BlueCross BlueShield Federal Employee Program

2022 BENEFITS AT A GLANCE

fepblue.org

Let's compare plans:

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

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

*Available if you have Medicare Part B primary.

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

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 care visits[1]
Specialists	**$35** copay	**$40** copay[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.

[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.

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

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.