BlueCross BlueShield
Federal Employee Program.

2021 BENEFITS AT A GLANCE
Blue Cross and Blue Shield Service Benefit Plan

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.

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 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.
**Deductible applies.*
[1]You pay 30% of our allowance for agents, drugs and/or supplies you receive during your care.
†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.*

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: **$65** copay Tier 5: **$90** 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, premiums and other cost information

	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	**$5,000** for Self Only **$10,000** for Self + One and Self & Family	**$5,500** for Self Only **$11,000** for Self + One and Self & Family	**$7,500** for Self Only **$15,000** 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)
Non-Postal Premium (Bi-weekly)	$123.45	$280.81	$300.12	$78.60	$189.17	$201.27	$53.14	$114.25	$125.67
Non-Postal Premium (Monthly)	$267.48	$608.43	$650.26	$170.31	$409.87	$436.08	$115.15	$247.55	$272.29
Postal Premium (Bi-weekly Category 1)	$120.09	$273.62	$292.31	$75.46	$181.98	$193.46	$51.02	$109.68	$120.65
Postal Premium (Bi-weekly Category 2)	$110.03	$252.06	$268.89	$65.24	$160.42	$170.04	$44.11	$94.83	$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.