

CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare and Other Health Benefits: Your Guide to **Who Pays First**



This official government booklet tells you

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

If you have questions about who pays first or if your coverage changes, call the Medicare Coordination of Benefits Contractor (COBC) at 1-800-999-1118. TTY users should call 1-800-318-8782.



Welcome to

Medicare and Other Health Benefits: Your Guide to Who Pays First

How This Guide Can Help You

Some people with Medicare have other coverage that must pay before Medicare pays its share of your 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 coverage to make sure your bills are sent to the right payer to avoid delays.



“I used this guide when I needed to know who paid first for my health care.”

Where Can I Get Basic Information on Medicare?

Get the “Medicare & You” handbook by visiting www.medicare.gov/publications, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

“Medicare and 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.

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**“We keep this booklet
with other insurance
papers so we know
where to find it if we
have a question.”**

Section 1: When You Have Other Health Coverage



Who Pays First If I Have Other Health Coverage?

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 your provider sends the rest to the “secondary payer” to pay. In some 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 two pages. However, this chart doesn’t cover every situation.

Be sure to tell your doctor and other **health care providers** if you have 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 whole bill **up to** the limits of the payer’s coverage. It doesn’t always mean the primary payer pays first *in time*.

Where to Go with Questions

If you have questions about who pays first, or if your coverage changes, call the **Medicare Coordination of Benefits Contractor (COBC)** at 1-800-999-1118. **TTY** users should call 1-800-318-8782.

To better serve you, please have the following information ready when you call: your Medicare number (located on your red, white, and blue Medicare card) and one additional piece of information, such as your Social Security Number (SSN), address, Medicare effective date(s), or whether you have **Medicare Part A (Hospital Insurance)** and/or **Medicare Part B (Medical Insurance)** coverage.

Words in red are defined on pages 25–26.

Section 1: When You Have Other Health Coverage

If you	Situation	Pays first	Pays second	See page(s)
Are covered by Medicare and Medicaid	Entitled to Medicare and Medicaid	Medicare	Medicaid, but only after other coverage (such as employer group health plans) has paid	8
Are 65 or older and covered by a group health plan because you or your spouse is still working	Entitled to Medicare The employer has 20 or more employees	Group health plan	Medicare	8
	..... The employer has less than 20 employees*	Medicare	Group health plan	9
Have an employer group health plan after you retire and are 65 or older	Entitled to Medicare	Medicare	Retiree coverage	10–11
Are disabled and covered by a large group health plan from your work, or from a family member who is working	Entitled to Medicare The employer has 100 or more employees	Large group health plan	Medicare	12
	..... The employer has less than 100 employees	Medicare	Group health plan	12
**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	12
	..... After 30 months of eligibility or entitlement to Medicare	Medicare	Group health plan	12
Have ESRD and COBRA coverage	First 30 months of eligibility or entitlement to Medicare	COBRA	Medicare	23
	..... After 30 months	Medicare	COBRA	12

* If your employer participates in a plan that is sponsored by two or more employers, the rules are slightly different.

** 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 due to ESRD.

Section 1: When You Have Other Health Coverage

If you	Situation	Pays first	Pays second	See page(s)
Are 65 or over OR disabled and covered by Medicare and COBRA coverage	Entitled to Medicare	Medicare	COBRA	22–23
Have been in an accident where no-fault or liability insurance is involved	Entitled to Medicare	No-fault or liability insurance for services related to accident claim	Medicare	13–15
Are covered under workers' compensation because of a job-related illness or injury	Entitled to Medicare	Workers' compensation for services related to workers' compensation claim	Usually doesn't apply. However, Medicare may make a conditional payment.	15–19
Are a veteran and have Veterans' benefits	Entitled to Medicare and Veterans' benefits	Medicare pays for Medicare-covered services. Veterans' Affairs pays for VA-authorized services. Note: Generally, Medicare and VA can't pay for the same service.	Usually doesn't apply	19–20
Are covered under TRICARE	Entitled to Medicare and TRICARE	Medicare pays for Medicare-covered services. TRICARE pays for services from a military hospital or any other federal provider .	TRICARE may pay second.	20–21
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	21–22

Section 1: When You Have Other Health Coverage

How Medicare Coordinates with Other Coverage

I'm not yet 65. How will Medicare know I have other coverage?

About 3 months before you get Medicare, Medicare will send you a letter with a username and password for MyMedicare.gov, a free, secure online service where you can keep personalized information on your Medicare benefits and services. Medicare doesn't automatically know if you have other coverage. Fill out your "Initial Enrollment Questionnaire" (IEQ) at MyMedicare.gov to make sure your medical bills are paid correctly and on time.

The IEQ asks if you have group health plan coverage through your work or a family member's work. Medicare uses your answers to help set up your file and make sure your **claims** get paid correctly.

You can also complete your IEQ over the phone by calling the **Coordination of Benefits Contractor** at 1-800-999-1118. **TTY** users should call 1-800-318-8782.

Example: Harry is almost 65 and is getting ready to retire and join Medicare. Harry's wife Jane, 63, works for a large company (more than 20 people). Both Harry and Jane have health insurance coverage through Jane's employer's **group health plan**.

After he gets a letter from Medicare with his username and password for MyMedicare.gov, Harry goes to the Web site and fills out his IEQ. He reports he has coverage through his wife's employment. This insurance will pay Harry's claims first, and Medicare will pay Harry's claims second.

What happens if my health coverage changes after I fill out the IEQ?

Call the Medicare Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782. Give the following 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.

Section 1: When You Have Other Health Coverage

How Medicare Coordinates with Other Coverage (continued)

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 [Medicare Coordination of Benefits Contractor](#) at 1-800-999-1118. TTY users should call 1-800-318-8782.

When is Medicare a secondary payer for domestic partners with group health insurance coverage?

Medicare is generally a secondary payer for domestic partners:

- When the domestic partner can get Medicare because of disability and is covered by a [large group health plan](#) through his/her own current employer or that of a family member (**A domestic partner is considered a family member**)
- For a 30-month coordination period when the domestic partner is eligible for Medicare due to End-Stage Renal Disease and is covered by a [group health plan](#)
- When the domestic partner can get Medicare because of age and has group health plan coverage through his/her current employer

When is Medicare a primary payer for domestic partners with group health insurance coverage?

If a domestic partner can get Medicare due to his/her age and has group health plan coverage through his/her partner's current employer.

Where can I get more information about who pays first?

Call your health insurance plan's benefits administrator. You can also call the Medicare Coordination of Benefits Contractor.

Section 2: Medicare and Other Types of Health Coverage



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Section 2: Medicare and Other Types of Health Coverage

Medicare and Medicaid

Medicaid (also called Medical Assistance) 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, employer group health plans, and/or Medicare Supplement Insurance (**Medigap**) policies have paid.

Medicare and Group Health Plan Coverage

You have a number of important decisions to make when you turn 65: should you join **Medicare Part B**, join a **Medicare Prescription Drug Plan**, buy a 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 www.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 their phone number, visit www.medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227). **TTY** users should call 1-877-486-2048.

Should I get group health plan coverage?

Many employers and unions offer group health plan coverage to current employees or retirees. 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.

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

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

- 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
- 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 as appropriate. You'll have to pay whatever costs Medicare or the group health plan doesn't cover.

Words in red are defined on pages 25–26.

Section 2: Medicare and Other Types of Health Coverage

Medicare and Group Health Plan Coverage (continued)

If your employer has less than 20 employees, Medicare generally pays first. But if your employer joins with other employers or employee organizations (like unions) to sponsor a **group health plan** (called a **multi-employer plan**), and any of the other employers have 20 or more employees, Medicare would generally pay second. However, your plan might ask for an exception, so even if your employer has less than 20 employees, 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, you might not get any payment from the plan or Medicare. Call your plan before you go outside the network to find out if the service will be covered.

I decided not to take group health plan coverage from my employer. Will this affect what Medicare will pay?

Medicare pays its share for any Medicare-covered health care service you get 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 (see page 10) 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.

Section 2: Medicare and Other Types of Health Coverage

Medicare and Group Health Plan Coverage (continued)

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

Generally, 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, they must offer the same coverage to spouses 65 and older that they offer to spouses under 65.

Medicare and 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.

What do I need to find out about retiree coverage?

- **Can I continue my employer coverage after I retire?** Generally, 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.
- **What happens to my retiree coverage when I'm eligible for Medicare?** For example, retiree 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**.

Words in red are defined on pages 25–26.

Section 2: Medicare and Other Types of Health Coverage

Medicare and Group Health Plan Coverage After You Retire (continued)

How does retiree coverage compare with a Medicare Supplement Insurance (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, such as **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 www.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 policies, visit www.medicare.gov/find-a-plan, or call 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048.

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.

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 22–23. 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.

Section 2: Medicare and Other Types of Health Coverage

Medicare and Group Health Plan Coverage for People Who Are Disabled (Non-ESRD Disability)

I'm under age 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 age 65 or if you have Medicare because of a disability.

Sometimes employers with less than 100 employees join with other employers to form a **multi-employer plan**. If at least 1 employer in the multi-employer plan has 100 employees or more, Medicare pays second.

If the employer has 100 employees or more, 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, 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 XYZ Company, which 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 and 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 **ESRD**, your group health plan will pay first on your hospital and medical bills for 30 months, whether or not you're in 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.

Section 2: Medicare and Other Types of Health Coverage

Medicare and No-Fault or Liability Insurance

What is no-fault insurance?

No-fault insurance pays 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 is liability insurance?

Liability insurance protects against **claims** for negligence—inappropriate action or inaction that causes someone to get injured or causes property damage.

Some types include:

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

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 appropriate.

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.

Section 2: Medicare and Other Types of Health Coverage

Medicare and 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.

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 when a settlement, judgment, award, or other payment is made.

Note: If Medicare makes a conditional payment for an item or service, and you get a settlement, judgment, award, or other payment for that item or service from an insurance company later, the conditional payment must be repaid to Medicare. You're responsible for making sure Medicare gets repaid for the conditional payment.

Words in red are defined on pages 25–26.

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 liability insurer. 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 liability insurer, Joan must make sure Medicare gets its money back for the conditional payment.

Section 2: Medicare and Other Types of Health Coverage

Medicare and No-Fault or Liability Insurance (continued)

How does Medicare get its money back for the conditional payment?

If Medicare makes a conditional payment, you or your representative should call the Medicare **Coordination of Benefits Contractor** (COBC) at 1-800-999-1118. **TTY** users should call 1-800-318-8782.

The COBC will notify the **recovery contractor** to work on your case. The recovery contractor is a separate contractor who uses the information you or your representative gives to the COBC to see Medicare gets repaid for the conditional payments.

The recovery contractor will gather information about any conditional payments Medicare made related to your pending settlement, judgment, award, or other payment. Once a settlement, judgment, award, or other payment is final, you or your representative should call the recovery contractor. The recovery contractor will get the final repayment amount (if any) on your case and issue a letter requesting repayment.

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

In this case, Medicare pays the same as it would if it were the only payer. However, Medicare only pays for Medicare-covered services. You're responsible for your share of the bill, like **coinsurance**, a **copayment** or a **deductible**, and for services Medicare doesn't cover.

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 COCB.

Medicare and Workers' Compensation

What is 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.

Section 2: Medicare and Other Types of Health Coverage

Medicare and Workers' Compensation (continued)

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 (usually 120 days).

However, if the workers' compensation insurer denies payment for your medical bills pending a review of your **claim**, Medicare may make a conditional payment, unless you get funds from a **Workers' Compensation Medicare Set-aside Arrangement (WCMSA)** following the settlement of a workers' compensation case. See next page for more information on WCMSAs.

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 COBC at 1-800-999-1118 as soon as you file your workers' compensation claim. **TTY** users should call 1-800-318-8782.

Words in red are defined on pages 25–26.

Example: Tom was injured at work. He filed a claim with workers' compensation insurance. His doctor billed the state workers' compensation insurance for payment. Tom's doctor didn't get paid within 120 days, so he billed Medicare and sent a copy of Tom's workers' compensation claim with the claim for Medicare payment. Medicare made a conditional payment to the doctor for the health care services Tom got. When a settlement is reached with the state workers' compensation agency, Tom must make sure Medicare gets its money back for the conditional payment.

Section 2: Medicare and Other Types of Health Coverage

Medicare and Workers' Compensation (continued)

How does Medicare get its money back 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 **Medicare Coordination of Benefits Contractor** at 1-800-999-1118. **TTY** users should call 1-800-318-8782.

The COBC will notify the **recovery contractor** to work on your case with the information you or your lawyer gave to the COBC. The recovery contractor will gather information about any conditional payments Medicare made relating to your pending settlement, judgment or award. Once a settlement, judgment or award is final, you or your lawyer should call the recovery contractor, who will identify the final repayment amount (if any) on your case and issue a letter requesting repayment.

What if I want to settle my workers' compensation claim?

You or your lawyer should contact the recovery contractor. Settlements of workers' compensation claims are handled differently than a settlement of a no-fault or liability insurance claim. As part of settling your workers' compensation claim, you must repay Medicare for any Medicare payments for workers' compensation claim-related services you already got.

When and why would I need a Workers' Compensation Medicare Set-aside Arrangement (WCMSA)?

If you settle your worker's compensation claim, the settlement may provide for funds to be set aside to pay for future medical and prescription drug expenses related to your injury, illness or disease. When you have Medicare, ask your workers' compensation lawyer to set up a **Workers' Compensation Medicare Set-aside Arrangement (WCMSA)** for depositing these funds.

The WCMSA ensures workers' compensation funds are spent on expenses otherwise covered by Medicare. In other words, **workers' compensation** pays before Medicare, even after a settlement. If you have a WCMSA as part of your workers' compensation settlement, you must be careful how you spend money specifically set aside for Medicare.

You or your lawyer need to send your proposed WCMSA to the Medicare Coordination of Benefits Contractor at:

CMS
c/o Coordination of Benefits Contractor
P.O. Box 33849
Detroit, Michigan 48232
Attention: WCMSA Proposal

Section 2: Medicare and Other Types of Health Coverage

Medicare and Workers' Compensation (continued)

How am I allowed to use the money in my Workers' Compensation Medicare Set-aside Arrangement (WCMSA) if I manage (self-administer) the account?

Keep the following in mind if you manage your WCMSA (**Note:** workers' compensation **claims** can be resolved by settlements, judgments, awards, or other payments. The information below applies only to settlements.):

- Money placed in your WCMSA is for paying future medical and/or prescription drug expenses related to your work injury or illness/disease that otherwise would have been paid back by Medicare.
- 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 have used all of your set-aside money appropriately.
- If you aren't sure what type of services Medicare covers, call Medicare at 1-800-MEDICARE (1-800-633-4227) for more information, before you use any of the money that was placed in your WCMSA. **TTY** users should call 1-877-486-2048.
- Keep records of your workers' compensation-related medical and 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 and/or prescription drug expenses.
- After you use all of your WCMSA money appropriately, Medicare can start paying for Medicare-covered services related to your work-related injury, illness, or disease.

What if workers' compensation denies payment?

If the state **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 claim for workers' compensation. 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.

Section 2: Medicare and Other Types of Health Coverage

Medicare and 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.

Medicare and 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. **Note:** To get the Department of Veterans Affairs (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 doesn't pay for all of the services you get during your hospital stay, then Medicare may pay for the Medicare-covered part of the services the VA doesn't pay for.

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.

Section 2: Medicare and Other Types of Health Coverage

Medicare and 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 the following conditions apply:

- 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 www.medicare.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 and TRICARE

What is 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)

What is 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 and Medicare Part B** to get TFL benefits.

Words in red are defined on pages 25–26.

Section 2: Medicare and Other Types of Health Coverage

Medicare and TRICARE (continued)

Can I have both Medicare and TRICARE?

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

- Dependents of active-duty service members who are allowed Medicare for any reason
- People under 65 with **Medicare Part A** because of a disability or **End-Stage Renal Disease (ESRD)** and with **Medicare Part B**
- People 65 or older who can get Medicare Part A and who join Medicare 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 www.medicare.osd.mil
- Call the health benefits advisor at a military hospital or clinic.
- Call 1-866-773-0404.

Medicare and 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.

Section 2: Medicare and Other Types of Health Coverage

Medicare and the Federal Black Lung Benefits Program (continued)

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 **Medicare Coordination of Benefits Contractor** at 1-800-999-1118. **TTY** users should call 1-800-318-8782.

Medicare and COBRA

What is 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 insurers 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.

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 administrator 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 is 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.

Section 2: Medicare and Other Types of Health Coverage

Medicare and COBRA (continued)

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

In general, the rules described on pages 8–11 that apply to group health plan coverage also apply to COBRA continuation coverage. For example, if you or your spouse are retired and have COBRA continuation coverage, Medicare pays first.

If you have Medicare based on **End-Stage Renal Disease (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.

Whether 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.

Where can I get more information about COBRA?

- Before you elect COBRA coverage, it's a good idea to talk with your **State Health Insurance Assistance Program (SHIP)** about Part B and Medigap. Visit www.medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227) to get their phone number. 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 **Medicare Coordination of Benefits Contractor** at 1-800-999-1118. TTY users should call 1-800-318-8782.
- If your **group health plan** coverage was from a private employer (not a government employer), visit the Department of Labor's Web site at www.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's Web site at www.opm.gov.

Section 2: Medicare and Other Types of Health Coverage

Notes

Section 3: Definitions



Claim—A request for payment that you submit to Medicare or other health insurance when you receive 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 or a prescription. 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.

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, former employees, and their families.

Health Care Provider—A person or organization that is 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 100 or more employees.

Section 3: Definitions

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 Coordination of Benefits

Contractor—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.

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

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

Medicare Prescription Drug Plan (PartD)—A stand-alone drug plan that 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 is sponsored jointly by two or more employers.

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

Recovery Contractor—A company that acts on behalf of Medicare to obtain repayment when Medicare makes a conditional payment, and the other payer is determined to be primary.

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 teletypewriter (TTY) 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—A plan that employers are required to have to cover employees who get sick or injured on the job.

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- Call the Medicare Coordination of Benefits Contractor at 1-800-999-1118 with any changes in your insurance or any questions about who pays first. TTY users should call 1-800-318-8782.
- ¿Necesita usted una copia en español? Llame GRATIS al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deberán llamar al 1-877-486-2048.