Make every moment better with great options from your Service Benefit Plan and Medicare coverage.

2017 MEDICARE & BLUE

Working together to benefit you.

BlueCross BlueShield
Federal Employee Program.

fepblue.org
As you reach or get closer to age 65, you have a number of things to do or think about—such as retirement or working on your bucket list. One thing you shouldn’t have to worry about is your health insurance coverage.

The Blue Cross and Blue Shield Service Benefit Plan (we’ll refer to the Service Benefit Plan as “we” or “us” throughout the rest of this booklet) has been serving members since 1960. Our coverage works nationwide and overseas, so no matter where your bucket list takes you, you can rest assured that you’re covered.

The other great thing about our coverage is that you can take it into retirement with you. You’ll receive the same benefits as our actively working members. The main difference is that you’ll pay your premium monthly, rather than bi-weekly.

Your enrollment options

Our Plan offers two different coverage types: **Standard Option** and **Basic Option**. Under either coverage type, you get to choose from three levels of enrollment.

- **Self Only** is coverage just for you.
- **Self Plus One** is coverage for you and one eligible family member, such as your spouse or a child.
- **Self and Family** is coverage for you and multiple eligible family members, such as your spouse and child(ren).

To learn more about our enrollment types, visit [fepblue.org/enrollment](http://fepblue.org/enrollment).
GETTING TO KNOW

MEDICARE

Medicare is a health insurance program provided by the federal government. It is available to:

- Individuals 65 and older
- People with certain disabilities
- Anyone with permanent kidney failure requiring dialysis treatment or a transplant, known as End-Stage Renal Disease

Medicare has four different parts

Each part covers different healthcare services.

Part A is hospital insurance. It covers inpatient care, home healthcare and hospice care. If you’re at least 65 and eligible to receive Social Security benefits, you do not need to pay a premium for Part A.

Part B is medical insurance. It covers outpatient services, doctor’s visits, durable medical equipment and some other services not covered by Part A. The standard Part B premium for 2017 is $134 per month. However, most people will pay less than this amount (usually closer to $109).

Part C is also known as Medicare Advantage or a Medicare Supplement. It’s private healthcare insurance that helps to cover Part A and B services. The benefits and premiums vary by plan.

Part D is prescription drug coverage. The benefits and premiums vary by plan.

Visit medicare.gov or call 1-800-MEDICARE (1-800-633-4227) to learn more. For TTY, dial 1-877-486-2048.
DECIDING TO COMBINE YOUR COVERAGE

If you’re close to age 65 and/or considering retirement, you may be asking one of the following questions:

1. Should I keep my Service Benefit Plan coverage and not enroll in Medicare?
2. Should I enroll in Medicare and give up my Service Benefit Plan coverage?
3. Should I keep my Service Benefit Plan coverage and also enroll in Medicare Part A and B?

The answer is: It’s up to you. But there are some things to keep in mind before you make a decision.

Even if you’re in perfect health now, you may want to consider some of your future healthcare needs before you decide to go with Medicare or the Service Benefit Plan alone.
Enrolling in Medicare coverage

Usually, your initial Medicare eligibility period begins three months before your 65th birthday and ends three months after your 65th birthday. If you decide you don’t want to enroll in Medicare right away, you’ll have an opportunity to enroll during Medicare’s annual enrollment period. Learn more at medicare.gov.

Late enrollment penalty

If you’re 65 or over, retired and you delay your Medicare Part B enrollment, Medicare may charge you a penalty for each year you forgo Part B coverage. This means you’ll pay a higher monthly premium than most people for your Part B coverage if you decide to enroll later.

However, if you or your spouse is still actively working and you receive health insurance coverage through one of your employers, the late enrollment penalty does not apply to you. You can apply for coverage at any point while one of you is still working. Once you stop receiving employer coverage or you both retire, you have eight months from that point to enroll in Part B before the penalty kicks in.

Keeping your Service Benefit Plan coverage into retirement

If you want to keep your Service Benefit Plan coverage into retirement, you usually can. You can learn more about eligibility requirements at opm.gov or by speaking with someone in your human resources (HR) department.

If you’re thinking about dropping your Service Benefit Plan coverage, keep these two rules in mind:

1. In order to remain eligible for coverage under any Federal Employees Health Benefits (FEHB) Program health plan once you are retired, you or your spouse must have at least five (5) consecutive years of coverage in the FEHB. These five years do not need to be with the same FEHB carrier.

2. If you are retired and you decide to drop your current FEHB coverage and you don’t enroll in a different FEHB Plan, you cannot re-enroll in FEHB coverage later in retirement.
Combining Medicare and Blue can be a winning combination—you can get maximum coverage and minimize your out-of-pocket costs.

Medicare works best with Service Benefit Plan coverage when Medicare is the primary payer, meaning it pays first. Generally, if you are retired, Medicare is your primary insurance coverage, and we are your secondary coverage. If you are still actively working, it’s the opposite: we pay first and Medicare pays second.

Throughout the rest of this booklet, we’ll discuss how we pay benefits if Medicare is your primary insurance and we are secondary. If you want to learn more about your benefits when we’re primary, you can view a copy of our brochure at fepblue.org/brochure.

Closing Medicare gaps

Medicare covers many of your healthcare services, but there are certain things Medicare Part A and B alone don’t cover.

**Prescription drug coverage**

Medicare Part A and B do not provide prescription drug coverage. Keeping your Service Benefit Plan coverage ensures that you will continue to receive comprehensive prescription drug benefits.

You’ll have access to our three prescription drug programs: the Retail Pharmacy Program, the Mail Service Pharmacy Program and the Specialty Pharmacy Program. If you have Basic Option, you have access to the Mail Service Pharmacy as long as you have Part B primary.

**MEDICARE PART D**

The U.S. Office of Personnel Management (OPM) determined that our prescription drug coverage pays out on average the same amount as Part D coverage. Therefore, you do not need to pay an extra premium to enroll in Part D coverage. However, if you decide you want to, we’ll coordinate our benefits with your Part D plan.

If you keep your Service Benefit Plan coverage, you will not have to pay the Medicare Part D penalty. However, if you drop your coverage and don’t enroll in another prescription drug plan within two months, you will have to pay a penalty for each month you went without prescription drug coverage if you decide to enroll in Medicare Part D later.
Hearing aid coverage
As a Service Benefit Plan member you can receive benefits for both the hearing tests needed to prescribe hearing aids, as well as an allowance of up to $2,500 every three years for the purchase of hearing aids and hearing aid supplies.

Routine foot care
If you have a long-term condition such as diabetes, your Service Benefit Plan coverage will cover necessary routine foot care. And, when combined with Medicare coverage, you’ll pay nothing out-of-pocket for these treatments.

Acupuncture
With Standard Option you can receive up to 24 acupuncture visits per year, and with Basic Option you can receive up to 10 visits per year. These are covered in full when Medicare is primary.

Dental care
Your Service Benefit Plan coverage provides preventive dental care. Under Standard Option, we’ll pay up to the fee schedule amount listed in the Service Benefit Plan brochure. Under Basic Option, you’ll pay nothing for covered dental services when Medicare is primary.

Overseas care
Medicare only provides coverage in the U.S., while the Service Benefit Plan provides coverage worldwide.
Even though you continue to pay your premiums when you combine your coverage, your total out-of-pocket costs for healthcare expenses may still be lower than the amount you pay annually in premiums.

See the chart on page 9 for an overview of what you’ll pay when you combine your coverage.
YOUR COST
FOR COVERED SERVICES

Cost is a big deciding factor in whether or not to choose Medicare coverage and keep your current Service Benefit Plan coverage.

What you won’t pay

Annual deductibles
A deductible is an amount you must pay before your health insurance carrier, in this case Medicare or the Service Benefit Plan, will pay for your healthcare services.

• Service Benefit Plan: If you’re enrolled in Standard Option, you currently have a calendar year deductible of $350 per person or $700 per family. We’ll waive this if you have Medicare primary.

• Medicare Part A: Part A has an inpatient hospital deductible of $1,316 per benefit period. We’ll waive this when Medicare Part A is primary.

• Medicare Part B: Part B has a deductible of $183 per year. We’ll waive this when Medicare Part B is primary.

Out-of-pocket costs
When you have Medicare primary, you usually have no additional out-of-pocket costs when combined with your Service Benefit Plan coverage. You also don’t need precertification (approval from us or Medicare) for your inpatient admissions.

What you will pay

Your monthly premiums
As both a Service Benefit Plan and Medicare member, you’ll pay both our monthly premium, as well as Medicare’s if you have Part B. The federal government will continue to pay a portion of your Service Benefit Plan premium even after you retire. The amount will be deducted from your monthly annuity.

Prescription drug costs
You will continue to pay your out-of-pocket costs for prescription drug coverage if you have Medicare primary. However, you’ll pay less than members without Medicare.

• Standard Option: You’ll pay less for generic prescriptions

• Basic Option: You’ll pay less for drugs in Tiers 2 through 5
## COMBINING STANDARD OPTION WITH MEDICARE IN 2017

### What you pay when you use Preferred providers

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Standard Option</th>
<th>Standard Option with Primary Medicare A &amp; B</th>
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<tr>
<td>Wellness Incentive Program</td>
<td>Earn $50 for completing the Blue Health Assessment and up to $120 for achieving up to three eligible Online Health Coach goals. Learn more at fepblue.org/healthtools.</td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>You pay nothing</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Physician Care</td>
<td>$25 for primary care $35 for specialists</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Lab and Diagnostic Services</td>
<td>15%* of our allowance</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Hospital Care</td>
<td><strong>Inpatient:</strong> $350 per admission <strong>Outpatient:</strong> 15%* of our allowance</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Surgical Services</td>
<td>15%* of our allowance</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$30 for urgent care center</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Emergency Care</td>
<td><strong>Accidental Injury:</strong> You pay nothing for outpatient services within 72 hours <strong>Medical Emergency:</strong> Regular benefits for physician and hospital care*</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td><strong>Preferred Retail Pharmacy:</strong> Tier 1 (Generics): 20% of our allowance Tier 2 (Preferred brand): 30% of our allowance Tier 3 (Non-preferred brand): 45% of our allowance Tier 4 (Preferred specialty): 30% of our allowance Tier 5 (Non-preferred specialty): 30% of our allowance <strong>Mail Service Pharmacy:</strong> Tier 1 (Generics): $15 copay Tier 2 (Preferred brand): $80 copay Tier 3 (Non-preferred brand): $105 copay <strong>Specialty Pharmacy:</strong> Tier 4 (Preferred specialty): $35 copay Tier 5 (Non-preferred specialty): $55 copay</td>
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<td>Physical, Speech and Occupational Therapy</td>
<td>$25 for primary care $35 for specialists Limited to a combined 75 visits per person per year</td>
<td>You pay nothing for up to a combined 75 visits per person per year</td>
</tr>
</tbody>
</table>

* Is subject to the 2017 Standard Option calendar year deductible: $350 per person or $700 in total for Self Plus One or Self and Family contracts.

If you use a Non-preferred provider under Standard Option, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown in the table above.
## COMBINING BASIC OPTION WITH MEDICARE IN 2017

### What you pay when you use Preferred providers

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<td><strong>Preventive Care</strong></td>
<td>You pay nothing</td>
<td>You pay nothing</td>
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<td><strong>Physician Care</strong></td>
<td>$30 for primary care $40 for specialists</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Lab and Diagnostic Services</strong></td>
<td>You pay nothing¹ for lab tests, pathology services and EKGs $40¹ for diagnostic tests such as home sleep studies, EEGs, ultrasounds and X-rays $100¹ for angiography, bone density tests, CT scans, MRIs, PET scans, genetic testing, nuclear medicine and sleep studies in an office setting; $150¹ at a hospital</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Hospital Care</strong></td>
<td>Inpatient: $175 per day; up to $875 per admission</td>
<td>You pay nothing</td>
</tr>
<tr>
<td></td>
<td>Outpatient: $100¹ per day per facility</td>
<td></td>
</tr>
<tr>
<td><strong>Surgical Services</strong></td>
<td>$150¹ in an office setting $200¹ in a non-office setting</td>
<td>You pay nothing</td>
</tr>
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<td><strong>Urgent Care</strong></td>
<td>$35 for urgent care center</td>
<td>You pay nothing</td>
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<tr>
<td><strong>Emergency Care</strong></td>
<td><strong>Accidental Injury and Medical Emergency:</strong> $125 per day for emergency room care Regular benefits for physician care</td>
<td>You pay nothing</td>
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<td><strong>Prescription Drugs</strong></td>
<td><strong>Preferred Retail Pharmacy:</strong></td>
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<td>Tier 1 (Generics): $10 copay</td>
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</tr>
<tr>
<td></td>
<td>Tier 2 (Preferred brand): $50 copay</td>
<td>Tier 2 (Preferred brand): $45 copay</td>
</tr>
<tr>
<td></td>
<td>Tier 3 (Non-preferred brand): 60% of our allowance ($65 minimum)</td>
<td>Tier 3 (Non-preferred brand): 50% of our allowance ($55 minimum)</td>
</tr>
<tr>
<td></td>
<td>Tier 4 (Preferred specialty): $65 copay</td>
<td>Tier 4 (Preferred specialty): $60 copay</td>
</tr>
<tr>
<td></td>
<td>Tier 5 (Non-preferred specialty): $90 copay</td>
<td>Tier 5 (Non-preferred specialty): $80 copay</td>
</tr>
<tr>
<td></td>
<td><strong>Mail Service Pharmacy:</strong></td>
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</tr>
<tr>
<td></td>
<td>Not a benefit</td>
<td>Tier 1 (Generics): $20 copay</td>
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<td><strong>Specialty Pharmacy:</strong></td>
<td>Tier 2 (Preferred brand): $90 copay</td>
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<td>Tier 4 (Preferred specialty): $55 copay</td>
<td>Tier 3 (Non-preferred brand): $115 copay</td>
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<td>Tier 5 (Non-preferred specialty): $80 copay</td>
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<td></td>
<td>Tier 4 (Preferred specialty): $50 copay</td>
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<tr>
<td></td>
<td></td>
<td>Tier 5 (Non-preferred specialty): $70 copay</td>
</tr>
<tr>
<td></td>
<td><strong>Physical, Speech and Occupational Therapy</strong></td>
<td>You pay nothing for up to a combined 50 visits per person per year</td>
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<td>$30¹ for primary care $40¹ for specialists</td>
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<td>Limited to a combined 50 visits per person per year</td>
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</table>

¹Under Basic Option you pay 30% of our allowance for agents, drugs and/or supplies you receive during your care.

Basic Option generally does not provide benefits when you use Non-preferred providers.
RECEIVING
THE RIGHT CARE

Service Benefit Plan network
Our network of Preferred providers consists of nearly 1 million providers nationwide. When you visit one of these providers, they submit your claims for you. You can locate a Preferred provider at fepblue.org/provider.

Medicare network
Medicare has network providers, too. These providers accept Medicare’s payment (known as the Medicare assignment).

If your provider does not accept the Medicare assignment, they are only allowed to charge you up to 115% of the Medicare approved amount. This is called the Medicare limiting charge. See how this works below:

- Provider’s billed charge: $2,500
- Medicare’s approved amount (assignment): $2,000
- The most your provider can charge you (limiting charge): $2,000 \times 115\% = $2,300

As your health plan, when you combine our coverage with Medicare coverage, we will pay up to Medicare’s limiting charge for covered services. Therefore, we would pay the difference between what Medicare pays and what the provider is owed—you would pay nothing. If you have Basic Option, the provider must be a Service Benefit Plan Preferred provider in order for us to pay our portion of the service.

Make sure you show your provider both your Medicare member ID card and your Service Benefit Plan ID card when you receive services. This helps to ensure that the claim is sent to the correct location.
Note about private contracts: Some providers may ask patients to sign a contract agreeing that you can be billed directly for services usually covered by Medicare. **Do not sign a contract like this**—if you do, Medicare will not cover any portion of your service. In addition, our payment will be limited to the amount that Medicare would have paid. You will be responsible for all other charges.
There are a number of resources available to you if you want to learn more about Medicare, the Service Benefit Plan or other benefit programs.

**Social Security**
Your local Social Security office can help you with all your Medicare enrollment needs.

You can locate your local Social Security office at [ssa.gov](https://www.ssa.gov), or you can call the national number at **1-800-772-1213**. For TTY, dial 1-800-325-0778.

**Medicare**
To learn more about Medicare benefits and services, visit [medicare.gov](https://www.medicare.gov) or call **1-800-MEDICARE (1-800-633-4227)**. For TTY, dial 1-877-486-2048.

**U.S. Office of Personnel Management (OPM)**
Once you retire, OPM becomes your payroll office. You can visit [opm.gov](https://www.opm.gov) to learn more about the FEHB and other federal benefit programs.

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**SERVICE BENEFIT PLAN**
To learn more about the Service Benefit Plan, visit our website at [fepblue.org](https://www.fepblue.org).

To speak to a customer service representative, you can call the customer service number on the back of your member ID card. You can also visit our Contact Us page at [fepblue.org/contact](https://www.fepblue.org/contact) to look up your local customer service number.
The Blue Cross and Blue Shield Service Benefit Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Blue Cross and Blue Shield Service Benefit Plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, contact the Civil Rights Coordinator of your local Blue Cross and Blue Shield company by calling the customer service number on the back of your member ID card.

If you believe that this Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator of your local BCBS company. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, your local BCBS company’s Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)


Language assistance
Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

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This is a summary of the features of 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.

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