**2026 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option**
**Section 5. Benefits**
**Section 5(f). Prescription Drug Benefits**
**Covered Medication and Supplies**

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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**
**Preferred 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 (prior approval required)
  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 prescribed to treat obesity (prior approval required)
- Contraceptive drugs and devices, limited to:
  - Diaphragms and contraceptive rings
  - Injectable contraceptives
  - Intrauterine devices (IUDs)
  - Implantable contraceptives
  - Oral and transdermal contraceptives
- Medical foods
- Insulin, diabetic test strips, lancets, and tubeless insulin delivery systems (See Section 5(a) for our coverage of insulin pumps with tubes.)

- Needles and disposable syringes for the administration of covered medications
- 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, 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.

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).

**Standard Option - You Pay**
Tier 1 (generic drug): $7.50 copayment for each purchase of up to a 30-day supply ($22.50 copayment for a 31 to 90-day supply) (no deductible)

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 described.

Tier 2 (preferred brand-name drug): 30% of the Plan allowance for each purchase of up to a 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): 30% of the Plan allowance (no deductible), limited to one purchase of up to a 30-day supply

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**

Tier 1 (generic drug): $15 copayment for each purchase of up to a 30-day supply ($40 copayment for a 31 to 90-day supply)

Tier 2 (preferred brand-name drug): 35% of the Plan allowance ($150 maximum) for each purchase of up to a 30-day supply ($400 maximum for a 31 to 90-day supply)

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

Tier 4 (preferred specialty drug): 35% of the Plan allowance ($250 maximum) limited to one purchase of up to a 30-day supply

Tier 5 (non-preferred specialty drug): 35% of the Plan allowance ($500 maximum) limited to one purchase of up to a 30-day supply

**When Medicare Part B is primary, you pay the following:**

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): 35% of the Plan allowance ($100 maximum) for each purchase of up to a 30-day supply ($300 maximum for a 31 to 90-day supply)

Tier 3 (non-preferred brand-name drug): 60% of the Plan allowance up to a 90-day supply

Tier 4 (preferred specialty drug): 35% of the Plan allowance ($200 maximum) limited to one purchase of up to a 30-day supply

Tier 5 (non-preferred specialty drug): 35% of the Plan allowance ($450 maximum) limited to one purchase of up to a 30-day supply