Bystolic®
(nebivolol) tablets
2.5 mg • 5 mg • 10 mg • 20 mg

Check your eligibility and activate your card at www.BYSTOLICsavings.com or by calling 1.800.572.5252

BYSTOLIC® SAVINGS CARD

MOST ELIGIBLE INSURED PATIENTS
PAY NO MORE THAN $30
FOR A 30-DAY OR 90-DAY PRESCRIPTION*

This card must be activated before use.
Visit www.BYSTOLICsavings.com or call 1.800.572.5252

RxBIN# 637765
RxPCN# CRX
RxGRP# COMP2
RxID# CW359512450

Bystolic® (nebivolol) tablets 2.5 mg • 5 mg • 10 mg • 20 mg

*Please see back of card for Terms, Conditions, and Eligibility Criteria.

1. Get a BYSTOLIC prescription from your doctor
2. Read the rules and restrictions to confirm your eligibility
3. Activate this card at www.BYSTOLICsavings.com or by calling 1.800.572.5252
4. Bring this printout and your prescription to your pharmacy

*Restrictions apply. See Terms & Conditions below.

Terms, Conditions, and Eligibility Criteria: 1. This offer is valid only for patients 18 years of age or older with commercial prescription drug insurance and is good for use only with a valid prescription for BYSTOLIC® (nebivolol) 2.5 mg, 5 mg, 10 mg, and/or 20 mg tablets at the time the prescription is filled by the pharmacist and dispensed to the patient. **2.** Depending on your insurance coverage, most eligible insured patients may pay no more than $30 (a) per 30-day supply for each of up to twelve (12) prescription fills, (b) per 60-day supply for each of up to six (6) prescription fills, or (c) per 90-day supply for each of up to four (4) prescription fills. Other eligible insured patients check with your pharmacist for your copay discount. Maximum reimbursement limits apply; patient out-of-pocket expense may vary. **3.** This card is not valid for prescriptions submitted for reimbursement to Medicare, Medicaid, or other federal or state programs (including any state pharmaceutical assistance programs), or private indemnity or HMO insurance plans that reimburse you for the entire cost of your prescription drugs. Patients may not use this card if they are Medicare-eligible and enrolled in an employer-sponsored health plan or prescription drug benefit program for retirees. **4.** This offer is valid for up to 12 prescription fills of a 30-day supply, or 12 monthly uses. A 60-day supply counts as two (2) monthly uses and a 90-day supply counts as three (3) monthly uses towards the 12-monthly-use limit. Offer applies only to prescriptions filled before the program expires on 12/31/17. **5.** Allergan reserves the right to rescind, revoke, or amend this offer without notice. **6.** Offer good only in the USA at participating retail pharmacies. **7.** Void if prohibited by law, taxed, or restricted. **8.** This card is not transferable. The selling, purchasing, trading, or counterfeiting of this card is prohibited by law. **9.** This card has no cash value and may not be used in combination with any other discount, coupon, rebate, free trial, or similar offer for the specified prescription. **10.** This offer is not health insurance. **11.** This card expires December 31, 2017. **12. By redeeming this card, you acknowledge that you are an eligible insured patient and that you understand and agree to comply with the terms and conditions of this offer.**

For questions about the program, including savings on mail-order prescriptions, please call 1.800.572.5252.

Pharmacist Instructions for a Patient with an Eligible Third-party Payer:
When you redeem this card, you certify that you have not submitted and will not submit a claim for reimbursement under any federal, state, or other government programs for this prescription. Submit the claim to the primary Third-party Payer first, then submit the balance due to **COMP, LLC** using BIN #637765 as a Secondary Payer COB [coordination of benefits] with patient responsibility amount and a valid Other Coverage Code **(eg, 3 or 8)**. The patient's out-of-pocket expense will be reduced up to the maximum reimbursement limit for the program. Reimbursement will be received from **COMP, LLC.** For any questions regarding online processing, call the Help Desk at **1.800.572.5252.**

Program managed by COMP, LLC on behalf of Allergan. **This is not insurance.**

For reimbursement when using mail order, please submit:

- A photocopy of the front and back of your BYSTOLIC Savings Card.
- Your original proof of purchase (original pharmacy receipt with your name and address, pharmacy name, product name, prescription numbers, NDC number, date filled, quantity, and price) and a photocopy of the front and back of your insurance card.
- Your date of birth.

Mail all of the information to:

BYSTOLIC Claims Processing Department,
P.O. Box 1785
New York, NY 10156

Please allow 6-8 weeks to receive your reimbursement. Reimbursement requests must be postmarked within 4 weeks of fill date. Reimbursements are subject to Program Terms, Conditions, and Eligibility Criteria.

Allergan

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