Medicare & Other Health Benefits:

Your Guide to

# Who Pays First

CENTERS FOR MEDICARE & MEDICAID SERVICES

**This official government booklet tells you:**

- How Medicare works with other types of coverage
- Who should pay your bills first
- Where to get more help

## Notice of Availability of Auxiliary Aids & Services

We're committed to making our programs, benefits, services, facilities, information, and technology accessible in accordance with Sections 504 and 508 of the Rehabilitation Act of 1973. We'll take appropriate steps to make sure that people with disabilities, including people who are deaf, hard of hearing or blind, or who have low vision or other sensory limitations, have an equal opportunity to participate in our services, activities, programs, and other benefits. We provide various auxiliary aids and services to communicate with people with disabilities, including:

### Relay service — TTY users should call 1-877-486-2048.

### Alternate formats

- To request other Medicare publications in alternate formats, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- For all other CMS publications:
  - Call 1-844-ALT-FORM (1-844-258-3676). TTY users should call 1-844-716-3676.
  - Send a fax to 1-844-530-3676.
  - Send an email to AltFormatRequest@cms.hhs.gov.
  - Send a letter to: Centers for Medicare & Medicaid Services Office of Equal Employment Opportunity & Civil Rights (OEOCR), 7500 Security Boulevard, Room N2-22-16, Baltimore, MD 21244-1850, Attn: CMS Alternate Format Team

**Note:** Your request for a CMS publication should include your name, phone number, mailing address where we should send the publications, and the publication title and product number, if available. Also include the format you need, like Braille, large print, compact disc (CD), audio CD, or a qualified reader.

### Nondiscrimination Notice

The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age. If you think you've been discriminated against or treated unfairly for any of these reasons, you can file a complaint with the Department of Health and Human Services, Office for Civil Rights by:

- Calling 1-800-368-1019. TTY users should call 1-800-537-7697.
- Visiting hhs.gov/ocr/civilrights/complaints.
- Writing: Office for Civil Rights

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

# Table of contents

Introduction . . . . . 4

Section 1: When you have other health coverage . . . . . 5

Coordination of benefits . . . . . 5

Where to go with questions . . . . . 5

How Medicare works with other coverage . . . . . 6

Section 2: Medicare & other types of health coverage . . . . . 11

Medicare & Medicaid . . . . . 11

Medicare & group health plan coverage . . . . . 11

Medicare & group health plan coverage after you retire . . . . . 13

Medicare & group health plan coverage for people who are disabled (non-ESRD disability) . . . . . 15

Medicare & group health plan coverage for people with End-Stage Renal Disease (ESRD) . . . . . 16

Medicare & no-fault or liability insurance . . . . . 17

Medicare & workers' compensation . . . . . 19

Medicare & Veterans' benefits . . . . . 23

Medicare & TRICARE . . . . . 24

Medicare & the Federal Black Lung Benefits Program . . . . . 26

Medicare & COBRA . . . . . 26

Section 3: Definitions . . . . . 29

Section 4: Index . . . . . 31

# Introduction

## How this guide can help you

Some people with Medicare have other health coverage that must pay before Medicare pays its share of the bill. This guide tells how Medicare works with other kinds of coverage and who should pay your bills first.

Tell your doctor, hospital, and all other health care providers about your other health coverage to make sure your bills are sent to the right payer to avoid delays.

## Where to get basic information about Medicare

Visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

The information in this booklet describes the Medicare program at the time this booklet was printed. Changes may occur after printing. Visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users should call 1-877-486-2048.

**"Medicare & Other Health Benefits: Your Guide to Who Pays First"** isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

SECTION 1

# When you have other health coverage

## Coordination of benefits

If you have Medicare and other health coverage, each type of coverage is called a "payer." When there's more than one payer, "coordination of benefits" rules decide who pays first. The "primary payer" pays what it owes on your bills first, and then you or your health care provider sends the rest to the "secondary payer" to pay. In some rare cases, there may also be a "third payer."

Whether Medicare pays first depends on a number of things, including the situations listed in the chart on the next 3 pages. However, this chart doesn't cover every situation. Be sure to tell your doctor and other providers if you have health coverage in addition to Medicare. This will help them send your bills to the correct payer to avoid delays.

**Note:** Paying "first" means paying the bill **up to** the limits of the payer's coverage. It doesn't mean the primary payer is always the first one **in time** to pay its share of the costs.

## Where to go with questions

**If you have questions about who pays first, or if your coverage changes, call the Benefits Coordination & Recovery Center (BCRC) toll-free at 1-855-798-2627. TTY users should call 1-855-797-2627.**

To better serve you, have your Medicare number ready when you call. You can find your Medicare number on your red, white, and blue Medicare card.

You also may be asked for additional information, like:

- Your Social Security Number (SSN)
- Address
- Medicare effective date(s)
- Whether you have Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance)

**Words in purple are defined on pages 29–30.**

## How Medicare works with other coverage

Use the **chart below** to find your type(s) of coverage and situation to see which payer pays first.

| If you | Situation | Pays first | Pays second | Page(s) |
|---|---|---|---|---|
| Are covered by Medicare and Medicaid | Entitled to Medicare and Medicaid | Medicare | Medicaid | 11 |
| Are 65 or older and covered by a group health plan because you or your spouse is still working | Entitled to Medicare<br>The employer has 20 or more employees (See page 12 for information about multi-employer and multiple employer group health plans.) | Group health plan | Medicare | 12 |
| | The employer has less than 20 employees | Medicare | Group health plan | 12 |
| Have an employer group health plan through your former employer after you retire and are 65 or older | Entitled to Medicare | Medicare | Retiree coverage | 13–15 |
| Are disabled and covered by a large group health plan from your work, or from a family member (like spouse, domestic partner, son, daughter, or grandchild) who's working | Entitled to Medicare<br>The employer has 100 or more employees | Large group health plan | Medicare | 15 |
| | The employer has less than 100 employees (See page 12 for information about multi-employer and multiple employer group health plans.) | Medicare | Group health plan | 15 |

| If you | Situation | Pays first | Pays second | Page(s) |
|---|---|---|---|---|
| *Have End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant) and group health plan coverage (including a retirement plan) | First 30 months of eligibility or entitlement to Medicare | Group health plan | Medicare | 16 |
| | After 30 months of eligibility or entitlement to Medicare | Medicare | Group health plan | 16 |
| Have ESRD and COBRA coverage | First 30 months of eligibility or entitlement to Medicare based on having ESRD | COBRA | Medicare | 27 |
| | After 30 months | Medicare | COBRA | 16 |
| Are 65 or over OR disabled (other than by ESRD) and covered by Medicare and COBRA coverage | Entitled to Medicare | Medicare | COBRA | 26–27 |
| Have been in an accident where no-fault or liability insurance is involved | Entitled to Medicare | No-fault or liability insurance for services or items related to accident claim | Medicare | 17–19 |
| Are covered under workers' compensation because of a job-related illness or injury | Entitled to Medicare | Workers' compensation for services or items related to workers' compensation claim | Usually doesn't apply. However, Medicare may make a conditional payment (a payment that must be repaid to Medicare when a settlement, judgment, award, or other payment is made.) | 19–23 |

* If you originally got Medicare due to your age or a disability other than ESRD, and Medicare was your primary payer, it still pays first when you become eligible because of ESRD.

| If you | Situation | Pays first | Pays second | Page(s) |
|---|---|---|---|---|
| Are a Veteran and have Veterans' benefits | Entitled to Medicare and Veterans' benefits | Medicare pays for Medicare-covered services or items.<br>Veterans' Affairs pays for VA-authorized services or items.<br>**Note:** Generally, Medicare and VA can't pay for the same service or items. | Usually doesn't apply | 23–24 |
| Are covered under TRICARE | Entitled to Medicare and TRICARE | Medicare pays for Medicare-covered services or items.<br>TRICARE pays for services or items from a military hospital or any other federal provider. | TRICARE may pay second. | 24–25 |
| Have black lung disease and are covered under the Federal Black Lung Benefits Program | Entitled to Medicare and the Federal Black Lung Benefits Program | The Federal Black Lung Benefits Program for services related to black lung. | Medicare | 26 |

### How will Medicare know I have other coverage?

Medicare doesn't automatically know if you have other coverage. However, insurers must report to Medicare when they're responsible to pay first on your medical claims. In some cases your employer or your insurer may ask you questions about your current coverage so they can report that information to Medicare.

You can also report your coverage information by calling the Benefits Coordination & Recovery Center (BCRC) toll-free at 1-855-798-2627. TTY users should call 1-855-797-2627.

## How Medicare works with other coverage (continued)

**Example:** Harry recently turned 65 and is eligible to enroll in Medicare. He works for a large company with more than 20 people and has coverage through his employer's group health plan. The insurer sends Harry a questionnaire asking whether Harry is still currently working. If Harry replies that he's still working, the insurer will report Harry's group health plan insurance information to Medicare so that Medicare knows to pay Harry's claims second.

### What happens if my health coverage changes?

Insurers must report these changes to Medicare, but the changes can take some time to be posted to Medicare's records.

If that happens, call the Benefits Coordination & Recovery Center (BCRC) toll-free at 1-855-798-2627. TTY users should call 1-855-797-2627. You'll have to give this information:

- Your name
- The name and address of your health plan
- Your policy number
- The date coverage was added, changed, or stopped, and why

Tell your doctor and other health care providers about changes in your coverage when you get care. Also, contact your health plan to make sure they reported these changes to Medicare. Medicare uses your answers to help keep your file correct so your claims get paid correctly.

### What if I have Medicare and more than one type of coverage?

Check your insurance policy—it may include the rules about who pays first. You can also call the BCRC.

## How Medicare works with other coverage (continued)

### Can I get coverage through the Health Insurance Marketplace if I already have Medicare?

Generally, no. It's against the law for someone who knows that you have Medicare to sell or issue you a Marketplace policy. This is true even if you have only Medicare Part A or only Medicare Part B. Therefore, if you already have Medicare, you shouldn't need to coordinate benefits between Medicare and a Marketplace plan.

On the other hand, if you don't yet have Medicare but have coverage through the Marketplace, you can choose to keep your Marketplace plan after your Medicare coverage starts. But, if you've been getting premium tax credits or other savings on a plan you bought through the Marketplace, these savings will end once your Part A coverage starts, so you'd have to pay full price for the Marketplace plan. If you age into Medicare and decide to keep your Marketplace plan, then Medicare pays first.

### Where can I get more information about who pays first?

Call your health insurance plan's benefits administrator. You can also call the Benefits Coordination & Recovery Center (BCRC) toll-free at 1-855-798-2627. TTY users should call 1-855-797-2627.

SECTION 2

# Medicare & other types of health coverage

You have a number of important decisions to make when you turn 65, like whether you should enroll in Medicare Part B (Medical Insurance), join a Medicare Prescription Drug Plan, buy a Medicare Supplement Insurance (Medigap) policy, and/or keep employer or retiree coverage. By understanding your choices, you can avoid paying more than you need to, and get coverage that meets your needs.

Visit Medicare.gov/find-a-plan to compare Medicare health and drug plans in your area. You can also call your State Health Insurance Assistance Program (SHIP). To get the phone number for your state, visit shiptacenter.org, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

## Medicare & Medicaid

Medicaid is a joint federal and state program that helps pay medical costs for certain people and families who have limited income and resources and meet other requirements. **Medicaid never pays first for services covered by Medicare**. It only pays after Medicare has paid. In rare cases where there's other coverage, Medicaid pays after the other coverage has paid.

## Medicare & group health plan coverage

### Should I get group health plan coverage?

Many employers and unions offer group health plan coverage to current employees or retirees (if you have Federal Employees Health Benefits (FEHB) Program coverage, your coverage works the same as it does for all group health plans). You may also get group health plan coverage through the employer of a spouse or family member.

If you have Medicare and you're offered coverage under a group health plan, you can choose to accept or reject the plan. The group health plan may be a fee-for-service plan or a managed care plan, like an HMO or PPO.

**Words in purple are defined on pages 29–30.**

## Medicare & group health plan coverage (continued)

### I have Medicare and group health plan coverage. Who pays first?

If your employer has less than 20 employees, Medicare generally pays first.

Generally, your group health plan pays first if **both** of these are true:

1. You're 65 or older and covered by a group health plan through your **current** employer or the **current** employer of a spouse of any age.

   **Note:** "Spouse" includes both opposite-sex and same-sex marriages where either 1) you're entitled to Medicare as a spouse based on Social Security's rules; or 2) the marriage was legally entered into in a U. S. jurisdiction that recognizes the marriage—including one of the 50 states, the District of Columbia, or a U.S. territory—or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction.

2. The employer has 20 or more employees and covers any of the same services as Medicare (this means the group health plan pays first on your hospital and medical bills).

If the group health plan didn't pay all of your bill, the doctor or health care provider should bill Medicare for secondary payment. Medicare will look at what your group health plan paid, and pay any additional costs up to the Medicare-approved amounts for Medicare covered and otherwise reimbursable items and services, as appropriate. In some cases, you may pay whatever costs Medicare or the group health plan doesn't cover.

### My employer participates in a multi-employer plan or a multiple employer plan. Who pays first?

Multi-employer and multiple employer group health plans are plans sponsored by or contributed to by 2 or more employers. If your employer joins with other employers or employee organizations (like unions) to sponsor or contribute to a multi-employer or a multiple employer plan, and any of the other employers has 20 or more employees, your group health plan pays first and Medicare would generally pay second. **However, your plan might ask for an exception, so even if your employer has less than 20 employees and participates in a multi-employer or multiple employer plan, you'll need to find out from your employer whether Medicare pays first or second.**

### I'm in a Health Maintenance Organization (HMO) Plan or an employer Preferred Provider Organization (PPO) Plan that pays first. Who pays if I go outside the employer plan's network?

If you go for care outside your employer plan's network, it's possible that neither the plan nor Medicare will pay. Call your plan before you go outside the network to find out if the service will be covered.

## Medicare & group health plan coverage (continued)

### If I don't accept coverage from my employer, how will this affect what Medicare will pay?

Medicare pays its share for any Medicare-covered health care service you get, even if you don't take group health plan coverage from your employer, and you don't have coverage through an employed spouse.

### What happens if I drop coverage from my employer?

Medicare pays first unless you have coverage through an employed spouse, and your spouse's employer has at least 20 employees.

**Note:** If you don't take employer coverage when it's first offered to you, you might not get another chance to sign up. If you take the coverage but drop it later, you may not be able to get it back. Also, you might be denied coverage if your employer or your spouse's employer generally offers retiree coverage but you weren't in the plan while you or your spouse was still working. Call your employer's benefits administrator for more information before you make a decision.

### If I'm 65 or older and still working, what health benefits does my employer have to offer me?

Employers with 20 or more employees must offer current employees 65 and older the same health benefits, under the same conditions, that they offer younger employees. If the employer offers coverage to spouses, it must offer the same coverage to spouses 65 and older that it offers to spouses under 65.

## Medicare & group health plan coverage after you retire

### How does my group health plan coverage work after I retire?

It depends on the terms of your specific plan. Your employer or union or your spouse's employer or union might not offer any health coverage after you retire. If you can get group health plan coverage after you retire, it might have different rules and might not work the same way with Medicare.

### Can I continue my employer coverage after I retire?

When you have retiree coverage from an employer or union, they manage this coverage. Employers aren't required to provide retiree coverage, and they can change benefits or premiums, or even cancel coverage.

### What are the price and benefits of the retiree coverage, and does it include coverage for my spouse?

Your employer or union may offer retiree coverage that limits how much it will pay. It might only provide "stop loss" coverage, which starts paying your out-of-pocket costs only when they reach a maximum amount.

## Medicare & group health plan coverage after you retire (continued)

### What happens to my retiree coverage when I'm eligible for Medicare?

If your former employer offers retiree coverage, the coverage might not pay your medical costs during any period in which you were eligible for Medicare but didn't sign up for it. When you become eligible for Medicare, you may need to join both Medicare Part A and Medicare Part B to get full benefits from your retiree coverage.

### What effect will my continued coverage as a retiree have on both my health coverage and my spouse's health coverage?

If you're not sure how your retiree coverage works with Medicare, get a copy of your plan's benefit materials, or look at the summary plan description provided by your employer or union. You can also call your employer's benefits administrator and ask how the plan pays when you have Medicare. You may want to talk to your State Health Insurance Assistance Program (SHIP) for advice about whether to buy a Medicare Supplement Insurance (Medigap) policy. To get the phone number for your state, visit shiptacenter.org, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

### How does retiree coverage compare with a Medigap policy?

Since Medicare pays first after you retire, your retiree coverage is likely to be similar to coverage under a Medigap policy. Retiree coverage isn't the same thing as a Medigap policy but, like a Medigap policy, it usually offers benefits that fill in some of Medicare's gaps in coverage, like coinsurance and deductibles. Sometimes retiree coverage includes extra benefits, like coverage for extra days in the hospital.

### If I choose to buy a Medigap policy, when should I buy it?

The best time is during your 6-month Medigap Open Enrollment period, because you can buy any Medigap policy sold in your state, even if you have health problems. This period automatically starts the month you're 65 **and** enrolled in Part B, and once it's over, you can't get it again.

**Remember:** You and your spouse would each have to buy your own Medigap policy, and you can only buy a policy when you're eligible for Medicare.

For more information about Medigap policies, visit Medicare.gov/publications to view the booklet "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare." To find and compare Medigap polices, visit Medicare.gov/find-a-plan, or call 1-800-MEDICARE.

## Medicare & group health plan coverage after you retire (continued)

**I'm retired and have Medicare. I also have group health plan coverage from my former employer. Who pays first?**

Generally, Medicare pays first for your health care bills and your group health plan (retiree) coverage pays second.

**I'm retired and have Medicare. My spouse is still working and I have group health plan coverage through my spouse's employer. Who pays first?**

If your spouse's employer has 20 or more employees (or if the employer is part of a multi-employer or multiple employer plan), your spouse's coverage pays first and Medicare pays second. If your spouse's employer has less than 20 employees, Medicare pays first.

**What happens if I have group health plan coverage after I retire and my former employer goes bankrupt or out of business?**

If your former employer goes bankrupt or out of business, federal COBRA rules may protect you if any other company within the same corporate organization still offers a group health plan to its employees. That plan is required to offer you COBRA continuation coverage. See pages 26–27. If you can't get COBRA continuation coverage, you may have the right to buy a Medigap policy even if you're no longer in your Medigap Open Enrollment Period.

## Medicare & group health plan coverage for people who are disabled (non-ESRD disability)

**I'm under 65, disabled, and have Medicare and group health plan coverage based on current employment. Who pays first?**

It depends. Generally, if your employer has less than 100 employees, Medicare pays first if you're under 65 and you have Medicare because of a disability.

Sometimes employers with less than 100 employees join with other employers to form a multi-employer plan or a multiple employer plan. If at least one employer in the multi-employer plan or multiple employer plan has 100 employees or more, your group health plan coverage pays first and Medicare pays second.

## Medicare & group health plan coverage for people who are disabled (non-ESRD disability) (continued)

### I'm under 65, disabled, and have Medicare and group health plan coverage based on current employment. Who pays first? (continued)

If the employer has at least 100 employees, the health plan is called a large group health plan. If you're covered by a large group health plan because of your current employment or the current employment of a family member (including, but not limited to a spouse, a domestic partner, son, daughter, or grandchild), your group health plan coverage pays first and Medicare pays second. A large group health plan can't treat any plan member differently because they're disabled and have Medicare.

**Example:** Mary works full-time for a company that has 120 employees. She has large group health plan coverage for herself and her husband. Her husband has Medicare because of a disability, so Mary's group health plan coverage pays first for Mary's husband, and Medicare pays second.

## Medicare & group health plan coverage for people with End-Stage Renal Disease (ESRD)

### I have ESRD and group health plan coverage. Who pays first?

If you're eligible for Medicare because of End Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant) , your group health plan will pay first on your hospital and medical bills for 30 months, whether or not you have Medicare. During this time, Medicare pays second.

The group health plan pays first during this period no matter how many employees work for your employer, or whether you or a family member are currently employed. At the end of the 30 months, Medicare pays first. This rule applies to most people with ESRD, whether you have your own group health plan coverage, or you're covered as a family member.

**Example:** Bill has Medicare coverage because of ESRD. He also has group health plan coverage through his company. Bill's group health plan coverage will pay first for the first 30 months after he becomes eligible for Medicare. After 30 months, Medicare pays first.

## Medicare & no-fault or liability insurance

### What's no-fault insurance?

No-fault insurance may pay for health care services you get because you get injured or your property gets damaged in an accident, regardless of who is at fault for causing the accident.

Some types of no-fault insurance include:

- Automobile insurance
- Homeowners' insurance
- Commercial insurance plans

### What's liability insurance?

Liability insurance (including self-insurance) protects individuals who have liability insurance coverage against claims for things like negligence or other types of potential wrongdoing— for example, inappropriate action or inaction that causes someone to get injured or causes property damage.

Some types of liability insurance include:

- Homeowners'
- Automobile
- Product
- Malpractice
- Uninsured motorist
- Underinsured motorist

If you have an insurance claim for your medical expenses, you or your lawyer should notify Medicare as soon as possible.

### Who pays first if I have a claim for no-fault or liability insurance?

No-fault insurance or liability insurance pays first and Medicare pays second.

If doctors or other providers are told you have a no-fault or liability insurance claim, they must try to get paid from the insurance company before billing Medicare. However, this may take a long time. If the insurance company doesn't pay the claim promptly (usually within 120 days), your doctor or other provider may bill Medicare. Medicare may make a conditional payment to pay the bill, and then later get back any payments the primary payer should have made.

## Medicare & no-fault or liability insurance (continued)

### Who pays first if I have a claim for no-fault or liability insurance? (continued)

**Example:** Nancy is 69 years old. She's a passenger in her granddaughter's car, and they have an accident. Nancy's granddaughter has Personal Injury Protection/ Medical Payments (Med Pay) coverage as part of her automobile insurance. While at the hospital emergency room, Nancy is asked about available coverage related to the accident. Nancy tells the hospital that her granddaughter has Med Pay coverage. Because this coverage pays regardless of fault, it's considered no-fault insurance. The hospital bills the no-fault insurance for the emergency room services and only bills Medicare if any Medicare-covered services aren't paid for by the no-fault insurance.

### Who pays if the no-fault or liability insurance denies my medical bill or is found not liable for payment?

In certain circumstances, Medicare will make conditional payments when a no-fault insurer or liability insurer doesn't pay. If you have group health plan coverage, it must pay before Medicare. You're still responsible for your share of the bill, like coinsurance, copayment, or a deductible, and for services Medicare doesn't cover.

### What's a conditional payment?

A conditional payment is a payment Medicare makes for services another payer may be responsible for. Medicare makes this conditional payment so you won't have to use your own money to pay the bill. The payment is "conditional" because it must be repaid to Medicare if you get a settlement, judgment, award, or other payment later.

**Note:** You're responsible for making sure Medicare gets repaid from the settlement, judgment, award, or other payment.

## Medicare & no-fault or liability insurance (continued)

**Example:** Joan is driving her car when someone in another car hits her. Joan has to go to the hospital. The hospital tries to bill the other driver's insurance company. The insurance company disputes who was at fault and won't pay the claim right away. The hospital bills Medicare, and Medicare makes a conditional payment to the hospital for health care services Joan got. When a settlement is reached with the other driver's insurance company, Joan must make sure Medicare gets repaid for the conditional payment.

**Example:** Bob has a heart attack. Medicare pays for Bob's medical care for his heart attack and his recovery. Bob later learns that a prescription medication he takes may have triggered his heart attack. He's part of a class action lawsuit against the company that makes the medication and he gets a settlement. Bob must make sure that Medicare gets repaid for any conditional payments it made to him related to the settlement he got.

### How does Medicare get repaid for the conditional payment?

If you file a no-fault insurance or liability insurance claim, you or your representative should call the Benefits Coordination & Recovery Center (BCRC) toll-free at 1-855-798-2627. TTY users should call 1-855-797-2627. The BCRC will set up and work on your recovery case, using information from you or your representative.

The BCRC will gather information about any conditional payments Medicare made related to your no-fault insurance or liability claim. If you get a settlement, judgment, award, or other payment, you or your representative should call the BCRC. The BCRC will determine the final repayment amount (if any) on your recovery case and send you a letter requesting repayment.

### Where can I get more information?

If you have questions about a no-fault or liability insurance claim, call the insurance company. If you have questions about who pays first, call the BCRC.

## Medicare & workers' compensation

### What's workers' compensation?

Workers' compensation is a law or plan requiring employers to cover employees who get sick or injured on the job. Workers' compensation plans cover most employees. If you don't know whether you're covered, ask your employer, or contact your state workers' compensation division or department.

## Medicare & workers' compensation (continued)

**If you think you have a work-related illness or injury, tell your employer, and file a workers' compensation claim.**

You or your lawyer also need to call the Benefits Coordination & Recovery Center (BCRC) toll-free at 1-855-798-2627 as soon as you file your workers' compensation claim. TTY users should call 1-855-797-2627.

### I have Medicare and filed a workers' compensation claim. Who pays first?

If you have Medicare and get injured on the job, workers' compensation pays first on health care items or services you got because of your work-related illness or injury. There can be a delay between when a bill is filed for the work-related illness or injury and when the state workers' compensation insurance decides if they should pay the bill. Medicare can't pay for items or services that workers' compensation will pay for promptly (generally within 120 days).

Medicare may make a conditional payment if the workers' compensation insurance company denies payment for your medical bills pending a review of your claim (generally 120 days or longer).

**Note:** This isn't the same situation as when your workers' compensation case has been settled and you're using funds from your Workers' Compensation Medicare Set-aside Arrangement (WCMSA) to pay for your medical care. See next page for more information on WCMSAs.

**Example:** Tom was injured at work. He filed a workers' compensation claim. His doctor billed the state workers compensation agency for payment, but she didn't get paid within 120 days, so she billed Medicare, requesting a conditional payment. Medicare made a conditional payment to Tom's doctor for the health care services Tom got. If Tom gets a settlement, judgment, award, or other payment from the state workers compensation agency, Tom must make sure Medicare gets repaid for the conditional payment Medicare made to his doctor.

### What if workers' compensation denies payment?

If workers' compensation insurance denies payment, and you give Medicare proof that the claim was denied, Medicare will pay for Medicare-covered items and services as appropriate.

**Example:** Mike was injured at work. He filed a workers' compensation claim. The workers' compensation agency denied payment for Mike's medical bills. Mike's doctor billed Medicare and sent Medicare a copy of the workers' compensation denial with the claim for Medicare payment. Medicare will pay Mike's doctor for the Medicare-covered items and services Mike got as part of his treatment. Mike must pay for anything Medicare doesn't cover.

## Medicare & workers' compensation (continued)

### Can workers' compensation decide not to pay my entire bill?

In some cases, workers' compensation insurance may not pay your entire bill. If you had an injury or illness before you started your job (called a "pre-existing condition"), and the job made it worse, workers' compensation may not pay your whole bill because the job didn't cause the original problem. In this case, workers' compensation insurance may agree to pay only a part of your doctor or hospital bills. You and workers' compensation insurance may agree to share the cost of your bill. If Medicare covers the treatment for your pre-existing condition, then Medicare may pay its share for part of the doctor or hospital bills that workers' compensation doesn't cover.

### How does Medicare get repaid for the conditional payment?

If Medicare makes a conditional payment, and you or your lawyer haven't reported your worker's compensation claim to Medicare, call the Benefits Coordination & Recovery Center (BCRC) toll-free at 1-855-798-2627. TTY users should call 1-855-797-2627. The BCRC will work on your case using information from you or your representative, to see that Medicare gets repaid for the conditional payments.

The BCRC will gather information about any conditional payments Medicare made relating to your workers' compensation claim. If you get a settlement, judgment, award, or other payment, you or your lawyer should call the BCRC. The BCRC will calculate the repayment amount (if any) on your case and issue a letter requesting repayment.

You or your lawyer should contact the BCRC if you have a pending claim for workers' compensation benefits and then contact the BCRC again if your claim is settled, abandoned or dismissed.

### My worker's compensation claim is getting ready to settle. When and why would I need a Workers' Compensation Medicare Set-aside Arrangement (WCMSA)?

If you settle your worker's compensation claim, you must use the settlement money to pay for related medical care before Medicare will begin again to pay for related care. In many cases, the workers' compensation agency contacts Medicare before a settlement is reached to ask Medicare to approve an amount to be set aside to pay for future medical care. Medicare will look at certain medical documentation and approve an amount of money from the settlement that must be used up first before Medicare starts to pay for related care that's otherwise covered and reimbursable by Medicare.

You and the workers' compensation agency aren't required to set up a WCMSA--it's completely voluntary. However, you must make sure the settlement money is used for related medical care.

If you prefer to request approval of a proposed WCMSA amount yourself or if you'd like more information about WCMSAs, visit go.cms.gov/wcmsa.

## Medicare & workers' compensation (continued)

**What if I have a Medicare-approved WCMSA amount? How am I allowed to use the money if I manage the account myself?**

Keep these in mind if you manage your WCMSA account:

- Money placed in your WCMSA is for paying future medical expenses, including prescription drug expenses related to your work injury or illness/disease that otherwise would've been paid by Medicare. You should also use WCMSA funds to pay for these medical services and items, as well as prescription drug expenses, if you're enrolled in a Medicare Advantage Plan (like an HMO or PPO).
- You can't use the WCMSA to pay for any other work injury, or any medical items or services that Medicare doesn't cover (like dental services).
- Medicare won't pay for any medical expenses related to the injury until after you've used all of your set-aside money appropriately.
- If you aren't sure what type of services Medicare covers, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227) for more information, before you use any of the money that was placed in your WCMSA account. TTY users should call 1-877-486-2048.
- Keep records of your workers' compensation-related medical expenses, including prescription drug expenses. These records show what items and services you got and how much money you spent on your work-related injury, illness, or disease. You need these records to prove you used your WCMSA money to pay your workers' compensation-related medical expenses, including prescription drug expenses.
- After you use all of your WCMSA money appropriately, Medicare can start paying for Medicare-covered and otherwise reimbursable items and services related to your workers' compensation claim.

To find out how to manage (self-administer) your WCMSA, visit go.cms.gov/WCMSASelfAdm.

## Medicare & Veterans' benefits

### I have Medicare and Veterans' benefits. Who pays first?

If you have or can get both Medicare and Veterans' benefits, you can get treatment under either program. When you get health care, you must choose which benefits to use each time you see a doctor or get health care. Medicare can't pay for the same service that was covered by Veterans' benefits, and your Veterans' benefits can't pay for the same service that was covered by Medicare. Also, Medicare is never the secondary payer after the Department of Veterans Affairs (VA). **Note:** To get the VA to pay for services, you must go to a VA facility or have the VA authorize services in a non-VA facility.

### Are there any situations when both Medicare and the VA may pay?

Yes. If the VA authorizes services in a non-VA hospital, but didn't authorize all of the services you get during your hospital stay, then Medicare may pay for the Medicare-covered services the VA didn't authorize.

**Example:** Bob, a Veteran, goes to a non-VA hospital for a service authorized by the VA. While at the non-VA hospital, Bob gets other non-VA authorized services that the VA won't pay for. Some of these services are Medicare-covered services. Medicare may pay for some of the non-VA authorized services that Bob got. Bob will have to pay for services that Medicare or the VA doesn't cover.

## Medicare & Veterans' benefits (continued)

### I have a VA fee-basis identification (ID) card. Who pays first?

The VA may give "fee-basis ID cards" to certain Veterans if:

- You have a service-connected disability.
- You'll need medical services for an extended time period.
- There are no VA hospitals in your area.

If you have a fee-basis ID card, you may choose any doctor listed on your card to treat you.

If the doctor **accepts** you as a patient and bills the VA for services, the doctor must accept the VA's payment as payment in full. The doctor can't bill you or Medicare for these services.

If your doctor **doesn't accept** the fee-basis ID card, you'll need to file a claim with the VA yourself. The VA will pay the approved amount either to you or to your doctor.

### Where can I get more information on Veterans' benefits?

Visit VA.gov, call your local VA office, or call the national VA information number at 1-800-827-1000. TTY users should call 1-800-829-4833.

## Medicare & TRICARE

### What's TRICARE?

TRICARE is a health care program for active-duty and retired uniformed services members and their families that includes:

- TRICARE Prime.
- TRICARE Extra.
- TRICARE Standard.
- TRICARE for Life (TFL). TFL provides expanded medical coverage to Medicare-eligible uniformed services retirees 65 or older, to their eligible family members and survivors, and to certain former spouses. You **must** have Medicare Part A (Hospital Insurance) **and** Medicare Part B (Medical Insurance) to get TFL benefits.

## Medicare & TRICARE (continued)

### Can I have both Medicare and TRICARE?

Some people can have both Medicare and other types of TRICARE, including:

- Dependents of active-duty service members who are allowed Medicare for any reason.
- People under 65 with Medicare Part A (Hospital Insurance) because of a disability or End-Stage Renal Disease (ESRD) and with Medicare Part B (Medical Insurance).
- People 65 or older who can get Part A and who join Part B.

### I have Medicare and TRICARE. Who pays first?

In general, Medicare pays first for Medicare-covered services. TRICARE will pay the Medicare deductible and coinsurance amounts and for any service not covered by Medicare that TRICARE covers. You pay the costs of services Medicare or TRICARE doesn't cover.

### Who pays if I get services from a military hospital?

If you get services from a military hospital or any other federal health care provider, TRICARE will pay the bills. Medicare usually doesn't pay for services you get from a federal health care provider or other federal agency.

### Where can I get more information?

- Visit Tricare.mil/tfl.
- Call the health benefits advisor at a military hospital or clinic.
- Call TRICARE For Life at 1-866-773-0404.

## Medicare & the Federal Black Lung Benefits Program

### I have Medicare and coverage under the Federal Black Lung Benefits Program. Who pays first?

The Federal Black Lung Benefits Program pays first for any health care for black lung disease covered under that program. Medicare won't pay for doctor or hospital services covered under the Federal Black Lung Benefits Program. Your doctor or other health care provider should send all bills for the diagnosis or treatment of black lung disease to:

Federal Black Lung Program
P.O. Box 8302
London, Kentucky 40742-8302

For all other health care **not** related to black lung disease, Medicare pays first, and your doctor or health care provider should send your bills directly to Medicare.

### What if the Federal Black Lung Benefits Program won't pay my bill?

Ask your doctor or other health care provider to send Medicare the bill. Ask them to include a copy of the letter from the Federal Black Lung Benefits Program that says why it won't pay your bill.

### Where can I get more information?

Call 1-800-638-7072 if you have questions about the Federal Black Lung Benefits Program. If you have questions about who pays first, call the Benefits Coordination & Recovery Center (BCRC) toll-free at 1-855-798-2627. TTY users should call 1-855-797-2627.

## Medicare & COBRA

### What's COBRA?

COBRA is a federal law that may allow you to temporarily keep employer or union health coverage after the employment ends or after you lose coverage as a dependent of the covered employee. This is called "continuation coverage."

In general, COBRA only applies to employers with 20 or more employees. However, some state laws require insurance companies covering employers with fewer than 20 employees to let you keep your coverage for a period of time.

In most situations that give you COBRA rights (other than a divorce), you should get a notice from your employer's benefits administrator or the group health plan telling you your coverage is ending and offering you the right to elect COBRA continuation coverage.

## Medicare & COBRA (continued)

This coverage generally is offered for 18 months (or 36 months, in some cases). If you don't get a notice, but you find out your coverage has ended, or if you get divorced, call the employer's benefits administrator or the group health plan as soon as possible and ask about your COBRA rights.

If you qualify for COBRA because the covered employee either died, lost his/her job, or can now get Medicare, then the employer must tell the plan administrator. Once the plan administer is notified, the plan must let you know you have the right to choose COBRA coverage.

However, if you qualify for COBRA because you've become divorced or legally separated (court issued separation decree) from the covered employee, or if you were a dependent child or dependent adult child who's no longer a dependent, then you or the covered employee needs to let the plan administrator know about your change in situation within 60 days of the change happening.

### I have Medicare and COBRA continuation coverage. Who pays first?

If you have Medicare because you're 65 or over or because you have a disability other than End-Stage Renal Disease (ESRD), Medicare pays first.

If you have Medicare based on ESRD, COBRA continuation coverage pays first. Medicare pays second to the extent COBRA coverage overlaps the first 30 months of Medicare eligibility or entitlement based on ESRD.

If and when you should elect COBRA coverage can be a very complicated decision. When you lose employer coverage and you have Medicare, you need to be aware of your COBRA election period, your Part B enrollment period, and your Medigap Open Enrollment Period. These may all have different deadlines that overlap, so be aware that what you decide about one type of coverage (COBRA, Part B, and Medigap) might cause you to lose rights under one of the other types of coverage.

## Medicare & COBRA (continued)

**Where can I get more information about COBRA?**

- Before you elect COBRA coverage, you can talk with your State Health Insurance Assistance Program (SHIP) about Medicare Part B (Medical Insurance) and Medicare Supplement (Medigap) Insurance. To get the phone number for your state, visit shiptacenter.org, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call your employer's benefits administrator for questions about your specific COBRA options.
- If you have questions about Medicare and COBRA, call the Benefits Coordination & Recovery Center (BCRC) toll-free at 1-855-798-2627. TTY users should call 1-855-797-2627.
- If your group health plan coverage was from a private employer (not a government employer), visit the Department of Labor at dol.gov, or call 1-866-444-3272.
- If your group health plan coverage was from a state or local government employer, call the Centers for Medicare & Medicaid Services (CMS) at 1-877-267-2323, extension 61565.
- If your coverage was with the federal government, visit the Office of Personnel Management at opm.gov.

SECTION 3

# Definitions

## Where words in purple are defined

**Benefits Coordination & Recovery Center (BCRC)**—The company that acts on behalf of Medicare to collect and manage information on other types of insurance or coverage that a person with Medicare may have, and determine whether the coverage pays before or after Medicare. This company also acts on behalf of Medicare to obtain repayment when Medicare makes a conditional payment, and the other payer is determined to be primary.

**Claim**—A request for payment that you submit to Medicare or other health insurance when you get items and services that you think are covered.

**Coinsurance**—An amount you may be required to pay as your share of the cost for services, after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

**Copayment**—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 a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

**Deductible**—The amount you must pay for health care or prescriptions, before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

**End-Stage Renal Disease (ESRD)**—Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.

**Group health plan**—In general, a health plan offered by an employer or employee organization that provides health coverage to employees, and their families.

**Health care provider**—A person or organization that's licensed to give health care. Doctors, nurses, and hospitals are examples of health care providers.

**Large group health plan**—In general, a group health plan that covers employees of either an employer or employee organization that has at least 100 employees.

**Medicaid**—A joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

**Medicare Part A (Hospital Insurance)**—Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

**Medicare Part B (Medical Insurance)**—Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

**Medicare Advantage Plan (Part C)**—A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

**Medicare Prescription Drug Plan (Part D)**—Part D adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

**Medigap policy**—Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage.

**Multi-employer plan**—In general, a group health plan that's sponsored jointly by 2 or more employers.

**Premium**—The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

**State Health Insurance Assistance Program (SHIP)**—A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

**TTY**—A TTY (teletypewriter) is a communication device used by people who are deaf, hard-of-hearing, or have a severe speech impairment. People who don't have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages.

**Workers' compensation**—An insurance plan that employers are required to have to cover employees who get sick or injured on the job.

SECTION 4

# Index

## An alphabetical list of what's in this guide

1-800-MEDICARE **2, 4, 11, 14, 22, 28**

**A**

Accident **7, 17, 18**

**B**

Benefits Coordination & Recovery Center (BCRC) **5, 8, 9, 10, 19–21, 26, 28, 29**

Black lung disease **8, 26**

**C**

Claim **7, 8, 9, 17–22, 24, 29**

COBRA **7, 15, 26–28**

Coinsurance **14, 19, 25, 29**

Conditional payment **7, 17–21, 29**

Copayment **19, 29**

**D**

Deductible **14, 19, 25, 29**

Denial of payment **22**

Disabled **15–16**

**E**

End-Stage Renal Disease **7, 25, 27, 29**

**F**

Federal Employees Health Benefits (FEHB) Program **11**

Federal Black Lung Program **26**

**G**

Group health plan **6–16, 19, 26–30**

**H**
Health care provider **2, 5, 9, 12, 25, 26, 30**
**L**
Large group health plan **6, 16, 30**
Liability Insurance **7, 17–19**
**M**
Medicaid **6, 11, 30**
Medicare Part A (Hospital Insurance) **5, 24, 25, 30**
Medicare Part B (Medical Insurance) **5, 11, 24, 25, 28, 30**
Medicare Prescription Drug Plan **11, 30**
Medigap **11, 14, 15, 27, 28, 30**
Multi-employer plan **12, 30**
**N**
No-fault insurance **7, 17–19**
**P**
Pre-existing condition **23**
Premium **10, 13**
Primary payer **5, 7**
**R**
Retiree coverage **6, 11, 13–15**
**S**
Secondary payer **5, 23**
State Health Insurance Assistance Program (SHIP) **11, 14, 28, 30**
**T**
TRICARE **8, 24–25**
TRICARE for Life (TFL) **24**
**V**
Veterans' benefits **8, 23–25**
**W**
Workers' compensation **7, 19–23, 30**
Workers' Compensation Medicare Set-aside Arrangement (WCMSA) **20–22**

# Notes

# Notes

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

7500 Security Blvd.
Baltimore, Maryland 21244-1850

---

Official Business
Penalty for Private Use, $300

CMS Product No. 02179
Revised July 2016

- Medicare.gov
- 1-800-MEDICARE (1-800-633-4227)
- TTY: 1-877-486-2048

¿ Necesita usted una copia en español?
Llame GRATIS al 1-800-MEDICARE (1-800-633-4227).