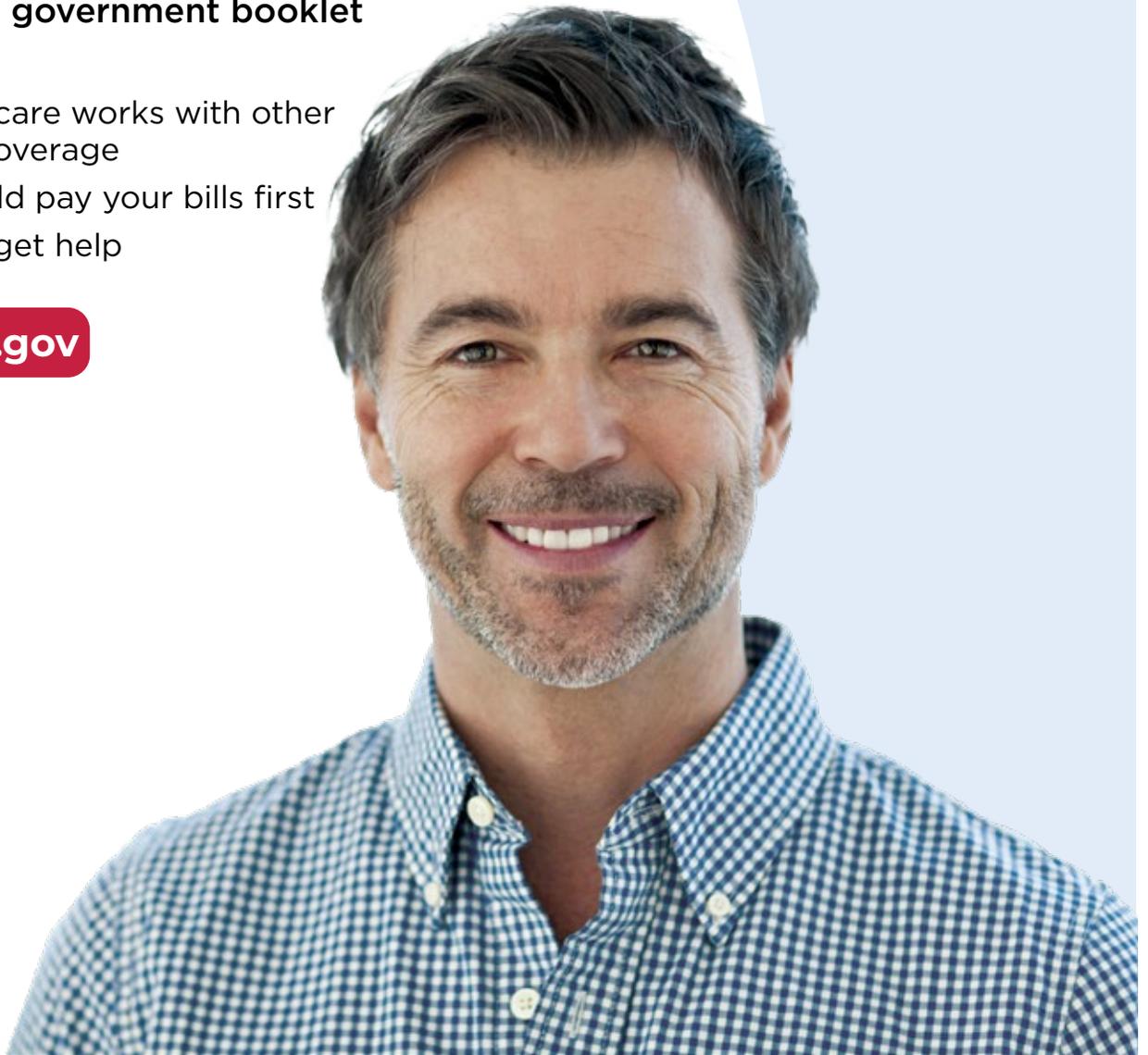


How Medicare Works with Other Insurance

This official government booklet tells you:

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

[Medicare.gov](https://www.Medicare.gov)



Medicare

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Section 1:

What's coordination of benefits?

If you have Medicare and other health insurance, each type of coverage is called a “payer.” Coordination of benefits with Medicare depends on which insurance is considered “primary” and which is “secondary.” The insurance that pays first (primary payer) pays up to the limits of its coverage. The insurance that pays second (secondary payer) only pays if there are costs the primary insurance didn't cover and the secondary payer covers the service. The same coordination of benefits rules apply whether you have Original Medicare, Medicare Advantage (Part C) (with or without drug coverage), or Medicare drug coverage (Part D).

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There are many factors that determine how Medicare decides what coverage is considered “primary” and “secondary” for payment.

The types of coverage that are considered payers can include:

- Group health plans for workers or retirees
- COBRA plans
- Federal programs like Veterans’ benefits, TRICARE, Indian Health Service, Federal Black Lung Program, and Medicaid
- Non-group health plans like liability insurance, no-fault insurance, and workers’ compensation

Whether Medicare or your other coverage pays first depends on your situation. You can find common situations in section 2, but this booklet doesn’t cover every situation. Be sure to tell your providers if you have health coverage in addition to Medicare. This will help them send your bills to the correct payer and avoid delays.

How will Medicare know you have other coverage?

Medicare doesn’t automatically know if you have other coverage. However, insurers must notify Medicare when they’re responsible for paying first on your medical claims. In some cases, your health care provider, employer, or insurer may ask you questions about your current coverage so they can report that information to Medicare. If you’re in a Medicare Advantage Plan (Part C) or Medicare drug plan (Part D), you’re responsible for answering questions from your plan about your other coverage.

Example: Harry recently turned 65 and is signed up for Medicare. He works for a company with 20 or more employees, and he has coverage through his employer’s group health plan. Since Harry is still working, Harry’s group health plan will report his insurance information to Medicare so that Medicare knows to pay Harry’s claims second.

If your group health plan or retiree coverage is the secondary payer, you may need to sign up for Medicare Part B before they’ll pay. If you have questions about who pays first, or if your coverage changes, call the Benefits Coordination & Recovery Center at 1-855-798-2627 (TTY: 1-855-797-2627), or visit [Medicare.gov/health-drug-plans/coordination](https://www.medicare.gov/health-drug-plans/coordination).



Section 2:

How does Medicare work with other types of coverage?

Coordination of benefits with Medicare depends on which insurance is considered “primary” and which is “secondary.” The insurance that pays first (primary payer) pays up to the limits of its coverage. The insurance that pays second (secondary payer) only pays if there are costs the primary insurance didn’t cover, and the secondary payer covers the service.

Some of the factors that influence who pays first are:

- The type of coverage you have
- Your age
- If you’re retired
- If you’re disabled and/or have End-Stage Renal Disease (ESRD)

Note: For the situations described in this section, “spouse” includes both opposite-sex and same-sex marriages where you’re:

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- Entitled to Medicare as a spouse based on Social Security’s rules; and
- Legally married 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).

An employer, insurer, third party administrator, group health plan, or other plan sponsor may choose to have a more inclusive definition of spouse than what’s described above. If that happens, the plan may (but isn’t required to) pay first for someone it considers a spouse under its definition. Contact your employer or insurer if you have a question about its definition of “spouse” and how it pays claims for you and your spouse.

Coverage from a group health insurance plan

Many employers, employee organizations and unions offer group health plan coverage to current employees or retirees. You may also get group health plan coverage through the employer of your spouse or another family member (like a domestic partner, parent, son, daughter, or grandchild). Generally, a group health insurance plan gives health coverage to employees and their families.

If you have Federal Employees Health Benefits (FEHB) Program coverage, your coverage works the same as other group health insurance plans.

If you have coverage from a group health insurance plan through your (or a spouse or family member’s) current employer, who pays first depends on things like your age and the number of employees in the company (or multi-employer health insurance group).

You’re 65 or older and have group health plan coverage based on your (or your spouse’s) current employment status (including self-employment). Who pays first?

- If your (or your spouse’s) employer has 20 or more employees (or has less than 20 employees, but is part of a multi-employer group where at least one company has 20 or more employees):
 - Generally, your (or your spouse’s) group health plan pays first and Medicare pays second. If the group health plan didn’t pay your entire bill, your provider should send the bill to Medicare for secondary payment. You may have to pay any costs Medicare or the group health plan doesn’t cover.
 - Employers with 20 or more employees must offer current employees age 65 and older the same health benefits under the same conditions that they offer employees under 65. 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.
Note: Your plan may ask for an “exception” to opt out of a multi-employer group health plan. Check with your plan first and ask whether it will pay first or second for your claims.
- If your (or your spouse’s) employer has fewer than 20 employees (and isn’t part of a multi-employer group where at least one company has 20 or more employees):
 - Medicare pays first and the group health plan pays second.

What happens if you don't accept your (or your spouse's) employer coverage?

Medicare pays its share for any of your Medicare-covered health care services, even if you don't take group health plan coverage from your or your spouse's employer.

Remember: 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 (or your spouse's) employer generally offers retiree coverage, but you weren't in the plan while you or your spouse were still working. Call your employer's benefits administrator for more information before you decide.

You're 65 or older, still working, and in a Health Maintenance Organization (HMO) Plan or an employer Preferred Provider Organization (PPO) Plan that pays first. Who pays if you get services outside the employer plan's network?

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

You're 65 or older, retired, and have retiree coverage from a group health insurance plan through your (or your spouse's) former employer. Who pays first?

Medicare pays first, and your (or your spouse's) group health plan pays second.

What about drug coverage?

- Check with your benefits administrator before you add Medicare drug coverage. If you have employer or union coverage and add Medicare drug coverage, you may lose your employer or union benefits (including any non-drug health coverage) for yourself and/or your spouse or dependents. If this happens, you may not be able to get your employer or union coverage back. This is true even if you get Extra Help (a Medicare program to help people with limited income and resources pay Medicare drug coverage premiums, deductibles, coinsurance, and other costs). If you have retiree coverage, check with your benefits administrator to find out if you'll lose retiree benefits (including any non-drug health coverage) for yourself and/or your spouse or dependents if you add Medicare drug coverage.
- If you have drug coverage through your current or former employer, your employer or union will notify you each year to let you know if your drug coverage is creditable. Keep this information for your records.
- You can wait to join a Medicare drug plan and not pay a penalty if your drug coverage is creditable and you don't go without creditable prescription drug coverage for 63 or more days.
- Federal Employee Health Benefits Program (FEHB) plans include creditable prescription drug coverage, so you don't need to get Medicare drug coverage. However, if you decide to get Medicare drug coverage, you can keep your FEHB plan, and in most cases, Medicare will pay first.

What happens to your group health plan coverage after you retire?

It depends on the terms of your specific plan. Your or your spouse's employer or union might not offer any health coverage after you retire. Also, if you can get group health plan coverage after you retire, the plan might have different rules and might not work the same way with Medicare. Call your employer's benefits administrator for more information.

How does retiree coverage work with Medicare?

Your former employer or union manages any retiree coverage you have with that organization. Employers and unions aren't required to offer retiree coverage, and they can change benefits or premiums, or even cancel coverage at any time.

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

Your former employer or union may offer limited retiree coverage. For example, it might only provide "stop loss" coverage, which starts paying only when your out-of-pocket costs reach a certain amount.

If you aren't sure how your retiree coverage works with Medicare, get a copy of your plan's benefit materials, or review the summary plan description your former employer or union gave you. Call your former employer's benefits administrator for more information about how the retiree plan pays when you have Medicare.

Coverage from COBRA

What's COBRA?

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that may allow you to temporarily keep employer or union health coverage after your 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 states require insurance companies covering employers with fewer than 20 employees to let you keep your employer or union coverage for a period of time.

If you 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, Medicare pays first.

If you're eligible for Medicare because of ESRD, COBRA pays first, and Medicare pays second during a coordination period that lasts up to 30 months after you're first eligible for Medicare. After the coordination period ends, Medicare pays first.

What happens if you have group health plan coverage after you retire, and your 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 its employees a group health plan. That plan may be required to offer you COBRA continuation coverage. If you can't get COBRA continuation coverage, you may have the right to buy a Medigap policy even if your Medigap Open Enrollment Period is over. Contact your State Health Insurance Assistance Program (SHIP) to find out if you can still buy a Medigap policy. To get the phone number for your local SHIP, visit shiphelp.org, or call 1-800-MEDICARE. TTY users can call 1-877-486-2048.

What about drug coverage?

There may be reasons why you should take Medicare drug coverage instead of, or in addition to, COBRA. If you take COBRA and it includes creditable prescription drug coverage, you'll have a Special Enrollment Period to join a Medicare drug plan without a penalty when COBRA ends.

What else do you need to know?

Deciding if and when you should take COBRA coverage can be very complicated. When you lose employer coverage and you have Medicare, you need to be aware of your COBRA election period, your Medicare Part B (Medical Insurance) enrollment period, and your Medigap Open Enrollment Period. Each of these periods may have different deadlines, and those deadlines might overlap. You should be aware that what you decide about one coverage type (COBRA, Medicare Part B, and Medigap) might cause you to lose rights under another.

Before you take COBRA coverage, you can talk with your SHIP counselor about Medicare Part B and Medicare Supplement Insurance (Medigap). To get the phone number for your state's SHIP, visit shiphelp.org, or call 1-800-MEDICARE.

Coverage from a federal program

If you have Medicare and Veterans' benefits, who pays first?

If you have (or can get) both Medicare and Veterans' benefits, you can get coverage under either program. However, Medicare doesn't pay for any care that you get at a [U.S. Department of Veterans Affairs \(VA\)](#) facility. Medicare and the VA can't pay for the same items or services. Each time you get health care or visit a provider, you'll have to choose which coverage to use.

Medicare pays for Medicare-covered items and services. The VA pays for VA-authorized items or services in a VA or (authorized) non-VA facility.

What about drug coverage?

You may be able to get drug coverage through the VA program. You may also join a Medicare drug plan, but if you do:

- You can't use both types of coverage for the same drug at the same time.
- You won't be able to use the VA "Meds by Mail" program.

What else do you need to know?

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

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

There may be circumstances where 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.

For more information, visit [VA.gov](#), call your local VA office, or call the national VA information number at 1-800-827-1000. TTY users can call 1-800-829-4833.

You have Medicare and TRICARE. Who pays first?

If you're on active duty and have Medicare, TRICARE pays first for Medicare-covered services or items, and Medicare pays second.

If you aren't on active duty, Medicare pays first for Medicare-covered services, and TRICARE may pay second.

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

TRICARE For Life (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. Visit tricare.mil/tfl, or call 1-866-773-0404 to learn more. TTY users can call 1-866-773-0405.

What about drug coverage?

Most people with TRICARE who are entitled to Medicare Part A must also have Medicare Part B to keep their TRICARE drug benefits. If you have TRICARE, you don't need to join a Medicare drug plan. However, if you do, your Medicare drug plan pays first, and TRICARE pays second.

If you join a Medicare drug plan, TRICARE and your plan may coordinate their benefits if your plan's network pharmacy is also a TRICARE network pharmacy.

For more information, visit tricare.mil, or call the TRICARE Pharmacy Program 1-877-363-1303. TTY users can call 1-877-540-6261.

You have Medicare and get care from Indian Health Services (IHS) or an IHS provider. Who pays first?

Generally, Medicare pays first for your health care bills, before the IHS delivery system. The IHS delivery system is comprised of health facilities operated by IHS, a Tribe or Tribal organization, or an urban Indian organization. However, these conditions apply:

- If you have non-tribal group health plan coverage through an employer, the non-tribal group health plan pays first, and Medicare pays second if:
 - The employer has 20 or more employees, or
 - The employer has fewer than 20 employees, but is part of a multi-employer group where at least one employer has 20 or more employees

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- If you have non-tribal group health plan coverage through an employer who has fewer than 20 employees, Medicare pays first, and the non-tribal group health plan pays second.
- If you have a health insurance through a Tribal health plan, Medicare pays first and the Tribal health plan pays second.

What about drug coverage?

Many Indian health facilities participate in the Medicare Part D drug program. If you get drugs through an Indian health facility, you'll continue to get them at no cost to you, and your coverage won't be interrupted. Your local Indian health benefits coordinator can help you choose a plan that meets your needs and tell you how Medicare works with the Indian health care system.

You have Medicare and coverage under the Federal Black Lung Program. Who pays first?

For any health care including drugs related to black lung disease, the Federal Black Lung Program pays first as long as the program covers the service. Medicare won't pay for doctor or hospital services or drugs covered under the Federal Black Lung Program.

Your 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 that isn't related to black lung disease, Medicare pays first, and your health care provider should send your bills directly to Medicare. If the Federal Black Lung Program won't pay your bill, ask your health care provider to send Medicare the bill. Also ask them to include a copy of the letter from the Federal Black Lung Program that says why it won't pay your bill.

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

You have Medicare and Medicaid. Who pays first?

Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid never pays first for services Medicare covers. It only pays after Medicare has paid. In rare cases where there's other coverage besides Medicare, Medicaid pays after the other coverage has paid.

What about drug coverage?

Medicare covers your drug costs. You'll need to join a separate Medicare drug plan or a Medicare health plan with drug coverage for Medicare to pay for your drugs. Medicaid can pay for a limited number of drugs that are excluded from Medicare drug coverage.

If you have full Medicaid coverage or qualify for your state's Medicare Savings Program, you automatically qualify for Extra Help with your Medicare drug coverage costs. If you don't join a drug plan on your own, Medicare will sign you up for one. Visit [Medicare.gov/basics/costs/help/drug-costs](https://www.medicare.gov/basics/costs/help/drug-costs) for more information about how Extra Help works.

- If you have full coverage from Medicaid and live in a nursing home, you pay nothing for covered drugs.
- If you have full coverage from Medicaid and live at home or in an assisted living or adult living facility, you'll pay a small copayment for each drug.

Visit [Medicaid.gov/about-us/where-can-people-get-help-medicare-chip](https://www.medicare.gov/about-us/where-can-people-get-help-medicare-chip), or call 1-800-MEDICARE (1-800-633-4227) to get the phone number for your state's Medicaid office. TTY users can call 1-877-486-2048.

Medicare coverage because of End-Stage Renal Disease (ESRD) or a disability

Who pays first depends on things like:

- Your age
- Your disability
- How long you've gotten disability benefits
- Your other health plan coverage

You have Medicare because of ESRD and have group health plan (including retiree) coverage (or coverage from a spouse or family member). Who pays first?

Once you become eligible for Medicare because of permanent kidney failure, there will be a **30-month coordination period**. During this time, your group or retiree health plan will continue to pay first for your health care bills, regardless of:

- The employer's number of employees
- Whether you're currently employed or retired
- Whether your group or retiree plan says its policy is to pay second to Medicare, or otherwise rejects or limits its payments to people with Medicare

During your 30-month coordination period, if your plan doesn't pay for covered services in full, Medicare may pay second for all Medicare-covered items and services, not just ones for the treatment of ESRD. Check with your plan if you're not sure if it will pay for covered services in full.

After the coordination period ends, Medicare pays first and your group health plan (or retiree coverage) pays second.

Tell your health care provider if you have group or retiree health plan coverage so they bill your services correctly. Your group or retiree health plan coverage may still pay for services that Medicare doesn't cover. Check with your plan's benefits administrator for more information.

You first got Medicare when you turned 65 or because of a disability other than ESRD. You also have group health plan coverage (including retiree coverage or coverage from a spouse or family member). Now you have ESRD. Who pays first?

Whichever coverage paid first when you became eligible for Medicare because of your age or non-ESRD disability continues to pay first when you become eligible because of ESRD.

You have Medicare because of ESRD and COBRA coverage. Who pays first?

COBRA pays first and Medicare pays second during the coordination period that lasts up to 30 months after you're first eligible for Medicare because of ESRD. After the coordination period ends, Medicare pays first.

You're under 65 and have Medicare because of a disability and group health coverage. Who pays first?

Who pays first depends on if your group health coverage comes from your (or a spouse or family member's) current or former employer and the size of that employer.

- **You're under 65 and have Medicare because of a disability, and you have coverage from a former employer.**

In this case, Medicare pays first because the employer coverage isn't based on active employment.

Note: Retiree coverage might not pay your medical costs during any period when you were eligible for Medicare but didn't sign up for it. When you become eligible for Medicare, you'll need to sign up for both Medicare Part A and Medicare Part B to get full benefits from your retiree coverage.

Check with your retiree coverage to find out if you'll lose retiree benefits (including any non-drug health coverage) for yourself and/or your spouse or dependents if you get Medicare drug coverage.

- **You're under 65 and have Medicare because of a disability. You also have coverage from your (or your spouse or family member's) current employer.**

If that employer has either **100 or more employees** or has fewer than 100 employees but is part of a multi-employer group where one or more companies has at least 100 employees, the group health plan pays first, and Medicare pays second.

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.

Note: Health plans offered by employers with 100 or more employees are also called "large group health plans." They can't treat any plan member differently because they're disabled and have Medicare.

If that employer has **fewer than 100 employees** and isn't part of a multi-employer group plan (where one or more companies has 100 or more employees), then Medicare pays first, and the group health plan pays second.

You're under 65 and have Medicare because of disability. You also get disability benefits from either the Social Security Administration (SSA) or Railroad Retirement Board (RRB). Who pays first?

If you've been getting disability benefits from the SSA or the RRB for less than 24 months, you aren't eligible for Medicare coverage yet. That means your group health plan is your only payer.

Once you've had disability benefits for 24 months, you'll automatically be signed up for Medicare, and who pays first will be determined by your group health coverage.

Note: There's no 24-month waiting period for people with Amyotrophic Lateral Sclerosis (ALS), also known as Lou Gehrig's disease.

You're under 65 and have Medicare because of a disability. You also have retiree group health plan coverage through your former employer. Who pays first?

If you aren't currently employed, Medicare pays first for your health care bills and your retiree group health plan coverage pays second.

Retiree coverage might not pay your medical costs during any period when you were eligible for Medicare but didn't sign up for it. When you become eligible for Medicare, you'll need to sign up for both Medicare Part A and Medicare Part B to get full benefits from your retiree coverage.

Check with your retiree coverage to find out if you'll lose retiree benefits (including any non-drug health coverage) for yourself and/or your spouse or dependents if you get Medicare drug coverage.

Coverage from a different source

No-fault, liability, or workers' compensation accident or injury claims

What's no-fault insurance?

No-fault insurance may pay for health care services you get if you're injured or your property gets damaged in an accident, regardless of who's at fault for causing the accident. Some types of no-fault insurance include:

- Automobile plans
- Homeowners' plans
- Commercial insurance plans

Your no-fault insurance pays first, and Medicare pays second for health care services related to the accident or injury.

What's liability insurance?

Liability insurance (including self-insurance) protects 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 a liability insurance claim for your medical expenses, you or your lawyer should notify Medicare as soon as possible.

Your liability insurance pays first and Medicare pays second for health care services related to the accident or injury.

If doctors or other providers are told you have a no-fault insurance or liability insurance claim, they must try to get the insurance company to pay before billing Medicare. If your accident or injury is an open Ongoing Responsibility for Medicals case, then the liability or no-fault insurance must pay first. However, if your liability or no-fault case doesn't receive Ongoing Responsibility for Medicals, then processing your bill 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 recover the payment after a settlement, judgment, award, or other payment on the claim has been made by the liability insurance.

What else do you need to know?

If the no-fault or liability insurance denies your medical bill or is found not liable for payment, Medicare pays first, but only for Medicare-covered services. You're still responsible for your share of the bill (like coinsurance, a deductible or copayment) and for the cost of services Medicare doesn't cover.

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 emergency room, the hospital asks Nancy 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 the no-fault insurance doesn't pay for some Medicare-covered services.

What's workers' compensation?

Workers' compensation is a law or plan requiring employers to give benefits to most employees who get sick or injured on the job. To find out if you're covered, talk to your employer, or contact your state workers' compensation division or department.

Workers' compensation pays first for items, including drugs, or services related to the workers' compensation claim.

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 doctor or other provider bills for a work-related illness or injury and when the workers' compensation insurance (a private insurance carrier or a state fund) decides if it should pay the bill.

Medicare can't pay for items or services that workers' compensation will pay for promptly or if the claim falls under an Ongoing Responsibility for Medicals case, or there is an open Workers' Compensation Medicare Set-aside Arrangement. Generally, these include items or services that Workers' Compensation Medicare Set-aside Arrangement pays within 120 days of the date you received the service or the date of your inpatient hospital discharge (if applicable), whichever is earlier.

Medicare may make a conditional payment if the workers' compensation insurance company denies payment for your medical bills, pending a review of your claim.

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 to pay for your medical care. The conditional payment rules don't apply to an open and active Ongoing Responsibility for Medicals case. They also don't apply to open Workers' Compensation Medicare Set-aside Arrangement, accident, and injury cases.

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 for a conditional payment. Medicare made a conditional payment to Tom's doctor for Tom's health care services. If Tom eventually gets a settlement, judgment, award, or other payment from the state workers' compensation agency, it's Tom's responsibility to make sure Medicare gets repaid for the conditional payment.

What else do you need to know?

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 toll-free at 1-855-798-2627 as soon as you file your workers' compensation claim. TTY users can call 1-855-797-2627.

What if workers' compensation denies payment?

If workers' compensation insurance denies payment, and you give Medicare proof of the claim's denial, Medicare may pay for Medicare-covered items and services as appropriate. Medicare can't pay, however, if you have a Workers' Compensation Medicare Set-aside Arrangement that has contributed funds towards your future workers' compensation-related health care needs, unless all of those funds have been used to pay for medical care. Medicare can't pay for accident-related claims if you have an open Ongoing Responsibility for Medicals case related to this accident or injury.

Can workers' compensation decide to pay only part of your bill?

Yes, 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.

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.

Your workers' compensation claim is getting ready to settle. What happens next?

If you settle your workers' compensation claim, you can volunteer to put some of the settlement money in a Workers' Compensation Medicare Set-aside Arrangement, to pay for future medical care and drugs that are related to your work injury or illness. In many cases, before reaching a settlement, the workers' compensation agency will ask Medicare to review certain medical documentation and approve an amount that can be put in the Workers' Compensation Medicare Set-aside Arrangement.

You must use all funds in your arrangement to pay for related medical care, including drugs, before Medicare will begin paying for related care. Visit go.cms.gov/WCMSASelfAdm to learn more about Workers' Compensation Medicare Set-aside Arrangements.

What if you have a Medicare-approved Workers' Compensation Medicare Set-aside Arrangement amount?

You must:

- Only use money from your arrangement to pay for future medical expenses, including drugs, related to your work injury or illness that otherwise would've been paid by Medicare.
- Use funds from the arrangement to pay for future medical expenses, including drugs, even if you're in a Medicare Advantage Plan.
- Use money from your Workers' Compensation Medicare Set-aside Arrangement to pay for drugs that are related to your work illness or injury, even if you have a Medicare drug plan (or a Medicare Advantage Plan with drug coverage).

You can't use money from your arrangement to pay for any other work-related injury or illness, or for any medical items or services that Medicare doesn't cover (like dental services). You must spend all of your money from the arrangement on appropriate related medical expenses before Medicare (either Original Medicare or Medicare Advantage) will pay for any Medicare-covered medical expenses or drugs related to your workers' compensation claim.

Before using any of the funds from your arrangement, you should become familiar with the types of services Medicare covers by visiting [Medicare.gov/coverage](https://www.medicare.gov/coverage) or calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Keep detailed records of your workers' compensation-related medical expenses, including drug expenses. These records should show what items and services you received and how much money you spent on your work-related injury or illness. You'll need these records to prove you used the money from your arrangement to pay your workers' compensation-related medical expenses.

Visit go.cms.gov/WCMSASelfAdm to learn more about managing your Workers' Compensation Medicare Set-aside Arrangement.

Conditional Payments

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 by the responsible person or payer. If you get a settlement, judgment, award, or other payment, you're responsible for repaying Medicare for the conditional payment.

When does Medicare make conditional payments?

Medicare may make a conditional payment if the liability, no-fault, or workers' compensation insurance company doesn't pay the claim promptly (usually within 120 days). Medicare may recover any payments the primary payer should've made. Your doctor should bill the accident or injury insurer first if they want to get quicker payment. However, if the insurer denies the claim, the insurer must send the reason for denial to your doctor. Then your doctor must send the denial to Medicare, so Medicare can review the claim to determine whether a Medicare payment can be made before the 120-day period.

Note: Medicare can't make a conditional payment for an accident or injury-related claim if you have either an open Workers' Compensation Medicare Set-aside Arrangement or an Ongoing Responsibility for Medicals case related to that claim.

How does Medicare recover conditional payments?

If Medicare makes a conditional payment for your liability, no-fault, or workers' compensation related claim, and you or your representative haven't reported your settlement, judgment, award, or other payment to Medicare, call the Benefits Coordination & Recovery Center at 1-855-798-2627 (TTY: 1-855-797-2627). The Benefits Coordination & Recovery Center:

- Gathers information about conditional payments Medicare makes.
- Calculates the final amount owed (if any) on your recovery case.
- Sends you a letter asking for repayment.

How do you make sure that Medicare gets repaid for the conditional payment?

If a conditional payment is made for a liability, no-fault, or workers' compensation related claim, you're responsible for making sure Medicare gets repaid from any settlement, judgment, award, or other payment you get.

If you or your provider files a liability, no-fault or workers' compensation claim and Medicare makes a conditional payment for medical claims, you or your lawyer should report the claim and payment by calling the Benefits Coordination & Recovery Center toll-free at 1-855-798-2627. TTY users can call 1-855-797-2627.

The Benefits Coordination & Recovery Center will gather information about any conditional payments for medical claims Medicare made related to your liability, no-fault, or workers' compensation claim. If you get a settlement, judgment, award, or other payment, you or your lawyer should call the Benefits Coordination & Recovery Center.

If you have Original Medicare, the Benefits Coordination & Recovery Center will calculate the final repayment amount (if any) on your case and send you a letter asking for repayment. If your pending workers' compensation claim is eventually abandoned or dismissed, you or your lawyer should contact the Benefits Coordination & Recovery Center with that information.

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 for Joan's health care services. 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 Joan's health care services. 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 one of his prescription medications 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 for him that are related to his settlement.

What if Medicare pays for a claim that should have been paid for by your Workers' Compensation Medicare Set-aside Arrangement?

Medicare may pay for medical or drug claims before knowing that the claims are related to your workers' compensation settlement. When this occurs, Medicare must be repaid from the Workers' Compensation Medicare Set-aside Arrangement. If you have Original Medicare, the Benefits Coordination & Recovery Center will investigate claims and ask you for repayment. If you're in a Medicare Advantage Plan or a Medicare drug plan, the plan will contact you to investigate claims and ask for repayment. You are responsible for cooperating with the Benefits Coordination & Recovery Center, Medicare Advantage Plan, or Medicare drug plan's efforts to verify if claims are related to your workers' compensation settlement and repaying Medicare for those claims from your Workers' Compensation Medicare Set-aside Arrangement.

If you're in another situation

What if you have Medicare and more than one other source of coverage?

Check with each of your types of coverage to find out who pays first. You can also call the Benefits Coordination & Recovery Center at 1-855-798-2627. TTY users can call 1-855-797-2627.

What happens if your health coverage changes?

Insurers must report health coverage changes to Medicare, but it can take some time before they appear in Medicare's records. If that happens, call the Benefits Coordination & Recovery Center toll-free at 1-855-798-2627. TTY users can call 1-855-797-2627. When you call, you'll need to tell them:

- Your name
- Your health plan's name and address
- 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 the change to Medicare so your claims get paid correctly.

Can you get coverage through the Health Insurance Marketplace® if you 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 only have either Medicare Part A or 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 have Medicare yet, but have coverage through the Marketplace, you can choose to keep your Marketplace plan after your Medicare coverage starts. However, once your Medicare Part A coverage starts, any premium tax credits or other savings you've been getting on a Marketplace plan will end. **If you choose to keep your Marketplace plan, you'll have to pay full price for it.**

If you age into Medicare and decide to keep your Marketplace plan, then Medicare pays first. If you have questions about a Marketplace plan, call the Health Insurance Marketplace® Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

Questions

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

The Benefits Coordination & Recovery Center helps to:

- Collect and manage information on other types of insurance or coverage that you may have
- Determine if other coverage pays before or after Medicare
- Pursue repayment when Medicare makes a conditional payment, and another payer is determined to be primary

When you call the Center, have your Medicare Number ready from your red, white, and blue Medicare card. They may also ask for information like:

- Your Social Security Number (SSN)
- Your address
- Whether you have Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance) and when your coverage started (in the lower right corner of your Medicare card)

CMS Accessible Communications

Medicare provides free auxiliary aids and services, including information in accessible formats like braille, large print, data/audio files, relay services and TTY communications. If you request information in an accessible format, you won't be disadvantaged by any additional time necessary to provide it. This means you'll get extra time to take any action if there's a delay in fulfilling your request.

To request Medicare or Marketplace information in an accessible format you can:

1. Call us:

For Medicare: 1-800-MEDICARE (1-800-633-4227)

TTY: 1-877-486-2048

For Marketplace: 1-800-318-2596

TTY: 1-855-889-4325

2. Email us: altformatrequest@cms.hhs.gov

3. Send us a fax: 1-844-530-3676

4. Send us a letter:

Centers for Medicare & Medicaid Services

Offices of Hearings and Inquiries (OHI)

7500 Security Boulevard, Mail Stop DO-01-20

Baltimore, MD 21244-1850

Attn: Customer Accessibility Resource Staff (CARS)

Your request should include your name, phone number, type of information you need (if known), and the mailing address where we should send the materials. We may contact you for additional information.

Note: If you're enrolled in a Medicare Advantage Plan or Medicare drug plan, contact your plan to request its information in an accessible format. For Medicaid, contact your state or local Medicaid office.

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 in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

You can contact CMS in any of the ways included in this notice if you have any concerns about getting information in a format that you can use.

You may also file a complaint if you think you've been subjected to discrimination in a CMS program or activity, including experiencing issues with getting information in an accessible format from any Medicare Advantage Plan, Medicare drug plan, state or local Medicaid office, or Marketplace Qualified Health Plans. There are 3 ways to file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

1. Online:

[HHS.gov/civil-rights/filing-a-complaint/complaint-process/index.html](https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html)

2. By phone:

Call 1-800-368-1019.

TTY users can call 1-800-537-7697.

3. In writing: Send information about your complaint to:

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

**U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services**

7500 Security Blvd.
Baltimore, MD 21244-1850

Official Business
Penalty for Private Use, \$300

Need a copy of this booklet in Spanish?

To get a free copy of this booklet in Spanish, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Esta publicación está disponible en Español. Para obtener una copia gratis, visite es.Medicare.gov o llame al 1-800-MEDICARE.



Medicare

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 can call 1-877-486-2048.

“How Medicare Works With Other Insurance” isn’t a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

This product was produced at U.S. taxpayer expense.