Medicare & You

The knowledge to make good decisions

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

This booklet explains:

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

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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Health Care Financing Administration

Table of Contents

Note: Terms in red are defined on pages 28-30.

Medicare and Other Health Benefits: Your Guide to Who Pays First explains how Medicare works with other kinds of insurance, and who should pay your bills first. It is not a legal document. The official Medicare provisions are contained in relevant laws, regulations and rulings.

Section 1 - Introduction

Who pays first for my health care?

Some people who have Medicare have other insurance or coverage that must pay before Medicare pays its share of your bill. You may have more than one type of insurance or coverage that will pay before Medicare. This applies no matter how you get your Medicare benefits: through the Original Medicare Plan, a Medicare managed care plan, or Private-Fee-for-Service plan. Tell your doctor, hospital, and all other health providers about your other insurance or coverage. This is important to make sure that your bills are sent to the right payer to avoid delays.

This guide has five sections. The first section has general information that everyone should read. The second section gives more detail on common situations where Medicare pays second to other insurance or coverage. You will find important information about how Medicare works with a specific type of insurance or coverage. The third section includes definitions of important terms, and the fourth section lists useful telephone numbers. These pages are clearly marked at the very top of each page. You can also use the index in Section 5 to help you find information about a specific topic.

Terms in red are defined on pages 28-30.

If you have Medicare and other health insurance or coverage, be sure to tell your doctor and other providers so your bills can be sent to the appropriate payer to avoid delays. Some of the most common situations where Medicare can pay second are listed below; however, this chart does not cover every situation.

If you....	Condition
Are age 65 or older and covered by a group health plan because you are working or are covered by a group health plan of a working spouse of any age	♦ The employer has less than 20 employees ♦ The employer has 20 or more employees
Have an employer retiree plan and are age 65 or older or disabled age 65 or older	♦ Eligible for Medicare
Are disabled and covered by a large group health plan from your work, or from a family member who is working	♦ The employer has less than 100 employees ♦ Employer has 100 or more employees
Have End-Stage Renal Disease (permanent kidney failure) and group health plan coverage (including a retirement plan)	♦ First 30 months of eligibility or entitlement to Medicare ♦ After 30 months
Are covered under workers' compensation because of a job-related illness or injury	♦ Eligible for Medicare
Have black lung disease and covered under the Federal Black Lung Program	♦ Eligible for Federal Black Lung Program
Have been in an accident where no-fault or liability insurance is involved	♦ Eligible for Medicare
Are age 65 or over OR disabled and covered by Medicare and COBRA coverage	♦ Eligible for Medicare
Have End-Stage Renal Disease (permanent kidney failure) and COBRA coverage	♦ First 30 months of eligibility or entitlement to Medicare ♦ After 30 months

Pays first	Pays second	See page
♦ Medicare ♦ Group health plan	♦ Group health plan ♦ Medicare	12 12
♦ Medicare	♦ Retiree coverage	13
♦ Medicare ♦ Large group health plan	♦ Group health plan ♦ Medicare	14 14
♦ Group health plan ♦ Medicare	♦ Medicare ♦ Group health plan	15 15
♦ Workers' compensation, for workers' compensation related services	♦ Medicare	19-20
♦ Federal Black Lung Program, for black lung related services	♦ Medicare	25
♦ No-fault or Liability insurance, for accident related services	♦ Medicare	16-18
♦ Medicare	♦ COBRA	26-27
♦ COBRA ♦ Medicare	♦ Medicare ♦ COBRA	26-27 15

What everyone needs to know about Medicare and other insurance or coverage

What is Medicare?

Medicare is a health insurance program for:

- People age 65 or older.
- Some people with disabilities under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

There are two parts of Medicare:

Part A - Hospital Insurance, helps pay for: Care in hospitals as an inpatient, critical access hospitals, some skilled nursing facilities, hospice care, and some home health care.

Cost: Most people qualify for Medicare Part A when they turn age 65. They do not have to pay a monthly payment, called a premium, for Part A because they or a spouse paid Medicare taxes while they were working.

Part B - Medical Insurance, helps pay for: Doctors' services, outpatient hospital care, and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health care.

Cost: You pay the Medicare Part B premium of $45.50 per month. This is the 2000 amount, and may change January 1, 2001. Premiums can change yearly. In some cases, this amount may be higher if you did not choose Part B when you first became eligible for Medicare.

How do I get Part B?

You are automatically eligible for Medicare Part B if you are eligible for premium-free Medicare Part A. You are also eligible if you are a United States citizen or permanent resident age 65 or older.

Terms in red are defined on pages 28-30.

What everyone needs to know about Medicare and other insurance or coverage (continued)

Just before you turn 65 years old you have to decide whether or not to take Medicare Part B. You should keep in mind that the cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not sign up for it, except in special cases. **You will have to pay this extra 10% for the rest of your life.** If you choose to have Part B, the monthly premium is usually taken out of your monthly Social Security, Railroad Retirement, or Civil Service Retirement payment. If you don't get any of these payments, Medicare sends you a bill for your Part B premium every 3 months.

If you didn't take Medicare Part B when you were first eligible, you can sign up during two enrollment periods. The two enrollment periods are:

The General Enrollment Period, which is from January 1 through March 31 of each year. During that time, you can sign up for Medicare Part A or Part B at your local Social Security office. Your Medicare Part B coverage will start on July 1 of that year.

The Special Enrollment Period. If you didn't take Part B when you were first eligible because you or your spouse were working and had group health plan coverage through your or your spouse's employer or union, you can sign up for Medicare Part B during a Special Enrollment Period.

You can sign up:

1. Anytime you are still covered by the employer or union group health plan through your or your spouse's **current** employment, or

2. Within 8 months of the date when the employer or union group health plan coverage ends, or when the employment ends (whichever is first).

If you are disabled and working (or you have coverage from a working family member), the Special Enrollment Period rules also apply. Most people who sign up for Medicare Part B during a Special Enrollment Period do not pay higher premiums.

What everyone needs to know about Medicare and other insurance or coverage (continued)

However, if you are eligible, but do not sign up for Medicare Part B during the Special Enrollment Period, the cost of Medicare Part B may go up.

Call the Social Security Administration at 1-800-772-1213 (TTY: 1-800-325-0778) for more information about signing up for Medicare Parts A and B. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

General Information

Medicare and Other Insurance or Coverage

I am not yet 65. How will Medicare know that I have other insurance or coverage?

Medicare does not automatically know if you have other insurance or coverage. Medicare sends you a questionnaire called the Initial Enrollment Questionnaire about three months before you are eligible for Medicare. This questionnaire will ask you if you have and plan to keep your group health insurance through your work or that of a family member. Your answers to this questionnaire are used to help Medicare set up your file, and make sure that claims are paid by the right insurance.

Example ▶

Harry is almost 65 and is getting ready to retire and enroll in Medicare. Harry's wife, Jane, is 63, and works for a large company. Both Harry and Jane have health insurance coverage through Jane's employers' group health plan. When Harry gets the Initial Enrollment Questionnaire in the mail from Medicare, he fills it out and reports that he has insurance through his wife's employment. This insurance is Harry's primary payer. In this situation, Medicare will be the secondary payer.

What happens if my health insurance or coverage changes after I fill out the Initial Enrollment Questionnaire?

If your health insurance or coverage changes, you will need to:

- Tell your Medicare Carrier that your health insurance or coverage has changed. Note: **After January 1, 2001,** you should call the Medicare Coordination of Benefits Contractor at 1-800-999-1118 with your changes.
- Give your Medicare Carrier (or the Medicare Coordination of Benefits Contractor after January 1, 2001) the name and address of your health plan, your policy number, the date coverage changed or stopped, and why.
- Tell your doctor and other providers about the change in your insurance or coverage when you get care.

General Information (continued)

What if I have more than one type of insurance or coverage, as well as Medicare?

You may have more than one type of insurance or coverage that will pay before, or along with, Medicare. If you have a question about who should pay, or who should pay first, check your insurance policy or coverage. It may include a coordination of benefits clause. You should call the benefits administrator at the plan. After January 1, 2001, you should call the Medicare Coordination of Benefits Contractor at 1-800-999-1118 with questions about Medicare, who pays first, or how your coverage works with Medicare.

Whom can I call if I have a general question about who pays first?

You should call the benefits administrator at your health insurance plan.

Starting on January 1, 2001, you should call the Medicare Coordination of Benefits Contractor at 1-800-999-1118. Until then, you can call the Medicare Carrier in your state.

Section 2 - Medicare and Other Types of Insurance or Coverage

Section 2 goes into greater detail about the different types of insurance or coverage that you might have, and how these types of insurance or coverage work with Medicare.

Section 2:

Medicare and Group Health Coverage

When you turn 65, there are a number of important insurance decisions you must make, like: whether to take Medicare Part B, buy a Medigap policy, and/or keep employer/retiree coverage. To make sure you understand how to avoid paying more for Medicare Part B and other insurance, as well as get the coverage that is best for you, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of the *Guide to Health Insurance for People with Medicare*. You can also call your State Health Insurance Assistance Program (see pages 31-33).

What is group health coverage?

Group health coverage is coverage offered by many employers and unions for current employees or retirees. You may also get group health coverage through a spouse or family member's employer.

If you can get Medicare and you are 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.

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

If you are age 65 or over and covered by a group health plan because of **current** employment or the **current** employment of a spouse of any age, Medicare is the secondary payer if the employer has 20 or more employees, and covers any of the same services as Medicare. This means that the group health plan is the primary payer (see example on page 11). The group health plan pays first on your hospital and medical bills. If the group health plan did not pay all of your bill, the provider should submit the bill to Medicare for secondary payment. Medicare will review what your group health plan paid for Medicare-covered health care services, and pay any

Medicare and Group Health Coverage (continued)

additional costs up to the Medicare-approved amount. You will have to pay the costs of services that Medicare or the group health plan does not cover.

Example ▶

Marge is 72 years old and works full time for the ABC Company with 75 employees. She has group health coverage through her employer. Therefore, her group health plan will be the primary payer, which makes Medicare the secondary payer.

I work for a small company and have Medicare. Who pays first?

If your employer has fewer than 20 employees, Medicare is the primary payer for all beneficiaries enrolled in the group health plan.

I decided not to take group health plan coverage from my employer. Who is my primary payer?

If you do not take group health plan coverage from your employer, Medicare will be your primary payer (see example on page 12). Medicare will pay its share for any Medicare-covered health care service you get.

What type of health insurance can my employer offer?

Your employer can offer you a plan that will pay for services not covered by Medicare such as hearing aids, routine dental care, prescription drugs, and routine physical check-ups. However, the employer cannot offer you a plan that pays supplemental benefits for Medicare-covered services or pays for these benefits in any other way.

What happens if I drop my employer-based coverage?

Medicare is your primary payer.

Note: If you don't take or drop your employer-based group health coverage, you may not be able to get it back. Call your benefits administrator for more information before you make a decision.

Terms in red are defined on pages 28-30.

Medicare and Group Health Coverage (continued)

Example ▶

John is 67 years old and works full time for DEK Company and decided not to take his employer's group health plan. Therefore, Medicare is the primary (and only) payer.

What health benefits must my employer provide if I am age 65 or older and still working?

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

Medicare and retiree coverage

How does retiree coverage work?

Retiree coverage (not a Medigap policy) might not fill the gaps in Medicare coverage, but might offer other benefits such as prescription drug coverage and routine dental care. Retiree coverage might not pay your medical costs during any period in which you were eligible for Medicare but did not sign up for it. Find out if your employer coverage can be continued after you retire. Check the price and the benefits, including benefits for your spouse. Make sure you know what effect your continued coverage as a retiree will have on both you and your spouse's insurance protections. Retiree coverage provided by your employer or union may have limits on how much it will pay. It may also provide "stop loss" coverage, or a limit on your out-of-pocket costs.

If you are not sure how your retiree coverage works with Medicare, get a copy of your plan's benefits booklet, or look at the summary plan description provided by your employer or union. You can also call your benefits administrator and ask how the plan pays when you have Medicare.

Note: When you have retiree coverage from an employer or union, they have control over this insurance. They may change the benefits or the premiums and can also cancel the insurance if they choose.

I have Medicare and retiree coverage. Who pays first?

Generally, Medicare will pay first for your health insurance claims, and your retiree coverage will be the secondary payer. If you are not sure how your plan works with Medicare, get a copy of your plan's benefits booklet or look at the summary plan description provided by your employer or union. You can also call your benefits administrator and ask how the plan pays when you have Medicare.

Medicare and group health coverage for people who are disabled

I am under 65, disabled and have Medicare and group health coverage. Who pays first?

It depends. If your employer has less than 100 employees, Medicare is the primary payer if:

- you are under age 65, and
- have Medicare because of a disability.

If the employer has 100 employees or more, the health plan is called a large group health plan. If you are covered by a large group health plan because of your current employment or the current employment of a family member, Medicare is the secondary payer (see example below).

Sometimes employers with fewer than 100 employees join other employers in a multi-employer plan. If at least one employer in the multi-employer plan has 100 employees or more, then Medicare is the secondary payer for disabled Medicare beneficiaries enrolled in the plan, including those covered by small employers. Some large group health plans let others join the plan, such as a self-employed person, a business associate of an employer, or a family member of one of these people. A large group health plan cannot treat any of its plan members differently because they are disabled and have Medicare.

Example ▶

Mary works full-time for GHI 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. Therefore, Mary's group health plan coverage pays first for Mary's husband, and Medicare is his secondary payer.

Terms in red are defined on pages 28-30.

Medicare and group health coverage for people with End-Stage Renal Disease (ESRD) (permanent kidney failure)

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

If you are eligible to enroll in Medicare because of End-Stage Renal Disease (permanent kidney failure), your group health plan will pay first on your hospital and medical bills for 30 months, whether or not you are enrolled in Medicare and have a Medicare card. During this time, Medicare is the secondary payer. 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 becomes the primary payer. This rule applies to all people with ESRD, whether you have your own group health coverage or you are covered as a family member.

Example ▶

Bill has Medicare coverage because of permanent kidney failure. He also has group health plan coverage through the company he works for. His group health coverage will be his primary payer for the first 30 months after Bill becomes eligible for Medicare. After 30 months, Medicare becomes the primary payer.

For more information on ESRD, you can get a free copy of *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* by calling 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). You can also see and print a copy of this booklet by using a computer to look on the Internet at www.medicare.gov.

Can a group health plan deny me coverage if I have permanent kidney failure?

No. Group health plans cannot deny you coverage, reduce your coverage, or charge you a higher premium because you have ESRD and Medicare. Group health plans cannot treat any of their plan members who have ESRD differently because they have Medicare.

Medicare and no-fault or liability insurance

Medicare is the secondary payer where no-fault insurance or liability insurance is available as the primary payer.

What is no-fault insurance?

No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.

Types of no-fault insurance include, but are not limited to:

- Automobile insurance
- Homeowners' insurance
- Commercial insurance plans

What is liability insurance?

Liability insurance is coverage that protects against claims based on negligence, inappropriate action or inaction which results in injury to someone or damage to property.

Liability insurance includes, but is not limited to:

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

Example ▶

Nancy, 68 years old, falls while visiting at her daughter's house and injures herself. While at the hospital emergency room, Nancy is asked whether her daughter has homeowner's insurance. Since she does, the hospital will supply Medicare with the information that another insurer (in this case, homeowner's liability insurance) may pay first.

Medicare and no-fault or liability insurance (continued)

If I expect to receive money from no-fault or liability insurance, and I also have Medicare, which one should pay first?

No-fault or liability insurance should be the primary payer. If doctors or other providers decide that the services you got can be paid for by a no-fault or liability insurance company, they should try to get payments from the insurance company before billing Medicare. However, this may take a long time. If the insurance company does not pay the claim within 120 days, your doctor or other provider may bill Medicare. Medicare may make a conditional payment to pay the bill.

What is a conditional payment?

A conditional payment is a payment that Medicare makes if the insurance company will not pay a claim within 120 days so that you will not have to use your own money to pay the bill. The money that Medicare used for the conditional payment must be repaid to Medicare when a settlement is reached.

Note: If Medicare makes a conditional payment, and later you get a settlement from an insurance company, Medicare may try to get the conditional payment from you. You are responsible for making sure that Medicare gets repaid for the conditional payment.

Terms in red are defined on pages 28-30.

Medicare and no-fault or liability insurance (continued)

Example ▶

Joan is driving her car when someone in another car hits her. Joan has to go to the hospital. The hospital tries to bill the other driver's liability insurer. The insurance company disputes who was at fault, and will not pay the claim right away. The hospital bills Medicare, and Medicare makes a conditional payment. Later, a settlement is reached and Medicare gets its money back for the conditional payment.

Who pays if the no-fault or liability insurance does not pay, or denies my medical bill?

In this case, Medicare will pay first. However, Medicare will only pay for Medicare-covered services. You will be responsible for your share of the bill, and those services that Medicare does not cover.

Who should I call if I have questions?

If you have questions about a no-fault or liability insurance claim, call the insurance company. If you have Medicare questions, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

Medicare and Workers' Compensation

What is workers' compensation?

Workers' compensation is insurance that employers are required to have to cover employees who get sick or injured on the job. Most employees are covered under workers' compensation plans. If you do not know whether you are covered, ask your employer.

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

If you think you have a work-related illness or injury, you have to tell your employer, and file a workers' compensation claim. Workers' compensation pays first on the bills for 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 cannot pay for items or services that workers' compensation will pay for within 120 days. If workers' compensation does not pay your bill within 120 days, Medicare may then make a conditional payment.

What is a conditional payment?

A conditional payment is a payment that Medicare makes if the state workers' compensation insurance will not pay a claim within 120 days. This conditional payment is made so you will not have to use your own money to pay the bill. The payment is "conditional" because it must be repaid to Medicare when a workers' compensation settlement is reached.

Note: If Medicare makes a conditional payment, and later you get a settlement from an insurance company, Medicare may try to get the conditional payment from you. You are responsible for making sure that Medicare gets repaid for the conditional payment.

Medicare and Workers' Compensation (continued)

Example ▶

John was injured at work. He filed a claim for workers' compensation insurance and his doctor billed the state workers' compensation for payment. After 120 days passed, and the state workers' compensation insurance did not pay the bill, John's doctor billed Medicare and sent a copy of the workers' compensation claim with the claim for Medicare payment. Medicare can make a conditional payment to the doctor for the health care services that John received. When John receives a settlement from the state workers' compensation agency, Medicare will get its money back for the conditional payment.

What if workers' compensation denies payment?

If payment is denied by the state workers' compensation insurance, Medicare will only pay for Medicare-covered items and services.

Example ▶

John was injured at work. He filed a claim for workers' compensation. The workers' compensation agency denied payment for John's medical bills. John's doctor billed Medicare and sent a copy of the workers' compensation denial with the claim for Medicare payment. Medicare will pay John's doctor for the Medicare-covered items and services John received as part of his treatment. John will have to pay for anything not covered by Medicare.

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

In some cases, workers' compensation may not pay your entire bill. If you have a pre-existing condition that gets worse because of your job, your entire bill may not be paid. In this case, a pre-existing condition is any health problem that you had before you started your job. For example, you may have a disc problem in your back that gets worse because of your job. In this case, workers' compensation may agree to pay only a part of your doctor or hospital bills. You and workers' compensation may agree to share in the costs of your bill. If your pre-existing condition is covered by Medicare, Medicare may pay its share for part of the doctor or hospital bills not covered by workers' compensation.

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 you are going to use. You must make this choice each time you see a doctor or get health care, like in a hospital. Medicare cannot pay for the same service that was covered by Veterans' benefits, and your Veterans' benefits cannot pay for the same service that was covered by Medicare. You do not always have to go to a Department of Veterans' Affairs (VA) hospital or to a doctor who works with the VA for the VA to pay for the service. To get services under VA, 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 VA can 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 that the VA does not pay for.

Example ▶

John, a veteran, goes to a non-VA hospital for a service that is authorized by the VA. While at the non-VA hospital, John gets other non-VA authorized services that the VA refuses to pay for. Some of these services are Medicare-covered services. Medicare may pay for some of the non-VA authorized services that John received. John will have to pay for services that are not covered by Medicare or the VA.

Can Medicare help pay my VA copayment?

Sometimes. The VA charges a copayment to some veterans. The copayment is your share of the cost of your treatment, and is based on income. Medicare may be able to pay all or part of your copayment if you are billed for VA-authorized care by a doctor or hospital who is not part of the VA.

Terms in red are defined on pages 28-30.

Medicare and Veterans' Benefits (continued)

I have a VA fee basis ID card. Who pays first?

The VA gives "fee basis ID cards" to certain veterans. You may be given a fee basis card if:

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

If you have a fee basis ID card, you may choose any doctor that is listed on your card to treat you for the condition.

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 may not bill either you or Medicare for any charges.

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

Where can I get more information?

You can get more information on Veterans' benefits by calling your local VA office, or the national VA information number 1-800-827-1000. Or, you can use a computer to look on the Internet at www.va.gov. If you do not have a computer, your local library or senior center may be able to help you get this information using their computer.

Medicare and TRICARE

What is TRICARE?

TRICARE (formerly known as CHAMPUS) is health coverage for retired members of the uniformed services, as well as the spouses and children of active duty, retired, and deceased service members. It covers civilian hospital services and services of civilian doctors, suppliers, and other providers.

What happens to my TRICARE coverage when I become eligible for Medicare?

Generally, if you have TRICARE and are eligible for premium-free Medicare Part A, you lose your TRICARE coverage. This means that Medicare is your primary payer. If you are under age 65 and have Medicare Part A because you have a disability or End-Stage Renal Disease (permanent kidney failure), you will lose your TRICARE coverage if you do not take Medicare Part B. If you get better, and your Medicare coverage ends, you can return to TRICARE.

Example ▶

Jim, who is 64 and retired from active duty in the uniformed services, has TRICARE coverage. When he is eligible, he enrolls in Medicare and therefore loses his TRICARE coverage. Medicare will be the primary payer.

Can I have both Medicare and TRICARE? Who pays first?

There are four groups of people who can have both TRICARE and Medicare. They are:

- Dependents of active duty service members;
- People who are entitled only to Medicare Part B;
- People who pay the monthly Medicare Part A premium; or
- People who are under age 65 and entitled to Medicare Part A because of a disability or ESRD and take Medicare Part B.

Terms in red are defined on pages 28-30.

Medicare and TRICARE (continued)

These individuals will not lose their TRICARE coverage when they enroll in Medicare.

In general, Medicare pays first. If Medicare does not pay all of the bill, TRICARE may pay some of the costs. TRICARE will pay up to the amount they would have paid if you did not have Medicare. For example, TRICARE may pay the Medicare deductible and coinsurance amounts, and for any services not covered by Medicare but covered by TRICARE.

Who pays if I get services from a military hospital?

If you get services from a military hospital or any other federal provider, TRICARE will pay the bills. Medicare does not usually pay for services you get from a federal provider or other federal agency.

Note: At the time of this printing, there were special demonstration projects for certain Medicare beneficiaries who were eligible for TRICARE. You can look on the Internet at www.medicare.gov to see if one of these projects is available in your state, and click on Medicare Health Plan Compare for more information on health plans available to military retirees.

Where can I get more information?

You can get more information on TRICARE by calling the health benefits advisor at a military hospital or clinic. Or, you can use a computer to look on the Internet at www.tricare.osd.mil. If you do not have a computer, your local library or senior center may be able to help you get this information using their computer.

Medicare and the Federal Black Lung Program

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

Health care related to black lung disease is covered under workers' compensation. For all other health care not related to black lung, your bills should be sent directly to Medicare. Medicare will not pay for doctor or hospital services that are covered under the Federal Black Lung Program. Your doctor or other provider should send all bills for the diagnosis or treatment of black lung to the following address:

Federal Black Lung Program
P.O. Box 828
Lanham-Seabrook, MD 20703-0828.

If the Federal Black Lung Program will not pay your bill, your doctor or other provider can send the bill to Medicare. Your doctor or other provider should send a copy of the letter from the Federal Black Lung Program that says they will not pay with your bill.

Who should I call if I have questions?

If you have questions about the Federal Black Lung Program, call 1-800-638-7072. If you have questions about Medicare, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

Medicare and COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1985)

What is COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1985)?

COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions. This is called continuation coverage. You may have this right if you lose your job or have your working hours reduced, or if you are covered under your spouse's plan and your spouse dies or you get divorced. COBRA generally lets you and your dependents stay in your group health plan for 18 months (or up to 29 or 36 months in some cases), but you may have to pay both your share and the employer's share of the premium. Some state's laws require employers with less than 20 employees to let you keep your group health coverage for a time, but you should check with your State Department of Insurance to make sure. In most situations that give you COBRA rights, other than a divorce, you should get a notice from your benefits administrator. If you don't get a notice, or if you get divorced, you should call your benefits administrator as soon as possible.

What happens if I have COBRA and enroll in Medicare?

If you already have group health coverage under COBRA when you enroll in Medicare, your COBRA may end. The length of time your spouse may get coverage under COBRA may change when you enroll in Medicare. For more information about group health coverage under COBRA, call your State Department of Insurance, (see pages 31-33).

What happens if I am in Medicare and choose to get COBRA coverage?

If you elect COBRA coverage after you enroll in Medicare, you can keep your COBRA continuation coverage. If you have only Medicare Part A when your group health plan coverage based on **current** employment ends, you can enroll in Medicare Part B during a Special Enrollment Period without having to pay a Part B premium penalty. You need to enroll in Part B **either** at the same time you enroll in Part A or during a Special Enrollment Period after your group health plan

Terms in red are defined on pages 28-30.

Medicare and COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1985) (continued)

coverage based on **current** employment ends. However, if you have Medicare Part A only, sign-up for COBRA coverage, and wait until the COBRA coverage ends to enroll in Medicare Part B, **you will have to pay a Part B premium penalty. You do not get a Part B special enrollment period when COBRA coverage ends.** State law may give you the right to continue your coverage under COBRA beyond the point COBRA coverage would ordinarily end. Your rights will depend on what is allowed under the state law.

Remember, enrolling in Medicare Part B will also trigger your Medigap open enrollment period. To make sure you understand about this, you should call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for your free copy of the *Guide to Health Insurance for People with Medicare*. You can also call your State Health Insurance Assistance Program (see pages 31-33).

Who pays first, Medicare or my COBRA continuation coverage?

If you or your spouse are age 65 or over and have COBRA continuation coverage, Medicare is the primary payer. If you or a family member has Medicare based on a disability and COBRA continuation coverage, Medicare is the primary payer. However, if you or a family member have Medicare based on ESRD, COBRA continuation coverage is the primary payer for a 30-month period and Medicare is the secondary payer.

Who should I call if I have questions?

You should call your benefits administrator for questions about COBRA coverage and payments. If you have Medicare questions, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). After January 1, 2001 you should call the Coordination of Benefits Administrator at 1-800-999-1118.

If you are not offered COBRA and feel you should be, you should contact the Department of Labor. The Department of Labor Internet website is www.dol.gov. If you do not have a computer, your local library or senior center may be able to help you get this information using their computer.

Section 3 - Definitions of Important Terms

Beneficiary - The name for a person who has health care insurance through the Medicare or Medicaid program.

Claim - A claim is a request for payment for a provided service. "Claim" and "Bill" are used for all Part A and Part B services billed through Fiscal Intermediaries; "Claim" is used for Part B physicians/supplier services billed through the Medicare Carrier.

Coinsurance - The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the cost of the service (like 20%).

Conditional Payment - A payment made by Medicare in certain circumstances if the insurance company or other payer does not pay the bill within 120 days.

Consolidated Omnibus Budget Reconciliation Act (COBRA) - A law that requires employers to provide coverage under the employer's group health plan for a period of time after the death of your spouse, losing your job, or having your work hours reduced, or getting a divorce. You may have to pay both your share and the employer's share of the premium.

Copayment - A copayment is usually a set amount you pay for a service, like $5.00 or $10.00 for a doctor visit.

Deductible - The amount you must pay for health care, before Medicare begins to pay, either each benefit period for Part A, or each year for Part B. These amounts can change every year.

*End-Stage Renal Disease - Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

Group Health Plan - A health plan that provides health coverage to employees, former employees, and their families, and is supported by an employer or employee organization.

Large Group Health Plan - A group health plan that covers employees of an employer that employs 100 or more employees.

Liability Insurance - Liability insurance is insurance that protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property.

Medicare - The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (those with permanent kidney failure who need regular dialysis or a kidney transplant).

Section 3 - Definitions of Important Terms

Medicare Carrier - A private company that contracts with Medicare to process Medicare Part B bills.

Medicare Part A (Hospital Insurance) - Medicare hospital insurance that pays for hospice care, home health care, care in a skilled nursing facility, and inpatient hospital stays.

Medicare Part B (Medical Insurance) - Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, and other medical services that are not covered by Part A.

Medicare Secondary Payer - Any situation where another payer or insurer pays your medical bills before Medicare.

Medigap - A Medicare supplemental health insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are 10 standardized policies labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

Multi-Employer Plan - A group health plan that is sponsored jointly by two or more employers or by employers and unions.

No-Fault Insurance - No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.

Pre-Existing Condition - Health problems that needed medical treatment within the 6 months before the date that a new health insurance policy goes into effect.

Premium - Your monthly payment for health care coverage to Medicare, an insurance company, or a health care plan.

Primary Payer - The insurance company that pays first on a claim for medical care. This could be Medicare or another insurance company.

Provider - A doctor, hospital, health care professional, or health care facility.

Secondary Payer - The insurer that pays second on a claim for medical care.

State Health Insurance Assistance Program - A state organization that receives money from the federal government to give free health insurance counseling and assistance to Medicare beneficiaries.

TRICARE - (formerly known as CHAMPUS) - A medical program run by the Department of Defense to give medical care to the dependents of active duty members of the military and to retired members of the military.

Worker's Compensation - Insurance that employers are required to have to cover employees who get sick or injured on the job.

Section 4 - Phone Numbers

State Health Insurance Assistance Program: Call for help with buying a Medigap policy or long-term care insurance, dealing with payment denials or appeals, Medicare rights and protections, help with complaints about your care or treatment, for help choosing a Medicare health plan, or Medicare bills.

State Deparment of Insurance: Call with questions about the Medigap policies sold in your area and any insurance-related problems.

State	State Health Insurance Assistance Program	State Department of Insurance
Alabama	(334) 242-5743	(334) 241-4101
Alaska	(907) 269-3680	(907) 269-7900
American Samoa	(808) 586-7299	(808) 586-2790
Arizona	(800) 432-4040	(602) 912-8444
Arkansas	(800) 224-6330	(800) 224-6330
California	(800) 434-0222	(213) 897-8921
Colorado	(303) 894-7499 ext. 356	(303) 894-7499
Connecticut	(860) 424-5245	(860) 297-3800
Delaware	(302) 739-6266	(302) 739-6775
Florida	(850) 414-2060	(850) 922-3100
Georgia	(404) 657-5334	(404) 656-2070
Guam	(808) 586-7299	(808) 586-2790
Hawaii	(808) 586-7299	(808) 586-2790
Idaho	(208) 334-4350	(208) 334-4250
Illinois	(217) 785-9021	(312) 814-2427
Indiana	(800) 452-4800	(317) 232-2395
Iowa	(800) 351-4664	(515) 281-5705
Kansas	(316) 337-7386	(785) 296-3071
Kentucky	(502) 564-7372	(800) 595-6053
Louisiana	(225) 342-0825	(225) 342-5301
Maine	(800) 750-5353	(207) 624-8475
Maryland	(410) 767-1100	(410) 468-2000

Section 4 - Phone Numbers

State	State Health Insurance Assistance Program	State Department of Insurance
Massachusetts	(617) 727-7750	(617) 521-7794
Michigan	(800) 803-7174	(877) 999-6442
Minnesota	(800) 333-2433	(651) 296-4026
Mississippi	(800) 948-3090	(601) 359-3569
Missouri	(800) 390-3330	(800) 726-7390
Montana	(406) 444-7781	(406) 444-2040
Nebraska	(800) 234-7119	(800) 234-7119
Nevada	(800) 307-4444	(775) 687-4270
New Hampshire	(603) 225-9000	(800) 852-3416
New Jersey	(609) 588-3139	(609) 292-5360
New Mexico	(505) 827-7640	(505) 827-4601
New York	(800) 333-4114	(212) 480-6400
North Carolina	(919) 733-0111	(919) 733-0111
North Dakota	(701) 328-2440	(701) 328-2440
Ohio	(614) 644-3458	(614) 644-2673
Oklahoma	(405) 521-6628	(405) 521-2828
Oregon	(503) 947-7984	(503) 947-7984
Pennsylvania	(800) 783-7067	(717) 787-2317
Puerto Rico	(787) 721-8590	(787) 722-8686
Rhode Island	(401) 222-2880	(401) 222-2223
South Carolina	(803) 898-2850	(803) 737-6180
South Dakota	(605) 773-3656	(605) 773-3563
Tennessee	(800) 525-2816	(800) 525-2816
Texas	(800) 252-9240	(800) 252-3439
Utah	(801) 538-3910	(801) 538-3805

Section 4 - Phone Numbers

State	State Health Insurance Assistance Program	State Department of Insurance
Vermont	(800) 642-5119	(802) 828-2900
Virgin Islands	(340) 778-6311 ext. 2338	(340) 774-7166
Virginia	(800) 552-3402	(804) 371-9691
Washington	(800) 397-4422	(800) 397-4422
Washington D.C.	(202) 676-3900	(202) 727-8000
West Virginia	(877) 987-4463	(304) 558-3386
Wisconsin	(877) 333-0202	(608) 266-3585
Wyoming	(800) 856-4398	(307) 777-7401

Note: At the time of printing, the phone numbers listed on pages 31-33 were correct. Phone numbers sometimes change. To get the most up-to-date phone numbers, call 1-800-MEDICARE (1-800-633-4227, TTY/TTD: 1-877-486-2048 for the hearing and speech impaired) or go to the Internet at www.medicare.gov and click on Helpful Contacts.

After January 1, 2001, call the Coordination of Benefits Administrator at 1-800-999-1118 with any changes in your insurance, or any questions about who pays first.

Section 5 - Index

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NOTES

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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¿Necesita usted una copia en Español? Por favor llame gratis al 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 para personas con impedimento auditivo o de lenguaje oral).