

## PHARMACY BENEFITS

For up to a 30-day supply

Standard Option	
Preferred Retail Pharmacy	<b>Tier 1: \$7.50</b> copay <b>Tier 2: 30%</b> of our allowance <b>Tier 3: 50%</b> of our allowance <b>Tier 4: 30%</b> of our allowance <b>Tier 5: 30%</b> of our allowance
Mail Service Pharmacy	<b>Tier 1: \$15</b> copay <b>Tier 2: \$90</b> copay <b>Tier 3: \$125</b> copay
Specialty Pharmacy	<b>Tier 4: \$50</b> copay <b>Tier 5: \$70</b> copay

Basic Option	
Preferred Retail Pharmacy	<b>Tier 1: \$10</b> copay <b>Tier 2: \$55</b> copay <b>Tier 3: 60%</b> of our allowance (\$75 minimum) <b>Tier 4: \$65</b> copay <b>Tier 5: \$90</b> copay
Mail Service Pharmacy	Available to members with Medicare Part B primary only Visit <a href="http://fepblue.org">fepblue.org</a> for more information
Specialty Pharmacy	<b>Tier 4: \$70</b> copay <b>Tier 5: \$95</b> copay

FEP Blue Focus	
Preferred Retail Pharmacy	<b>Tier 1: \$5</b> copay <b>Tier 2: 40%</b> of our allowance (\$350 maximum)
Mail Service Pharmacy	No benefit
Specialty Pharmacy	<b>Tier 2: 40%</b> of our allowance (\$350 maximum)

**Note:** The tier your drug falls in can vary between Standard Option, Basic Option and FEP Blue Focus. Please look at our approved drug lists (formularies) prior to selecting a plan to make sure we cover your drug in that plan. You can view the drug lists at [fepblue.org/formulary](http://fepblue.org/formulary).

## WHAT YOU'LL PAY

Standard Option		
	BI-WEEKLY	MONTHLY
Self Only (104)	\$112.23	\$243.17
Self + One (106)	\$256.54	\$555.83
Self & Family (105)	\$268.21	\$581.13

Basic Option		
	BI-WEEKLY	MONTHLY
Self Only (111)	\$73.72	\$159.74
Self + One (113)	\$170.57	\$369.56
Self & Family (112)	\$177.24	\$384.02

FEP Blue Focus		
	BI-WEEKLY	MONTHLY
Self Only (131)	\$53.14	\$115.15
Self + One (133)	\$114.25	\$247.55
Self & Family (132)	\$125.67	\$272.29

These rates don't apply to all enrollees. If you are in a specific enrollment category, please contact the agency or Tribal employer that maintains your health benefits enrollment.

Visit [fepblue.org](http://fepblue.org) to learn more.



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This is a summary of the features of the Blue Cross and Blue Shield Service Benefit Plan. Before making a final decision, please read the Plan's Federal brochures (Standard Option and Basic Option: RI 71-005; FEP Blue Focus: RI 71-017). All benefits are subject to the definitions, limitations and exclusions set forth in the Federal brochures.

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The Blue Cross and Blue Shield Service Benefit Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您ID卡上的客服號碼以尋求中文協助。

SBPSBS2019

BlueCross  
BlueShield  
Federal Employee Program.  
[fepblue.org](http://fepblue.org)

2019 BLUE CROSS AND BLUE SHIELD SERVICE BENEFIT PLAN  
**BENEFITS AT A GLANCE**

## LET'S COMPARE:

In-Network Care	<b>S0</b> <b>B0</b> <b>BF</b>
Out-of-Network Care	<b>S0</b>
Preferred Drug Coverage	<b>S0</b> <b>B0</b> <b>BF</b>
Non-Preferred Drug Coverage	<b>S0</b> <b>B0</b>
Access to Mail Service Pharmacy	<b>S0</b> <b>B0*</b>
Medicare Part B Reimbursement - \$600	<b>B0</b>

\*Available if you have Medicare Part B primary.

## PLAN ICON KEY

<b>S0</b>	<b>B0</b>	<b>BF</b>
Standard Option Benefit	Basic Option Benefit	FEP Blue Focus Benefit

# WHAT YOU'LL PAY WITH EACH PLAN

## SO STANDARD OPTION

Common services at Preferred providers	
Primary care doctor	\$25 copay
Specialists	\$35 copay
Virtual doctor visits	\$10 copay
Urgent care centers	\$30 copay
Maternity	\$0 copay
Inpatient hospital	\$350 copay
Outpatient hospital	15% of our allowance*
Surgery	15% of our allowance*
ER (accidental injury)	\$0 within 72 hours
ER (medical emergency)	15% of our allowance*
Lab work (such as lab tests and EKGs)	15% of our allowance*
Diagnostic services (such as sleep studies, X-rays, CT scans)	15% of our allowance*
Chiropractic care	\$25 for up to 12 visits a year

Deductible	
Self Only	\$350
Self + One and Self & Family	\$700

Out-of-pocket maximum (Preferred providers)	
Self Only	\$5,000
Self + One and Self & Family	\$10,000

\*Deductible applies. If you have Medicare primary, different cost-share amounts may apply.

## B0 BASIC OPTION

Common services at Preferred providers	
Primary care doctor	\$30 copay
Specialists	\$40 copay
Virtual doctor visits	\$15 copay
Urgent care centers	\$35 copay
Maternity	\$175 inpatient \$0 outpatient
Inpatient hospital	\$175 per day; up to \$875 per admission
Outpatient hospital	\$100 per day per facility <sup>1</sup>
Surgery	\$150 in an office <sup>1</sup> \$200 in a non-office setting <sup>1</sup>
ER (accidental injury)	\$125 per day + cost of doctor care
ER (medical emergency)	\$125 per day + cost of doctor care
Lab work (such as lab tests and EKGs)	\$0 copay <sup>1</sup>
Diagnostic services (such as sleep studies, X-rays, CT scans)	Up to \$100 in an office <sup>1</sup> Up to \$150 in a hospital <sup>1</sup>
Chiropractic care	\$30 for up to 20 visits a year

Deductible	
Self Only	\$0
Self + One and Self & Family	\$0

Out-of-pocket maximum (Preferred providers)	
Self Only	\$5,500
Self + One and Self & Family	\$11,000

<sup>1</sup>Under Basic Option, you pay 30% of our allowance for agents, drugs and/or supplies you receive during your care. If you have Medicare primary, different cost-share amounts may apply.

## BF FEP BLUE FOCUS

Common services at Preferred providers	
Primary care doctor	\$10 per visit for your first 10 primary and/or specialty care visits
Specialists	\$0 first 2 visits \$10 all additional visits
Virtual doctor visits	\$0 first 2 visits \$10 all additional visits
Urgent care centers	\$25 copay
Maternity	\$0 for doctor's visits \$1,500 for facility care
Inpatient hospital	30% of our allowance*
Outpatient hospital	30% of our allowance <sup>†</sup>
Surgery	30% of our allowance <sup>†</sup>
ER (accidental injury)	\$0 within 72 hours
ER (medical emergency)	30% of our allowance*
Lab work (such as lab tests and EKGs)	30% of our allowance <sup>†</sup>
Diagnostic services (such as sleep studies, X-rays, CT scans)	30% of our allowance <sup>†</sup>
Chiropractic care	\$25 for up to 10 visits a year <sup>2</sup>

Deductible	
Self Only	\$500
Self + One and Self & Family	\$1,000

Out-of-pocket maximum (Preferred providers)	
Self Only	\$6,500
Self + One and Self & Family	\$13,000

\*Deductible applies. <sup>†</sup>Deductible applies. In addition, you pay 30% of our allowance for agents, drugs and/or supplies you receive during your care. <sup>2</sup>Up to 10 visits combined for chiropractic care and acupuncture. If you have Medicare primary, different cost-share amounts may apply.