BlueCross BlueShield Federal Employee Program

2023 BENEFITS AT A GLANCE

fepblue.org

Let's compare plans:

F FEP Blue Focus | B Basic Option | S Standard Option

	F	B	S
In-Network Care	✓	✓	✓
Out-of-Network Care	✗	✗	✓
No Deductible	✗	✓	✗
Pay Mostly Copays	✗	✓	✗
Preferred Drug Coverage	✓	✓	✓
Non-preferred Drug Coverage	✗	✓	✓
Medicare Part B Reimbursement — $800	✗	✓	✗

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

If you have Medicare primary or receive care overseas, different cost share amounts may apply.

[1]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.

**Deductible applies.*

***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.

What you'll pay for common services at Preferred providers

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

Pharmacy benefits

What you pay for a 30-day supply

	FEP Blue Focus	Basic Option	Standard Option
Preferred Retail Pharmacy	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
Mail Service Pharmacy	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
Specialty Pharmacy	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.

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)*	**$8,500** for Self Only **$17,000** 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.

The Blue Cross Blue Shield Association is an association of independent, locally operated Blue Cross and Blue Shield companies.

Premiums

Bi-weekly

	FEP Blue Focus	Basic Option	Standard Option
Self Only	$54.21	$86.67	$142.40
Enrollment Code	**131**	**111**	**104**
Self + One	$116.54	$217.90	$318.85
Enrollment Code	**133**	**113**	**106**
Self & Family	$128.19	$237.91	$347.89
Enrollment Code	**132**	**112**	**105**

Monthly

	FEP Blue Focus	Basic Option	Standard Option
Self Only	$117.46	$187.78	$308.53
Enrollment Code	**131**	**111**	**104**
Self + One	$252.51	$472.12	$690.84
Enrollment Code	**133**	**113**	**106**
Self & Family	$277.75	$515.48	$753.77
Enrollment Code	**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.