMACY RECEIPT



PHYSICIAN RECEIPT



MAIL TO:

Blue Cross and Blue Shield of Michigan
NASCO Claims Processing Center — National Groups
P.O. Box 5124
Southfield, Michigan 48086-5124

medco®

Health, Allergy & Medication Questionnaire (HMQ)

Your answers to the following questions will help protect you against potentially harmful drug interactions and side effects. We will alert your pharmacist about possible drug allergies and interactions that can be harmful. To best serve you, we need to know if you have any medication allergies or medical conditions. We also need to know what prescription and nonprescription medications you take regularly.

Your privacy is important to us. Medco complies with federal privacy regulations and will protect this information.

Follow the steps listed below.

Step 1: Verify and complete information in SECTION 1.

Step 2: Complete all sections below using blue or black ink. Please print.

Step 3: Return the completed questionnaire in the self-addressed envelope with your mail-order form or refills. If you do not have a preaddressed envelope, please return the questionnaire to:

MEDCO HEALTH SOLUTIONS OF FAIRFIELD
PO BOX 6575
CINCINNATI OH 45273-7983

SECTION 1: Patient information

Patient name: _____ Gender: _____

Month/Year of birth: _____ Contact phone: | | | | | | | | | | |

Patient member number: _____ Group: _____

(Located on your member ID card and/or in your benefit information.)

SECTION 2: Your medication allergies

Fill in the oval **completely if you have had an allergy or serious reaction to any of these medications:**

○	Aspirin and salicylates (for example: ZORprin®, Trilisate®)
○	Codeine (for example: Tylenol® #3)
○	Erythromycin, Biaxin®, Zithromax®
○	Nonsteroidal anti-inflammatory drugs (NSAIDS) (for example: ibuprofen, Advil®, Motrin®)
○	Penicillins/cephalosporins (for example: Amoxil®, amoxicillin, ampicillin, Keflex®, cephalexin)
○	Sulfa drugs (for example: Septra®, Bactrim®, TMP/SMX)
○	Tetracycline antibiotics
If you have an allergy to a medication that is not listed above, print the name of that medication in the space below. Example: morphine	
other:	
other:	

(over, please)

SECTION 3: Your medical conditions

Has your doctor ever told you that you have any of the conditions listed below? If so, fill the oval completely next to all that apply.

○	Allergies, hay fever (allergic rhinitis)	○	Heart failure (CHF)
○	Arthritis	○	Hemophilia and hemophilia-like conditions
○	Asthma	○	High blood pressure (hypertension)
○	Bladder control problem (urinary incontinence)	○	High blood sugar (diabetes)
○	Brittle bones (osteoporosis)	○	High cholesterol (hypercholesterolemia)
○	Chest pain (angina)	○	Inflammatory bowel disease
○	Crohn's disease	○	Migraine headache
○	Depression	○	Overactive thyroid (hyperthyroid)
○	Emphysema (COPD, chronic bronchitis)	○	Peptic, stomach, or duodenal ulcer
○	Enlarged prostate (benign prostatic hyperplasia, BPH)	○	Poor circulation in the legs (peripheral vascular disease)
○	Gastric reflux, heartburn, or esophagitis (GERD)	○	Seizures (epilepsy)
○	Glaucoma	○	Stroke (TIA)
○	Heart attack (myocardial infarction)	○	Underactive thyroid (hypothyroid)

If you have a medical condition that is not listed above, print the name of that medical condition in the space below. Example: breast cancer

other:

other:

SECTION 4: Your nonprescription medications

Fill in the oval completely for each nonprescription medication that you are currently taking on a regular basis.

○	Advil®/ibuprofen	○	Prilosec OTC®/omeprazole
○	Aleve®/naproxen	○	Sominex®, Nytol®/diphenhydramine
○	Bayer®/aspirin	○	Tagamet®/cimetidine
○	Benadryl®/diphenhydramine	○	Tylenol®/acetaminophen
○	Orudis KT®/ketoprofen	○	Zantac®/ranitidine
○	Pepcid AC®/famotidine		

If you take a nonprescription medication that is not listed above, print the name of that medication in the space below.

other:

other:

SECTION 5: Patient prescription medications*

Please list the **prescription medications** you are currently taking in the space below. *Information can be found on the prescription labels. If none, please check here. **[ ] NONE**

Did you complete both sides? **Thank you very much.**

Medco By Mail ORDER FORM

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

medco®

1 Member information: Please verify or provide member information below.

Member ID: _____

Group: ***BCBSMAN***

Name: _____

Street Address: _____

Street Address: _____

Street Address: _____

City, ST, ZIP: _____

☐ Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at:

_____ @ _____ . _____

☐ New shipping address:

_____

_____

_____

(Medco will keep this address on file for all orders from this membership until another shipping address is provided by any person in this membership.)

Daytime phone: ☐☐☐ ☐☐☐ ☐☐☐☐

Evening phone: ☐☐☐ ☐☐☐ ☐☐☐☐

FOLD HERE

2 Patient/doctor information: Complete **one section** for each person with a prescription. If a person has prescriptions from more than one doctor, complete a new section for each doctor (additional sections are on back). Send all prescriptions in the envelope provided.

First name _____ Last name _____

Birth date (MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐ Sex ☐M ☐F Patient's relationship to member ☐Self ☐Spouse ☐Dependent

Doctor's last name _____ 1st initial ☐ Doctor's phone number ☐☐☐ ☐☐☐ ☐☐☐☐

First name _____ Last name _____

Birth date (MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐ Sex ☐M ☐F Patient's relationship to member ☐Self ☐Spouse ☐Dependent

Doctor's last name _____ 1st initial ☐ Doctor's phone number ☐☐☐ ☐☐☐ ☐☐☐☐

FOLD HERE

3 Complete your order : You can pay by e-check, check, money order, or credit card. Make checks and money orders **payable to Medco Health Solutions, Inc.,** and write your member ID number on the front. You can enroll for e-check payments and price medications at **www.medco.com**, or call **1 800 948-8779.**

Number of prescriptions sent with this order: ☐

Payment options: ☐ e-check ☐ Payment enclosed ☐ Credit card ☐ Send bill

For credit card payments:

☐ Visa ☐ MC ☐ Discover ☐ Amex ☐ Diners

Credit card number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration date ☐☐ ☐☐ (M M Y Y)

X _____ Cardholder signature

☐ I authorize Medco to charge this card for all orders from any person in this membership.

Rush the mailing of this shipment ($15, cost subject to change). NOTE: This will only rush the shipping, not the processing of your order. Street address is required; P.O. box is not allowed.

FORM # HH55434M

Mailing instructions are provided on the back of this form.

Patient/doctor information continued

First name

Last name

Birth date (MM/DD/YYYY)

Sex
☐ M ☐ F

Patient's relationship to member
☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex
☐ M ☐ F

Patient's relationship to member
☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

FOLD HERE

Important reminders and other information

Please be sure that you have included your doctor's signed prescription form and filled out the patient information on the front of the order form for each new prescription. Check that your doctor has prescribed the maximum days' supply allowed by your plan, plus refills for up to 1 year, if appropriate (not a 30-day supply plus refills).

Complete the Health, Allergy & Medication Questionnaire.

There may be a limit to the balance that you can carry on your account. If this order takes you over the limit, you must include payment. Avoid delays in processing by using e-checks or a credit card. (See Section 3 for details.)

Please take a minute to make sure that you have either filled out the credit card section on the front of this order form or included a check or money order for the required co-payment. If you elect to have this and all future orders automatically charged to your credit card, bear in mind that the automated payment plan feature will apply to all mail orders.

Automatic generic equivalent substitution of certain brand-name drugs is allowed by law in Texas, Florida, and Ohio, unless you or your doctor specifically directs otherwise.

☐ If you live in Texas, you have a right to refuse safe, effective generics. Check the box **if you do not want the less expensive**, generic drug. This applies only to the prescription drug(s) on this order.

☐ Pennsylvania law permits pharmacists to substitute a less expensive generically equivalent drug for a brand name drug unless you or your physician direct otherwise. **Check the box if you do not wish a less expensive brand or generic drug "product."**

Please note that this applies only to new prescriptions and to any future refills of that prescription.

For additional information or help, visit us at **www.medco.com** or call Member Services at 1 800 778-0735.

FOLD HERE

Place your prescription(s), this form, and your payment in the envelope provided. Do not use staples or paper clips.

MEDCO HEALTH SOLUTIONS OF FAIRFIELD
PO BOX 747050
CINCINNATI OH 45724-7050

FROM

_____

_____

_____

FORM #AB677 (06/01)

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 487 COLUMBUS, OH

POSTAGE WILL BE PAID BY ADDRESSEE

MEDCO HEALTH
PO BOX 747050
CINCINNATI OH 45274-7050

How to place your initial order with Walgreens Specialty Pharmacy:

1) Print and complete the Enrollment Form. Please print clearly.
2) Attach ORIGINAL prescription provided by your physician or ask your physician to fax the prescription to Walgreens Specialty Pharmacy at 1.866.515.1356.
3) Mail Enrollment Form and ORIGINAL prescription to Walgreens Specialty Pharmacy, 1350 Highland Drive, Suite D, Ann Arbor, Michigan 48108.

If you have questions or concerns, please call the Walgreens Specialty Pharmacy Customer Care Team toll free at 1.866.515.1355. Our hours are Monday through Friday, 8:00 a.m. to 8:00 p.m. and Saturday 8 a.m. to 5 p.m.

Step 1: Demographic Information

Subscriber's Name _____ Date of Birth ____/____/_____

Policy # _____ Group # _____

Patient Name _____ Date of Birth ____/____/_____

Delivery Address _____

Day Phone Number w/area code _____ Evening Phone Number w/area code _____

E-mail Address _____

Physician's Name _____ Phone Number w/area code _____

Check One: ☐ Original Prescription Enclosed ☐ Physician Will Fax Prescription

Step 2: Delivery Information

Requested Date of Delivery ____/____/____ (You will be contacted by Walgreens Specialty Pharmacy if the delivery date cannot be accommodated. Deliveries are available Tuesday through Friday.)

Medication(s) Requested

_____ _____

_____ _____

Supplies Needed* ☐ No ☐ Yes If yes, please circle supplies needed:

Alcohol Wipes Sharps Container Pen Needles Injection Syringes Mixing Syringes Inject-Ease

*Please note: Walgreens Specialty Pharmacy provides standard supplies as a courtesy and cannot accommodate special requests. The quantity of supplies sent is based on the days supply of medication dispensed.

Step 3: Payment Information

1) Paying by Credit Card *(circle one)* Visa MC Discover AMEX

Credit Card # _____ Exp Date _____/_____

Security Code _____ (3 digits on back of card for Visa and 4 digits on front of card for AMEX)

Cardholder's Signature _____

☐ Check here to authorize Walgreens Specialty Pharmacy to bill and debit your credit card for future orders.
Call Walgreens Specialty Pharmacy at 1.866.515.1355 to set up autopay by phone.

2) Paying by Check via Phone *(circle one)* Checking Savings

Account Number _____ Routing Number _____

Signature _____ Name of Financial Institution _____

☐ Check here to authorize Walgreens Specialty Pharmacy to bill your checking/savings account for future orders.
Call Walgreens Specialty Pharmacy at 1.866.515.1355 to set up autopay by phone.

3) Paying by Check or Money Order via Mail.

Please make your check or money order payable to Walgreens Specialty Pharmacy, and mail to: Walgreens Specialty Pharmacy, 1350 Highland Drive, Suite D, Ann Arbor, Michigan 48108.

Questions

Questions?

A knowledgeable Customer Service representative is just a toll-free phone call away and ready to assist you with your questions about Blue Cross Blue Shield coverage.

1-877-671-2583

Note: You can find doctors and hospitals in your area by searching our provider directory on bcbsm.com, or by calling 1-800-810-BLUE (2583).