2027 Blue Cross and Blue Shield Service Benefit Plan
FEP Blue Standard and FEP Blue Basic
Section 5(f)(a). FEP Medicare Prescription Drug Program

Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.

Benefits Description

Covered Medications and Supplies
Mail Service Prescription Drug Program

For members enrolled in the FEP Medicare Prescription Drug Program, if your doctor orders more than a 21-day supply of covered drugs or supplies, up to a 90-day supply, you can use this service for your prescriptions and refills.

Please refer to Section 7 for instructions on how to use the Mail Service Prescription Drug Program.

Note: You must obtain prior approval for certain drugs before Mail Service will fill your prescription. See Section 3.

Note: Not all drugs are available through the Mail Service Prescription Drug Program.

Note: We waive your cost-share for available forms of generic contraceptives and for brand-name contraceptives that have no generic equivalent or generic alternative, as listed in each therapeutic class under the HRSA guidelines found at https://www.hrsa.gov/womens-guidelines, when purchased from a Preferred retail pharmacy. You may seek an exception for any contraceptive that is not available with zero-member cost-share. Your provider will need to complete the Contraceptive Exception Form under Pharmacy Forms found on our website at www.fepblue.org/claim-forms. If you have questions about the exception process, call 800-624-5060. Once we have been contacted with exception request information sufficient for us to make a determination, you will receive a response within 24 hours or the next business day. Contraceptive exception requests are not subject to Section 8, *The Disputed Claims Process*. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.

Contact Us: If you have any questions about this program, or need assistance with your Mail Service drug orders, please call 800-262-7890, TTY: 711.

Note: If the cost of your prescription is less than your copayment, you pay only the cost of your prescription. The Mail Service Prescription Drug Program will charge you the lesser of the prescription cost or the copayment when you place your order. If you have already sent in your copayment, they will credit your account with any difference.

Standard Option - You Pay
Tier 1 (generic drug): $5 copayment (no deductible)

Tier 2 (preferred brand-name drug): $85 copayment (no deductible)

Tier 3 (non-preferred brand-name drug): $125 copayment (no deductible)

Tier 4 (specialty drug): $150 copayment (no deductible)

Basic Option - You Pay
Tier 1 (generic drug): $15 copayment

Tier 2 (preferred brand-name drug): $95 copayment

Tier 3 (non-preferred brand-name drug): $175 copayment

Tier 4 (specialty drug): $200 copayment