PHARMACY BENEFITS

For up to a 30-day supply

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

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

FEP Blue Focus	
Preferred Retail Pharmacy	**Tier 1: $5** copay **Tier 2: 40%** of our allowance ($350 maximum)
Mail Service Pharmacy	No benefit
Specialty Pharmacy	**Tier 2: 40%** 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**.*

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** to learn more.

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SBPSBS2019

LET'S COMPARE:

In-Network Care	SO BO BF
Out-of-Network Care	SO
Preferred Drug Coverage	SO BO BF
Non-Preferred Drug Coverage	SO BO
Access to Mail Service Pharmacy	SO BO*
Medicare Part B Reimbursement - $600	BO

**Available if you have Medicare Part B primary.*

PLAN ICON KEY

SO	BO	BF
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.

BO 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[1]
Surgery	**$150** in an office[1] **$200** in a non-office setting[1]
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[1]
Diagnostic services (such as sleep studies, X-rays, CT scans)	Up to **$100** in an office[1] Up to **$150** in a hospital[1]
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

[1]*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	
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†
Surgery	**30%** of our allowance†
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†
Diagnostic services (such as sleep studies, X-rays, CT scans)	**30%** of our allowance†
Chiropractic care	**$25** for up to 10 visits a year[2]

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