2024 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option
Section 5(f). Prescription Drug Benefits
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Benefit Description

Covered Medication and Supplies (cont.)

- Clotting factors and anti-inhibitor complexes for the treatment of hemophilia

Note: For a list of the Preferred Network Long-Term Care pharmacies, call 800-624-5060, TTY: 711.

Note: For coordination of benefits purposes, if you need a statement of Preferred retail pharmacy benefits in order to file claims with your other coverage when this Plan is the primary payor, call the Retail Pharmacy Program at 800-624-5060, TTY: 711, or visit our website at www.fepblue.org.

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 when purchased from a Preferred retail pharmacy.

Standard Option - You Pay
Continued from previous page:

Tier 5 (non-preferred specialty drug): 30% of the Plan allowance (no deductible), limited to one purchase of up to a 30-day supply

Basic Option - You Pay
Continued from previous page:

Tier 2 (preferred brand-name drug): $50 copayment for each purchase of up to a 30-day supply ($150 copayment for a 31 to 90-day supply)

Tier 3 (non-preferred brand-name drug): 50% of the Plan allowance ($60 minimum) for each purchase of up to a 30-day supply ($175 minimum for a 31 to 90-day supply)

Tier 4 (preferred specialty drug): $80 copayment limited to one purchase of up to a 30-day supply

Tier 5 (non-preferred specialty drug): $100 copayment limited to one purchase of up to a 30-day supply

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Benefit Description

Non-preferred Retail Pharmacies

Standard Option - You Pay
45% of the Plan allowance (Average wholesale price – AWP), plus any difference between our allowance and the billed amount (no deductible)

Note: If you use a Non-preferred retail pharmacy, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.

Basic Option - You Pay
All charges

Benefit Description

Mail Service Prescription Drug Program

For Standard Option and Basic Option members when Medicare Part B is Primary, 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. There are no specialty drugs available through the Mail Service Program.

Standard Option - You Pay
Tier 1 (generic drug): $15 copayment (no deductible)

Note: You pay a $10 copayment per generic prescription filled (and/or refill ordered) when Medicare Part B is primary.

Note: You may be eligible to receive your first 4 generic prescriptions filled (and/or refills ordered) at no charge when you change from certain brand-name drugs to a corresponding generic drug replacement, as previously stated.

Basic Option - You Pay
When Medicare Part B is primary, you pay the following:
Tier 1 (generic drug): $20 copayment

Tier 2 (preferred brand-name drug): $100 copayment

Tier 3 (non-preferred brand-name drug): $125 copayment

When Medicare Part B is not primary: No benefits

Covered Medication and Supplies - continued on next page

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