CITY OF JACKSON – Community Blue[SM] PPO$5000 – RETIREE (Under Age 65) Medical Coverage #007000992

Effective July 1, 2013

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.

Note: To be eligible for coverage, the following services require your provider to obtain approval **before** they are provided – select radiology services, inpatient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, rehabilitation therapy and applied behavioral analyses.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals – BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician **must** contact BCBSM to request preauthorization of the drugs. If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Member's responsibility (deductibles, copays and dollar maximums)	In-network	Out-of-network *
Deductibles	**$5,000** for one member $10,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** See attached **Deductible Reimbursement Guidelines & Claim Form** outlining Employer payment of **$4500**/person, $9000/family of stated deductible requirement.	$10,000 for one member $20,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also apply toward the in-network deductible.
Fixed dollar copays	• **$10** copay for office visits • $50 copay for emergency room visits	$50 copay for emergency room visits
Percent copays **Note:** Copays apply once the deductible has been met.	50% of approved amount for private duty nursing See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.	• 50% of approved amount for private duty nursing • 40% of approved amount for most other covered services See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.
Annual copay dollar maximums – applies to copays for all covered services – including mental health and substance abuse services – but **does not** apply to fixed dollar copays and private duty nursing percent copays **Note:** For groups with 50 or fewer employees or groups that are **not** subject to the MHP law, mental health care and substance abuse treatment copays **do not** contribute to the copay dollar maximum.	Not applicable	$5,000 for one member $10,000 for two or more members each calendar year
Lifetime dollar maximum	None	

* 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 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. 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		
Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay), one per member per calendar year	Not covered
Gynecological exam	100% (no deductible or copay), one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay)	60% after out-of-network deductible
Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay)	60% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay) • 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)	Not covered
Fecal occult blood screening	100% (no deductible or copay), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay) **Note:** Subsequent or medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	60% 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 Colonoscopy	100% (no deductible or copay) for the first billed colonoscopy **Note:** Subsequent or medically necessary colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	60% after out-of-network deductible
	One per member per calendar year	
Physician office services		
Office visits – must be medically necessary	$10 copay per office visit	60% after out-of-network deductible
Outpatient and home medical care visits – must be medically necessary	100% after in-network deductible	60% after out-of-network deductible
Office consultations – must be medically necessary	$10 copay per office visit	60% after out-of-network deductible
Urgent care visits – must be medically necessary	$10 copay per office visit	60% after out-of-network deductible
Emergency medical care		
Hospital emergency room	$50 copay per visit (copay waived if admitted or for an accidental injury)	$50 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	100% after in-network deductible	100% after in-network deductible

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	In-network	Out-of-network *
Diagnostic services		
Laboratory and pathology services	100% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	60% after out-of-network deductible
Maternity services provided by a physician		
Prenatal and postnatal care visits	100% (no deductible or copay)	60% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	100% after in-network deductible	60% 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	60% after out-of-network deductible
	Unlimited days	
Inpatient consultations	100% after in-network deductible	60% after out-of-network deductible
Chemotherapy	100% after in-network deductible	60% 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 120 days per member per calendar year	
Hospice care	100% (no deductible or copay)	100% (no deductible or copay)
	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	60% after out-of-network deductible
Voluntary sterilization for males **Note:** See "Preventive care services" section for voluntary sterilizations for females.	100% after in-network deductible	60% 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% (no deductible or copay)	100% (no deductible or copay) – 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	60% after out-of-network deductible
Specified oncology clinical trials	100% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	100% after in-network deductible	60% 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 copays. Mental health and substance abuse copays are included in the annual copay dollar maximums for all covered services. See "Annual copay dollar 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	100% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Inpatient substance abuse treatment	100% after in-network deductible	60% 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 **	60% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities **only**	100% after in-network deductible **	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)
Autism spectrum disorders, diagnoses and treatment		
Applied behavioral analyses (ABA) treatment – limited to an annual maximum of $50,000 per member, through age 18 (limits may be waived on an individual consideration basis) **Note:** ABA treatment is only payable after an Approved Autism Evaluation Center confirms the ASD diagnosis & treatment plan. Refer to BCBSM online provider directory for listing of approved AAEC's.	100% after in-network deductible	100% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder – through age 18	100% after in-network deductible	60% after out-of-network deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	100% after in-network deductible	60% after out-of-network deductible
Other covered services		
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by a network provider. **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) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$10 copay per office visit	60% after out-of-network deductible
	Limited to a **combined** maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy – provided for rehabilitation	100% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** maximum of 60 visits per member per calendar year	
Durable medical equipment **Note:** DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by a network provider.	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	50% after in-network deductible	50% after in-network deductible

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Prescription Drug Coverage
(3-Year Eligibility from date of Retirement; Rx benefit now with Blue Cross, no longer utilize a separate Scriptguide card)

Covered Services:	
• Federal-legend drugs • State-controlled drugs • Needles and syringes • Contraceptive Medications (**Note**: FDA-approved Generic prescription contraceptive medication is covered at 100% of approved amounts. Following PPACA guidelines, stated Tier 1 Generic copay does not apply)	**Preferred Rx Pharmacy (in Michigan): $10/$20/$40 copay*** **Medco Pharmacy (outside Michigan): $10/$20/$40** copay* **Non-Preferred or Non-Medco Pharmacy:** 75% of approved amount less **$10/$20/$40** copay* Mail Order Prescription Drugs: A 90-day supply of prescribed medications by mail from Medco Rx Services, with a **$20/$40/$80 copay for each 90-day prescription or refill** ***$10 Copay for Generic Medications, $20 for Preferred Brand Name Medications; $40 for medically necessary Non-Preferred Brand Name Medications** **(2x stated copay amounts/maximums for 90-day Mail Order/Retail Rx Supply)**

NOTE: Plan Features

Mandatory PreAuthorization: A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (identified by BCBSM) will be covered.

Step Therapy: An initial step in the Prior Authorization process which applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online via *bcbsm.com*. Log in under 'I am a Member' and click 'Prescription Drugs.'

Mandatory MAC-Maximum Allowable Cost: If you obtain a formulary or non-formulary Brand name drug when a generic equivalent drug is available for that specific medication you must pay the difference in cost between the brand name drug dispensed and the maximum allowable cost for the generic drug plus your copay regardless of whether you or your doctor requests (DAW) the formulary brand name drug.

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CITY OF JACKSON—Non Union Retirees (Under Age 65)
161 W. Michigan Avenue, Jackson MI 49201
Health/Deductible Reimbursement Arrangement – Community Blue PPO
Effective 07/01/13

Your employer has implemented a Health Reimbursement Arrangement (HRA) plan to help offset your deductible healthcare expenses. JFP Benefit Management, Inc., a Third Party Administrator (TPA) has been retained to process claims for this plan.

Outlined below are the specifics of the plan and how to get reimbursed for eligible benefits that have been applied to your deductible.

Benefit of the Health Reimbursement Arrangement (HRA) Plan designed to pay the following *DEDUCTIBLE's:

1. Single Coverage: $5000.00 w/ $4500 Reimbursed by Employer – after $500 Employee Responsibility
2. 2 Person/Family Coverage: $10,000.00 w/ $9000 Reimbursed by Employer – after $1000 Employee Responsibility

**NOTE: Once the $5000/$10,000 deductible amount has been met, Blue Cross Blue Shield will reimburse hospital-medical/surgical services at 100% for the remainder of the year. EXCEPTION: Services with flat copays (OV, Chiropractic Adjustment, ER, Rx) do NOT apply to deductible/coinsurance requirement. Thus the Employee is responsible for such copays both prior to and after deductible has been met. See attached Benefit Chart for complete detail.*

Expenses eligible for reimbursement: Medical expenses applied to your deductible by BCBSM

How to submit a claim:

1. Use Attached claim form (Obtain add'l claim forms from your Human Resources Department or JFP.)
2. Complete the claim form with supporting documentation (Explanation of Benefits from Blue Cross Blue Shield of Michigan *AND* Provider Statement) for each expense that has been applied to your deductible.
3. You can submit your claims by fax, mail or in person:
   a. Fax - (517) 784-0821
   b. Mail - JFP Benefit Management, Inc., P.O. Box 189, Jackson, MI 49204
   c. Email - mwarren@jpfbenefitmanagement.com
   d. Person - JFP Benefit Management, Inc., 100 S. Jackson, Ste 200, Jackson, MI 49201
4. Claims received prior to 2:00 p.m. will be processed that day. Claims received after 2:00 p.m. will be processed the next business day.
5. Reimbursements will be made as directed on the claim form directly to the Provider.

Additional information:

1. Questions about processing claims for payment and reimbursement can be directed to the claims department at JFP Benefit Management, Inc. Please ask for Mindy Warren or Donna Pelham.
2. CBPPO Plan (Deductible) year is on a calendar year basis – January 1 through December 31.
3. There is no carry-over amount of unused balances from one plan year to another.
4. Claims can be submitted up to 90 days after the end of the plan year for service during the preceding plan year.

CITY OF JACKSON – DEDUCTIBLE REIMBURSEMENT FORM CBPPO

REQUEST FOR REIMBURSEMENT
(Deductible Payment to PROVIDERS)

Employee Name		Employee Ph#
Street Address		
City	State	Zip

The undersigned participant in the City of Jackson's CBPPO HRA/deductible reimbursement benefit plan certifies that all expenses, for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the City of Jackson's health benefit plan. The undersigned fully understands that he or she cannot submit a claim for reimbursement or payment unless the claim has ***first been submitted to Blue Cross***, and a copy of the Blue Cross Explanation of Benefits (***EOB***), including the "Detail of Services" is ***attached*** to this claim form. The undersigned understands that expenses for non-covered benefits under the applicable Blue Cross health insurance plan are not eligible for reimbursement under this deductible reimbursement plan. Checks will be mailed, as appropriate, to the service provider or to the employee at the address on file. ***Remember to retain a personal copy of this form and any documents submitted to substantiate expenses.***

HEALTH EXPENSES ELIGIBLE FOR EMPLOYEE REIMBURSEMENT OR PAYMENT TO PROVIDER

1. Check "Pay Provider" and *include the original itemized bill or statement from the Provider showing their name/address*. Also attach a *complete copy of Explanation of Benefits form (EOB) from BCBS*. BOTH documents must be attached in order to pay for any deductible amounts exceeding the $500/person or $1000/family initial employee responsibility.

☐ **Pay Provider**

☐ Complete EOB Attached. (**Must** include the 'Detail' description of individual claim data-not just the summary page.)

☐ Statement or bill from Provider. (**Must** include name and address of provider.)

Signature:	Date:

Provide completed form and supporting documentation to:

JFP Benefit Management, Inc.
Phone: (517) 784-0535; or (800) 589-7660;
Fax: (517) 784-0821
Mail: P.O. Box 189 - Jackson, Michigan 49204
Delivery: 100 S. Jackson, Suite 200, Jackson, MI 49201.

Questions – JFP Benefit Management, Inc.
Mindy Warren or Donna Pelham

BLUE CROSS BLUE SHIELD OF MICHIGAN

Procedure Code Guidelines – COMMUNITY BLUE PPO – Effective 1/1/2011

Preventative Benefits*

Referrals NOT eligible=Payable In Network only;

Payable at 100% IF billed with ***ROUTINE** Diagnosis

The following procedure codes are accepted through Michigan claims processing system:

I. ROUTINE/PREVENTATIVE PROCEDURES:

HEALTH MAINTENANCE EXAM – One per calendar year
- Codes 99384 to 99387; Codes 99394 to 99397; Code G0344

ANNUAL GYNECOLOGICAL EXAM – One per calendar year
- Code G0101, S0610, S0612, S0613

ROUTINE PAP SMEAR – One per calendar year
- Codes G0123, G0124, G0141 to G0143, G0144, G0145, G0147, G0148, P3000, P3001 (Panel Lab Only*)
- Codes Q0091, 87620, 87621, 88141-88143, 88147, 88148, 88150, 88152, 88155, 88164, 88167, 88174, 88175

ROUTINE MAMMOGRAM / ROUTINE COLONOSCOPY – One per calendar year

WELL BABY AND CHILD CARE – Through Age 15
(6 visits=birth thru 12 mos; 6 visits=13 mos thru 23 mos; 2 visits=24 mos thru 35 mos;
2 visits=36 mos thru 47 mos; and 1 visit per birth year=48 mos thru age 15)
- Codes 99381 to 99384, 99391 to 99394

IMMUNIZATIONS – Through Age 16
(+Adult Immunization as recommended by the Advisory Committee on Immunization Practices)
(DTP-5 dose; Polis-6 dose; MMR-2 dose; HIB-4 dose; Hepatitis B-3 dose; ChickenPox)
- Codes 90465, 90466, 90471, 90472, 90632, 90633, 90634, 90645 to 90648, 90649, 90655, 90656, 90657, 90658, 90660, 90669, 90680, 90700, 90702 to 90708, 90710, 90713, 90714, 90715, 90716; 90718, 90721, 90723, 90732; 90740, 90743, 90744, 90746, 90747, 90748

FLEXIBLE SIGMOIDOSCOPY – One per calendar year
- Code G0104

FECAL OCCULT BLOOD SCREENING – One per calendar year
- Code 82270 & 82274, G0107, G0328

CHOLESTEROL TEST/SCREENING – One per calendar year
- Code 83718 - Lipoprotein (Panel Lab Only*)
- Code 80061 - Lipid Panel – must include Cholesterol, serum #82465; Lipoprotein-HDL #83718; and Triglyceride #84478 (Panel Lab Only*)

CHEMICAL/LAB PROFILES – One per calendar year
- Codes 80050, 80051, 80053, 80061 (Panel Lab Only*)

CHEMISTRY – One per calendar year
- Codes 83655, 83718 (Panel Lab Only*)

URINALYSIS – One per calendar year
- Code 81000-81003

COMPLETE BLOOD COUNT (CBC) – One per calendar year
- Code 85004, 85013, 85014, 85018, 85025, 85027, G0306, G0307

EKG – One per calendar year
- Codes 93000, 93010, 93005,G0366, G0367, G0368

CHEST X-RAY – One per calendar year
- Code 71020

PROSTATE SPECIFIC ANTIGEN (PSA) – One per calendar year
- Code 84153, 84154, G0103

PLEASE NOTE THAT THE ABOVE LIST OF PROCEDURE CODES REPRESENT THOSE CPT CODES RECOGNIZED THROUGH MICHIGAN BLUE CROSS BLUE SHIELD CLAIM SYSTEMS AS PART OF THE COMMUNITY BLUE CERTIFICATE OF BENEFITS & THE AFFORDABLE CARE ACT of 2010. FOR DETAILED NARRATIVE AND DESCRIPTION PLEASE REFER TO CPT CODE MANUALS.

*Panel Labs are independent labs that have contracted with the PLUS Lab Program for PPO members.

BLUE CROSS BLUE SHIELD OF MICHIGAN
Helpful Hints – Community Blue PPO

COMMUNITY BLUE PPO PLAN COVERAGE

- Always request that your provider bill directly for all covered services
- In the event that you must file your own claims, please follow the below instructions:

  - Obtain completely Itemized Billing including Date of Service, Type of Service, Patient, Itemized charges, Diagnosis, Provider Name/Address, etc.
  - NO CLAIM FORM IS NECESSARY
  - Simply write your ***CONTRACT#*** directly on the itemized statement and mail to:

    Blue Cross Blue Shield of Michigan
    600 Lafayette East, Dept B321
    Detroit MI 48226

- Please keep copies for your records.

BCBSM/CBPPO CUSTOMER SERVICE:

- Please contact customer service for all questions on claims, benefits, billings that you may receive:

1-800-258-8000

- For names of Out-of-State participating PPO providers, call:

1-800-810-2583
OR
Refer to attached Provider Locator Assistance

Additional Assistance can be provided by Contacting JFP

784-0535 / 1-800-589-7660 (JFP-Jackson)
(BCBSM Questions-Mary, Frank, Lori or Tom)
mkania@jfpbenefitmanagemetn.com
fhill@jfpbenefitmanagement.com
lzajac@jfpbenefitmanagement.com
tstevens@jfpbenefitmanagement.com

BLUE CROSS BLUE SHIELD OF MICHIGAN

Helpful Hints – MedcoHealth Mail Order Prescription Drugs –

RETAIL90 & MOPD2x

Purpose: Allows members to receive a 90-day supply of medications for two (2) copays rather than three (3). ***Retail Pharmacy** prescriptions are also available in a 90-day supply of medications. Both the retail and the mail order program will allow you to pay 2 copay amounts, however you will receive a 3-month supply of medication thus saving you 1 copay per prescription every 3 months.

Instructions:

1) Ask your doctor to give you a new prescription for any medications you are taking on a long-term (maintenance) basis. The prescription should give you enough medication to last at least 90 days. (i.e. If you are taking 1 pill a day, the doctor should request of Quantity of 90 pills; If you are taking 2 pills a day, then he should request 180 pills; etc.)

2) The prescription should also include the appropriate number of refills to last as long as your doctor intends you to take the medication (but not more than 1 year).

EXAMPLE – If you are taking a prescription medication in the amount of 1 pill per day and your doctor wants you to take the medication for at least the next 12 months, his prescription should read: Quantity of 90 pills w/ 3 refills

3) You can take the Rx to the pharmacy or submit through the mail your prescription with 2x your normal copay in the attached envelope w/ a completed Member Information Form and Health/Allergy/ Medication Questionnaire.

4) If using the Mail Order service, your prescription will be delivered to your home in approximately 7-10 days. Included with it will be a packing slip that tells you when you are eligible for refills. To order your next refill, wait until the date indicated on the form then call the Medco telephone number listed and provide your Rx number requesting a refill. Be sure to wait on the line until after your address has been confirmed and you receive the message that your order has been placed. Your next 90-day supply will arrive within 7-10 days with a bill for your double (rather than triple) copay. (Retail refills are handled in the traditional call-in fashion.)

Questions: For questions or follow up on orders, you can contact MedcoHealth directly at 1-800-903-8346.

NOTE: A 90-day supply of prescriptions is also available at **participating** Retail pharmacy locations as well. Please refer to www.bcbsm.com and enter the 'Member Area' followed by the 'Prescription Drugs/90-day Retail Prescription Program' link on the left margin of the Member Area general screen for verification of participating pharmacies in your city.

BLUE CROSS PPO PROVIDER ON-LINE DIRECTORY

(NOTE: Community Blue PPO contracts do NOT require a "Primary Care Physician." In order to receive "In-Network" reimbursement, services must be rendered by providers within the state/national Blue Cross PPO network.)

A) MICHIGAN

Blue Cross Blue Shield of Michigan
On Line Provider Locator

1) www.bcbsm.com
2) Select "Find a Doctor" near left margin
3) Select Plan = PPO/Traditional
4) Top Left – Identify Location
    a. Enter Distance AND Zip Code, Start
5) Search type of Provider (i.e. Primary Care, Specialist, Hospital, etc.)
6) Select Plan Type (i.e. PPO Plans-All Other)
7) Can also continue with 'Advanced' Search by entering specific SPECIALTY
8) 'SEARCH'

B) OUT-OF-MICHIGAN

Blue Cross Blue Shield Association
On Line Provider Locator

Follow the below steps to locate national PPO Providers:

1) www.bcbsm.com
2) Select "Find a Doctor" near left margin
3) Select Plan = PPO/Traditional
4) Top Left – Identify Location
    a. Enter Distance AND Zip Code, Start
5) Select type of Provider you are looking for (Doctors, Hospitals)
6) Enter Prefix found on Blue Cross ID Card (ie. XYQ)
7) Choose a Plan (PPO)
8) Search Specialty or type of Provider (i.e. General Hospital, Family Doctor, OB-GYN, etc.)
9) 'SEARCH'