

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



Welcome to

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

How This Guide Can Help You

This Guide explains how Medicare works with other kinds of insurance or coverage and who should pay your bills first. Some people with 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. Tell your doctor, hospital, and all other health **providers** about your other insurance or 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.”

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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: The Medicare Program



What Is Medicare?

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with **End-Stage Renal Disease** (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare has

- **Medicare Part A** (Hospital Insurance)
- **Medicare Part B** (Medical Insurance)
- Medicare Part C (combines Part A and Part B coverage)
- Medicare Part D (prescription drug coverage)

Medicare Part A

Medicare Part A helps cover inpatient care in hospitals, including critical access hospitals. It also covers skilled nursing facility, hospice, and home health care. You must meet certain conditions to get these benefits.

Cost: You usually don't pay a monthly **premium** for Part A coverage if you or your spouse paid Medicare taxes while working.

You pay up to \$461 (in 2010) each month if you don't get premium-free Part A. If you pay a late enrollment penalty, this amount is higher.

Words in red are defined on pages 33–34.

Section 1: The Medicare Program

Medicare Part B

Medicare Part B helps cover medical services like doctors' services, outpatient care, and other medical services Medicare Part A doesn't cover, if those services are medically necessary. Medicare Part B is optional. You have to enroll in Part B and pay a monthly premium. Your monthly premium depends on your income (see chart). Part B also covers some preventive services.

Part B (Medical Insurance) Monthly Premium

| If Your Yearly Income is (in 2008) | | You pay |
|------------------------------------|-----------------------|-----------|
| File Individual Tax Return | File Joint Tax Return | |
| \$85,000 or below | \$170,000 or below | \$110.50* |
| \$85,001-\$107,000 | \$170,001-\$214,000 | \$154.70 |
| \$107,001-\$160,000 | \$214,001-\$320,000 | \$221.00 |
| \$160,001-\$214,000 | \$320,001-\$428,000 | \$287.30 |
| Above \$214,000 | Above \$428,000 | \$353.60 |

* Most people will continue to pay the 2009 Part B premium of \$96.40 in 2010. If you have questions about your Part B premium, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

You also pay a Medicare Part B deductible (\$155 in 2010) each year before Medicare starts to pay its share. Medicare premium and deductible rates may change every year in January.

Medicare Part C

Medicare Advantage Plans (Part C) are another way to get your Medicare benefits. They combine Part A, Part B, and, sometimes, Part D (prescription drug) coverage. Medicare Advantage Plans are managed by private insurance companies approved by Medicare. These plans must cover medically-necessary services. However, plans can charge different copayments, coinsurance, or deductibles for these services.

Medicare Part D

Medicare prescription drug coverage (Part D) is available to everyone with Medicare. Private companies approved by Medicare provide this coverage. If you are in Original Medicare, you choose a separate Medicare Prescription Drug Plan and pay a monthly premium. See page 4 for more information about Medicare Prescription Drug Coverage. Costs vary by plan.

Words in red are defined on pages 33–34.

Section 1: The Medicare Program

Below and on page 4 is a quick look at your Medicare plan choices. People with Medicare can make changes to their coverage from November 15—December 31 each year.

Original Medicare—This is a fee-for-service plan that is managed by the Federal government. You can go to any doctor or supplier that is enrolled in Medicare and accepts new Medicare patients. No referrals are necessary.

Original Medicare covers most health care services and supplies, but it doesn't cover most prescription drugs. It only covers certain drugs (like certain cancer drugs). If you don't have prescription drug coverage through another source (your employer, the VA, etc.) you may want to enroll in a **Medicare Prescription Drug Plan** to help pay for your prescription drugs. Also, you may want to buy additional coverage, such as a **Medigap** (Medicare Supplement Insurance) **policy**. You can choose one or both types of additional coverage.

Medicare Advantage Plans (like an HMO or PPO)—Medicare Advantage Plans are health plan options approved by Medicare and run by private companies. These plans are part of the Medicare Program and are sometimes called “Part C” or “MA plans.” Medicare pays an amount for your care every month to these private health plans. Medicare Advantage Plans must follow rules set by Medicare. Medicare Advantage Plans aren't supplemental insurance.

Medicare Advantage Plans include the following:

- Medicare Preferred Provider Organization (PPO) Plans
- Medicare Health Maintenance Organization (HMO) Plans
- Medicare Private Fee-for-Service (PFFS) Plans
- Medicare Special Needs Plans
- Medicare Medical Savings Account (MSA) Plans

There are other Medicare health plans that provide health care coverage that aren't part of Medicare Advantage but are still part of the Medicare Program. They include Medicare Cost Plans, Demonstrations/Pilot Programs, and PACE (Programs of All-inclusive Care for the Elderly).

Section 1: The Medicare Program

Medicare Prescription Drug Coverage—Medicare offers prescription drug coverage for everyone with Medicare. This is called “Part D.” This coverage may help lower prescription drug costs and help protect against higher costs in the future. It can give you greater access to drugs that you can use to prevent complications from diseases and stay well.

There are two ways to get Medicare prescription drug coverage:

- 1) Join a **Medicare Prescription Drug Plan** that adds drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service Plans, and Medicare Medical Savings Account Plans.
- 2) Join a Medicare Advantage Plan or other Medicare health plan that includes prescription drug coverage as part of the plan. You get all of your Medicare coverage through these plans, including prescription drugs.

Generally, both types of these plans are called “Medicare drug plans.”

If you don’t join a Medicare drug plan when you are first eligible, the next chance you have to join is from November 15—December 31 each year. If you decide later that you want to join a Medicare drug plan, you may have to pay a penalty unless you had certain other kinds of prescription drug coverage.

Important: If you have prescription drug coverage through an employer or union, before you sign up for Medicare drug coverage you need to check with your benefits administrator to learn how your current coverage would be affected. In addition, if you have other insurance that pays for your prescriptions and you join a Medicare drug plan, you must let your Medicare drug plan know about your other coverage.

For more information about Medicare drugs plans, get a free copy of “Your Guide to Medicare Prescription Drug Coverage” by visiting www.medicare.gov/Publications/Pubs/pdf/11109.pdf or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Words in red are defined on pages 33–34.

Section 2: Basic Information



Know Who Pays First If You Have Other Health Insurance or Coverage

If you have Medicare and other health insurance or coverage, each type of coverage is called a “payer.” When there is more than one payer, there are “coordination of benefits” rules that decide which one pays first. The “primary payer” pays what it owes on your bills first, and then 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 **providers** if you have coverage in addition to Medicare. This will help them send your bills to the correct payer to avoid delays. If you have questions about who pays first or if your insurance changes, call the **Medicare Coordination of Benefits Contractor (COBC)** at 1-800-999-1118. TTY users should call 1-800-318-8782.

Section 2: Basic Information

| If you | Situation | Pays first | Pays second | See page(s) |
|--|---|--------------------------------|-------------------|-------------|
| 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 | 12 |
| | The employer has less than 20 employees.* | Medicare | Group Health Plan | 13 |
| Have an employer group health plan after you retire and are 65 or older | Entitled to Medicare | Medicare | Retiree Coverage | 14–16 |
| 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 | 16–17 |
| | The employer has less than 100 employees. | Medicare | Group Health Plan | 16 |
| 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 | Group Health Plan | Medicare | 18 |
| | After 30 months | Medicare | Group Health Plan | 18 |
| Have End-Stage Renal Disease (permanent kidney failure) and COBRA coverage | First 30 months of eligibility or entitlement to Medicare | COBRA | Medicare | 31 |
| | After 30 months | Medicare | COBRA | 18 |
| Are 65 or over OR disabled and covered by Medicare and COBRA coverage | Entitled to Medicare | Medicare | COBRA | 30–31 |

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

Section 2: Basic Information

| If you | Situation | Pays first | Pays second | See page(s) |
|---|---|---|--|-------------|
| 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 | 19–22 |
| 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. | 22–26 |
| 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 | 26–28 |
| 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. | 28–29 |
| Have black lung disease and covered under the Federal Black Lung Program | Entitled to Medicare and Federal Black Lung Program | Federal Black Lung Program for services related to black lung | Medicare | 29–30 |

Section 2: Basic Information

General Information about Medicare and Other Insurance or Coverage

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

Medicare doesn't automatically know if you have other insurance or coverage. Medicare sends you a questionnaire called the "Initial Enrollment Questionnaire" about 3 months before you're entitled to Medicare. This questionnaire will ask you if you have **group health plan** coverage 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 your **claims** are paid correctly.



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 (more than 20 people). Both Harry and Jane have health insurance coverage through Jane's employer's 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 will pay Harry's claims first, and Medicare will pay claims second.

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 call the **Medicare Coordination of Benefits Contractor** at 1-800-999-1118. TTY users should call 1-800-318-8782. Give the Medicare Coordination of Benefits Contractor your name; the name and address of your health plan; your policy number; and the date coverage was added, changed or stopped, and why. Tell your doctor and other **providers** about the change in your insurance or coverage when you get care.

Words in red are defined on pages 33–34.

Section 2: Basic Information

General Information about Medicare and Other Insurance or Coverage (continued)

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

If you have a question about who should pay, or who should pay first, check your insurance policy or coverage. 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 is entitled to Medicare on the basis of disability and covered by a large group health plan on the basis of his/her own current employment status 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 on the basis of end stage renal disease (ESRD) and is covered by a group health plan on any basis;
- When the domestic partner is entitled to Medicare on the basis of age and has group health plan coverage on the basis of his/her own current employment status.

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

If a domestic partner is entitled to Medicare on the basis of age and has group health plan coverage based on the current employment status of his/her partner.

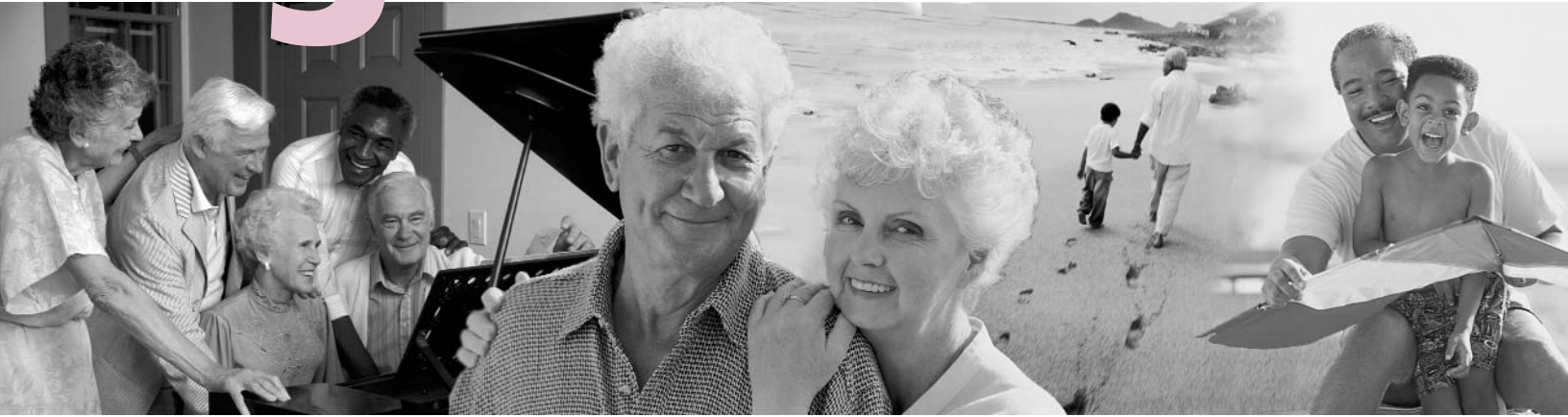
Who should I call if I have a general question about who pays first?

You should call the benefits administrator at your health insurance plan. You can also call the Medicare Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782.

Words in red are defined on pages 33–34.

Section 3: Medicare and Other Types of Insurance or Coverage

3



This section has more detailed information about the different types of coverage you might have, and how they work with Medicare.

Section 3 includes

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| Medicare and Group Health Plan Coverage After You Retire | 14–16 |
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Section 3: Medicare and Other Types of Insurance or Coverage

Medicare and Group Health Plan Coverage

When you turn 65, you have a number of important decisions to make. These may include whether to enroll in **Medicare Part B**, join a **Medicare Prescription Drug Plan**, buy a **Medigap policy**, and/or keep employer or retiree coverage. Understanding your choices may help you avoid paying more than you need to for Medicare Part B and other insurance, and get the coverage that's best for you. You can visit www.medicare.gov and select "Compare Medicare Prescription Drug Plans" and "Compare Health Plans and Medigap Policies in Your Area." You can also call your **State Health Insurance Assistance Program**. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What is group health plan coverage?

Group health plan coverage is coverage offered by many employers and unions for 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 are offered coverage under a group health plan, you can choose to accept or reject the plan. Note that 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 the following conditions apply:

- You're age 65 or older and covered by a group health plan because of your **current** employment or the **current** employment of a spouse of any age.
- The employer has 20 or more employees and covers any of the same services as Medicare. This means that 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 **provider** should send the bill to Medicare for secondary payment. Medicare will review what your group health plan paid, and pay any additional costs up to the Medicare-approved amounts. You will have to pay the costs of services that Medicare or the group health plan doesn't cover.

Words in red are defined on pages 33–34.

Section 3: Medicare and Other Types of Insurance or Coverage

Medicare and Group Health Plan Coverage (continued)

I have Medicare, and I work for a small company that has a group health plan. Who pays first?

If your employer has fewer 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 fewer than 20 employees, you will need to find out from your employer whether Medicare pays first or second.

If my group health plan is a Health Maintenance Organization (HMO) Plan or an employer Preferred Provider Organization (PPO) Plan that is primary to Medicare, who pays if I go outside the employer plan's network?

If you go outside your employer plan's network, you might not get any payment from the plan or Medicare. Call your employer 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?

If you don't take **group health plan** coverage from your employer and you don't have coverage through an employed spouse, Medicare payment isn't affected. Medicare will pay its share for any Medicare-covered health care service you get.

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 or you drop employer coverage when it is first offered to you, you might not get another chance to sign up. If you take the coverage, but later drop it, you may not be able to get it back. Also, if your or your spouse's employer generally offers retiree coverage (see page 14), you might be denied that coverage if you weren't enrolled 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 3: Medicare and Other Types of Insurance or Coverage

Medicare and Group Health Plan Coverage (continued)

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

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

Medicare and Group Health Plan Coverage After You Retire

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

This will depend on the terms of your specific plan. Your or your spouse's employer or union might not provide any health coverage after you retire. If group health plan coverage continues to be available after you retire, it might have different rules, and it might not work the same way with Medicare.

First, find out if you can continue your employer coverage after you retire. Note that employers aren't required to provide retiree coverage, and they can change the benefits or **premiums**, or even cancel the coverage.

Second, find out what happens to your retiree coverage when you're 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 enroll in both **Medicare Part A** and **Medicare Part B** to get full benefits from your retiree coverage.

Words in red are defined on pages 33–34.

Section 3: Medicare and Other Types of Insurance or Coverage

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

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

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

Check the price and benefits of the retiree coverage, including whether it includes coverage for your spouse. Retiree coverage provided by your employer or union may have limits on 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.

It would make sense to compare the retiree coverage to available Medigap policies. The best time to buy a Medigap policy is during your 6-month open enrollment period, when you can buy any Medigap policy sold in your state, even if you have health problems. This period automatically starts the month you're age 65 **and** enrolled in Part B, and once it's over, you can't get it again. Also, remember that you and your spouse would each have to have 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/Pubs/pdf/02110.pdf 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 and select "Compare Medicare Health Plans and Medigap Policies in Your Area." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Words in red are defined on pages 33–34.

Make sure you know what effect your continued coverage as a retiree will have on both your and your spouse's health coverage. If you aren't sure how your retiree coverage works with Medicare, get a copy of your plan's benefit booklet, 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. It would also be a good idea to talk to your **State Health Insurance Assistance Program (SHIP)** for advice about whether to buy a Medigap policy.

Section 3: Medicare and Other Types of Insurance or Coverage

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

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

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

Generally, Medicare will pay first for your health care bills and your **group health plan** (retiree) coverage will pay 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, you may be protected under Federal COBRA rules if there is any other company within the same corporate organization that still offers a group health plan to its employees. If there is, that plan is required to offer you COBRA continuation coverage through that plan. See pages 30–32. If COBRA continuation coverage isn't available, you may have the right to buy a **Medigap policy**, even if you're no longer in your Medigap open enrollment period.

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 the following are true:

- You are under age 65.
- You 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 pays second.

Words in red are defined on pages 33–34.

Section 3: Medicare and Other Types of Insurance or Coverage

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

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

Sometimes employers with fewer than 100 employees join other employers to form a **multi-employer plan**. If at least one employer in the multi-employer plan has 100 employees or more, then Medicare pays second. 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 can't treat any of its plan members 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. Therefore, Mary's group health plan coverage pays first for Mary's husband, and Medicare pays second.

Words in red are defined on pages 33–34.

Section 3: Medicare and Other Types of Insurance or Coverage

Medicare and Group Health Plan Coverage for People with End-Stage Renal Disease (ESRD) (permanent kidney failure)

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 enrolled in Medicare and have a Medicare card. 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 (permanent kidney failure). 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.



Words in red are defined on pages 33–34.

Section 3: Medicare and Other Types of Insurance or Coverage

Medicare and No-fault or Liability Insurance

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 in an accident, regardless of who is at fault for causing the accident.

Some types of no-fault insurance include, but aren't limited to, the following:

- Automobile insurance
- Homeowners' insurance
- Commercial insurance plans

What is liability insurance?

Liability insurance is coverage that protects the policyholder against **claims** for negligence, inappropriate action, or inaction that results in injury to someone or damage to property.

Liability insurance includes, but isn't limited to, the following:

- 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 attorney should notify Medicare as soon as possible.

Words in red are defined on pages 33–34.

Section 3: Medicare and Other Types of Insurance or Coverage

Medicare and No-fault or Liability Insurance (continued)

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.

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 insurance coverage related to the accident. Nancy tells the hospital that her granddaughter has Med Pay coverage. Because this insurance pays regardless of fault, it is 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 liability insurance.



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

As explained on page 19, no-fault or liability insurance should pay first.

Note: Paying “first” means paying the whole bill **up to** the limits of the coverage. It doesn't always mean that the primary payer pays first in time. If doctors or other **providers** are told that you have a no-fault or liability insurance claim, they must try to get payments 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 recover any payments that the primary payer should have made.

Words in red are defined on pages 33–34.

Section 3: Medicare and Other Types of Insurance or Coverage

Medicare and No-fault or Liability Insurance (continued)

What is a conditional payment?

A conditional payment is a payment that Medicare makes for services for which another payer is potentially responsible. This conditional payment is made 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, or award is reached.

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



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 that Joan received. Later, when a settlement is reached with the liability insurer, Joan must make sure that Medicare gets its money back for the conditional payment.

**Words in
red are
defined
on pages
33–34.**

Section 3: Medicare and Other Types of Insurance or 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 responsible for getting conditional payments repaid to Medicare.

The recovery contractor will use the information you or your representative gave to the COBC. It will gather information about any conditional payments Medicare made which relate to your pending settlement, judgment, or award. Once a settlement, judgment, or award 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 will pay the same as it would if it were the only payer. However, Medicare will only pay for Medicare-covered services, and you will be responsible for your share of the bill (for example, **coinsurance**, **copayment**, or **deductible**) and for services that Medicare doesn't 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 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 Workers' Compensation

What is **workers' compensation**?

Workers' compensation is a law or plan of the United States or any state, that requires employers to cover employees who get sick or injured on the job. Most employees are covered under workers' compensation plans. If you don't know whether you're covered, ask your employer, or contact your state workers' compensation division or department.

Words in red are defined on pages 33–34.

Section 3: Medicare and Other Types of Insurance or Coverage

Medicare and Workers' Compensation (continued)

I have Medicare and filed a **workers' compensation claim**.

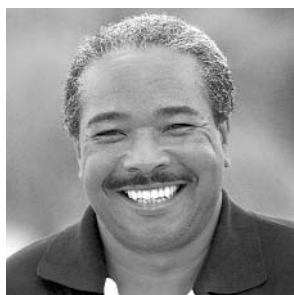
Who pays first?

If you have Medicare and get injured on the job, workers' compensation pays first on 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 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.

Words in red are defined on pages 33–34.

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 **Medicare Coordination of Benefits Contractor** (COBC) at 1-800-999-1118 as soon as you file your workers' compensation claim. TTY users should call 1-800-318-8782.



Example

Tom was injured at work. He filed a claim for workers' compensation insurance. His doctor billed the state workers' compensation insurance for payment. Payment wasn't received in 120 days. Tom'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 Tom received. When a settlement is reached with the state workers' compensation agency, Tom must make sure that Medicare gets its money back for the conditional payment.

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, you should call the Medicare Coordination of Benefits Contractor (COBC) at 1-800-999-1118. TTY users should call 1-800-318-8782.

Section 3: Medicare and Other Types of Insurance or Coverage

Medicare and Workers' Compensation (continued)

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

If your lawyer contacts Medicare for you, your lawyer should call the **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 will use the information that you or your lawyer gave to the COBC. It will gather information about any conditional payments Medicare made that relate to your pending settlement, judgment, or award. Once a settlement, judgment, or award is final, you or your lawyer should call the recovery contractor. The recovery contractor 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**?

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 that you have already received. However, the settlement may also provide for funds to be set aside to pay for future medical and/or prescription drug services related to the workers' compensation injury or illness/disease.

When you have Medicare, these funds should be deposited into a **Workers' Compensation Medicare Set-aside Arrangement (WCMSA)**, which may be set up by your workers' compensation lawyer. The purpose of the WCMSA is to make sure the workers' compensation funds are spent on expenses that would otherwise be covered by Medicare. In other words, workers' compensation pays before Medicare, even after a settlement.

If you want to settle your workers' compensation claim, you or your lawyer should contact the recovery contractor. If your proposed settlement includes funds for any future medical services and/or prescription drug expenses, you or your lawyer should send your proposed WCMSA to the **Medicare Coordination of Benefits Contractor** at the address below:

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

Words in red are defined on pages 33–34.

Section 3: Medicare and Other Types of Insurance or Coverage

Medicare and Workers' Compensation (continued)

I have a **Workers' Compensation Medicare Set-aside Arrangement (WCMSA)**. How do I use the money if I manage (self-administer) my Medicare set-aside arrangement?

If you have a WCMSA as part of your **workers' compensation** settlement, you must be careful how you spend the money that was specifically set aside for Medicare. The money that was placed in your WCMSA is to pay for future medical and/or prescription drug expenses related to your work injury or illness/disease that would otherwise have been covered (payable) by Medicare. This means you can't use the WCMSA to pay for any other work injury, or any medical items or services that Medicare doesn't cover (for example, dental services).

In addition, 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, you should call Medicare for more information before you use any of the money that was placed in your WCMSA. For more information, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Be sure to keep records of your workers' compensation-related medical and/or prescription drug expenses. These records show what items and services you got and how much money you spent on your work injury or illness/disease. You will need these records to prove that 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 injury or illness/disease.

Note: Workers' compensation **claims** can be resolved by settlements, judgments, or awards. The information listed here about WCMSAs only applies to settlements.

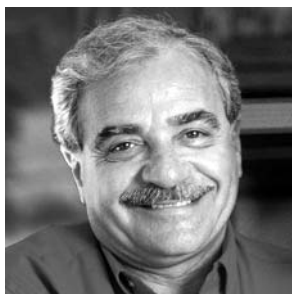
Words in red are defined on pages 33–34.

Section 3: Medicare and Other Types of Insurance or Coverage

Medicare and Workers' Compensation (continued)

What if workers' compensation denies payment?

If the state workers' compensation insurance denies payment, and if you provide proof to Medicare that the **claim** was denied, then Medicare will pay for Medicare-covered items and services.



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 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 will have to pay for anything Medicare doesn't cover.

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.

Words in red are defined on pages 33–34.

Medicare and Veterans' Benefits

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

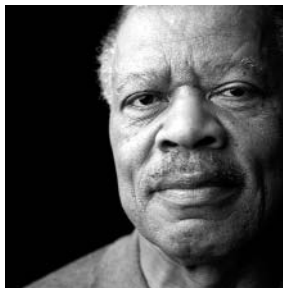
If you have or can get both Medicare and Veterans' benefits, you can get treatment under either program. When you get health care, you must choose which benefits to use each time you see a doctor or get health care. Medicare can't pay for the same service that was covered by Veterans' benefits, and your Veterans' benefits can't pay for the same service that was covered by Medicare. You don't 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 the VA to pay for services you must go to a VA facility or have the VA authorize services in a non-VA facility.

Section 3: Medicare and Other Types of Insurance or Coverage

Medicare and Veterans' Benefits (continued)

Are there any situations when both Medicare and the 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 doesn't pay for.



Bob, a veteran, goes to a non-VA hospital for a service that is authorized by the VA. While at the non-VA hospital, Bob 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 Bob got. Bob will have to pay for services 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 isn't part of the VA.

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

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

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

If you have a fee-basis ID card, you may choose any doctor who is 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 either you or Medicare for these services.

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.

Words in red are defined on pages 33–34.

Section 3: Medicare and Other Types of Insurance or Coverage

Medicare and Veterans' Benefits (continued)

Who should I call if I need more information?

You can get more information on Veterans' benefits by calling your local VA office or the national VA information number at 1-800-827-1000. TTY users should call 1-800-829-4833. You can also visit www.va.gov.

Medicare and TRICARE

What is TRICARE?

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

- TRICARE Prime
- TRICARE Extra
- TRICARE Standard
- TRICARE for Life (TFL)

What is TRICARE for Life?

TRICARE for Life (TFL) was created to provide expanded medical coverage to Medicare-eligible uniformed services retirees age 65 or older, their eligible family members and survivors, and certain former spouses. To get TFL benefits, you **must** have Medicare Part A **and** Part B.

Can I have both Medicare and TRICARE?

The following groups of people can have both Medicare and other types of TRICARE:

- Dependents of active-duty service members who are entitled to Medicare for any reason
- People under age 65 who are entitled to **Medicare Part A** because of a disability or **End-Stage Renal Disease (ESRD)** **and** enrolled in **Medicare Part B**
- People age 65 or older who are entitled to Medicare Part A **and** enrolled in Medicare Part B

Words in red are defined on pages 33–34.

Section 3: Medicare and Other Types of Insurance or Coverage

Medicare and TRICARE (continued)

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 will have to pay the costs of services that 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 **provider**, TRICARE will pay the bills. Medicare usually doesn't pay for services you get from a federal provider or other federal agency.

Who should I call if I need more information?

You can get more information on TRICARE by calling the health benefits advisor at a military hospital or clinic. You can also call 1-866-773-0404, or visit www.TRICARE.osd.mil.

Medicare and the Federal Black Lung Program

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

The Federal Black Lung 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 Program. Your doctor or other provider should send all bills for the diagnosis or treatment of black lung disease to the following address:

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

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

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

If the Federal Black Lung Program won't pay your bill, your doctor or other provider can send the bill to Medicare. Your doctor or other provider should send your bill and a copy of the letter from the Federal Black Lung Program that says why it won't pay your bill.

Words in red are defined on pages 33–34.

Section 3: Medicare and Other Types of Insurance or Coverage

Medicare and the Federal Black Lung Program (continued)

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 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 (The Consolidated Omnibus Budget Reconciliation Act of 1985)

What is COBRA?

COBRA is a federal law that may let you keep your employer **group health plan** coverage for a limited time after your employment ends or after you would otherwise lose coverage. 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 that your coverage is ending and offering you the right to elect COBRA continuation coverage, generally for 18 months, or in some cases 36 months. If you don’t get a notice, but you find out that your coverage has ended, or if you get divorced, you should call the employer’s benefits administrator or the group health plan as soon as possible and ask about your COBRA rights.

Words in red are defined on pages 33–34.

Section 3: Medicare and Other Types of Insurance or Coverage

Medicare and COBRA (continued)

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

In general, the rules described on pages 12–16 that apply to **group health plan** coverage apply to COBRA continuation coverage as well. For example, if you or your spouse are retired and have COBRA continuation coverage, Medicare pays first.

However, if you have Medicare based on **End-Stage Renal Disease (ESRD)**, COBRA continuation coverage pays first, and Medicare pays second to the extent COBRA coverage overlaps the first 30 months of Medicare eligibility or entitlement based on ESRD.

This publication can only give a brief description of COBRA coverage and who pays first. The decision about whether and when to elect COBRA can be very complicated. 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, and 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.

**Words in
red are
defined
on pages
33–34.**

Section 3: Medicare and Other Types of Insurance or Coverage

Medicare and COBRA (continued)

Who should I call if I have questions 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. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- You can also get a free copy of "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare." You can visit www.medicare.gov/Publications/Pubs/pdf/02110.pdf or call 1-800-MEDICARE.
- 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), you can visit the Department of Labor's (DoL) 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, you can call 1-877-267-2323 extension 61565.
- If your coverage was with the Federal government, you can visit the Office of Personnel Management's website at www.opm.gov.

Section 4: Words to Know

Claim—A claim is 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—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.

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.

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)—Hospital insurance that pays 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 (Part D)—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.

Section 4: Words to Know

Original Medicare—Original Medicare is fee-for-service coverage under which the government pays your health care providers directly for your Part A and/or Part B benefits.

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

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

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.

Workers' Compensation—A plan that employers are required to have to cover employees who get sick or injured on the job.

Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs)

Account—An account set up with funds from a Workers' Compensation settlement to pay for future medical and/or prescription drug expenses which are both related to the Workers' Compensation injury or illness/disease and would otherwise be covered by Medicare.

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“Medicare and Other Health Benefits: Your Guide to Who Pays First” isn’t a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

The information in this booklet was correct when it was posted on www.medicare.gov. To find out if the booklet is available in print, other formats, or if the information has been updated, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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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.