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	Non-Postal Premium		Postal Premium	
	BIWEEKLY	**MONTHLY**	**BIWEEKLY** Category 1	**BIWEEKLY** Category 2
Self Only (104)	$116.91	$253.30	$113.63	$103.81
Self + One (106)	$267.15	$578.83	$260.15	$239.14
Self & Family (105)	$286.74	$621.27	$279.15	$256.39

Basic Option	Non-Postal Premium		Postal Premium	
	BIWEEKLY	**MONTHLY**	**BIWEEKLY** Category 1	**BIWEEKLY** Category 2
Self Only (111)	$75.94	$164.55	$72.91	$63.03
Self + One (113)	$178.61	$386.99	$171.61	$150.60
Self & Family (112)	$191.22	$414.31	$183.63	$160.87

FEP Blue Focus	Non-Postal Premium		Postal Premium	
	BIWEEKLY	**MONTHLY**	**BIWEEKLY** Category 1	**BIWEEKLY** Category 2
Self Only (131)	$53.14	$115.15	$51.02	$44.11
Self + One (133)	$114.25	$247.55	$109.68	$94.83
Self & Family (132)	$125.67	$272.29	$120.65	$104.31

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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SBPSBS2020

BENEFITS AT A GLANCE

2020 Blue Cross and Blue Shield Service Benefit Plan

BlueCross BlueShield Federal Employee Program.

fepblue.org

LET'S COMPARE:

In-Network Care	S B F
Out-of-Network Care	S
Preferred Drug Coverage	S B F
Non-Preferred Drug Coverage	S B
Access to Mail Service Pharmacy	S B*
Medicare Part B Reimbursement - $800	B

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

PLAN ICON KEY

S Standard Option

B Basic Option

F FEP Blue Focus

WHAT YOU'LL PAY WITH EACH PLAN

Different cost share amounts may apply if you have Medicare primary coverage.

S STANDARD OPTION

Common services at Preferred providers	
Primary care doctor	**$25** copay
Specialists	**$35** copay
Virtual doctor visits through Teladoc®	**$0** first 2 visits **$10** all additional visits
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 blood tests)	**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.*

B BASIC OPTION

Common services at Preferred providers	
Primary care doctor	**$30** copay
Specialists	**$40** copay
Virtual doctor visits through Teladoc®	**$0** first 2 visits **$15** all additional visits
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 per facility
ER (medical emergency)	**$125** per day per facility
Lab work (such as blood tests)	**$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.

F 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 through Teladoc®	**$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 blood tests)	**$0** for first 10 specific lab tests**
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.

***Please see brochure for covered lab services.*