







# Let's compare plans:

## **FEP Blue** Basic Standard **Focus Option Option** No Deductible **Pay Mostly Copays In-Network Care** X **Out-of-Network Care Preferred Drug** Coverage Non-preferred **Drug Coverage Medicare Part B** Reimbursement — \$800



For more detailed benefit and cost information, visit fepblue.org.

#### What you'll pay for common services at Preferred providers

Benefit	FEP Blue Focus	Basic Option	Standard Option
Primary care doctor		<b>\$35</b> copay <sup>1</sup>	<b>\$30</b> copay
Specialists	<b>\$10</b> per visit for your first 10 primary and/or specialty care visits <sup>1</sup>	<b>\$45</b> copay <sup>1</sup>	<b>\$40</b> copay
Mental health visits	care visits	<b>\$35</b> copay <sup>1</sup>	<b>\$30</b> copay
Virtual doctor visits through Teladoc®	<b>\$0</b> first 2 visits and all nutrition visits <b>\$10</b> all additional visits	<b>\$0</b> first 2 visits and all nutrition visits <b>\$15</b> all additional visits	<b>\$0</b> first 2 visits and all nutrition visits <b>\$10</b> all additional visits
Urgent care centers	<b>\$25</b> copay	<b>\$35</b> copay	<b>\$30</b> copay
Maternity	<b>\$0</b> for doctor's visits <b>\$1,500</b> for facility care	<b>\$250</b> inpatient <b>\$0</b> outpatient	<b>\$0</b> copay
Inpatient hospital	<b>30</b> % of our allowance*	<b>\$250</b> per day; up to <b>\$1,500</b> per admission	<b>\$350</b> copay
Outpatient hospital	<b>30</b> % of our allowance <sup>†</sup>	\$150 per day per facility <sup>1</sup>	<b>15%</b> of our allowance*
Surgery	<b>30</b> % of our allowance <sup>†</sup>	\$150 per surgeon in an office <sup>1</sup> \$200 per surgeon in other settings <sup>1</sup>	<b>15%</b> of our allowance*
ER (accidental injury)	<b>\$0</b> within 72 hours	\$250 per day per facility	<b>\$0</b> within 72 hours
ER (medical emergency)	<b>30</b> % of our allowance*	\$250 per day per facility	<b>15%</b> of our allowance*
Lab work (such as blood tests)	<b>\$0</b> for first 10 specific lab tests**	<b>15</b> % of our allowance <sup>1</sup>	15% of our allowance*
<b>Diagnostic services</b> (such as sleep studies, X-rays, CT scans)	<b>30</b> % of our allowance*	Up to <b>\$100</b> in an office <sup>1</sup> Up to <b>\$200</b> in a hospital <sup>1</sup>	15% of our allowance*
Chiropractic care	\$25 for up to 10 visits a year <sup>2</sup>	<b>\$35</b> for up to 20 visits a year	<b>\$30</b> for up to 12 visits a year

If you have Medicare primary or receive care overseas, different cost share amounts may apply. You pay 30% of our allowance for agents, drugs and/or supplies you receive during your care.

<sup>&</sup>lt;sup>2</sup>Up to 10 visits combined for chiropractic care and acupuncture.

<sup>\*</sup>Deductible applies.

<sup>\*\*</sup>Please see brochure for covered lab services.

Deductible applies. In addition, you pay 30% of our allowance for agents, drugs and/or supplies you receive during your care.

## **Pharmacy benefits**

	FEP Blue Focus	Basic Option	Standard Option
Preferred Retail Pharmacy (for a 30-day supply)	Tier 1: \$5 copay Tier 2: 40% of our allowance (\$350 maximum)	Tier 1: \$15 copay Tier 2: \$60 copay Tier 3: 60% of our allowance (\$90 minimum) Tier 4: \$85 copay Tier 5: \$110 copay	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
FEP Mail Service Pharmacy (for a 90-day supply)	Not a benefit	Available to members with Medicare Part B primary only. Visit fepblue.org for more information.	Tier 1: \$15 copay Tier 2: \$90 copay Tier 3: \$125 copay
FEP Specialty Pharmacy (for a 30-day supply)	Tier 2: 40% of our allowance (\$350 maximum)	Tier 4: \$85 copay Tier 5: \$110 copay	Tier 4: \$65 copay Tier 5: \$85 copay

Note: The tier your drug falls in can vary between FEP Blue Focus, Basic Option and Standard Option. 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**.

Different cost share amounts may apply if you have Medicare primary coverage. For more information on the FEP Medicare Prescription Drug Program, visit fepblue.org/medicarerx.

# **Deductibles and out-of-pocket maximums**

	FEP Blue Focus	Basic Option	Standard Option
Deductible	\$500 for Self Only \$1,000 for Self + One and Self & Family	No deductible	\$350 for Self Only \$700 for Self + One and Self & Family
Out-of-Pocket Maximum (Preferred providers)	\$9,000 for Self Only \$18,000 for Self + One and Self & Family	\$6,500 for Self Only \$13,000 for Self + One and Self & Family	\$6,000 for Self Only \$12,000 for Self + One and Self & Family

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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## **Premiums**

#### **Bi-weekly**

	FEP Blue Focus	Basic Option	Standard Option
Self Only	\$55.30	\$95.74	\$150.79
Enrollment Code	131	111	104
Self + One	\$118.88	\$238.63	\$336.84
<b>Enrollment Code</b>	133	113	106
Self & Family	\$130.76	\$262.60	\$370.68
<b>Enrollment Code</b>	132	112	105

### Monthly

	FEP Blue Focus	Basic Option	Standard Option
Self Only	\$119.83	\$207.44	\$326.71
Enrollment Code	131	111	104
Self + One	\$257.58	\$517.03	\$729.82
<b>Enrollment Code</b>	133	113	106
Self & Family	\$283.32	\$568.96	\$803.14
<b>Enrollment Code</b>	132	112	105

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.