

2022 BENEFITS AT A GLANCE







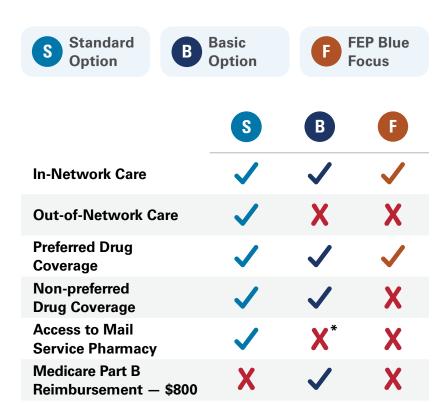






fepblue.org

Let's compare plans:



^{*}Available if you have Medicare Part B primary.



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



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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What you'll pay for common services at Preferred providers

Benefit	Standard Option	Basic Option	FEP Blue Focus	
Primary care doctor	\$25 copay	\$30 copay ¹	\$10 per visit for your first 10 primary and/or specialty	
Specialists	\$35 copay	\$40 copay ¹	care visits ¹	
Virtual doctor visits through Teladoc®	\$0 first 2 visits \$10 all additional visits	\$0 first 2 visits \$15 all additional visits	\$0 first 2 visits \$10 all additional visits	
Urgent care centers	\$30 copay	\$35 copay	\$25 copay	
Maternity	\$0 copay	\$175 inpatient \$0 outpatient	\$0 for doctor's visits \$1,500 for facility care	
Inpatient hospital	\$350 copay	\$175 per day; up to \$875 per admission	30 % of our allowance*	
Outpatient hospital	15% of our allowance*	\$100 per day per facility ¹	30 % of our allowance [†]	
Surgery	15% of our allowance*	\$150 in an office ¹ \$200 in a non-office setting ¹	30 % of our allowance [†]	
ER (accidental injury)	\$0 within 72 hours	\$175 per day per facility	\$0 within 72 hours	
ER (medical emergency)	15 % of our allowance*	\$175 per day per facility	30 % of our allowance*	
Lab work (such as blood tests)	15 % of our allowance*	\$0 copay ¹	\$0 for first 10 specific lab tests**	
Diagnostic services (such as sleep studies, X-rays, CT scans)	15% of our allowance*	Up to \$100 in an office ¹ Up to \$150 in a hospital ¹	30 % of our allowance [†]	
Chiropractic care	\$25 for up to 12 visits a year	\$30 for up to 20 visits a year	\$25 for up to 10 visits a year ²	

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.

²Up to 10 visits combined for chiropractic care and acupuncture.

*Deductible applies.

^{**}Please see brochure for covered lab services.

Pharmacy benefits

What you pay for up to a 30-day supply

	Standard Option	Basic Option	FEP Blue Focus		
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	Tier 1: \$10 copay Tier 2: \$55 copay Tier 3: 60% of our allowance (\$75 minimum) Tier 4: \$85 copay Tier 5: \$110 copay	Tier 1: \$5 copay Tier 2: 40% of our allowance (\$350 maximum)		
Mail Service Pharmacy	Tier 1: \$15 copay Tier 2: \$90 copay Tier 3: \$125 copay	Available to members with Medicare Part B primary only Visit fepblue.org for more information	No benefit		
Specialty Pharmacy	Tier 4: \$65 copay Tier 5: \$85 copay	Tier 4: \$85 copay Tier 5: \$110 copay	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**. Different cost share amounts may apply if you have Medicare primary coverage.

Deductibles, out-of-pocket maximums and premiums

	Standard Option	Basic Option	FEP Blue Focus			
Deductible	\$350 for Self Only \$700 for Self + One and Self & Family	No deductible	\$500 for Self Only \$1,000 for Self + One and Self & Family			
Out-of-Pocket Maximum	\$6,000 for Self Only \$12,000 for Self + One and Self & Family	\$6,500 for Self Only \$13,000 for Self + One and Self & Family	\$8,500 for Self Only \$17,000 for Self + One and Self & Family			

	Standard Option			Basic Option			FEP Blue Focus		
	Self Only (104)	Self + One (106)	Self & Family (105)	Self Only (111)	Self + One (113)	Self & Family (112)	Self Only (131)	Self + One (133)	Self & Family (132)
Bi-weekly Premium	\$127.47	\$289.61	\$314.11	\$80.18	\$196.13	\$212.29	\$53.14	\$114.25	\$125.67
Monthly Premium	\$276.19	\$627.49	\$680.57	\$173.73	\$424.95	\$459.96	\$115.15	\$247.55	\$272.29