



Medicare & Other Health Benefits:

Your Guide to

Who Pays First

CENTERS FOR MEDICARE & MEDICAID SERVICES



This official government booklet tells you:

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

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

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



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SECTION

When you have other health coverage

1

Coordination of benefits

If you have Medicare and other health coverage, you may have questions about how Medicare works with your other insurance and who pays your bills first. Each type of coverage is called a “payer.” When there’s more than one payer, “coordination of benefits” rules decide who pays first. The “primary payer” pays what it owes on your bills first, then you or your health care provider sends the rest to the “secondary payer” (supplemental payer) to pay. In some rare cases, there may also be a “third payer.”

Whether Medicare pays first depends on a number of things, including the situations listed on the next 4 pages. However, this booklet doesn’t cover every situation. Be sure to tell your doctor and other providers if you have health coverage in addition to Medicare. This will help them send your bills to the correct payer and avoid delays.

Where to go with questions

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

The Benefits Coordination & Recovery Center is the contractor 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
- Determine whether the coverage pays before or after Medicare
- Pursue repayment when Medicare makes a conditional payment, and another payer is determined to be primary

When you call the Center, have your Medicare Number ready—you can find it on your red, white, and blue Medicare card. They may also ask for information:

- Your Social Security Number (SSN)
- Your address
- The date you were first eligible for Medicare (you can find this date in the lower right corner of your Medicare card)
- Whether you have Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance).

How Medicare works with other coverage

Find your situation on pages 6 through 8 to see which payer generally pays first for Medicare-covered items and services, and which page to visit for more details. You can also get this information by visiting [Medicare.gov](https://www.Medicare.gov).

I've got Medicaid. (See page 11.)

Medicare pays first, and Medicaid pays second.

I'm 65 or older and have group health plan coverage based on my or my spouse's current employment status. (See pages 12–13.)

- If the employer has 20 or more employees, then the group health plan pays first, and Medicare pays second.
- If the employer has fewer than 20 employees and **isn't** part of a multi-employer or multiple employer group health plan, then Medicare pays first, and the group health plan pays second.
- If the employer has fewer than 20 employees and **is** part of a multi-employer or multiple employer group health plan, then the group health plan pays first and Medicare pays second.

I'm in a Health Maintenance Organization (HMO) Plan or Preferred Provider Organization (PPO) Plan through my employer and get services outside the employer plan's network. (See page 13.)

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

I'm 65 or older, retired, and have group health plan coverage from my spouse's current employer. (See page 16.)

- If your spouse's employer has 20 or more employees, your spouse's plan pays first and Medicare pays second.
- If the employer has fewer than 20 employees and **isn't** part of a multi-employer or multiple employer group health plan, then Medicare pays first, and the group health plan pays second.
- If the employer has fewer than 20 employees and **is** part of a multi-employer or multiple employer group health plan, then the group health plan pays first and Medicare pays second.

I'm under 65, disabled, retired, and have group health plan coverage from my former employer. (See page 16.)

Medicare pays first and your group health plan (retiree) coverage pays second.

I'm under 65, disabled, retired and have group health plan coverage based on my family member's current employer. (See page 16.)

- If the employer has 100 or more employees, then the large group health plan pays first, and Medicare pays second.

How Medicare works with other coverage (continued)

I'm under 65, disabled, retired and have group health plan coverage based on my family member's current employer (See page 16.)

- If the employer has fewer than 100 employees, and **isn't** part of a multi-employer or multiple employer group health plan, then Medicare pays first, and the group health plan pays second.
- If the employer has fewer than 100 employees and **is** part of a multi-employer or multiple employer group health plan, the group health plan pays first and Medicare pays second.

I have Medicare due to End-Stage Renal Disease (ESRD), and group health plan coverage (including a retirement plan). (See page 19.)

When you're eligible for or entitled to Medicare due to ESRD, the group health plan pays first and Medicare pays second during a coordination period that lasts up to 30 months. After the coordination period ends, Medicare pays first and the group health plan pays second. If you originally got Medicare due to your age or a disability other than ESRD, and your group health plan was your primary payer, then it will continue to be the primary payer when you become eligible because of ESRD.

I have group health plan coverage, and I first got Medicare because I turned 65 or because of a disability (other than ESRD). Now I have ESRD. Who pays first? (See page 19.)

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

- If you originally got Medicare due to your age or a disability (other than ESRD) and Medicare paid first, then Medicare continues to pay first even when you become eligible because of ESRD.
- If you originally got Medicare due to your age or a disability (other than ESRD) and your group health plan paid first, then it continues to pay first when you become eligible because of ESRD.

I have Medicare due to End-Stage Renal Disease (ESRD), and COBRA coverage. (See page 29.)

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

How Medicare works with other coverage (continued)

I get health services from the Indian Health Service (IHS) or an IHS provider. (See page 19.)

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

I've been in an accident where no-fault or liability insurance is involved. (See pages 19–22.)

For services related to the accident or injury, the no-fault or liability insurance pays first and Medicare pays second.

I'm covered under workers' compensation because of a job-related illness or injury. (See pages 22–25.)

For services or items related to the workers' compensation claim, workers' compensation pays first. Medicare may make a conditional payment (a payment that must be repaid to Medicare when a settlement, judgment, award, or other payment is made).

I'm a Veteran and have Veterans' benefits. (See page 26.)

Generally, Medicare and Veteran's Affairs (VA) can't pay for the same service or item. Medicare pays for Medicare-covered services or items. The VA pays for VA-authorized services or items.

I'm covered under TRICARE. (See page 27.)

- For active-duty military enrolled in Medicare, TRICARE pays first for Medicare-covered services or items, and Medicare pays second.
- For inactive-duty military enrolled in Medicare, Medicare pays first and TRICARE may pay second.
- For services or items from a military hospital or any other federal provider, TRICARE pays first.

How Medicare works with other coverage—find your situation (continued)

I have black lung disease and I'm covered under the Federal Black Lung Program. (See page 28.)

The Federal Black Lung Program pays for services related to black lung. Medicare pays first for all other health care that's **not** related to black lung disease.

I have COBRA continuation coverage. (See pages 28–29.)

- If you have Medicare because you're 65 or over or because you have a disability other than End-Stage Renal Disease (ESRD), Medicare pays first.
- If you have Medicare due to ESRD, COBRA pays first and Medicare pays second during a coordination period that lasts up to 30 months after you're first eligible for Medicare. After the coordination period ends, Medicare pays first.

How will Medicare know I have other coverage?

Medicare doesn't automatically know if you have other coverage. However, insurers must notify Medicare when they're responsible for paying first on your medical claims. A claim is a payment request that you submit to Medicare or other health insurance when you get items and services that you think are covered. In some cases, your health care provider, employer, or insurer may ask you questions about your current coverage so they can report that information to Medicare.

You can also report your coverage information by calling the Benefits Coordination & Recovery Center toll-free at 1-855-798-2627.

TTY users can call 1-855-797-2627.

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

What happens if my health coverage changes?

Insurers must report these changes to Medicare, but it can take some time before the changes appear in Medicare's records.

If that happens, call the Benefits Coordination & Recovery Center toll-free at 1-855-798-2627. TTY users can call 1-855-797-2627. You'll have to give the following information when you call:

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

Tell your doctor and other health care providers about changes in your coverage when you get care. Also, contact your health plan to make sure they reported the changes to Medicare so your claims get paid correctly.

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

Check your insurance policy—it may include the rules about who pays first. You can also call the Benefits Coordination & Recovery Center for help.

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

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

On the other hand, if you don't yet have Medicare but have coverage through the Marketplace, you can choose to keep your Marketplace plan after your Medicare coverage starts. However, once your Medicare Part A coverage starts, any premium tax credits or other savings you've been getting on a Marketplace plan will end. If you choose to keep your Marketplace plan, you'll have to pay full price for it. For this reason, in most cases it makes sense to end Marketplace coverage once you're eligible for Medicare. If you age into Medicare and decide to keep your Marketplace plan, then Medicare pays first. If you have questions about a Marketplace plan, call the Health Insurance Marketplace® Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

SECTION

Medicare & other types of health coverage

2

This section provides detailed information on how Medicare works with your other health coverage and which payer pays first.

Medicare & Medicaid

Medicaid is a joint federal and state program that helps pay medical costs for certain people and families with limited income and resources, and who meet other requirements. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. **Medicaid never pays first for services Medicare covers.** It only pays after Medicare has paid. In rare cases where there's other coverage besides Medicare, Medicaid pays after the other coverage has paid.

Medicare & group health plan coverage when you're still working

Many employers, employee organizations and unions offer group health plan coverage to current employees or retirees. In general, a group health plan gives health coverage to employees and their families. If you have Federal Employees Health Benefits (FEHB) Program coverage, your coverage works the same as it does for all group health plans. You may also get group health plan coverage through the employer of your spouse or another family member (like a domestic partner, parent, son, daughter, or grandchild).

If you have Medicare and you're offered coverage under a group health plan, you can choose to accept or reject the plan.

Medicare & group health plan coverage when you're still working (continued)

I'm 65 or older and have group health plan coverage based on my or my spouse's current employment status, and the employer has 20 or more employees.

Generally, your group health plan pays first on your hospital and medical bills if **both** of these are true:

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

Note: For this situation, "spouse" includes both opposite-sex and same-sex marriages where:

- a. you're entitled to Medicare as a spouse based on Social Security's rules; and
- b. the marriage was legally entered into in a U. S. jurisdiction that recognizes the marriage—including one of the 50 states, the District of Columbia, or a U.S. territory—or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction.

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

2. The employer has 20 or more employees and covers any of the same services as Medicare.

If the group health plan didn't pay all of your bill, the doctor or health care provider should send the bill to Medicare for secondary payment. You may have to pay any costs Medicare or the group health plan doesn't cover.

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

Medicare & group health plan coverage when you're still working (continued)

I'm 65 or older and have group health plan coverage based on my or my spouse's current employment status, and the employer has fewer than 20 employees.

Medicare pays first. Medicare may pay second if both of these apply:

- Your employer (with fewer than 20 employees) joins other employers or employee organizations (like unions) to sponsor a multi-employer group health plan.
- At least one of the other employers has 20 or more employees.

Your plan may ask for an "exception" and request to opt out of a multi-employer group health plan. Check with your plan first and ask whether it will pay first or second for your claims.

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

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

Medicare & group health plan coverage (continued)

Does Medicare's share of a payment change if I don't accept my employer's coverage?

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

What happens if I drop my employer's coverage?

If you're 65 or older, Medicare pays first unless you have coverage through an employed spouse, and your spouse's employer has at least 20 employees.

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

Medicare & group health plan coverage after you retire

What happens to my group health plan coverage after I retire?

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

Can I continue my employer coverage after I retire?

Your former employer or union manages any retiree coverage you have with that organization. Employers and unions aren't required to provide retiree coverage, and they can change benefits or premiums (the periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage), or even cancel coverage at any time. Call your former employer's benefits administrator for more information.

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

How much does the retiree coverage cost, what benefits does it offer, and does it include coverage for my spouse?

Your former employer or union may offer limited retiree coverage. For example, it might only provide “stop loss” coverage, which starts paying only when your out-of-pocket costs reach a certain amount. Call your former employer’s benefits administrator for more information.

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

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

How will my retiree coverage affect my spouse’s and my Medicare coverage?

If you’re not sure how your retiree coverage works with Medicare, get a copy of your plan’s benefit materials, or look at the summary plan description your former employer or union gave you. You can also call your former employer’s benefits administrator and ask how the retiree plan pays when you have Medicare.

How does retiree coverage compare to a Medigap policy?

Private insurance companies sell Medigap policies, which are optional insurance policies that fill “gaps” in Original Medicare coverage. Since Medicare pays first after you retire, your retiree coverage is likely similar to coverage under a Medigap policy. However, retiree coverage sometimes includes extra benefits, like coverage for extra days in the hospital.

Like a Medigap policy, retiree coverage usually offers benefits that fill in some of Medicare’s coverage gaps, like deductibles (the amount you must pay for services before Original Medicare or your retiree coverage begins to pay) or coinsurance (an amount you may be required to pay as your share of the cost for services, after you pay any deductibles).

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

How does having group health plan coverage through my spouse's current employer affect my Medicare coverage if I'm 65 or older?

Your spouse's plan pays first and Medicare pays second when all of the following conditions apply:

- You're retired, but your spouse is still working
- You're covered by your spouse's group health plan coverage
- Your spouse's employer has 20 or more employees, or has fewer than 20 employees, but is part of a multi-employer plan or multiple employer plan

If the group health plan doesn't pay all of a bill, the doctor or health care provider should send the bill to Medicare for secondary payment. You may have to pay any costs Medicare or the group health plan doesn't cover.

How does having group health plan retiree coverage through my former employer affect my Medicare coverage if I'm under 65 and disabled?

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

How does having group health plan coverage through my spouse's or other family member's current employer affect my Medicare coverage if I'm under 65 and disabled?

Your spouse's or other family member's plan pays first and Medicare pays second when all of the following conditions apply:

- You're retired, but your spouse or other family member is still working
- You're covered by your spouse's or other family member's group health plan coverage
- Your spouse's or other family member's employer has 100 or more employees, or has fewer than 100 employees, but is part of a multi-employer plan or multiple employer plan

Medicare & Medicare Supplement Insurance (Medigap)

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

Your Medigap Open Enrollment Period is the best time to buy a Medigap policy. During your Open Enrollment Period, you can buy any Medigap policy sold in your state, even if you have health problems. This one-time, 6-month period automatically starts the first day of the month that you are both 65 or older and enrolled in Medicare Part B.

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

For more information about Medigap policies, visit [Medicare.gov/publications](https://www.medicare.gov/publications) to view the booklet “Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.” To find and compare Medigap policies, visit [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare), or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

You may also want to talk to your State Health Insurance Assistance Program (SHIP) for advice about buying a Medigap policy. SHIPs give free, unbiased, one-on-one health insurance counseling to people with Medicare, their families, and caregivers. To get the phone number for your state, visit shiphelp.org, or call 1-800-MEDICARE.

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

If your former employer goes bankrupt or out of business, federal COBRA rules may protect you if any other company within the same corporate organization still offers its employees a group health plan. That plan is required to offer you COBRA continuation coverage. See pages 28–29. If you can't get COBRA continuation coverage, you may have the right to buy a Medigap policy even if your Medigap Open Enrollment Period is over. You can contact your SHIP to find out if you can still buy a Medigap policy. To get the phone number for your state's SHIP, visit shiphelp.org, or call 1-800-MEDICARE.

Medicare & group health plan coverage for people who are disabled (not-End-Stage Renal Disease (ESRD))

I'm under 65 and disabled. I have large group health plan coverage based on my or my family member's current employment status. Who pays first?

When an employer has 100 or more employees, the health plan it offers is called a large group health plan. If you have large group health plan coverage because of your current employment status, or the current employment status of a family member (like a spouse, domestic partner, parent, child or grandchild), the health plan pays first and Medicare pays second. A large group health plan can't treat any plan member differently because they're disabled and have Medicare.

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

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

I'm under 65 and disabled. I have group health plan coverage through my or my family member's current employment status, and that employer has fewer than 100 employees. Who pays first?

If the employer has fewer than 100 employees, then Medicare pays first. However, Medicare may pay second if both of the following apply:

- Your employer (with fewer than 100 employees) joins with other employers or employee organizations (like unions) to sponsor a group health plan (called a multi-employer plan)
- At least one of the other employers has 100 or more employees

Your plan may ask for an "exception" and request to opt out of a multi-employer group health plan. Check with your plan first and ask whether it will pay first or second for your claims.

Example: Mary works full-time for a company with 53 employees. She has group health plan coverage for herself and her husband. Her company doesn't belong to a multi-employer plan. Mary's husband has Medicare because of a disability, so Medicare pays first and the group health plan coverage pays second.

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

I have both group health plan coverage (including a retirement plan) and Medicare due to ESRD. Who pays first?

People with ESRD have permanent kidney failure requiring dialysis or a kidney transplant. When you're eligible for Medicare due to ESRD, your group health plan pays first and Medicare pays second on your hospital and medical bills during a 30-month coordination period that begins when you become eligible for Medicare. This is true, regardless of:

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

This is also true if the reason for your Medicare eligibility changes, like if you were previously entitled to Medicare due to your age or a disability other than ESRD, and you've now become eligible for or entitled to Medicare on the basis of ESRD.

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

Medicare & Indian Health Service (IHS)

Medicare pays first for your health care bills, before the IHS. However, if you also have a non-tribal group health plan through an employer that has at least 20 employees, your plan usually pays first, followed by Medicare, and then IHS. If your employer has fewer than 20 employees, Medicare generally pays first, followed by your plan, and then the IHS. If you have a group health plan through tribal self-insurance, Medicare generally pays first and the plan pays second.

Medicare & no-fault insurance or liability insurance

What's no-fault insurance?

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

- Automobile plans
- Homeowners' plans
- Commercial insurance plans

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

What's liability insurance?

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

Some types of liability insurance include:

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

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

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

No-fault insurance or liability insurance pays first, and Medicare pays second for services related to the accident or injury.

If doctors or other providers are told you have a no-fault insurance or liability insurance claim, they must try to get paid from the insurance company before billing Medicare. However, this may take a long time. If the insurance company doesn't pay the claim promptly (usually within 120 days), your doctor or other provider may bill Medicare. Medicare may make a conditional payment to pay the bill, and then later will recover the payment after a settlement, judgment, award, or other payment on the claim has been made. (See "What's a conditional payment?" on page 21.)

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

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

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

In certain circumstances, Medicare will make conditional payments when a no-fault insurer or liability insurer doesn't pay. If you also have group health plan coverage that pays first, the group health plan must be billed before Medicare, whether or not the no-fault or liability insurance pays or denies the claim. Also, you're still responsible for your share of the bill (like coinsurance, copayment, or a deductible), and for services Medicare doesn't cover. A copayment is an amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. It's usually a set amount, rather than a percentage (like coinsurance). For example, you might pay \$10 or \$20 for a doctor's visit or prescription drug.

What's a conditional payment?

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

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

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

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

How do I repay Medicare for a conditional payment?

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

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

Where can I get more information?

If you have questions about a no-fault insurance or liability insurance claim, call the insurance company. If you have questions about who pays first, call the Benefits Coordination & Recovery Center.

Medicare & workers' compensation

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

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

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

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

If you have Medicare and get injured on the job, workers' compensation pays first on health care items or services you got because of your work-related illness or injury. There can be a delay between when a doctor or other provider bills for a work-related illness or injury and when the state workers' compensation insurance decides if they should pay the bill. Medicare can't pay for items or services that workers' compensation will pay for promptly. Generally, these include items or services that workers' compensation pays within 120 days of the date you received the service or the date of your inpatient hospital discharge (if applicable), whichever is earlier.

Medicare & workers' compensation (continued)

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

Note: This isn't the same situation as when your workers' compensation case has been settled and you're using funds from your Workers' Compensation Medicare Set-aside Arrangement to pay for your medical care. See the next 2 pages for more information.

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

What if workers' compensation denies payment?

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

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

Can workers' compensation decide to pay only part of 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. If Medicare covers the treatment for your pre-existing condition, then Medicare may pay its share for part of the doctor or hospital bills that workers' compensation doesn't cover.

Medicare & workers' compensation (continued)

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

If you or your provider files a workers' compensation claim and Medicare makes a conditional payment, you or your lawyer should report the claim and payment by calling the Benefits Coordination & Recovery Center toll-free at 1-855-798-2627. TTY users can call 1-855-797-2627.

The Benefits Coordination & Recovery Center will gather information about any conditional payments Medicare made related to your workers' compensation claim. If you get a settlement, judgment, award, or other payment, you or your lawyer should call the Benefits Coordination & Recovery Center. It will calculate the final repayment amount (if any) on your case and send you a letter requesting repayment. If your pending workers' compensation claim is eventually abandoned or dismissed, you or your lawyer should contact the Benefits Coordination & Recovery Center with that information.

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

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

For more information about Workers' Compensation Medicare Set-aside Arrangements, visit go.cms.gov/wcmsa.

Medicare & workers' compensation (continued)

What if I have a Medicare-approved Workers' Compensation Medicare Set-aside Arrangement amount? How am I allowed to use the money if I manage the account myself?

Keep these guidelines in mind if you manage your Workers' Compensation Medicare Set-aside Arrangement account:

- You must only use money from your arrangement to pay for future medical expenses, including prescription drugs related to your work injury or illness that otherwise would've been paid by Original Medicare.
- You should use funds from the arrangement to pay for future medical expenses, including prescription drugs, if you're enrolled in a Medicare Advantage Plan (Part C). Private companies contract with Medicare to offer these health plans that provide all Part A and Part B benefits (and most plans also offer prescription drug coverage). Medicare Advantage Plans include:
 - Health Maintenance Organizations
 - Preferred Provider Organizations
 - Private Fee-for-Service Plans
 - Special Needs Plans
 - Medicare Medical Savings Account Plans

If you're enrolled in a Medicare Advantage Plan, the plan (rather than Original Medicare) will cover most of your Medicare services.

- You can't use money from your arrangement to pay for any other work-related injury or illness, or for any medical items or services that Medicare doesn't cover (like dental services).
- You must spend all of your money from the arrangement on appropriate related medical expenses before Medicare will pay for any Medicare-covered medical expenses related to your workers' compensation claim.
- Before using any of the funds from your arrangement, you should become familiar with the types of services Medicare covers by visiting [Medicare.gov](https://www.Medicare.gov) or calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- You should keep detailed records of your workers' compensation-related medical expenses, including prescription drug expenses. These records should show what items and services you got and how much money you spent on your work-related injury or illness. You'll need these records to prove you used the money from your arrangement to pay your workers' compensation-related medical expenses.

To find out how to manage (self-administer) your Workers' Compensation Medicare Set-aside Arrangement, visit [go.cms.gov/WCMSASelfAdm](https://www.go.cms.gov/WCMSASelfAdm).

Medicare & Veterans' benefits

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

If you have (or can get) both Medicare and Veterans' benefits, you can get treatment under either program. However, Medicare is never the secondary payer after the Department of Veterans Affairs (VA). Each time you get health care or see a doctor, you must choose which benefits to use. Medicare can't pay for the same service that your Veterans' benefits covered, and your Veterans' benefits can't pay for the same service that Medicare covered.

Note: For the VA to pay for services, you must go to a VA facility or have the VA authorize services in a non-VA facility.

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

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

Example: Bob is a Veteran. He goes to a non-VA hospital for a surgery the VA authorized. While at the non-VA hospital, Bob gets other non-VA authorized services that the VA won't cover. Some of these services are Medicare-covered services. Medicare may pay for some of Bob's non-VA authorized services. Bob will have to pay for services that neither Medicare nor the VA cover.

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

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

Where can I get more information on Veterans' benefits?

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

Medicare & TRICARE

What's TRICARE?

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

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

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

Can I have both Medicare and TRICARE?

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

- Dependents of active-duty service members who have Medicare for any reason.
- People under 65 who have Part A because of a disability or End-Stage Renal Disease (ESRD) and who also have Part B.
- People 65 or older who can get Part A and who also sign up for Part B.

I have Medicare and TRICARE. Who pays first?

If you're on active duty, TRICARE pays first for Medicare-covered services. TRICARE will pay the Medicare deductible and coinsurance amounts, and will also pay for any TRICARE-covered services that Medicare doesn't cover. If you're not on active duty, Medicare pays first. TRICARE may pay second if you have TRICARE For Life coverage. You pay the costs of any services Medicare or TRICARE doesn't cover.

Who pays if I get services from a military hospital?

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

Where can I get more information?

- Visit [tricare.mil/tfl](https://www.tricare.mil/tfl).
- Call the health benefits advisor at a military hospital or clinic.
- Call TRICARE For Life at 1-866-773-0404. TTY users can call 1-866-773-0405.

Medicare & the Federal Black Lung Program

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

For any health care related to black lung disease, the Federal Black Lung Program pays first as long as the program covers the service. Medicare won't pay for doctor or hospital services covered under the Federal Black Lung Program. Your doctor or other health care provider should send all bills for the diagnosis or treatment of black lung disease to:

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

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

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

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

Where can I get more information?

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

Medicare & COBRA

What's COBRA?

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

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

Medicare & COBRA (continued)

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

If you have Medicare because you're 65 or over or because you have a disability, Medicare pays first.

When you're eligible for or entitled to Medicare due to End-Stage Renal Disease (ESRD), COBRA pays first and Medicare pays second during a coordination period that lasts up to 30 months after you're first eligible for Medicare. After the coordination period ends, Medicare pays first.

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

Where can I get more information about COBRA?

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

CMS Accessible Communications

The Centers for Medicare & Medicaid Services (CMS) provides free auxiliary aids and services, including information in accessible formats like Braille, large print, data or audio files, relay services and TTY communications. If you request information in an accessible format from CMS, you won't be disadvantaged by any additional time necessary to provide it. This means you'll get extra time to take any action if there's a delay in fulfilling your request.

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

1. Call us:

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

TTY: 1-877-486-2048

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

3. Send us a letter:

Centers for Medicare & Medicaid Services

Offices of Hearings and Inquiries (OHI)

7500 Security Boulevard, Mail Stop S1-13-25

Baltimore, MD 21244-1850

Attn: Customer Accessibility Resource Staff

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

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

Nondiscrimination Notice

The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

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

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

1. Online:

hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.

2. By phone:

Call 1-800-368-1019. TDD users can call 1-800-537-7697.

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

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

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

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

