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2025 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option
Section 5(f)(a). FEP Medicare Prescription Drug Plan
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Benefit Description

Covered Medications and Supplies (cont.)

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, 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. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.

Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7.

Note: For additional Family Planning benefits, see Section 5(a).

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

Continued from previous page:

Tier 4 (specialty-drugs): $150 copayment (no deductible)

Basic Option - You Pay
See previous page

Benefit Description

Asthma Medications

Network Retail Pharmacies:

Note: See Section 3 for information about drugs and supplies that require prior approval.

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

Tier 2 (preferred brand-name drug): $20 copayment for each purchase of up to a 30-day supply ($60 copayment for a 31 to 90-day supply) (no deductible)

Basic Option - You Pay
Tier 1 (generic drug): $5 copayment for each purchase of up to a 90-day supply

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

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: See earlier in this section for Tier 3 and Tier 4 prescription drug benefits

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

Tier 2 (preferred brand-name drug): $65 copayment (no deductible)

Basic Option - You Pay
Tier 1 (generic drug): $5 copayment

Tier 2 (preferred brand-name drug): $75 copayment

Covered Medications and Supplies - continued on next page

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