## WHAT YOU PAY WHEN YOU USE PREFERRED PROVIDERS

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>2015 STANDARD OPTION COVERAGE*</th>
<th>2015 BASIC OPTION COVERAGE**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHYSICIAN CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visits and outpatient consultations</td>
<td>$20 per visit copayment for primary care provider</td>
<td>$25 per visit copayment for primary care provider</td>
</tr>
<tr>
<td></td>
<td>$30 per visit copayment for specialists</td>
<td>$35 per visit copayment for specialists</td>
</tr>
<tr>
<td>Routine exams and other preventive care services</td>
<td>Nothing for covered services</td>
<td>Nothing for covered services</td>
</tr>
<tr>
<td>Surgical services</td>
<td>15% of the Plan allowance***</td>
<td>$150 copayment per performing surgeon in an office visit setting</td>
</tr>
<tr>
<td>Prior approval is required for certain surgical services</td>
<td></td>
<td>$200 copayment per performing surgeon in another setting</td>
</tr>
</tbody>
</table>

### HOSPITAL/FACILITY CARE
- **Hospital inpatient:**
  - Precertification is required
- Outpatient hospital/facility care:
  - 15% of the Plan allowance***
  - $100 per day per facility copayment

### PRESCRIPTION DRUGS
Certain prescription drugs require prior approval.

#### Mail Service Pharmacy Program
- Tier 1 (Generics): $15 copayment
- Tier 2 (Preferred brand name): $80 copayment
- Tier 3 (Non-preferred brand name): $105 copayment
  - Covers 22-90 day supply
  - Nothing for the first 4 prescription fills or refills when you switch from certain brand name drugs to specific generic drugs

#### Retail Pharmacy Program
- Tier 1 (Generics): 20% of the Plan allowance
- Tier 2 (Preferred brand name): 30% of the Plan allowance
- Tier 3 (Non-preferred brand name): 45% of the Plan allowance
  - Covers up to a 90-day supply
  - Nothing for the first 4 prescription fills or refills when you switch from certain brand name drugs to specific generic drugs when you use a Preferred pharmacy
- Tier 4 (Preferred specialty drugs): 30% of the Plan allowance
  - Covers up to a 30-day supply
  - Tier 4 and 5 specialty drugs are limited to a 30-day supply; only one fill allowed
  - All refills must be obtained from the Specialty Pharmacy Program.

#### Specialty Pharmacy Program
- Tier 4 (Preferred specialty drugs):
  - $35 copayment (30-day supply)
  - $95 copayment (90-day supply)
  - $155 copayment (90-day supply)
  - 90-day supply can only be obtained after 3rd fill

### LAB, X-RAY AND OTHER DIAGNOSTIC SERVICES
- Diagnostic test (X-ray, blood work, Imaging (CT/PET scans, MRIs)):
  - 15% of the Plan allowance***
  - $0 copayment for laboratory tests, pathology services and EKGs
  - $40 copayment for diagnostic tests such as EEGs, ultrasounds and X-rays
  - $100 copayment for angiography, bone density tests, CT scans, MRIs, PET scans, genetic testing, nuclear medicine and sleep studies at a professional provider; $150 copayment at a hospital

### EMERGENCY CARE
- Accidental injury:
  - Medical emergency: Not a benefit
  - Regular benefits for physician care
- Medical emergency:
  - $30 copayment for urgent care center

### MATERNITY CARE
- Inpatient/Outpatient hospital care (Precertification is not required for normal delivery):
  - Physician care:
  - Inpatient/Outpatient hospital care:
    - No out-of-pocket expenses for covered services
    - Physician care including delivery and pre and postnatal care: No out-of-pocket expenses for covered services

### DENTAL CARE
- Routine dental care:
  - Up to age 13: The difference between the fee schedule and the Maximum Allowable Charge (MAC)
  - Age 13 and over: The difference between the fee schedule and the MAC
  - $25 copayment per evaluation; up to 2 per calendar year

### CHIROPRACTIC/OSTEOPATHIC MANIPULATIVE TREATMENT
- Manipulative treatment:
  - $20 per visit copayment; up to 12 manipulations per year
  - $25 per visit copayment; up to 20 manipulations per year

### OTHER BENEFITS
- Catastrophic benefits:
  - 100% payment level begins after you pay $5,000 (Self Only) or $6,000 (Self and Family)
  - out-of-pocket in eligible coinsurance, copayment and deductible expenses with Preferred providers

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*When you use Non-preferred hospitals, facilities and professionals, your out-of-pocket expenses are greater. Please see the 2015 Service Benefit Plan brochure for details. ** Basic Option does not generally provide benefits for services rendered by Non-preferred providers. *** Subject to the calendar year deductible: $350 per person or $700 per family for 2015 Standard Option. **** Your costs for generic prescription drugs are lower if you have Medicare Part B as your primary coverage. Please see the 2015 Blue Cross and Blue Shield Service Benefit Plan brochure for complete details.*
# 2015 PREMIUMS & RATES

This is a summary of the features for the Blue Cross and Blue Shield Service Benefit Plan. Before making a final decision, please read the Plan’s Federal brochure (RI 71-005). All benefits are subject to the definitions, limitations and exclusions set forth in the Federal brochure.

## 2015 Premiums—Your Share

<table>
<thead>
<tr>
<th>TYPE OF ENROLLMENT</th>
<th>BIWEEKLY</th>
<th>MONTHLY</th>
<th>POSTAL PREMIUM BIWEEKLY</th>
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<tbody>
<tr>
<td>Standard Option Self Only (104)</td>
<td>$91.03</td>
<td>$197.23</td>
<td>$77.00</td>
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<tr>
<td>Standard Option Self &amp; Family (105)</td>
<td>$213.31</td>
<td>$462.17</td>
<td>$182.16</td>
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<tr>
<td>Basic Option Self Only (111)</td>
<td>$63.40</td>
<td>$137.38</td>
<td>$50.09</td>
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<tr>
<td>Basic Option Self &amp; Family (112)</td>
<td>$148.46</td>
<td>$321.67</td>
<td>$117.29</td>
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</table>

These rates do not apply to all Enrollees. If you are in a special enrollment category, please refer to your special Guide to Federal Benefits or contact the agency or Tribal Employer which maintains your health benefits enrollment.

### Standard Option

**Enrollment codes (104-105)**

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<td>RxPCN</td>
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<td>RxGrp</td>
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### Basic Option

**Enrollment codes (111-112)**

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