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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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- **Disclosure of information.** As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including the names of your prescribing physicians, to any treating physicians or dispensing pharmacies.
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**Important Contact Information**

FEP Medicare Prescription Drug Program: 888-338-7737, TTY: 711; or [www.fepblue.org/medicarerx](http://www.fepblue.org/medicarerx)

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**PDP EGWP Catastrophic Maximums**

Each individual enrolled in the FEP Medicare Prescription Drug Program has a separate and lower out-of-pocket catastrophic protection maximum for the drugs purchased while covered under this Program.

**Under Standard Option,** this separate catastrophic maximum is \$2,000

**Under Basic Option,** this separate catastrophic maximum is \$2,000.

This amount accumulates toward the out-of-pocket catastrophic protection maximums described in Section 4.

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**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.**

**Benefit Description**

**Covered Medication and Supplies**  
**Retail Pharmacies**

## **Covered drugs and supplies, such as:**

- Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a prescription for their purchase
- Drugs for the diagnosis and treatment of infertility
- Drugs for IVF – limited to 3 cycles annually  
Note: Drugs used for IVF must be purchased through the pharmacy drug program and you must meet our definition of infertility.
- Drugs associated with covered artificial insemination procedures
- Drugs to treat gender dysphoria (gonadotropin releasing hormone (GnRH) antagonists and testosterone)

### **Standard Option - You Pay**

Tier 1 (generic drug): \$5 copayment for each purchase of up to a 30-day supply (\$15 copayment for a 31 to 90-day supply) (no deductible)

Tier 2 (preferred brand-name drug): \$35 copayment for each purchase of up to a 30-day supply (\$105 copayment for a 31 to 90-day supply) (no deductible)

Tier 3 (non-preferred brand-name drug): 50% of the Plan allowance for each purchase of up to a 90-day supply (no deductible)

Tier 4 (preferred specialty drug): \$60 copayment for each purchase of up to a 30-day supply (\$170 copayment for a 31 to 90-day supply) (no deductible)

### **Basic Option - You Pay**

Tier 1 (generic drug): \$10 copayment for each purchase of up to a 30-day supply (\$30 copayment for a 31 to 90-day supply)

Tier 2 (preferred brand-name drug): \$45 copayment for each purchase of up to a 30-day supply (\$135 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)

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*Covered Medications and Supplies - continued on next page*

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