Medicare & Blue

Medicare, Blue and You.
As time marches on, your medical needs may change. The Blue Cross and Blue Shield Service Benefit Plan is here to help you understand your healthcare options and the choices available to you through Medicare. Whether you’re working or retired, your Blue Cross and Blue Shield Service Benefit Plan coverage offers the protection and value that you’ve come to rely on in your health plan. It’s accepted nationwide and around the world by doctors and specialists and has been a trusted name in healthcare since 1960.

We know that understanding healthcare benefits can be difficult. That’s why we’ve created this booklet — to help you discover the value of how the Blue Cross and Blue Shield Service Benefit Plan (Service Benefit Plan) and Medicare work together, providing protection from the high cost of medical care.

Medicare pays a significant part of your healthcare costs when it is the primary payer. But, Medicare alone has limitations and leaves gaps for full coverage. Your Service Benefit Plan coverage plus Medicare coverage work together to maximize your benefits and minimize your out-of-pocket costs. When you have both Medicare and the Service Benefit Plan coverage, you have peace of mind knowing that most of your health and medical costs are covered.

To help you understand the benefits explained in this booklet, and to understand how benefits are paid without Medicare coverage or when Medicare is secondary because you are still working, the 2014 Blue Cross and Blue Shield Service Benefit Plan brochure (RI 71-005) is available at www.fepblue.org/brochure. Medicare publications are available by calling 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) or visiting www.medicare.gov.

As you read this booklet, please keep in mind that “you” and “your” mean the contract holder who is enrolled in the Service Benefit Plan, or a covered family member who does not have additional health insurance coverage in his or her name.

Please note: The Medicare information in this booklet focuses on Original Medicare, Medicare Part A and Part B, unless otherwise noted.
What Is Medicare?

Medicare is a federal health insurance program for people age 65 or older, people under age 65 who are disabled and people of any age who have End Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Medicare Part A (hospital insurance) helps pay for medically necessary inpatient hospital care, inpatient care in a skilled nursing facility, home healthcare and hospice care.
- Medicare Part B (medical insurance) helps pay for medically necessary doctors’ services, outpatient hospital services and a number of other medical services and supplies that are not covered by Part A.
- Medicare Part C or Medicare Advantage covers all Medicare Part A and Part B services and allows individuals with Medicare Parts A and B to get Medicare benefits through private healthcare plans.
- Medicare Part D offers prescription drug coverage for individuals entitled to benefits under Part A or enrolled in Part B.

Medicare Part A is available free of charge to people age 65 and older who meet the eligibility requirements necessary to qualify for Social Security benefits. You automatically qualify if you were a federal employee on January 1, 1983. People age 65 and older who don’t qualify for Medicare Part A free of charge can obtain coverage under Part A by paying a monthly premium, and in most cases they must also enroll in Medicare Part B.

Most people pay monthly for Medicare Part B. The standard monthly premium is $104.90 in 2014. Current law requires some individuals to pay a higher amount for Parts B and D based on their income. Please contact Medicare for more information.

Medicare Part C or Medicare Advantage plans offer comprehensive benefits and premiums that vary by plan.
For Medicare Part D, there is a monthly premium to join a prescription drug plan offered in your area.

**Enrolling in Medicare**

For many federal employees and retirees, deciding whether to enroll in Medicare can be a difficult decision. Your federal health benefits are familiar to you — and pay many of your healthcare costs. Some of the questions you may be asking are: Should I enroll in Medicare Part B and pay the additional premium? Will I need the additional benefits? What if I don’t sign up now and change my mind, can I sign up later?

**When you are first eligible for Medicare, you have a 7-month period to enroll.** The 7-month period begins three months prior to your 65th birthday month, includes your birthday month, and ends three months after your birthday month. If you enroll before the month you turn 65, Medicare will start on the 1st of the month before your birthday. If you enroll during the month you turn 65 or within three months after your birthday month, your Medicare coverage starts one to three months later. You can enroll at your local Social Security office or online at [www.ssa.gov](http://www.ssa.gov). You can also call 1-800-772-1213 (TTY 1-800-325-0778) to set up an appointment to enroll.

If you are eligible for Medicare Part A coverage at no cost, it may make sense to enroll since it can reduce your out-of-pocket costs. Most federal employees and annuitants are entitled to Medicare Part A at age 65 without a cost.

Part B of Medicare is optional. Generally, if you opt not to enroll in Medicare Part B when you become eligible and change your mind later, your premium may be 10% higher for each year you delay your enrollment. If you enroll late, you may only enroll from January to March each year and your Medicare Part B benefits will not start until the following July. A delay in enrolling in Part B can cost you more due to this penalty.

Part B can also give you the peace of mind of knowing these medical expenses are covered.

If you are still working and have health insurance through your employer, or if you are covered through your spouse’s current employer, the Part B penalty does not apply to you. You can enroll in Medicare Part B without paying a penalty any time while you or your spouse are working and have health insurance through an employer, and during the 8 months after you stop working or your Federal Employees Health Benefits Program coverage ends, whichever comes first.

If you decide to enroll in Medicare Part D after you are first eligible, you will not have to pay a late penalty or a higher Medicare Part D premium as long as you keep your Service Benefit Plan coverage. Most federal employees and retirees don’t need Part D coverage as the prescription coverage in your Service Benefit Plan is as good as coverage offered by Medicare Part D, commonly known as “creditable coverage.”

For more information about enrolling in Medicare, visit [www.medicare.gov](http://www.medicare.gov).
Benefit Gaps

Medicare and the Blue Cross and Blue Shield Service Benefit Plan

When you or a covered family member have the Service Benefit Plan in addition to Medicare coverage, this is called double coverage. When you have double coverage, one plan normally pays its benefits first as the primary payer and the other plan pays second as the secondary payer. The Service Benefit Plan is primary if you are still working; Medicare Parts A and B are primary if you are retired.

When you have both Medicare Part A and B as your primary payer, a significant portion of your healthcare services are covered, but not all of your out-of-pocket expenses. That’s why many retired federal employees choose to combine their Service Benefit Plan coverage with Medicare Parts A and B to fill the gaps and get more value.

When you combine your Standard Option coverage with your primary Medicare coverage as a retiree, you no longer have to pay the Service Benefit Plan’s annual deductible, coinsurance or copayments. The one exception requires you to continue paying coinsurance or copayments for prescription drugs. However, your Standard Option coverage offers a lower cost-share for generic prescription drugs when you have Medicare Part B as your primary payer.

If you have Basic Option coverage and primary Medicare coverage, the copayment amounts are waived for covered services when you use Preferred providers. The cost of your Medicare premiums may be offset entirely by these savings. Please note that the Basic Option prescription drug copayment and coinsurance amounts are not waived.

Medicare Part A

Medicare Part A provides hospital benefits to help pay for the cost of inpatient care. Medicare will pay a portion of the covered expenses; however, there are costs that you will be responsible for paying. For example, if you receive inpatient hospital care, there is a Medicare Part A hospital deductible of $1,216 for the first 60 days of hospital care and a daily coinsurance amount for hospital care each day each day from the 61st day up to a 150-day admission. Also, Medicare generally does not cover inpatient hospital care received outside of the U.S.

The Value Of Medicare & Blue

If you have Medicare Part A as your primary coverage, the Service Benefit Plan provides benefits for covered services applied to your Medicare Part A hospital deductible and coinsurance amounts. The Service Benefit Plan hospital copayments and coinsurance amounts for inpatient care are waived, including:

- The Standard Option $250 per admission copayment for Preferred hospitals.
- The Standard Option $350 per admission copayment and 35% coinsurance for non-Preferred hospitals.
- The Basic Option $175 per day copayment (limit of $875 per admission) for Preferred hospitals.

When Medicare Part A is your primary coverage, you don’t have to get precertification for inpatient admissions. Standard Option also offers a limited benefit for care in qualified skilled nursing facilities for members who also have primary Medicare Part A coverage.
Generally, these facilities include services for skilled care and meet Medicare’s special qualifying criteria. Medicare pays the first 20 days in full, and the Service Benefit Plan pays the Medicare copayment for covered skilled nursing care through the 30th day of your confinement per benefit period.

**Medicare Part B**

Medicare Part B provides benefits to help you pay for the cost of medical care, but patients are responsible for paying some of the costs. For example, Medicare Part B pays 80% of most approved physician charges, after you pay the $147 Medicare Part B annual deductible.

**The Value Of Medicare & Blue**

If you have Medicare Part B as your primary coverage, the Service Benefit Plan pays the $147 Medicare Part B annual deductible and the 20% coinsurance amounts not paid for by Medicare for covered services. In this case, you will have no out-of-pocket costs for the entire approved amount of services when you use Preferred providers for covered services.

**Standard Option:** If you have Medicare Part B as your primary coverage and you have Standard Option, you don’t pay the Service Benefit Plan annual deductible, or copayment and coinsurance amounts. The Service Benefit Plan pays the balance, after Medicare’s payment, up to the allowed amount.

This eliminates your out-of-pocket costs for covered physician services when you have both Standard Option and Medicare Part B coverage and you use a physician who accepts Medicare. Additionally, your Standard Option coverage offers a lower cost-share for generic drugs when Medicare Part B is your primary payer.

**Basic Option:** If Medicare Part B is your primary coverage and you have Basic Option, you don’t pay coinsurance and copayment amounts for the services covered under Medicare Part B if you use Service Benefit Plan Preferred network providers.

The Service Benefit Plan pays the balance after Medicare’s payment up to the Medicare allowed amount. When you use Preferred network providers who accept Medicare, you eliminate your out-of-pocket costs for covered physician services.

**Medicare Part D**

If you have Medicare Part D as your primary coverage, the Service Benefit Plan will review claims for your prescription drug costs not covered by Medicare Part D and consider them for payment.
When you have Medicare Part A (hospital insurance) and Medicare is your primary coverage, you usually pay nothing when you also have Service Benefit Plan coverage:

**WHAT YOU PAY**

<table>
<thead>
<tr>
<th>Medicare Part A</th>
<th>2014 Standard Option Coverage</th>
<th>2014 Basic Option Coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>The inpatient hospital deductible of $1,216 for the first 60 inpatient days.</td>
<td>You pay nothing for covered services.</td>
<td>You pay nothing for covered services.</td>
</tr>
<tr>
<td>The $304 daily share of the inpatient hospital bill from the 61st day through the 90th day.</td>
<td>You pay nothing for covered services.</td>
<td>You pay nothing for covered services.</td>
</tr>
<tr>
<td>After the 90th day: • The $608 per day copayment if you use your lifetime reserve days. • All charges if you elect to save your 60 lifetime reserve days • All charges after you use all of your Medicare Part A benefits,** including your 60 lifetime reserve days and Medicare benefits end.</td>
<td>You pay nothing for covered services.</td>
<td>You pay nothing for covered services.</td>
</tr>
<tr>
<td>5% coinsurance for inpatient hospice care costs and copayments of $5 for prescription drugs.</td>
<td>You pay nothing for covered inpatient hospice care and nothing for prescription drug amounts.</td>
<td>You pay nothing for covered inpatient hospice care and nothing for prescription drug amounts.</td>
</tr>
<tr>
<td>$152 daily share for skilled nursing facility care from the 21st through the 100th day. Medicare pays the first 20 days in full.</td>
<td>You pay nothing for the 21st through the 30th day of your confinement. You are responsible for the daily share after the 30th day.</td>
<td>This is not a benefit. You pay all charges.</td>
</tr>
</tbody>
</table>

* Basic Option benefits are only available for care performed by Preferred network providers except in certain situations such as emergency care.

** Per Medicare benefit period.

*** Our allowance is based on the average amount paid nationally on a per day basis to contracting and non-contracting facilities for covered room, board and ancillary charges for your type of admission. For inpatient stays resulting from medical emergencies or accidental injuries, our allowance is the amount billed. A non-member facility is not required to accept our payment as payment in full. When Medicare is the primary payer, we will limit our payment to an amount that supplements the benefits that would be paid by Medicare, regardless of whether or not Medicare benefits are paid. However, we will pay regular benefits for emergency services to a facility, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare. See sections 9 and 10 of the 2014 Blue Cross and Blue Shield Service Benefit Plan brochure (RI 71-005) for more information about how benefits are paid.
When you have Medicare Part B (medical insurance) and Medicare is your primary coverage, you usually pay nothing when you also have Service Benefit Plan coverage and use Preferred providers:

**WHAT YOU PAY**

<table>
<thead>
<tr>
<th>Medicare Part B</th>
<th>2014 Standard Option Coverage</th>
<th>2014 Basic Option Coverage*</th>
</tr>
</thead>
</table>
| The Medicare Part B $147 deductible and the 20% coinsurance on approved charges for:  
  • Physician services for inpatient visits, inpatient and outpatient surgery, accidental injury care, laboratory tests and X-rays, office and home visits.  
  • Outpatient hospital services including laboratory tests and X-rays, accidental injury and medical emergency care and therapeutic treatments, such as physical, speech and occupational therapy. | You pay nothing for covered services.** | You pay nothing for covered services.** |
| Durable medical equipment and ambulance services. | You pay nothing for covered services.** | You pay nothing for covered services.** |

* Basic Option benefits are only available for care performed by Preferred network providers except in certain situations such as emergency care.

** Standard Option pays up to 100% of Medicare’s limiting charge (see the General Information section for a definition of limiting charge), if your physician does not accept Medicare. Basic Option pays up to 100% of the limiting charge for physicians who do not accept Medicare but who are Service Benefit Plan Preferred network physicians.
Five Things to Consider:

1. The decision to enroll in Medicare is voluntary during specific enrollment periods. If you don’t sign up when you are first eligible, you may have to pay a late enrollment penalty.

2. When you combine Medicare Parts A and B with your Service Benefit Plan coverage, you maximize your benefits and can minimize your out-of-pocket costs.


4. Your total out-of-pocket expenses may be lower when you enroll in Medicare Part B and also have Service Benefit Plan coverage.

5. Your Service Benefit Plan provides coverage anywhere in the U.S. and overseas, while Medicare does not cover services overseas. Having both plans covers you at home and abroad.
The Service Benefit Plan pays the balance after Medicare’s payment up to the Medicare allowed amount. When you use Preferred network providers who accept Medicare, you eliminate your out-of-pocket costs for covered physician services.

The following example shows how Medicare coordinates with Standard Option coverage when you use Preferred providers.

### EXAMPLE OF COVERED MEDICAL COSTS ASSOCIATED WITH TREATMENT OF A HEART ATTACK

<table>
<thead>
<tr>
<th>Service</th>
<th>Service Benefit Plan Cost-share</th>
<th>Without Part B, You Pay</th>
<th>With Part B, You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance transport</td>
<td>$100 copayment</td>
<td>$100</td>
<td>You pay nothing. The copayment is waived.</td>
</tr>
<tr>
<td>Physician office visits (6 visits)</td>
<td>$20 per visit copayment for primary care physician visits</td>
<td>$120</td>
<td>You pay nothing. The copayment is waived.</td>
</tr>
<tr>
<td>Cardiologist office visits (6 visits)</td>
<td>$30 per visit copayment for specialists visits</td>
<td>$180</td>
<td>You pay nothing. The copayment is waived.</td>
</tr>
<tr>
<td>Outpatient physical therapy (50 visits)</td>
<td>$20 copayment</td>
<td>$1000</td>
<td>You pay nothing. The copayment is waived.</td>
</tr>
<tr>
<td>Outpatient MRI ($3250)</td>
<td>$350 calendar year deductible</td>
<td>$350</td>
<td>You pay nothing. The deductible is waived.</td>
</tr>
<tr>
<td>15% coinsurance</td>
<td>$435</td>
<td></td>
<td>You pay nothing. The coinsurance amount is waived.</td>
</tr>
<tr>
<td>Three generic drug prescriptions</td>
<td>Mail Service Pharmacy Program $15 generic drug copayment ($10 generic drug copayment when Medicare Part B is primary)</td>
<td>$45</td>
<td>$30</td>
</tr>
<tr>
<td>Standard Medicare Part B annual premium in 2014</td>
<td>N/A</td>
<td>$1258.80 ($104.90 per month x 12 months)</td>
<td>$1288.80</td>
</tr>
<tr>
<td>Your total out-of-pocket costs</td>
<td>$2230.00</td>
<td></td>
<td>$1288.80</td>
</tr>
</tbody>
</table>

For more information about how Medicare coordinates with your Service Benefit Plan coverage, please visit www.fepblue.org/medicare.
The U.S. Office of Personnel Management (OPM) has determined that the Blue Cross and Blue Shield Service Benefit Plan prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage. Therefore, you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you do decide to enroll in Medicare Part D, we will coordinate benefits for prescription drugs with your Medicare Part D coverage.

**Mail Service Pharmacy Program — Standard Option Only**

Standard Option’s Mail Service Pharmacy Program is an easy and convenient way to get long-term prescriptions delivered right to your home.

If Medicare Part B is your primary coverage and you have Standard Option, the copayment for generic drugs is $10 in the Mail Service Pharmacy Program. Otherwise, the Standard Option generic drug copayment is $15.

If you have any questions about the Mail Service Pharmacy Program or want to talk to a pharmacist about your prescriptions, you can call anytime. This benefit is not available under Basic Option.

Using the Mail Service Pharmacy is easy. Call the Mail Service Pharmacy Program at 1-800-262-7890 to speak with a member services representative to get started, or visit www.fepblue.org.

**Retail Pharmacy Program**

Standard Option members can use any Preferred or Non-preferred retail pharmacy to obtain prescriptions. However, if you use a Non-preferred pharmacy, you pay the full cost of the drug and then you must file a claim for reimbursement. Your cost-share is 45% of the Average Wholesale Price, plus any difference between our allowance and the billed amount. Basic Option members must use a Preferred retail pharmacy to obtain prescriptions.

If Medicare Part B is your primary coverage and you have Standard Option, there is a 15% coinsurance amount for generic drugs received from a Preferred pharmacy. Otherwise, the Standard Option coinsurance amount for generic drugs is 20%.

Just show your Service Benefit Plan member ID card at a Preferred retail pharmacy. You pay only the appropriate copayment or coinsurance amount.

If you have any questions about the Preferred Retail Pharmacy Program, call 1-800-624-5060 to talk to a member service representative.

We have over 60,000 Preferred network retail pharmacies nationwide. You can locate a Preferred retail pharmacy near you by calling 1-800-624-5060 or by visiting the Pharmacy page on www.fepblue.org.
Discount Drug Program

The Discount Drug Program is available to Service Benefit Plan members at no additional cost. It allows you to buy certain prescription drugs, not covered by your prescription drug benefit, at discounted prices. Discounts vary by drug, but the average discount is about 20%. Discounts are available under this program for the drugs listed in Section 5(h) of the 2014 Blue Cross and Blue Shield Service Benefit Plan brochure.

To use the Discount Drug Program, present a valid prescription for the drug and your Service Benefit Plan member ID card at a network retail pharmacy. The pharmacist will process the prescription and will ask you to pay the full discounted price. If you have questions about this program, call 1-800-624-5060.

<table>
<thead>
<tr>
<th>Benefit Program</th>
<th>2014 Standard Option Coverage</th>
<th>2014 Basic Option Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRESCRIPTION DRUGS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mail Service Pharmacy</td>
<td><strong>Tier 1 (generics):</strong> $10 copayment if Medicare Part B is primary; $15 copayment without Medicare</td>
<td>Not a benefit</td>
</tr>
<tr>
<td></td>
<td><strong>Tier 2 (Preferred brand name):</strong> $80 copayment</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Tier 3 (Non-preferred brand name):</strong> $105 copayment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Covers 22-90-day supply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nothing for the first 4 prescription fills or refills when you switch from certain brand name drugs to specific generic drugs</td>
<td></td>
</tr>
<tr>
<td>Preferred Retail Pharmacy Program</td>
<td><strong>Tier 1 (generics):</strong> 15% coinsurance if Medicare Part B is primary; 20% coinsurance without Medicare</td>
<td>Tier 1 (generics): $10 copayment</td>
</tr>
<tr>
<td></td>
<td><strong>Tier 2 (Preferred brand name):</strong> 30% coinsurance</td>
<td>Tier 2 (Preferred brand name): $45 copayment</td>
</tr>
<tr>
<td></td>
<td><strong>Tier 3 (Non-preferred brand name):</strong> 45% coinsurance</td>
<td>Tier 3 (Non-preferred brand name): 50% coinsurance with a $55 minimum</td>
</tr>
<tr>
<td></td>
<td>Covers up to a 90-day supply</td>
<td>Covers 30-day supply, up to 90-day supply for additional copayments</td>
</tr>
<tr>
<td></td>
<td>Nothing for the first 4 prescription fills or refills when you switch from certain brand name drugs to specific generic drugs</td>
<td></td>
</tr>
<tr>
<td>Specialty Pharmacy Program</td>
<td><strong>Tier 4 (Preferred specialty drugs):</strong> $35 copayment (30-day supply); $95 copayment (90-day supply)</td>
<td>Tier 4 (Preferred specialty drugs): $50 copayment (30-day supply); $140 copayment (90-day supply)</td>
</tr>
<tr>
<td></td>
<td><strong>Tier 5 (Non-preferred specialty drugs):</strong> $55 copayment (30-day supply); $155 copayment (90-day supply)</td>
<td>Tier 5 (Non-preferred specialty drugs): $70 copayment (30-day supply); $195 copayment (90-day supply)</td>
</tr>
<tr>
<td></td>
<td>90-day supply can only be obtained after 3rd fill</td>
<td>90-day supply can only be obtained after 3rd fill</td>
</tr>
</tbody>
</table>

Certain prescription drugs require prior approval.
Preventive Care

Preventive care can help to prevent illness and help identify health concerns or conditions in the early stages. It is important to your health and well-being at any age. Identifying a condition, such as cancer, in the early stages may mean less invasive treatment and a greater chance of a full recovery. Both Medicare and the Service Benefit Plan cover preventive care services.

When you have Medicare Part B, you pay nothing for most Medicare covered preventive care services performed by a doctor or other healthcare provider who accepts Medicare. For some preventive services, you pay nothing for the service, but you may be responsible for the coinsurance amount for the related office visit charges.

Medicare pays for one routine physical exam within the first 12 months of your Medicare enrollment. You pay nothing for the exam if the doctor accepts Medicare. If you have had Medicare Part B for more than 12 months, Medicare pays for an annual wellness visit if the doctor accepts Medicare.

For more information about Medicare benefits for preventive care, review the 2014 Medicare & You handbook available at www.medicare.gov.
The Value Of Medicare & Blue

When you have Medicare Part B and your Service Benefit Plan coverage, Medicare pays in full for the covered preventive care services and the Service Benefit Plan pays for the 20% coinsurance amount for the related office visit for care performed by a provider who accepts Medicare. Your covered preventive care visit is paid in full and you pay nothing.

Covered preventive care services include:

- Colorectal cancer screening tests, such as a fecal occult blood test, screening colonoscopy, sigmoidoscopy and double contrast barium enema
- Screening mammograms
- Prostate cancer tests (PSA test)
- Cervical cancer tests, including Pap tests
- Ultrasound for aortic abdominal aneurysm

For more information about covered preventive care services under your Service Benefit Plan, please see Section 5(a) of the 2014 Blue Cross and Blue Shield Service Benefit Plan brochure.

Medicare Part B covers flu, pneumonia and hepatitis B vaccines in full. The Service Benefit Plan covers certain vaccines at no cost to you, when you don’t have Medicare Part D.

Certain immunizations are also free at Preferred pharmacies in our vaccine network. Check with your pharmacy or call our Retail Pharmacy Program at 1-800-624-5060 (TTY 1-800-624-5077) to see which vaccines your pharmacy can provide.

Standard Option Dental

Medicare does not pay for dental care, but Standard Option pays for many dental services based on a fee schedule as listed in Section 5(g) of the 2014 Blue Cross and Blue Shield Service Benefit Plan brochure. Covered dental services include oral examinations, prophylaxis (cleaning of the teeth), routine X-rays, simple extractions and fillings.

Benefits are provided for the dentist’s charge up to the fee schedule amount. There are no deductibles, coinsurance or copayment amounts. When you use a Preferred provider, you pay only the difference between our fee schedule allowance and the Maximum Allowable Charge (MAC). The MAC is the amount Preferred dentists have agreed to accept as payment in full.

Basic Option Dental

Basic Option dental benefits are available for routine dental care only. Benefits are available for the services listed in Section 5(g) of the 2014 Blue Cross and Blue Shield Service Benefit Plan brochure. This includes clinical oral evaluations, prophylaxis and X-rays. When you use a Preferred dentist, you pay a $25 copayment for each evaluation. Basic Option dental benefits are not available for care provided by non-Preferred dentists.
New Health Tools on MyBlue®

New year, new start! Blue has you covered!

The Blue Cross and Blue Shield Service Benefit Plan is introducing new Health Tools powered by WebMD, one of the most trusted healthcare brands in the U.S. Starting January 1, 2014, you’ll have new and improved wellness tools and resources available on the MyBlue website.

Imagine simple, private and smart tools and resources that you can securely access anytime, anywhere — on your computer, tablet or smartphone:

• Share your test results with a new doctor — in her office.
• Tell the pharmacist the dosage of your partner’s prescription — at the pharmacy.
• Access activities, challenges and trackers to help you achieve your health goals — from the gym, your home or the office.
• Chat online about your baby’s fever and sleep patterns with a nurse — on a Sunday morning.
• Organize and clear your filing cabinet of all your family’s health claims — even at midnight.
• Enter your symptoms and receive possible reasons for why you have that nagging cough — from the comfort of your home.

Our tools offer support that’s motivational and realistic to help you where and when you need it.

Your data is secure. The Service Benefit Plan and WebMD take the safety and security of your health information very seriously. All of our systems operate in accordance with federal privacy laws, and we take every effort to protect your privacy when you use any of our online tools and resources.

All-New Health Tools on MyBlue Website

MyBlue features new, mobile Health Tools and resources — the latest health and wellness information within easy reach from your computer, smartphone or tablet. It’s everything you already love about Blue — but better!

Start Here: Blue Health Assessment

What you don’t know can hurt you. Take the redesigned Blue Health Assessment (BHA) to address health risks before they become issues. Answer simple questions and in just 10 minutes receive a clear, concise, personalized approach to a healthier you. You can even take the BHA multiple times throughout the year to update your plan and see your progress. Earn $40 for completing the BHA in 2014!
Next: Online Health Coach

It’s your own private cheering section! When you work with the all-new Online Health Coach on your path to better health, you’ll get suggestions for realistic, personalized activities to stay on track. Start by taking the BHA, then earn rewards — up to $35 — when you achieve your exercise, stress management, emotional health, weight loss and nutrition goals. Get ideas and encouragement for managing your chronic conditions, like diabetes, asthma and others.

Anytime: Nurse Line

Call, chat online or email the Nurse Line for reliable health information, anytime day or night.

Visit www.fepblue.org or call 1-888-258-3432 to get reliable health information from knowledgeable, registered nurses.

Anytime: Personal Health Record

Your all-new Personal Health Record (PHR) gives you easy access to your health information, making it simple for you to keep track of your medical history, appointments and lab results. There’s no need to worry that you’ve forgotten important health details — your PHR has you covered. When you complete the BHA and work with the Online Health Coach, this information is fed to your PHR. Plus, wherever your smartphone goes, your PHR goes, too!

Anytime: Benefits Statements

Let your Benefits Statements be your benefits assistant! Find ways to save and see a snapshot of your claims and your benefits in annual or quarterly time periods — anytime you need answers, not just when you’re close to your filing cabinet. Access your statements on your computer, smartphone or tablet — from home, the doctor’s office or pharmacy. Starting February 2014, you can contact 1-888-258-3432 to request paper statements.

Anytime: Online Symptom Checker

Use the Online Symptom Checker to receive possible reasons for your symptoms* — from your computer, smartphone or tablet. If you have questions while using the Online Symptom Checker, you can chat online with the Nurse Line, too!

*Seek immediate medical attention for life-threatening health issues.
MyBlue® Wellness Card

The MyBlue Wellness Card is a pre-paid card we use to reward our members for taking charge of their health. The card is available to members who complete specific activities to improve their health and may be used to pay for qualified medical expenses.

Please note: For members who received a MyBlue Wellness Card in 2011-2013, any new credits will be applied to your existing card.

Wellness Incentive Program:

Blue Health Assessment (BHA) and Online Health Coach

Complete the BHA for 2014 to receive $40 on your MyBlue Wellness Card. Members must be 18 years of age or older to be eligible for the incentive. Family contracts are eligible to receive two $40 cards when two adult members complete the BHA.

After you take the BHA, if you need help reaching your health and wellness goals or maybe just a push in the right direction, the Online Health Coach is there for you. You can set and work toward any number of goals that you choose in a variety of areas.

You may also receive up to an additional $35 on your MyBlue Wellness Card for achieving goals related to a healthy lifestyle in the areas of exercise, nutrition, stress, weight management and emotional health.

After completing the BHA, you may choose to complete goals in any of these five areas, up to a maximum of three goals per calendar year to earn a reward.

When you achieve your first goal, you will receive $15 on your card. For the second and third goals, you will receive $10 on your card for each one. All three goals must be completed during the calendar year to earn the reward.
Extra Motivation!

Take steps toward better health and earn up to $75*

<table>
<thead>
<tr>
<th>EARN</th>
<th>WHEN YOU</th>
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<tbody>
<tr>
<td>$40</td>
<td>Complete the Blue Health Assessment</td>
</tr>
<tr>
<td>$15</td>
<td>Achieve your first goal with the Online Health Coach**</td>
</tr>
<tr>
<td>$10</td>
<td>Achieve your second goal with the Online Health Coach**</td>
</tr>
<tr>
<td>$10</td>
<td>Achieve your third goal with the Online Health Coach**</td>
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</table>

Up to two adult-covered family members can each earn up to $75 after completing all four steps.

* Incentive rewards are added to your MyBlue Wellness Card to pay for qualified medical expenses.

** Goals must be started and completed within the calendar year.

Diabetes Management Incentive Program

The Diabetes Management Incentive Program provides critical education if you have diabetes, assists in improving your blood sugar control and helps to manage or slow the progression of complications related to diabetes.

To be eligible for this program, you must be 18 years of age or older and complete the BHA and indicate you have diabetes. This program is limited to two adult members if you have family coverage.

You will receive credit on your MyBlue Wellness Card when you complete specific activities. Please note: Once you earn the maximum of $75 under the Diabetes Management Incentive Program, you will not earn additional credits to your MyBlue Wellness Card for completing additional activities under this incentive.

Tobacco Cessation Incentive Program

If you are ready to stop using tobacco, we have the support you need for success. Take the BHA and indicate that you use tobacco and then use the Online Health Coach to select the tobacco cessation goal and create a plan to quit. After you complete these steps, you’ll be eligible to receive tobacco cessation products for free.

Both prescription and over-the-counter (OTC) tobacco cessation products obtained from a Preferred retail pharmacy are included in this program for Standard Option and Basic Option members age 18 or older.

When you use a Preferred retail pharmacy to get certain prescription tobacco cessation medications, we will waive the cost share. In addition, we will provide benefits in full for specific OTC tobacco cessation medications when you purchase the medications at a Preferred retail pharmacy and have a doctor’s prescription.
Blue Extras

Health Club Membership
You pay a $25 initiation fee and $25 monthly for unlimited visits to over 8,000 fitness facilities nationwide. You are not limited to a specific facility.

For more information, visit www.fepblue.org.

Other Programs
• WalkingWorks® is a good start for any exercise routine with a free pedometer and online walking guide. Visit www.fepblue.org for more information.

• Blue365® offers access to information, discounts and savings that make it easier and more affordable to make healthy choices. For more information, visit www.fepblue.org.

• Our Vision Care Affinity Program provides savings on routine eye exams, frames, lenses, contact lenses and laser vision correction when you use a network provider. Visit www.fepblue.org for additional information about this program or call 1-800-551-3337.

• Local Care Management Programs, offered by local Blue Cross and Blue Shield Plans, provide patient education and support for select diagnoses. Call your local Blue Cross and Blue Shield Plan for more information about these programs.

MyBlue Customer eService
MyBlue Customer eService is like having your own personal customer service representative when you need help managing your enrollment. You can view your Explanation of Benefits online, request a new ID card, change your address, add children after a birth or adoption and let us know about a marriage or divorce. Visit www.fepblue.org for more information.

Online Explanation of Benefits
You can decide to go paperless and access your Explanation of Benefits (EOB) online through MyBlue Customer eService. You can see and print information about claims processed for you and your family. It is easy to opt in to paperless EOBS. Sign on to www.fepblue.org/myblue.

Finding Care
National Doctor and Hospital Finder
Our directory of Preferred providers gives you the control to choose your healthcare providers while saving you money on medical costs through our negotiated discounted rates. Visit www.fepblue.org/provider for details.

With the Blue Finder smartphone app, finding a doctor or hospital has never been easier! One tap with the Blue Finder app connects you to the closest provider, hospital, or urgent care center. You can dial a provider’s phone number and use the interactive GPS map and driving directions to get to your selected location. Text and email options allow you to share and save your results.
Worldwide Coverage

When work or travel takes you overseas, the Blue Cross and Blue Shield Service Benefit Plan has you covered around the world. However, Medicare does not cover medical care performed outside the United States. Your Service Benefit Plan member ID card is recognized worldwide and entitles you to world-class service.

Our free Worldwide Assistance Center offers help 24 hours a day, seven days a week to members who are traveling or living outside the United States. Members can call collect 1-804-673-1678 or send an email to the center at fepoverseas@axa-assistance.us.

The center can:

- Help locate a nearby participating provider, hospital or facility
- Verify your enrollment with a provider
- Translate your bill
- Convert local currency to U.S. dollars
- Make transportation arrangements to another healthcare setting

You can count on the Service Benefit Plan at home and abroad. For help with overseas claims or benefits, call 1-888-999-9862 or visit www.fepblue.org/overseas.
Medicare Assignment

Doctors and suppliers who participate with Medicare agree to accept Medicare assignment for all claims. This means that they have agreed to accept the charge approved by Medicare as total payment for covered services, and will not bill for more than the amount approved by Medicare. Providers who do not participate with Medicare can choose whether to accept Medicare assignment on a claim-by-claim basis.

Medicare pays your doctor or supplier 80% of the Medicare-approved charge, after subtracting any part of the $147 annual Part B deductible that you have not met. For covered services, the doctor or supplier can only charge you for the amount applied to the deductible and the remaining 20% of the approved charge. This 20% is your coinsurance amount, which is usually paid by your Service Benefit Plan coverage, as is the $147 Medicare annual deductible.

To find a doctor or supplier who accepts Medicare, you can locate Medicare participating providers online at www.medicare.gov.
Limiting Charge
If your doctor does not accept Medicare, he or she may charge up to 15% more than the Medicare-approved amount. This is called the limiting charge. The limiting charge places a limit on how much providers who do not participate with Medicare can charge for covered services. These providers are required by law to accept the limiting charge as payment in full.

The Service Benefit Plan pays for covered services up to Medicare’s limiting charge. For Basic Option members, the doctor must be a Preferred provider with Blue Cross and Blue Shield. You are not responsible for any difference between the limiting charge and the doctor’s charge. If this happens, please contact your local Social Security or Medicare office.

Filing Claims
All hospitals, doctors and other healthcare providers are required by law to file claims directly to Medicare when Medicare is your primary coverage (except when there is a private contract in place, as noted in the column to the right). This is true whether they accept Medicare or not.

Your provider must include your Blue Cross and Blue Shield Service Benefit Plan ID number on the Medicare claim form. This will help ensure that a claim for any balance remaining after Medicare’s payment is forwarded to your local Blue Cross and Blue Shield Plan for payment.

If the Service Benefit Plan is the primary payer or you need to send a claim to us after Medicare’s payment, submit your claim and any supporting documentation, such as the provider’s bill, as soon as possible.

Claims must be submitted to your local Blue Cross and Blue Shield Plan by December 31 of the year after the year you receive the service. There are some exceptions to this timely filing rule, such as legal incapacity. However, you must submit the claim as soon as is reasonably possible.

Primary Payer
Determining which coverage is primary can be confusing. The chart on page 138 of the 2014 Blue Cross and Blue Shield Service Benefit Plan brochure explains different scenarios in which Medicare or the Service Benefit Plan are the primary payer based on employment status and other factors. Medicare always makes the final determination as to whether they are the primary payer.

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other group coverage you or your covered family members may have, as this coverage may affect which plan is the primary payer.

Private Contracts
Please note that a doctor may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by the Original Medicare. If you sign this agreement:

• Medicare will not pay any portion of the charges, and
• The Service Benefit Plan payment will be limited to the amount that would have been paid after Medicare’s payment (even though Medicare pays nothing).

You are responsible for paying the balance between the amount billed and the amount paid by the Service Benefit Plan. Private contracts can substantially increase your out-of-pocket costs.
Important Tips

Carry both your Medicare ID card and your Service Benefit Plan member ID card with you at all times. They are your passports to quick service when you visit a doctor or hospital.

Your ID cards have unique identification numbers on them that are yours alone. Write these numbers down and keep them in a safe place, in case you ever misplace your cards.

Services not included in your coverage will be your responsibility to pay, so be sure to refer to official Medicare publications and the Blue Cross and Blue Shield Service Benefit Plan brochure for information. These publications are updated every year. The 2014 Blue Cross and Blue Shield Service Benefit Plan brochure (RI 71-005) is available at www.fepblue.org/brochure. Medicare publications are available by calling 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) or visiting www.medicare.gov.

Be sure to keep a record of all bills you receive for healthcare. Note payments received or those made to doctors and hospitals on your behalf. This may help you know if something is not right with a claim, and you can make an inquiry by calling your local Plan at the number on the back of your Service Benefit Plan member ID card. Be sure to provide both your Medicare and your Service Benefit Plan member ID numbers.

Fraud

According to the Federal Bureau of Investigation, healthcare fraud costs the U.S. an estimated $80 billion a year. Some examples of healthcare fraud include:

• Falsifying a claim to obtain benefits
• False or exaggerated medical disability
• Using an ID card to obtain services for someone not eligible for coverage or who is no longer enrolled
• Altered or fabricated medical bills and other documents
• Excessive or unnecessary treatments
• Provider billing schemes, such as charging for a more expensive service than the one provided, charging for services that were not provided, or duplicate charges.

Tips to protect yourself:

• Protect your health insurance ID cards like a credit card. Only give your Medicare or Service Benefit Plan member ID number to those who have provided you with medical services.
• Review your medical bills and your Medicare Summary Notices (MSNs) from Medicare and your Explanation of Benefits (EOBs) from the Service Benefit Plan after receiving healthcare services. Check to make sure the dates and services are correct.
• Never sign blank insurance claim forms.
• Never give blanket authorization to a medical provider to bill for services rendered.
• Ask your medical providers what they will charge and what you will be expected to pay out-of-pocket.
• Keep accurate records of all healthcare appointments.

The Service Benefit Plan is dedicated to identifying and eliminating fraud, and your help is key to our success. If you have any questions, if your Service Benefit Plan member ID card has been lost or stolen, or if you suspect any fraudulent activity, call our fraud hotline at 1-800-337-8440.

Medicare also views you as a partner in their fight against fraudulent behavior by healthcare providers. You can report any such behavior to Medicare by calling 1-800-HHS-TIPS (1-800-447-8477).
**Terms and Definitions**

**Assignment** — Doctors and suppliers who participate with Medicare agree to accept Medicare assignment for all claims. This means that they have agreed to accept the charge approved by Medicare as total payment for covered services, and will not bill for more than the amount approved by Medicare.

**Benefits** — The healthcare items or services covered under the Service Benefit Plan and Medicare. Covered benefits and excluded services are defined in your health insurance plan’s coverage documents.

**Centers for Medicare & Medicaid Services (CMS)** — The federal agency that runs Medicare, Medicaid, and Children’s Health Insurance Programs.

**Claim** — A request for payment that you or a provider submit to Medicare or the Service Benefit Plan when you get items and services that you think are covered.

**Coinsurance** — Your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service.

**Copayment** — A fixed amount (for example, $20) you pay for a covered healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service.

**Cost sharing** — An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or prescription drug. This amount can include copayments, coinsurance, and/or deductibles.

**Coordination of benefits** — The process for deciding who pays first when two or more group health insurance plans are responsible for paying for the same medical claim.

**Deductible** — The amount you owe for covered healthcare services or prescriptions before Medicare or Standard Option begins to pay for covered services.

**Limiting Charge** — If your doctor does not accept Medicare assignment, he or she may charge up to 15% more than the Medicare-approved amount. This is called the limiting charge. The limiting charge places a limit on how much providers who do not participate with Medicare can charge for covered services. These providers are required by law to accept the limiting charge as payment in full.

**Network** — The facilities, providers and suppliers that the Service Benefit Plan has contracted with to provide healthcare services for our members.

**Penalty** — An amount added to your monthly premium for Part B or a Medicare drug plan (Part D) if you don’t join when you’re first eligible. You pay this higher amount as long as you have Medicare. There are some exceptions.

**Premium** — The amount that must be paid for your health insurance plan. You and/or your employer usually pay it monthly, quarterly or yearly.
Resources for You

Contact Us
If you have a question about your Blue Cross and Blue Shield Service Benefit Plan coverage, please contact us.

Visit us online — www.fepblue.org is your go-to resource for information about your coverage any time, day or night. You can:

- View the 2014 Blue Cross and Blue Shield Service Benefit Plan brochure for benefit information.
- Find out if your doctor is in our network with the Provider Directory.
- Look up the contact number for a Blue Cross and Blue Shield Plan in another state.

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<tr>
<th>For questions about:</th>
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<tr>
<td>Your benefits or claims</td>
<td>Your local Blue Cross and Blue Shield Plan. The telephone number is on the back of your ID card.</td>
</tr>
<tr>
<td>Prescriptions purchased at Preferred retail pharmacies</td>
<td>The Retail Pharmacy Program at 1-800-624-5060 (TTY 1-800-624-5077).</td>
</tr>
<tr>
<td>Prescriptions ordered through the Standard Option Mail Service Pharmacy Program</td>
<td>The Mail Service Pharmacy Program at 1-800-262-7890 (TTY 1-800-216-5343).</td>
</tr>
<tr>
<td>Prescriptions ordered through the Specialty Pharmacy Program</td>
<td>The Specialty Pharmacy Program at 1-888-346-3731 (TTY 1-877-853-9549).</td>
</tr>
<tr>
<td>Locating a provider overseas</td>
<td>The Federal Employees Service Center at 800-699-4337 or collect at 1-804-673-1678.</td>
</tr>
<tr>
<td>Benefits or claims information about overseas healthcare services</td>
<td>The Federal Employees Service Center at 800-699-4337 or collect at 1-804-673-1678.</td>
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</table>
Medicare, Blue and You

MyBlue®
You can also visit the MyBlue webpage at www.fepblue.org/myblue. MyBlue is a secure website where you can view your personal information about your Service Benefit Plan coverage. After you create an account, you can:

• Change your address, order a new ID card, add children after a birth or adoption, let us know about a marriage or divorce and check paid claims — all through MyBlue® Customer eService.
• Check the status of a prescription you sent to the Mail Service Pharmacy Program and order refills under Standard Option.
• Take the Blue Health Assessment and earn $40 on a MyBlue Wellness Card in 2014. You can use the funds on the card to pay for qualified medical expenses, such as prescriptions and copayments.
• Learn about more incentive programs on MyBlue!

Contact Medicare
If you have questions about Medicare benefits or need additional information, call Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) or visit www.medicare.gov.

MyMedicare
You can also visit www.mymedicare.gov, which is a secure website to access your personal information about your Medicare benefits and services. After you create your account, you can:

• Check the status of your eligibility, enrollment, and other Medicare benefits
• Access your Medicare claims information
• Order a new Medicare ID card
• Change your address for Medicare
• Request Medicare publications

Visit OPM.gov
The U.S. Office of Personnel Management (OPM) has information on its website, www.opm.gov/insure about the Federal Employees Health Benefits Program and Medicare.
This is a summary of the Blue Cross and Blue Shield Service Benefit Plan. For a complete description, see the plan’s federal brochure (RI 71-005). All benefits are subject to the definitions, limitations and exclusions set forth in the federal brochure.

Please refer to the Medicare publications available at your local Social Security office or by calling 1-800-633-4227 for a description of Medicare coverage.

Blue Cross Blue Shield Association is an association of independent Blue Cross and Blue Shield companies.