

Medicare.gov

The Official U.S. Government Site for Medicare

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How Medicare works with other insurance

If you have [Medicare](#) and other health insurance or coverage, each type of coverage is called a "payer." When there's more than one payer, "[coordination of benefits](#)" rules 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.

What it means to pay primary/secondary

The insurance that pays first (primary payer) pays up to the limits of its coverage.

The one that pays second (secondary payer) only pays if there are costs the primary insurer didn't cover.

The secondary payer (which may be Medicare) may not pay all the uncovered costs.

If your employer insurance is the secondary payer, you may need to enroll in Medicare [Part B](#) before your insurance will pay.

Paying "first" means paying the whole bill **up to** the limits of the coverage. It doesn't always mean the primary payer pays first in 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 the primary payer should've made.

[Find out which insurance pays first.](#)

Call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 (TTY: 1-855-797-2627) if:

You have questions about who pays first

Your insurance changes

Note

Tell your doctor and other health care providers if you have coverage in addition to Medicare.

This will help them send your bills to the correct payer to avoid delays.

What's a conditional payment?

A conditional payment is a payment Medicare makes for services another payer may be responsible for. Medicare makes this conditional payment so you won't have to use your own money to pay the bill. The payment is "conditional" because it must be repaid to Medicare if you get a settlement, judgment, award, or

other payment later. You're responsible for making sure Medicare gets repaid from the settlement, judgment, award, or other payment.

How Medicare recovers conditional payments

If Medicare makes a conditional payment, and you or your lawyer haven't reported your settlement, judgment, award or other payment to Medicare, call the [Benefits Coordination & Recovery Center \(BCRC\)](#) at 1-855-798-2627 (TTY: 1-855-797-2627).

The BCRC will gather information about any conditional payments Medicare made related to your settlement, judgement, award or other payment. If you get a payment, you or your lawyer should could the BCRC. The BCRC will calculate the repayment amount (if any) on your recovery case and send you a letter requesting repayment.

Medicare.gov

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Medicare.gov

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Which insurance pays first

How Medicare coordinates with other coverage

If your health insurance or coverage changes, call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 (TTY: 1-855-797-2627). Tell your doctor and other [health care provider](#) about changes in your insurance or coverage when you get care.

I have Medicare and:

I'm 65 or older and have group health plan coverage based on my current employment (or the current employment of a spouse of any age), and my employer has 20 or more employees.

If the employer has more than 20 employees, the group health plan generally pays first.

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. Medicare will look at what your group health plan paid, and pay any additional costs up to the [Medicare-approved amount](#) for Medicare-covered and otherwise reimbursable items and services. You'll have to pay whatever costs Medicare or the group health plan doesn't cover.

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

I'm under 65, have a disability, and have group health plan coverage based on my current employment.

Generally, if your employer has fewer than 100 employees, Medicare pays first if you're under 65 or you have Medicare because of a disability.

Sometimes employers with fewer than 100 employees join with other employers to form a [multi-employer plan](#) or multiple employer plan. If at least one employer in the multi-employer plan or multiple employer plan has 100 employees or more, Medicare pays second.

If the employer has at least 100 employees, the health plan is called a large group health plan. If you're covered by a large group health plan because of your current employment or the current employment of a family member, Medicare pays second.

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

I work for a small company that has a group health plan.

If your employer has fewer than 20 employees, Medicare generally pays first.

But, Medicare would generally pay second if both of these apply:

Your employer joins with other employers or employee organizations (like unions) to sponsor a group health plan (called a multi-employer plan)

Any of the other employers have 20 or more employees

Your plan might also ask for an exception. So, even if your employer has fewer than 20 employees, you'll need to find out from your employer whether Medicare pays first or second.

Generally, if your employer has fewer than 100 employees, Medicare pays first if you're under 65 or you have Medicare because of a disability.

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

If the employer has at least 100 employees, the health plan is called a large group health plan. If you're covered by a large group health plan because of your current employment or the current employment of a family member, Medicare pays second.

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

I have a domestic partner with group health insurance coverage.

Medicare pays first if both of these apply:

A domestic partner is entitled to Medicare on the basis of age

A domestic partner has group health plan coverage based on the current employment status of his/her partner.

Medicare generally pays second:

When the domestic partner is entitled to Medicare on the basis of disability and is covered by a large group health plan on the basis of his/her own current employment status or the status of a family member (a domestic partner is considered a family member).

For the 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.

I have declined or dropped employer-offered coverage.

Medicare pays first for any Medicare-covered health care service you get if you don't take group health plan coverage from your employer, unless these apply:

You have coverage through an employed spouse.

Your spouse's employer has at least 20 employees.

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 both of these apply:

Your employer or your spouse's employer generally offers retiree coverage.

You weren't enrolled in the plan while you or your spouse was still working.

Call your employer's benefits administrator for more information.

I'm retired and have group health plan coverage from my former employer.

Generally, if you get your group health plan coverage through your own former employer:

Medicare pays first for your health care bills.

Your group health plan (retiree) coverage pays second.

Your spouse's plan pays first and Medicare pays second if both of these apply:

You retire but your spouse is still working.

You're covered by your spouse's group health plan coverage. Your spouse's employer must have 20 or more employees, or the employer must be part of a multi-employer plan or multiple employer plan.

If the employer has more than 20 employees, the group health plan generally pays first.

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. Medicare will look at what your group health plan paid, and pay any additional costs up to the Medicare-approved amount for Medicare-covered and otherwise reimbursable items and services. You'll have to pay whatever costs Medicare or the group health plan doesn't cover.

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

I have Medicaid.

Medicaid never pays first for services covered by Medicare. It only pays after Medicare, employer group health plans, and/or Medicare Supplement (Medigap) Insurance have paid.

I have COBRA continuation coverage.

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 based on ESRD, COBRA continuation coverage pays first. Medicare pays second to the extent COBRA coverage overlaps the first 30 months of Medicare eligibility or entitlement based on ESRD.

Find out more in 7 facts about COBRA.

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

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

I have more than one other type of insurance or coverage.

If you have Medicare and more than one other type of insurance, check your policy or coverage—it may include the rules about who pays first. You can also call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 (TTY: 1-855-797-2627).

I have TRICARE.

In general, Medicare pays first for Medicare-covered services. TRICARE will pay the Medicare deductible and coinsurance amounts and for any service not covered by Medicare that TRICARE covers. You pay the costs of services Medicare or TRICARE doesn't cover.

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

I have Veterans' benefits.

If you have or can get both Medicare and Veterans' benefits, you can get treatment under either program.

When you get health care, you must choose which benefits to use each time you see a doctor or get health care. Medicare can't pay for the same service that was covered by Veterans' benefits, and your Veterans' benefits can't pay for the same service that was covered by Medicare.

Note

To get the U.S. Department of Veterans Affairs (VA) to pay for services, you must go to a VA facility or have the VA authorize services in a non-VA facility.

Medicare may pay for the Medicare-covered part of the services the VA doesn't pay for if both of these apply:

- The VA authorizes services in a non-VA hospital.

- The VA doesn't pay for all of the services you get during your hospital stay.

Medicare may also be able to pay all or part of your copayment if you're 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.

If you have a fee-basis ID card, you may choose any doctor listed on your card to treat you. If the doctor accepts you as a patient and bills the Department of Veterans Affairs (VA) for services, the doctor must accept the VA's payment as payment in full. The doctor can't bill you or bill 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.

Note

You may be given a fee-basis ID card if:

- You have a service-connected disability.

- You'll need medical services for an extended period of time.

- There are no VA hospitals in your area.

I have ESRD and group health plan coverage.

If you're eligible for Medicare only because of permanent kidney failure, your coverage usually can't start until the fourth month of dialysis. This means your employer or union group health plan plan will be the only payer for the first 3 months of dialysis (unless you have other insurance).

Once you become eligible for Medicare because of permanent kidney failure (usually the fourth month of dialysis), there will still be a period of time called a "coordination period." During this time (30 months), your employer or union group health plan will continue to pay first on your health care bills, and Medicare will pay second. If you take a course in home-dialysis training or get a kidney transplant during the 3-month waiting period, the 30-month coordination period will start earlier.

The union group health plan pays first during this "coordination 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 union group health plan coverage, or you're covered as a family member.

I have coverage under the Federal Black Lung Program.

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

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 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, KY 40742-8302*

1-800-638-7072

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

I have a claim for no-fault or liability insurance.

No-fault insurance or liability insurance pays first and Medicare pays second.

If the no-fault or liability insurance denies the medical bill or is found not liable for payment, Medicare pays the same as it would if it were the only payer. However, Medicare only pays for Medicare-covered services; you're responsible for your share of the bill—for example, coinsurance, a copayment or a deductible—and for services Medicare doesn't cover.

If doctors or other providers are told 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 the primary payer should have made.

If Medicare makes a conditional payment, and you get a settlement from an insurance company later, the conditional payment from your settlement needs to go to Medicare. You're responsible for making sure Medicare gets repaid for the conditional payment.

If you have an insurance claim for your medical expenses, you or your attorney should notify Medicare as soon as possible. If you have questions about a no-fault or liability insurance claim, call the insurance company.

If you file a no-fault insurance or liability insurance claim, you or your representative should call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 (TTY: 1-855-797-2627).

The BCRC will gather information about any conditional payments Medicare made related to your no-fault insurance or liability insurance claim. If you get a settlement, judgement, award or other payment, you or your representative should contact the BCRC. The BCRC will determine the final repayment amount (if any) on your recovery case and send you a letter requesting repayment.

I filed a workers' compensation claim.

If you have Medicare and get injured on the job, workers' compensation pays first on health care items or services you got because of your work-related illness or injury.

Find out more about how settling your claim affects Medicare payments.

Where can I get more information?

If you have questions about who pays first, or if your coverage changes, call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 (TTY: 1-855-797-2627).

For local, personalized Medicare counseling, contact your State Health Insurance Assistance Program (SHIP).

Medicare.gov

A federal government website managed and paid for
by the U.S. Centers for Medicare &
Medicaid Services, 7500 Security Boulevard,
Baltimore, MD 21244



Resources for Gwen's Scenario

- Office of Personnel Management (OPM)
 - Medicare and FEHBP Coordination FAQs
 - Medicare and FEHBP booklet
 - Medicare and FEHBP Fast Facts Tip Sheet
- A Closer Look: Medicare for Federal Employees and Retirees: <https://www.ncoa.org/wp-content/uploads/medicare-for-federal-employees-and-retirees.pdf>

A Closer Look: Medicare for Federal Employees and Retirees

You may help beneficiaries who have worked or who are currently working for the federal government. According to the Office of Personnel Management (OPM), as of 2014, there are more than 4 million non-military, federal workers.¹ Federal employees and retirees can be found in every state, not just in our nation's capital, so you're likely to come across them in your counseling work. (Use OPM's interactive [online tool](#) to view the number of federal employees and retirees in your state as of 2014.)

Many federal workers need your help to understand when and if they should enroll in Medicare, and exactly how their federal health insurance benefits will work with Medicare. Here we'll review some important factors for federal employees and retirees to consider about their Medicare.

Background on the FICA Tax

Prior to 1983, all federal government employees were exempt from contributing toward the Part A, or hospital insurance portion, of the Federal Insurance Contributions Act (FICA) withholding payroll tax. In an effort to make the federal retirement program more in line with the private sector and also to increase the Part A trust fund, the Social Security Act was amended and as of January 1, 1983, federal employees were required to pay toward the Medicare Part A FICA tax.²

Because of this change, federal employees may qualify for premium-free Medicare Part A, as long as they have enough working credits. Remember, to be entitled to premium-free Medicare Part A, a person must have earned 10 years, or 40 working credits³ (formerly known as "quarters of coverage"), either through his own or through a spouse's⁴ (including divorced⁵ or deceased⁶) record. Those who worked for the federal government *before* this change took effect were grandfathered-in and deemed automatically eligible for premium-

¹ OPM, Historical Federal Workplace Tables, *Total Government Employment since 1962*, available at: <https://www.opm.gov/policy-data-oversight/data-analysis-documentation/federal-employment-reports/historical-tables/total-government-employment-since-1962/>

² CMS Manual, Chapter 2, Section 10.1 – Insured Status at <http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c02.pdf>

³ Social Security, Explanation of Working Credits ("Quarters of Coverage") at <http://www.ssa.gov/OACT/COLA/QC.html>

⁴ Social Security, Program Operations Manual System (POMS), HI 00801.008 - Entitlement for Aged Spouse of Age 62 Worker at <http://policy.ssa.gov/poms.nsf/lnx/0600801008>

⁵ Social Security, Program Operations Manual System (POMS), GN 00302.370 – Developing Evidence of Age of Eligible Worker When Uninsured Spouse Applies for HI at <http://policy.ssa.gov/poms.nsf/lnx/0200302370>

⁶ Social Security, Program Operations Manual System (POMS), GN 00302.005 – When a Deceased WE's Age Must Be Established at <http://policy.ssa.gov/poms.nsf/lnx/0200302005>

free Medicare Part A if they were a federal employee any time during the month in January 1983.⁷

Note about Social Security Retirement Benefits

Keep in mind, federal government employees who only paid the FICA tax are only insured for Part A, not for Social Security monthly retirement benefits. That is, they will not collect a monthly retirement check from Social Security because they have not contributed to it while working. However, they may have contributed to an alternative retirement system in order to collect benefits.

For example, before 1987, federal government employees contributed toward the Civil Service Retirement System (CSRS), which is similar to Social Security in that it provides monetary retirement, disability retirement, and survivor benefits. This system did not require employees to contribute toward Social Security. Starting January 1, 1987, the Federal Employees Retirement System (FERS) replaced the CSRS and required any *new* federal employees to contribute toward Social Security through the Old-Age, Survivor, and Disability Insurance (OASDI) payroll tax. Federal employees who contributed to the CSRS prior to 1987 had the choice to either keep CSRS or go with FERS, so you may have clients who kept CSRS, converted to FERS, or were new employees under the FERS system.

While you may not need to counsel beneficiaries on their Social Security benefits, it's helpful to be familiar with these government-related terms as they may come up during your counseling sessions. If beneficiaries have additional questions about their retirement benefits, you should encourage them to contact either Social Security (<http://www.ssa.gov/>) or the U.S. Office of Personnel Management (OPM) (<http://www.opm.gov/index.asp>).

Medicare & Federal Employees Health Benefits Program (FEHBP)

Here we review how Federal Employees Health Benefits Program (FEHBP) works with Medicare and what beneficiaries in this situation will need to consider when enrolling in the various parts of Medicare.

What is FEHBP?

FEHBP is a type of federal health insurance program available to non-military, federal government employees and retirees. FEHBP is administered through OPM. As of 2013, roughly 90% of federal employees participate in the FEHBP.⁸

⁷ Social Security, Program Operations Manual System (POMS), HI 00801.400 Medicare Qualified Government Employment (MQGE) at <https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801400>

FEHBP & Enrolling in Medicare Part A

Most people are eligible for premium-free Part A. Therefore, most people including federal employees and retirees should enroll in Part A when they are first eligible, that is, during their Initial Enrollment Period (IEP) in the six months surrounding their 65th birthday month.⁹

Even if the beneficiary continues to work, they can and should enroll in Part A. Medicare Part A will usually pay secondary to their FEHBP. Generally, Part A covers some of the costs that FEHBP may not cover such as deductibles, coinsurance, and charges that exceed the FEHBP allowable charges. However, there are a variety of FEHBP options and beneficiaries need to contact their specific FEHBP plan for specific details of coordination with Part A.

FEHBP & Enrolling in Medicare Part B

FEHBP is a type of employer-group health plan. Therefore, it's important to find out whether the federal employee will continue to work or plans to retire. This way, you can help them better understand their reasons for considering Part B now when they are first eligible or delaying Part B for enrollment later. Here are some factors they will need to consider depending on their situation:

- **Continuing to Work with FEHBP:** If they plan on continuing to work with FEHBP coverage past the age of 65, they should delay Part B until they retire or lose their insurance, whichever comes first. At that time, they will get an 8-month Special Enrollment Period (SEP) to enroll in Part B. Similar to employees in the private sector, federal employees are protected from the Part B late-enrollment penalty due to their current actively-working and employer group health plan (EGHP)-coverage status. And, by delaying Part B can save money by not having to unnecessarily pay for two premiums (i.e., the monthly Part B premium in addition to the premium for the FEHBP plan).
- **Retiring with FEHBP:** Remember private sector retiree health insurance becomes the secondary payer (after Medicare) when the employee retires or loses their work-related insurance, and therefore private sector retirees need to enroll in Part B. Unlike private sector retirees, federal retirees can keep their FEHBP-retiree coverage as a

⁸ OPM, News Release, September 20, 2012, *OPM Announces 2013 FEHBP Premium Rates*, at <http://www.opm.gov/news/opm-announces-2013-federal-employees-health-benefits-program-premium-rates.1758.aspx>

⁹ Medicare Tip Sheet, August 2014, *Understanding Medicare Enrollment Periods* at <http://www.medicare.gov/Pubs/pdf/11219.pdf>

primary insurance and it is as good as the coverage they had while still actively working.

However, it's important for retiring federal employees with FEHBP to carefully consider these factors to decide whether to delay or not enroll in Part B:

- (1) After retirement, a Part B late enrollment penalty applies if the retiree does not have other employer insurance coverage through an actively-working spouse. The penalty is 10 percent of the current Part B premium for each 12 months (following their IEP) they waited to enroll, which can be expensive. And, they have to wait for the General Enrollment Period (Jan. 1 – Mar. 31) to enroll in Part B, with coverage not taking effect until July 1 of that year.
- (2) Some FEHBPs waive coinsurance and deductibles after enrolling in Part B. If their FEHBP offers this coverage, it may be in their financial favor to enroll in Part B.
- (3) It's worth their time to weigh the financial risk of paying now for both premiums (Part B and the FEHBP) versus paying for a Part B late-enrollment penalty should they decide to enroll at a later time.
- (4) It's important to acknowledge that while FEHBP plans have a good history of providing comprehensive insurance coverage, employer-group health plans – even FEHBP – are susceptible to change their covered benefits, premiums, deductibles, and copayment amounts, and usually not in a member's favor.

FEHBP & Considering Medicare Advantage

Similar to other beneficiaries with Medicare, people with FEHBP (both actively working and retirees) can enroll in a Medicare Advantage plan *as long as they have both Medicare Parts A and B*. However, there are some important aspects to consider about enrolling in a Medicare Advantage plan.

Since a Medicare Advantage plan would provide benefits similar to FEHBP, your clients with FEHBP will likely not need both plans. Therefore, like many Medicare-eligible clients in the private sector, they should do a careful comparison of getting their Parts A and B benefits through a Medicare Advantage plan versus through Original Medicare, and what this enrollment means for their FEHBP. For example, most people with FEHBP may be able to suspend their benefits to enroll in a Medicare Advantage plan, however, they should be sure to find out what happens if they decide they want to return to their FEHBP benefits (e.g., Can they re-enroll? And if so, do they have to wait until the next FEHBP open enrollment season?). It's important they completely understand how their FEHBP works when enrolling in a Medicare Advantage plan to avoid losing access to their FEHBP. They should speak with their benefit's administrator for more details and get confirmation in writing.

FEHBP & Enrolling in Part D

Remember, a beneficiary enrolled in Medicare Part A or B, or both A & B can join a Part D plan. Most federal employees and retirees that keep FEHBP will not need to enroll in Part D since all FEHBP plans include prescription drug benefits that are considered as good as Medicare (“creditable coverage”). An exception worth considering are federal retirees eligible for Part D Extra Help because their costs may be lower. And if they should lose their FEHBP, they can join a Part D drug plan without penalty as long as they join during a Special Enrollment Period within 63 days after losing FEHBP.

In most cases, federal retirees will not lose their FEHBP if they enroll in Part D. FEHBP will coordinate benefits with Medicare. The exception is for those who are annuitants, or retired federal employees who are “re-hired”. These clients should be sure and contact their plan’s benefits administrator to find out the plan’s rules in order to avoid losing their FEHBP.¹⁰

It’s also important to note that if your clients decide to enroll in Part D, payments by the FEHBP (including retiree coverage) as well as TRICARE and VA do not count toward a person’s True Out-of-Pocket Expenses (TrOOP) in the coverage gap (also known as the donut hole).¹¹

Other Types of Federal Insurance Programs

In addition to FEHBP, here is a brief review of two other common types of federal insurance programs that you may come across and affect your clients with Medicare:

- **TRICARE for Life (military retirees):** TRICARE for Life, or TFL, is the health insurance program for military retirees and their dependent family members. People with TRICARE generally must enroll in both Medicare Parts A *and* B when they are eligible for it. TFL wraps around Medicare and is typically secondary payer to Medicare, usually covering out-of-pocket costs in Original Medicare such as deductibles and coinsurance. Beneficiaries with TFL do not need to purchase a Medigap policy. Likewise, TFL prescription coverage is credible (at least as good as) to Part D, so they do not need to enroll in Part D. An exception applies if the beneficiary is eligible for Extra Help and has lower costs. If they happen to lose TRICARE, they can join a Part D drug plan without penalty as long as they join a drug plan within 63 days after losing TRICARE.

¹⁰ OPM, *Letter from OPM about Medicare Part D* at <http://www.opm.gov/insure/health/medicare/disclosure.asp>

¹¹ Medicare Tip Sheet, Revised November 2014, *Understanding True Out-of-Pocket Costs (TrOOP)*, at <http://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/downloads/11223-P.pdf>

Note: If your clients have both FEHBP *and* TFL, they can suspend their FEHBP to use TFL. Your clients should contact OPM's retirement hotline at 1-888-767-6738 to request a suspension form.

For more information on TFL and Medicare, visit the TRICARE website at http://www.tricare.mil/Plans/Eligibility/MedicareEligible?sc_database=web

- **Veteran's Benefits:** The Veteran's Administration (VA) provides health care benefits to veterans of all ages except for those dishonorably discharged. Many eligible for VA benefits will find it to be very comprehensive coverage. However, some may choose to have both VA and Medicare. For example, some veterans use VA services to get their prescription drugs at the VA pharmacy that are excluded from Medicare Part D coverage. Others may not live near a VA facility, and find that using the VA is not as convenient, therefore, they also use Medicare. Keep in mind, however, that Medicare and VA benefits generally do not work together. That is, to receive VA benefits, they must get care at a VA facility. Medicare does not typically pay for any care provided at a VA facility. Find out more about VA health benefits at <http://www.va.gov/healthbenefits/>

Additional Resources

Here are some additional resources on how FEHBP works with Medicare to help you in your counseling sessions:

- *FAQs about Medicare vs. FEHBP Enrollment* at: <http://www.opm.gov/insure/health/medicare/medicare01.asp>
- *Fast Facts about FEHBP and Medicare* at: <http://www.opm.gov/insure/fastfacts/fehbmedicare.pdf>
- *Coordination of Medicare and FEHBP Benefits* at: <http://www.opm.gov/insure/health/medicare/medicare04.asp>
- Medicare's publication, *Who Pays First?* at: <http://www.medicare.gov/Pubs/pdf/02179.pdf>

References

See Medicare's General Information, Eligibility and Entitlement Manual, Chapter 2 – *Hospital Insurance and Supplementary Insurance*, Section 10.1 - Insured Status at <http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c02.pdf>

See Social Security's Program Operation Manual System (POMS), Hospital Insurance Entitlement, at: <https://secure.ssa.gov/apps10/poms.nsf/subchapterlist!openview&restricttcategory=06008>

Federal Benefits

FastFacts

The Federal Employees Health Benefits (FEHB) Program and Medicare

* **What is Medicare?** Medicare is health insurance for people:

- 65 years of age or older;
- Under 65 years of age with certain disabilities; and
- Any age with End Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

* **What does Medicare cover?** Medicare has four parts:

Part	Type of Coverage	Monthly Premium?
A	Hospital	No (in most cases)
B	Medical	Yes
C	Comprehensive	It depends (see Medicare & You handbook)
D	Prescription Drug	Yes

* **Do FEHB Plans and Medicare cover the same types of expenses?** Generally, plans under the FEHB Program help pay for the same kind of expenses as Medicare.

Some FEHB plans may provide coverage for certain items that Medicare doesn't cover, including but not limited to:

- routine physicals, and emergency care outside of the United States;
- some preventive services;
- dental and vision care.

Medicare may cover some services and supplies that some FEHB plans may not cover, including but not limited to:

- Some orthopedic and prosthetic devices, and durable medical equipment;
- home health care;
- limited chiropractic supplies.

* **Since I have FEHB coverage, do I need Medicare coverage?** The decision to enroll is yours.

Medicare Part A - If you are entitled to Part A without paying the premiums, you should take it, even if you are still working. This may help cover some of the hospital related costs that your FEHB plan may not cover, such as deductibles, coinsurance, and charges that exceed the plan's allowable charges.

Medicare Part B - If you are retired and enrolled in a fee-for-service (FFS) plan such as: Blue Cross Blue Shield (BCBS), GEHA, and Mail Handlers, Part B and your FFS plan may combine to provide almost complete coverage for all medical expenses. Refer to Section 9 of your plan's brochure to see how your FEHB plan works with Medicare.

If you are enrolled in an HMO, you may not need Part B. HMOs provide most medical services for small copays. However, you may want to consider Part B as it:

- Pays for costs involved with seeing doctors outside the Plan's network
- Pays for costs for non-emergency care in the U.S. if travel involved
- Is required for Medicare Advantage and Tricare

If you are working and have FEHB or you are covered under your spouse's group health insurance plan, then you do not have to enroll in Part B when you turn 65. You will have a special enrollment period when you retire or your spouse retires to enroll in Part B without paying a penalty.

Medicare Part C - Part C is a way to get Medicare benefits through private

companies approved by Medicare. Enrollees may receive additional benefits such as vision, dental, and/or podiatry that Part A and Part B don't cover. If you wish to enroll in a Medicare Advantage plan, you must be enrolled in Part A and Part B. You should contact your retirement office to discuss the option of suspending your FEHB enrollment.

Medicare Part D - Federal retirees and employees will likely not benefit from enrolling in Part D as they already have comprehensive drug coverage through their FEHB plan. However, retirees with limited resources may want to consider enrolling in Part D if they qualify for extra financial help under the Part D program.

* **If I decide to enroll in Medicare, when do I apply?** Contact your local Social Security Office for more information on when to enroll in Medicare.

* **Is my FEHB plan or Medicare the primary payer?** Your FEHB Plan must pay benefits first when you are an active Federal employee or reemployed annuitant and either you or your covered spouse has Medicare. (There is an exception if your reemployment position is excluded from FEHB coverage or you are enrolled in Medicare Part B only.)

Medicare must pay benefits first when you are an annuitant, (unless you are a reemployed annuitant, see above), and either you or your covered spouse has Medicare

* **Will my FEHB premiums be reduced if I enroll in Medicare?** Your FEHB premiums will not be reduced if you enroll in Medicare. Retirees pay the same FEHB premium as active employees.

* **Can I change my FEHB enrollment when I become eligible for Medicare?** Yes, you may change your FEHB enrollment to any available plan or option at any time beginning 30 days before you become

eligible for Medicare. You may use this enrollment change opportunity only once. You may also change your enrollment during the annual Open Season, or because of another event that permits enrollment changes such as a change in family status. See qualifying life events (QLE) at: www.opm.gov/insure/lifeevents/index.asp

* **Should I change plans?** Once Medicare becomes the primary payer, you may find that a lower cost FEHB plan is adequate for your needs, especially if you are currently enrolled in a plan's high option. Also, some plans waive deductibles, coinsurance, and copayments when Medicare is primary. **Carefully review your plan's benefits before you make any changes.**

* **How Can I Get More Information About Medicare and FEHB?**

- The FEHB website at: www.opm.gov/insure/health/medicare/index.asp
- Your FEHB plan brochure
- The Medicare website at www.medicare.gov
- The *Medicare & You* handbook at www.medicare.gov/publications/pubs/pdf/10050.pdf
- By calling 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048.
- If you are a CSRS or FERS annuitant, you may call OPM's Retirement Office at 1-888-767-6738 or 202-606-0500 from the metropolitan Washington, DC area.

The Federal Employees Health Benefits Program and Medicare

This booklet answers questions about how the Federal Employees Health Benefits (FEHB) Program and Medicare work together to provide health benefits coverage to active or retired Federal employees covered by both programs. It explains what Medicare does and does not cover, who is eligible for Medicare, and how benefits are coordinated between Medicare and FEHB plans.



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The Federal Employees Health Benefits Program and Medicare - Working Together for You!

As an active or retired Federal employee covered by both the Federal Employees Health Benefits (FEHB) Program and Medicare, you probably have had questions from time to time about how the two programs work together. This booklet contains answers to the questions that we at the Office of Personnel Management (OPM) are most frequently asked about FEHB and Medicare.

What Types of Programs Are Offered by Medicare?

Medicare beneficiaries may enroll in Original Medicare (Parts A and B) or choose to get their benefits from an array of Medicare Advantage Plans (Part C) plan options. Depending on where you live, Part C options may include Medicare Advantage Plans that are approved by Medicare but run by private companies. Medicare Advantage plans offer Medicare Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), private fee-for-service plans (PFFS), Medicare Special Needs Plans, and Medicare Medical Savings Account (MSA) plans.

The Medicare Prescription Drug, Improvement and Modernization Act (MMA) established a voluntary outpatient prescription drug benefit, Medicare Part D, effective January 1, 2006. Medicare enrollees are able to receive prescription drug coverage by enrolling in a Medicare Part D plan. Medicare Advantage Plans (Medicare Part C) may also offer prescription drug coverage that follows the same rules as the Medicare Part D coverage.

Other Medicare plans include Medicare Cost Plans, demonstration/pilot programs, and PACE (Programs of All-inclusive Care for the Elderly).

What Types of Expenses are covered by Medicare?

Medicare has four parts. Original Medicare includes Parts A and B:

Part A (Hospital Insurance) helps pay for:

- inpatient hospital care
- critical access hospitals
- skilled nursing facility care
- some home health care
- hospice care

Part B (Medical Insurance) helps pay for:

- doctor's services
- ambulance services
- outpatient hospital care
- x-rays and laboratory tests
- durable medical equipment and supplies
- some home health care (if you don't have Part A)
- certain preventive care
- other outpatient services
- some other medical services Part A doesn't cover, such as physical and occupational therapy

Part C (Medicare Advantage):

If you join a Medicare Advantage Plan you generally get all your Medicare benefits, which may include prescription drugs, through one of the following types of plans:

- Medicare HMOs--You must get your care from primary care doctors, specialists, or hospitals on the HMO's list of network providers, except in an emergency.
- Medicare PPO Plans—In most plans your share of plan costs is less when you use in-network primary care doctors, specialists and hospitals. Using out-of-network providers costs you more.
- Medicare Special Needs Plans—These plans generally limit enrollment to people in certain long-term care facilities (like nursing homes); people eligible for both Medicare and Medicaid; or those with certain chronic or disabling conditions.
- Medicare Private Fee-for-Service Plans—In these plans, you may go to any Medicare-approved primary care doctor, specialist, or hospital that will accept the terms of the private plan's payment.
- Medicare Medical Savings Account (MSA) Plans - These plans include a high deductible plan that will not begin to pay benefits until the high annual deductible is met. They also include a medical savings

account into which Medicare will deposit money for you to use to pay your health care costs. Medical Savings Account Plans do not cover prescription drugs.

Part D (Medicare Prescription Drug Coverage)

Under this program, private companies provide Medicare Prescription Drug Coverage and you pay a monthly premium. Federal retirees already have excellent access to health benefits coverage for drugs through participation in the FEHB Program. However, if you choose to enroll in Part D, Medicare benefits for drugs will be primary (will pay first) in most cases for FEHB enrollees. (Medicare C plans that include prescription drugs will also be primary to FEHB benefits.)

It will almost always be to your advantage to keep your current FEHB coverage without any changes. The exception is for those with limited incomes and resources who may qualify for Medicare's extra help with prescription drug costs. Contact your benefits administrator or your FEHB Program insurer for information about your FEHB coverage before making any changes.

It is important to note that FEHB Program prescription drug coverage is an integral part of your total health benefits package. You cannot suspend or cancel FEHB Program prescription drug coverage without losing your FEHB plan coverage in its entirety (in other words, losing coverage) for hospital and medical services which would mean you might have significantly higher costs for those services.

Because all FEHB Program plans have as good or better coverage than Medicare, they are considered to offer "creditable coverage." So, if you decide not to join a Medicare drug plan now, but change your mind later and you are still enrolled in FEHB, you can do so without paying a late enrollment penalty. As long as you have FEHB Program coverage you may enroll in a Medicare prescription drug plan from November 15 to December 31st of each year at the regular monthly premium rate. However, if you lose your FEHB Program coverage and want to join a

Medicare prescription drug program, you must join within 63 days of losing your FEHB coverage or your monthly premium will include a late enrollment penalty. The late enrollment penalty will change each year but will be included in your premium each year for as long as you maintain the coverage.

Medicare does not cover:

- your monthly Part B premium or Part C or Part D premiums
- deductibles, coinsurance or copayments when you get health care services
- outpatient prescription drugs (with only a few exceptions) unless you enroll in a Part C plan which provides drug coverage or a Part D plan
- routine or yearly physical exams
- custodial care (help with bathing, dressing, toileting, and eating) at home or in a nursing home
- dental care and dentures (with only a few exceptions)
- routine foot care
- hearing aids
- routine eye care
- health care you get while traveling outside of the United States (except under limited circumstances)
- cosmetic surgery
- some vaccinations
- orthopedic shoes

Complete Medicare benefits information can be found in the Centers for Medicare and Medicaid Services publication, Medicare & You handbook which can be found on the Medicare website (www.medicare.gov).

Am I Eligible for Medicare?

You are eligible for Medicare if you are age 65 or over. Also, certain disabled persons and persons with permanent kidney failure (or End Stage Renal Disease) are eligible. You are entitled to Part A without having to pay premiums if you or your spouse worked for at least 10 years in Medicare-covered employment. (You automatically qualify if you were a Federal employee on January 1, 1983.) If you don't automatically qualify for Part A, and you are age 65 or older, you may be able to buy it; contact the Social Security Administration.

You must pay premiums for Part B coverage, which are withheld from your monthly Social Security payment or your annuity.

You must have Medicare Parts A and B to enroll in Part C. You must have Part A or Part B before you can enroll in Part D. The cost of any additional premium will vary depending on the Part C or Part D plan that you select.

Do FEHB Plans and Medicare Cover the Same Type of Expenses?

Generally, plans under the FEHB Program help pay for the same kind of expenses as Medicare. FEHB plans also provide coverage for emergency care outside of the United States which Medicare doesn't provide. Some FEHB plans also provide coverage for dental and vision care.

Medicare covers some orthopedic and prosthetic devices, durable medical equipment, home health care, limited chiropractic services, and some medical supplies, which some FEHB plans may not cover or only partially cover (check your plan brochure for details).

Since I Have FEHB Coverage, Do I Need Medicare Coverage?

If you are entitled to Part A without paying the premiums, you should take it, even if you are still working. This will help cover some of the costs that your FEHB plan may not cover, such as deductibles, coinsurance, and charges that exceed the plan's allowable charges. There are other advantages to Part A, such as (if you also enroll in Part B,) being eligible to enroll in a Medicare Advantage Plan.

Do I Have to Take Part B Coverage?

You don't have to take Part B coverage if you don't want it, and your FEHB plan can't require you to take it. But, there are some advantages to enrolling in Part B:

- You must be enrolled in Parts A and B to join a Medicare Advantage Plan.
- You have the advantage of coordination of benefits (described later) between Medicare and your FEHB plan, reducing your out-of-pocket costs.
- Your FEHB plan may waive its copayments, coinsurance, and deductibles for services covered by Part B.
- Some services covered by Part B might not be covered or are only partially covered by your plan, such as orthopedic and prosthetic devices, durable medical equipment, home health care, and medical supplies (check your plan brochure for details).
- If you are enrolled in an FEHB HMO, you may go outside of the HMO network for Part B services and receive reimbursement by Medicare (when Medicare is the primary payer).

How Much Does Part B Coverage Cost?

The premium for Part B coverage is determined by Medicare. The monthly premium amount is available in the "Medicare & You" handbook produced by the U.S. Centers for Medicare and Medicaid (CMS) and is also available on the Medicare website at www.medicare.gov. Before 2006, the Government generally funded about 75 percent of the total Part B premium. Starting in 2007, higher income beneficiaries began to receive a reduced subsidy which will be fully phased in by 2009. At that time, subsidies for higher income beneficiaries will range from about 65 percent to 20 percent of the total premium. This change will affect only about four percent of all Medicare beneficiaries. The Part B premium for 2008 ranges from \$96.40 to \$238.40, but will be adjusted annually.

What Happens If I Don't Take Part B as Soon as I'm Eligible?

If you do not enroll in Medicare Part B during your initial enrollment period, you must wait for the general enrollment period (January 1- March 31 of each year) to enroll, and Part B coverage will begin the following July 1 of that year. If you wait 12 months or more, after first becoming eligible, your Part B premium will go up 10 percent for each 12 months that you could have had Part B but didn't take it. You will pay the extra 10 percent for as long as you have Part B.

If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

Does the FEHB Program Offer Medigap Policies?

FEHB is not one of the standard Medicare supplemental insurance policies - known as Medigap or Medicare SELECT policies. However, FEHB plans and options will supplement Medicare by paying for costs not covered by Medicare, such as the required deductibles and coinsurance, and by providing additional benefits not provided under Medicare A and B, such as prescription drugs.

Do I Need a Medigap Policy When I Have FEHB and Medicare Coverage?

No, you don't need to purchase a Medigap policy since FEHB and Medicare will coordinate benefits to provide comprehensive coverage for a wide range of medical expenses.

When FEHB and Medicare Coordinate Benefits, Which One Pays Benefits First?

Medicare law and regulations determine whether Medicare or FEHB is primary (that is, pays benefits first). Medicare automatically transfers claims information to your FEHB plan once your claim is processed, so you generally don't need to file a claim with both. You will receive an Explanation of Benefits (EOB) from your FEHB plan and an EOB or Medicare Summary Notice (MSN) from Medicare. If you have to file with the secondary payer, send along the EOB or MSN you get from the primary payer.

When is My FEHB Plan the Primary Payer?

Your FEHB Plan must pay benefits first when you are an active Federal employee or reemployed annuitant and either you or your covered spouse has Medicare. (There is an exception if your reemployment position is excluded from FEHB coverage or you are enrolled in Medicare Part B only.)

Your FEHB Plan must also pay benefits first for you or a covered family member during the first 30 months of eligibility or entitlement to Part A benefits because of End Stage Renal Disease (ESRD), regardless of your employment status, unless Medicare (based on age or disability) was your primary payer on the day before you became eligible for Medicare Part A due to ESRD.

Your FEHB Plan must also pay benefits first when you are under age 65, entitled to Medicare on the basis of disability, and covered under FEHB based on you or your spouse's employment status.

When is Medicare the Primary Payer?

Medicare must pay benefits first when you are an annuitant, (unless you are a reemployed annuitant, see above), and either you or your covered spouse has Medicare. (This includes Federal judges who retired under title 28, U.S.C., and Tax Court judges who retired under Section 7447 of title 26, U.S.C.) Medicare must pay benefits first when you are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation has determined that you're unable to return to Duty, except for claims related to the Workers' Compensation injury or illness.

If Medicare was the primary payer prior to the onset of End Stage Renal Disease, Medicare will continue to be primary during the 30-month coordination period. However, if Medicare was secondary prior to the onset of End Stage Renal Disease, it will continue to be secondary until the 30-month coordination period has expired. After the 30-month coordination period has expired, Medicare will be primary regardless of your employment status.

If I Continue to Work Past Age 65, is My FEHB Coverage Still Primary?

Your FEHB coverage will be your primary coverage until you retire.

I am Retired With FEHB and Medicare Coverage. I am Also Covered Under My Spouse's Insurance Policy Through Work. Which Plan is Primary?

Since you are retired but covered under your working spouse's policy, your spouse's policy is your primary coverage. Medicare will pay secondary benefits and your FEHB plan will pay third.

Do My FEHB Premiums Change When Medicare Becomes Primary?

No. You will continue to pay the same premiums, unless you change to another plan or option.

Medicare & FEHB Primary Payer Chart

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and ... You have FEHB coverage on your own or through your spouse who is also an active employee You have FEHB coverage through your spouse who is an annuitant	✓	✓
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and... • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and... • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

Can I Change My FEHB Enrollment When I Become Eligible for Medicare?

Yes, you may change your FEHB enrollment to any available plan or option at any time beginning 30 days before you become eligible for Medicare. You may use this enrollment change opportunity only once. You may also change your enrollment during the annual open season, or because of another event that permits enrollment changes (such as a change in family status).

Should I Change Plans?

Once Medicare becomes the primary payer, you may find that a lower cost FEHB plan is adequate for your needs, especially if you are currently enrolled in a plan's high option. Also, some plans waive deductibles, coinsurance, and copayments when Medicare is primary.

Will My FEHB Fee-For-Service Plan Cover All My Out-Of-Pocket Costs Not Covered by Medicare?

Not always. A fee-for-service plan's payment is typically based on allowable charges, not billed charges. In some cases, Medicare's payment and the plan's payment combined will not cover the full cost. Your out-of-pocket costs for Part B services will depend on whether your doctor accepts Medicare assignment. When your doctor accepts assignment, you can be billed only for the difference between the Medicare-approved amount and the combined payments made by Medicare and your FEHB plan.

When your doctor doesn't accept assignment, you can be billed up to the difference between 115 percent of the Medicare approved amount (limiting charge) and the combined payments made by Medicare and your FEHB plan. Medicare will pay its share of the bill and your FEHB plan will pay its share. Some services, such as medical supplies and some durable medical equipment, do not have limiting charges.

Must I Use My FEHB HMO's Participating Providers When Medicare is Primary?

If you want your FEHB HMO to cover your Medicare deductibles, coinsurance, and other services not covered by Medicare, you must use your HMO's participating provider network to receive services and get the required referrals for specialty care.

If I Go to My FEHB HMO's Providers, Do I Have to File a Claim With Medicare?

No. If needed, your HMO will file for you and then pay its portion after Medicare has paid.

When I Use My FEHB HMO's Doctors, Do I Have to Pay Medicare's Deductibles and Coinsurance?

No. Your HMO will pay the portion not paid by Medicare for covered services.

Do I Have to Pay My FEHB HMO's Copays?

Usually, you will still pay your FEHB HMO's required copays. Some HMOs waive payment of their copays and deductibles when Medicare is primary. Check your FEHB plan's brochure for details.

I Want to Join a Medicare Advantage Plan. Should I Suspend or Cancel My FEHB Coverage?

When you enroll in a Medicare Advantage plan, you may not need FEHB coverage because the Medicare Advantage plan will provide you with many of the same benefits. You should review the Medicare Advantage Plan benefits carefully before making a decision to suspend or cancel FEHB coverage. You should contact your retirement system to discuss suspension and reenrollment.

Can I Reenroll in FEHB If I Disenroll From the Medicare Advantage Plan?

If you provide documentation to your retirement system that you are suspending your FEHB coverage to enroll in a Medicare Advantage plan, you may reenroll in FEHB if you later lose or cancel your Medicare Advantage plan coverage. However, you must wait until the next open season to reenroll in FEHB, unless you involuntarily lose your coverage under the Medicare Advantage plan (including because the plan is discontinued or because you move outside its service area). In this case, you may reenroll from 31 days before to 60 days after you lose the Medicare Advantage plan coverage, and your reenrollment in FEHB will be effective the day after the Medicare Advantage plan coverage ends (or ended).

How Can I Get More Information About Medicare?

During the fall of each year, you will receive a copy of the *Medicare & You* handbook. It is also available by calling 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048, or at www.medicare.gov/publications/pubs/pdf/10050.pdf. The *Medicare & You* handbook has information on Medicare Parts A & B; Medicare Advantage Plans (Part C); Medicare Prescription Drug Coverage (Part D); Help for People with Limited Income and Resources; and Joining and Switching Plans. The Medicare website (www.medicare.gov) contains the handbook and other information about Medicare. If you do not have a personal computer, your local library or senior center may be able to help you access this web site. You should contact your retirement system before making any change to your coverage, especially if you are considering suspending your FEHB coverage to enroll in a Medicare Advantage Plan. If you are a CSRS or FERS annuitant, you may call OPM's Retirement Information Office at 1-88USOPMRET (1-888-767-6738) or 202-606-0500 from the metropolitan Washington area, or you may write to:

*Office of Personnel Management
Retirement Operations Center
P.O. Box 45
Boyers, PA 16017-0045*

Other useful publications, such as the *Guide to Health Insurance for People with Medicare*, are also available at the Medicare number (1-800-633-4227) or from your State Health Insurance Assistance Program (SHIP) counseling office. The SHIP counselors in your state are also available by telephone or sometimes as a walk-in resource if you would like more personalized attention. You can find SHIP counseling office telephone numbers in the *Medicare & You* handbook or on the Medicare website at <http://www.medicare.gov/contacts/static/allStateContacts.asp>.

Your FEHB plan brochure provides specific information on how its benefits are coordinated with Medicare. Some HMOs participating in the FEHB are structured to provide more comprehensive coverage if you enroll in both their HMO and their Medicare Advantage plan.

Terms Used in This Booklet

Assignment:	An arrangement where a doctor or health care supplier agrees to accept the Medicare approved amount (see definition) as full payment for services and supplies covered under Part B. When your doctor accepts assignment, you can be billed only for the difference between the Medicare approved amount and the combined payments made by Medicare and any secondary payer.
Coinsurance:	The amount that you pay (after you pay any plan deductibles) for each medical service you get, such as a doctor visit. Coinsurance is a percentage of the cost of the service; a copayment is usually a fixed dollar amount you pay for a service.
Coordination of Benefits:	When you have more than one type of insurance which covers the same health care expenses, one pays its benefits in full as the primary payer and the other(s) pays a reduced benefit as a secondary or tertiary payer. When the primary payer doesn't cover a particular service but the secondary payer does, the secondary payer will pay up to its benefit limit as if it were the primary payer.
Copayment:	The amount that you pay for each medical service you get, like a doctor visit. A copayment (or copay) is usually a fixed dollar amount you pay for a service; coinsurance is a percentage of the cost of the service.
Deductible:	The amount you must pay for health care before your health plan begins to pay. There is a deductible for each benefit period - usually a year. There may be separate deductibles for different types of services. Deductibles can change every year.
Disenroll:	Leaving or ending your health care coverage with a health plan.
Durable Medical Equipment (DME):	Medical equipment ordered by a doctor for use in the home. DME must be re-usable. DME includes walkers, wheelchairs, and hospital beds.
Enroll:	You enroll when you first sign up to join a health plan.
Health Maintenance Organization	A type of health benefits plan that provides care through a

(HMO):	network of doctors and hospitals in a particular geographic or service area. HMOs coordinate the health care services you receive. Your eligibility to enroll in an HMO is determined by where you live or, for some plans, where you work. Some FEHB HMOs have agreements with providers in other service areas for non-emergency care if you travel or are away from home for lengthy periods.
Home Health Care:	Home health care includes skilled nursing care, as well as other skilled care services, like physical and occupational therapy, speech-language therapy, and medical social services. These services must be ordered by a physician and are provided by a variety of skilled health care professionals at home. Important: Medicare does not cover long term care so this home health care coverage is limited.
Hospice Care:	A program for caring for the terminally ill that emphasizes palliative and supportive services, such as home care and pain control, rather than curative care of the terminal illness. These services include nursing care, medical social services, physician services, and short-term inpatient care for pain control and acute and chronic symptom management.
Inpatient Care:	All types of health services that require an overnight hospital stay.
Medicare:	The Federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (those with permanent kidney failure who need dialysis or a transplant, sometimes called ESRD).
Medicare Approved Amount:	The amount Medicare determines to be reasonable for a service that is covered under Part B of Medicare. It includes what Medicare pays and any deductible, coinsurance or copayment that you pay. It is usually less than the actual charge.
Medicare Advantage Plan:	A Medicare program offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. The Medicare Advantage Plan is called Part C. Medicare Advantage Plans include HMOs, PPOs, Private Fee-for-Service Plans, and Medicare Medical Savings Account Plans. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and are not paid for under the Original Medicare Plan. Some Medicare Advantage Plans offer prescription drug coverage

and may charge a monthly premium and require copayments.

Medigap:

A supplemental private insurance policy that you can buy for extra benefits either not covered or not fully covered by Medicare. There are 12 standard Medigap plans in most states, ranging from a basic benefits package to ones that cover expenses such as the Part A deductible, Part B deductible, prescription drugs, and/or the skilled nursing coinsurance.

Original Medicare:

The traditional fee-for-service arrangement that covers Part A and Part B services. Medicare pays its share of the Medicare approved amount and you pay your share (deductibles and coinsurance).

Out-of-Pocket Costs:

Health care costs that you must pay because they are not covered by insurance, such as deductibles, coinsurance, copayments, and non-covered expenses.

Outpatient Care:

Health services that do not require an overnight hospital stay.

Preferred Provider Organization (PPO):

A fee-for-service option under Medicare Advantage Plans where you pay less if you use providers who have agreements with the plan. You may use providers outside of the PPO network but the services may cost you more.

Premium:

The amount you pay monthly or biweekly for insurance.

Preventive Care:

Care to keep you healthy or to prevent illness, such as routine checkups and flu shots, and some tests like colorectal cancer screening and mammograms.

Primary Payer:

When coordinating benefits, the health plan that pays benefits first for a claim for medical care.

Private Fee-For- Service Plan:

A traditional type of insurance you can choose under Medicare Advantage Plans that lets you use any doctor or hospital, but you usually must pay a deductible and coinsurance or copayment. The insurance plan, rather than the Medicare program, decides how much it will pay the provider and how much you will pay for the services you receive. You may pay more or less for Medicare covered benefits but, you may get extra benefits not found in Original Medicare.

Referral:

Your primary care doctor's written approval for you to see a certain specialist or to receive certain services. Most FEHB

HMOs and some Medicare health plans may require referrals.

Important: If you either see a different doctor from the one on the referral, or if you see a doctor without a referral and the service isn't for an emergency or urgently needed care, you may have to pay the entire bill.

Secondary Payer:

When coordinating benefits, the health plan that pays benefits after the primary payer has paid its full benefits. When an FEHB fee-for-service plan is the secondary payer, it will pay the lesser of a) its benefits in full, or b) an amount that when added to the benefits payable by the primary payer, equals 100% of covered charges.

Service Area:

The geographic area where a health plan accepts members. For plans that provide coverage only when you use their doctors and hospitals, it is also the area where services are administered.

Skilled Nursing Facility:

A facility that specializes in skilled nursing care performed by or under the supervision of licensed nurses, skilled rehabilitation services, and other related care, and which meets Medicare's special qualifying criteria, but not an institution that primarily cares for and treats mental diseases. **Important:** Medicare does not cover long term care so this skilled nursing facility coverage is limited.

Suspension of FEHB Enrollment:

When you notify your retirement system that you are suspending your FEHB coverage to enroll in a Medicare Advantage plan, you retain the right to reenroll in FEHB if your enrollment in the Medicare Advantage plan ends. Otherwise, if you cancel your FEHB coverage as an annuitant, you will probably never be eligible to reenroll.



What is COBRA?

COBRA is a federal law that allows certain employees, their spouses and dependents, to keep their group health plan (GHP) for between 18 and 36 months after they leave their job or lose coverage for certain other reasons, as long as they pay the full cost of the premium. Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) in 1986.

Under COBRA, a GHP is defined as a plan that provides medical benefits for the employer's own employees, their spouses and their dependents. Medical benefits may include inpatient and outpatient hospital care; physician care; surgery and other major medical benefits; prescription drugs; any other medical benefits, such as dental and vision care. Life insurance is not covered under COBRA.

The federal COBRA law generally covers group health plans maintained by employers with 20 or more employees in the prior year. It applies to health plans in the private sector and those sponsored by state and local governments. The law does not, however, apply to plans sponsored by the federal government and certain church-related organizations.

Some states extend rights similar to COBRA to people who would not otherwise be eligible for COBRA, for example, people with companies that have fewer than 20 employees. Check with your state insurance department to find out if you qualify to keep your GHP coverage after you leave your job.

Employer group health coverage under COBRA is generally expensive because the coverage tends to be comprehensive and you pay the full cost of the premium yourself (employers generally pay part of the premium for current employees). However, COBRA coverage is still less expensive than similar individual health coverage, so, people with costly health care needs should probably purchase COBRA. Others may want to explore other health insurance options before choosing to continue with the employer plan through COBRA.



How do I know if I am eligible for COBRA?

Even if you already have Medicare, you are eligible for COBRA if **both** of the following conditions apply:

1. You are enrolled in an employer group health plan subject to COBRA;

and

2. You have a “qualifying event” (such as termination of employment) that causes you to lose employer group health insurance. The type of qualifying event also determines the length of COBRA coverage (see table below for details).

Qualifying Event	Length of COBRA
Employee retires, is terminated, or has a reduction in work hours. ¹	18 months
Employee develops a <u>disability</u> and has a reduction in work hours. ¹	18 months
Employee develops a disability and is eligible for Social Security Disability Insurance (SSDI) during the initial 18-month COBRA period.	18 months +11 months extra (=29 months total)
Employee is terminated for gross misconduct.	Nothing

Employee's spouse and dependent children lose the 36 months employer group health plan because:

- Employee becomes eligible for Medicare
- Employee and spouse are divorced
- Dependent child loses dependent child status
- Employee dies

[†] Ask your employer how many hours a week you have to work to qualify for group health insurance.

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Can I have both COBRA and Medicare?

If you qualify for Medicare based on age or disability, whether you can have both COBRA and Medicare depends on which you have first.

- If you already **have COBRA when you enroll in Medicare**, your COBRA coverage usually ends on the date you enroll in Medicare. If you have COBRA and become Medicare-eligible, you should enroll in Part B immediately because you are not entitled to a Special Enrollment Period (SEP) when COBRA ends. Your spouse and dependents may keep COBRA for up to 36 months, regardless of whether you enroll in Medicare during that time.

Note: You may also be able to keep COBRA coverage once you get Medicare for services that Medicare does not cover. For example, if you have COBRA dental insurance, the insurance company that provides your COBRA coverage may allow you to drop your medical coverage but keep paying a premium for the dental coverage for as long as you are entitled to COBRA.

- If you already **have Medicare when you become eligible for COBRA**, you must be allowed to enroll in COBRA. Unless you qualify for Medicare because you have End-Stage Renal Disease (ESRD), Medicare acts as the primary payer and COBRA as the secondary payer, so you should stay enrolled in Medicare Part B. You may wish to take COBRA if you have very high medical expenses and your COBRA plan offers you generous extra benefits, like prescription drug coverage.

If you are eligible for Medicare because you have **ESRD**, there is a period of time when your employer group health plan will pay first and Medicare will pay second. This is called the **30-month coordination period**. If you have COBRA during this time, COBRA will be your primary insurance during your 30-month coordination period. If your COBRA coverage ends before the 30 months have

passed, Medicare becomes primary. If you still have COBRA when the 30-month coordination period ends, Medicare will pay first and your COBRA coverage may end (check with your State Department of Insurance for details on your state laws regarding COBRA coverage).

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Can I extend my COBRA coverage if I develop a disability?

If you develop a disability **within the first 60 days** of getting COBRA coverage, then you and your family may be able to extend your COBRA by 11 months (to 29 months).

You must notify your COBRA insurer that you have developed a disability within 60 days of the date of your disability determination and before the expiration of the 18-month COBRA coverage, or you could lose all rights to the extension.

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When does COBRA coverage end?

COBRA coverage may be terminated if:

- You become eligible for Medicare;
- You reach the maximum coverage limit under the plan;
- You become eligible for another employer-sponsored health plan that does not have a pre-existing condition waiting period (if the new plan does have a waiting period, you may continue COBRA coverage during this period);
- The employer from whom you are getting coverage stops coverage for all employees;
- You do not pay your COBRA premiums on time.

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COBRA: 7 important facts

1. 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."
2. 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.
3. In most situations that give you COBRA rights (other than a divorce), you should get a notice from your employer's benefits administrator or the group health plan telling you your coverage is ending and offering you the right to elect COBRA continuation coverage.
4. COBRA coverage generally is offered for 18 months, and 36 months in some cases. If you don't get a notice, but you find out your coverage has ended, or if you get divorced, call the employer's benefits administrator or the group health plan as soon as possible and ask about your COBRA rights.
5. If you qualify for COBRA because the covered employee either 1) died, 2) lost his/her job, or 3) became entitled to Medicare, the employer must tell the plan administrator. Once the plan administrator is notified, the plan must let you know you have the right to choose COBRA coverage.
6. If you qualify for COBRA because you've become divorced or legally separated (court issued separation decree) from the covered employee, or if you were a dependent child or dependent adult child who is no longer a dependent, then you or the covered employee needs to let the plan administrator know about your change in situation within 60 days of the change.
7. 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](#).

Get answers to COBRA questions

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 (BCRC) at 1-855-798-2627 (TTY: 1-855-797-2627).

If your group health plan coverage was from a private employer (not a government employer), contact the [Department of Labor](#).

If your group health plan coverage was from a state or local government employer, call the Centers for Medicare & Medicaid Services (CMS) at 1-877-267-2323 extension 61565.

If your coverage was with the federal government, visit the [Office of Personnel Management](#).

Medicare.gov

A federal government website managed and paid for
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Baltimore, MD 21244





Medicare and COBRA Insurance

I recently lost my job and my employer offered me COBRA coverage. I will also be eligible for Medicare soon and would like to know, how do Medicare and COBRA work together?

~ Mr. Elliott

Dear Mr. Elliott,

COBRA, the Consolidated Omnibus Budget Reconciliation Act, is a federal law. COBRA provides people with the option of staying on their employer's group health plan (GHP) for a limited time after their employment ends. This is usually for 18 months but may last up to 36 months. COBRA coverage can be expensive and costs more than what you were paying for health coverage before your employment ended. How Medicare and COBRA work together depends on which type of coverage you have first.

If you have Medicare first and then become eligible for COBRA, you can have both Medicare and COBRA. It is important to remember that Medicare pays first and COBRA pays second. So, you do not want to drop your Medicare – without Medicare you have no primary insurance, which is essentially like having no insurance at all. After Medicare pays, COBRA may cover some or all of what Medicare does not pay.

Whether you should take COBRA depends on the type of coverage you want and can afford. Your COBRA coverage may include extra benefits that are not covered by Medicare, like coverage for routine dental care or eyeglasses. You have two options:

1. You can enroll in COBRA and keep your Medicare coverage. If you choose to do this, you will be responsible for paying both your Medicare Part B and COBRA monthly premiums.
2. You can decide to turn down COBRA and only have Medicare coverage. If you have dependents that are covered by your COBRA, make sure you talk to your benefits coordinator before turning down COBRA to see how this will impact your dependents.

If you only had Medicare Part A (not Part B) while you were working, make sure to enroll in Medicare Part B, even if your employer is offering you COBRA. You have up to eight months after your employment ends to enroll in Part B. However, it is best to plan ahead and enroll in Part B while you are still working so that your coverage starts by the time your employment ends. When your employment ends, Medicare becomes your primary insurance. If you wait to enroll in Part B until after your COBRA ends, you may not be able to get coverage right away and you may have to pay a late enrollment penalty.

When you enroll in Medicare Part B, you also trigger your Medigap open enrollment rights. Medigap policies are Medicare supplemental insurance plans that help pay your out-of-pocket costs (like coinsurances and deductibles) under Original Medicare. Your Medigap open enrollment period lasts six months from the date you enroll in Part B.

It lets you buy any Medigap policy regardless of any health problems you may have, without paying more for the policy. You will pay a monthly premium for any Medigap policy you buy. Compare the benefits and costs of having a Medigap policy to COBRA to see which is a better value for you.

If you have COBRA first and then become eligible for Medicare, your COBRA coverage may end. Since you will not be fully covered with COBRA you should enroll in Medicare Part A and Part B when you are first eligible to avoid a late enrollment penalty.

However, you may be allowed to keep your COBRA coverage if it is offered to you and you wish to use it for extra benefits like prescription drug or dental coverage. Ask your employer if your prescription drug coverage under COBRA is considered "creditable." Creditable coverage is drug coverage that is as good as or better than Medicare's prescription drug coverage. If you keep COBRA drug coverage and it is creditable, you may delay enrolling into **Medicare Part D** drug plan until your COBRA ends. You will **not** have to pay a Part D late enrollment penalty, as long as you enroll within 63 days of losing your drug coverage. If it is not creditable, consider enrolling in a Part D drug plan. Contact your former employer to find out whether enrolling in Part D will affect your other benefits.

If your family members have COBRA through your former employer's plan, they may be able to continue their COBRA coverage for a period of time, even after your COBRA coverage ends when you become eligible for Medicare.

Please note the rules are different if you qualify for Medicare due to End-Stage Renal Disease (ESRD). Please visit www.Medicare.gov for information about enrolling in Part B if you have ESRD.

Here is where you can go for additional information or if you need help:

Medicare: 800-MEDICARE (800-633-4227) or TTY 877-486-2048

Department of Labor: 866-487-2365 or TTY 877-889-5627

Online Resources:

Who Pays First - <http://www.medicare.gov/publications/pubs/pdf/02179.pdf>

Medicare and COBRA - <http://www.ssa.gov/disabilityresearch/wi/medicare.htm#cobra>

United States Department of Labor - <http://www.dol.gov/ebsa/faqs/faq-consumer-cobra.html>



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COBRA and Medicare, Part II

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Continued health care coverage authorized by the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly referred to as COBRA, provides a great step forward in reducing gaps in insurance for people between jobs or losing coverage due to the death of the covered worker in a family. The rules for COBRA coverage are, nonetheless, complicated. This is especially true when COBRA intersects with Medicare.

[A prior article](#) discussed the pitfalls of enrolling in Medicare Part B at the end of a period of COBRA coverage. Because COBRA coverage is not considered coverage due to current employment, an individual is not entitled to a Special Enrollment Period (SEP) for Part B when COBRA coverage ends and is not permitted to enroll in Medicare Part B until the next General Enrollment Period (GEP), which runs January through March of the year, with coverage beginning July 1. Moreover, the individual will pay a lifetime late enrollment penalty of 10% for every 12 months of delayed enrollment.

COBRA can be considered creditable coverage for purposes of Medicare Part D. Thus, if an individual has prescription drug coverage through a COBRA plan that is considered "creditable" (at least as good as what he or she can get through a Part D plan), the individual has a SEP to enroll in a Part D plan at the end of COBRA coverage, without a waiting period and without a penalty.[1]

COBRA and Medicare/Medicare and COBRA: When Can You Have Both?

Whether an individual has the right to COBRA in addition to Medicare depends on whether the individual has Medicare before or after he or she begins to receive COBRA. An individual who has qualified for and chosen COBRA before enrolling in Medicare will lose the right to COBRA when their Medicare becomes effective. In other words, the employer has the option of canceling the COBRA coverage when the individual enrolls in Medicare.[2] An employer can terminate COBRA coverage only when an individual actually obtains Medicare coverage.[3]

If, on the other hand, an individual enrolls in Medicare first – even if just in Part A – he or she would also be eligible to purchase COBRA coverage.[4] Indeed, Medicare enrollment is a qualifying event for the purpose of COBRA coverage when it causes the individual to lose existing health care coverage. So if an individual wants COBRA in addition to Medicare, it is important to sign up for Medicare before the COBRA qualifying event (which could be signing up for Medicare or could be termination of employer sponsored health care coverage due to retirement). Since, as we noted last week, loss of COBRA does not entitle one to a SEP to enroll in Medicare Part B, it is important to enroll in Part B at the time one applies for Part A.

When Acquiring Medicare Coverage IS the COBRA Qualifying Event

Mandatory COBRA coverage periods vary depending on several factors. The maximum COBRA coverage period for a qualified beneficiary who loses health insurance as a result of a covered employee enrolling in Medicare is 36 months. The 36-month period begins to run at the time of Medicare enrollment, even if the qualified beneficiary does not lose health

[5] Note that for individuals who qualify for Medicare because of ESRD and are also entitled to health coverage under an employer plan, the group plan will be the primary payer for a 90-month coordination of benefits period. See 42 U.S.C. §1395v(b)(1)(C), 42 C.F.R. §411.162. This rule applies regardless of whether the individual is a current or former employee and regardless of whether the individual has coverage through COBRA. Also note that if an individual enrolls in Medicare after electing COBRA coverage, the employer can elect to terminate the COBRA coverage.

[6] Section 1882(s)(3)(B)(ii) of the Social Security Act; see also "Your Rights to Buy a Medigap Policy" at <http://chealthadvocate.org/medigap/medigap-ed-issac.html> (site visited September 14, 2015).

[7] For a discussion of these plans, see <http://chealthadvocates.org/medigap/overview.html> (site visited September 14, 2015).

Comments are closed.

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Medicare and COBRA Insurance

I recently lost my job and my employer offered me COBRA coverage. I will also be eligible for Medicare soon and would like to know, how do Medicare and COBRA work together?

~ Mr. Elliott

Dear Mr. Elliott,

COBRA, the Consolidated Omnibus Budget Reconciliation Act, is a federal law. COBRA provides people with the option of staying on their employer's group health plan (GHP) for a limited time after their employment ends. This is usually for 18 months but may last up to 36 months. COBRA coverage can be expensive and costs more than what you were paying for health coverage before your employment ended. How Medicare and COBRA work together depends on which type of coverage you have first.

If you have Medicare first and then become eligible for COBRA, you can have both Medicare and COBRA. It is important to remember that Medicare pays first and COBRA pays second. So, you do not want to drop your Medicare – without Medicare you have no primary insurance, which is essentially like having no insurance at all. After Medicare pays, COBRA may cover some or all of what Medicare does not pay.

Whether you should take COBRA depends on the type of coverage you want and can afford. Your COBRA coverage may include extra benefits that are not covered by Medicare, like coverage for routine dental care or eyeglasses. You have two options:

1. You can enroll in COBRA and keep your Medicare coverage. If you choose to do this, you will be responsible for paying both your Medicare Part B and COBRA monthly premiums.
2. You can decide to turn down COBRA and only have Medicare coverage. If you have dependents that are covered by your COBRA, make sure you talk to your benefits coordinator before turning down COBRA to see how this will impact your dependents.

If you only had Medicare Part A (not Part B) while you were working, make sure to enroll in Medicare Part B, even if your employer is offering you COBRA. You have up to eight months after your employment ends to enroll in Part B. However, it is best to plan ahead and enroll in Part B while you are still working so that your coverage starts by the time your employment ends. When your employment ends, Medicare becomes your primary insurance. If you wait to enroll in Part B until after your COBRA ends, you may not be able to get coverage right away and you may have to pay a late enrollment penalty.

When you enroll in Medicare Part B, you also trigger your Medigap open enrollment rights. Medigap policies are Medicare supplemental insurance plans that help pay your out-of-pocket costs (like coinsurances and deductibles) under Original Medicare. Your Medigap open enrollment period lasts six months from the date you enroll in Part B.

It lets you buy any Medigap policy regardless of any health problems you may have, without paying more for the policy. You will pay a monthly premium for any Medigap policy you buy. Compare the benefits and costs of having a Medigap policy to COBRA to see which is a better value for you.

If you have COBRA first and then become eligible for Medicare, your COBRA coverage may end. Since you will not be fully covered with COBRA you should enroll in Medicare Part A and Part B when you are first eligible to avoid a late enrollment penalty.

However, you may be allowed to keep your COBRA coverage if it is offered to you and you wish to use it for extra benefits like prescription drug or dental coverage. Ask your employer if your prescription drug coverage under COBRA is considered "creditable." Creditable coverage is drug coverage that is as good as or better than Medicare's prescription drug coverage. If you keep COBRA drug coverage and it is creditable, you may delay enrolling into **Medicare Part D** drug plan until your COBRA ends. You will **not** have to pay a Part D late enrollment penalty, as long as you enroll within 63 days of losing your drug coverage. If it is not creditable, consider enrolling in a Part D drug plan. Contact your former employer to find out whether enrolling in Part D will affect your other benefits.

If your family members have COBRA through your former employer's plan, they may be able to continue their COBRA coverage for a period of time, even after your COBRA coverage ends when you become eligible for Medicare.

Please note the rules are different if you qualify for Medicare due to End-Stage Renal Disease (ESRD). Please visit www.Medicare.gov for information about enrolling in Part B if you have ESRD.

Here is where you can go for additional information or if you need help:

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Who Pays First - <http://www.medicare.gov/publications/pubs/pdf/02179.pdf>

Medicare and COBRA - <http://www.ssa.gov/disabilityresearch/wi/medicare.htm#cobra>

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Medicare and Employer Group Health Insurance for People with Disabilities Under 65

I am 50 years old and just became eligible for Medicare Part A and Part B due to a disability. I have insurance through my current employer. Do I need to keep my Medicare or can I drop it?

~ Mr. James

Dear Mr. James,

The enrollment rules for people under 65 years old who are eligible for Medicare due to a disability are different from the enrollment rules for people who are 65 and over. As you know, if you've been receiving Social Security Disability Insurance (SSDI) for 24 months you will be automatically enrolled in Medicare Parts A and B. You should have received a package in the mail from Medicare three months before your Medicare started. Most people take Part A since it is generally free (no premium). However, there is a monthly premium for Part B. Some people choose to turn down Part B because they have primary insurance from a current employer.

If your current employer has 100 or more employees, your insurance is called a large group health plan and your health plan pays first. This means that your employer group health plan is the primary payer. If you choose to keep Medicare, Medicare will pay after your employer's insurance. Many people with large group health plans turn down Medicare Part B because they are adequately covered under their employer's insurance.

The best way to find out how your health coverage will work with Medicare is to contact the benefits administrator for your insurance plan or work with your employer's benefits counselor. If you're happy with your group health plan and it is your primary insurance, then you can delay enrolling in Part B until a later time when you are no longer working or the group health plan no longer covers you – whichever happens first. It is important to sign up for Part B as soon as you stop working or lose employer coverage in order to avoid late enrollment penalties.

If your employer has less than 100 employees, your insurance is called a small group health plan and Medicare pays first and your employer pays second. This means that you should stay in Medicare Part A and Part B. You will need the primary coverage through Medicare - only having secondary insurance is like having no insurance at all.

Sometimes multiple employers with less than 100 employees come together and create what is called a **multi-employer plan**. If only one employer within the multi-employer plan has 100 or more employees, then the multi-employer plan acts like a large group health plan, meaning the plan pays first and Medicare pays second.

It is always a good idea to call your health plan's benefits administrator to find out exactly how your coverage will work with Medicare and ask what kind of plan they are and how many employees are counted. Be sure to keep careful records of your conversations, including the date, who you spoke with and what they told you. Try to get all information you receive from your benefits counselor or

insurance company in writing. You may need to remind them that the rules for primary and secondary insurance coverage for a person with Medicare who is under age 65 are based on 100 employees, while the deciding number for a person age 65 or older would be 20 employees.

Important tip: In addition to speaking to your employer, you should speak to someone at the Social Security Administration (800-772-1213) any time you make a decision about enrolling in or declining Part B to be sure you understand the consequences of your decisions. Write down the date, time, representative's name and the information you received – this information could be important if there is any problem with your benefits in the future.

Here is where you can go for additional information or if you need help:

Medicare: 800-MEDICARE (800-633-4227) or TTY 877-486-2048

Social Security Administration: 800-772-1213 or TTY 800-325-0778

Online Resources:

Medicare Part D for People Who Have Drug Coverage Through an Employer or Union:
<http://www.medicare.gov/Publications/pubs/pdf/11107.pdf>

Who Pays First: <http://www.medicare.gov/publications/pubs/pdf/02179.pdf>



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Medicare Q&A

General Medicare Questions

Q: Do I have to apply for Medicare or do I get it automatically?

A: If you are already collecting some form of Social Security (either retirement benefits or disability benefits) when you become eligible for Medicare, you will be automatically enrolled in both Part A and Part B. You become eligible for Medicare when you turn 65 or have been collecting Social Security Disability for 24 months.

If you are not collecting Social Security when you become eligible for Medicare, you must enroll through Social Security. You can do this online, over the phone or in person at your local Social Security office. Call 800-772-1213 to sign up for Parts A and B of Medicare or to find the location of your local Social Security office.

If you want Medicare Part D prescription drug coverage, you must actively enroll in it yourself. This is true whether you are automatically enrolled in Medicare or you have enrolled yourself.

Keep in mind that people with Lou Gehrig's disease (ALS) or End-Stage Renal Disease (ESRD) do not have to collect Social Security Disability benefits for 24 months to qualify for Medicare.

Q: Do I have to pay for Medicare?

A: Part A is free if you or your spouse has worked and paid taxes to Medicare for at least 40 quarters (10 years). If you do not have enough working quarters, you will have to pay a premium for Part A. Part B always has monthly premium. If you have a Medigap or Part D plan you may have pay a monthly premium for these as well. Keep in mind that Medicare Advantage (MA) plans have different costs than Original Medicare. If you have a low income, you may qualify for programs that can help pay your Medicare premiums and other costs.

Q: Do I need both Parts A and B?

A: Whether you need Medicare Part A and Part B depends on whether Medicare will be your primary or secondary insurer. Part A is hospital insurance and Part B is medical insurance. If your current employer insurance is primary, you do not need either Part A or Part B. However, most people choose to take Part A because it is free for them. If your Medicare is primary because, for example, you have retiree insurance or COBRA coverage you need both Part A and Part B.

Medicare Q&A

Q: When can I apply for Medicare?

A: You can apply for Medicare during your Initial Enrollment Period (IEP). The IEP is the seven months surrounding your 65th birthday. It includes the three months before you turn 65, the month you turn 65, and the three months after. If you have current employer insurance, you can also sign up while you are still working and for up to eight months after you stop working or you lose your coverage. This window of time is called the Part B Special Enrollment Period (SEP).

If you do not enroll during these times, you can enroll during the General Enrollment Period (GEP), which is January 1 through March 31 of every year. Your coverage will start July 1 of the year you enroll. You may face a late enrollment penalty if you were eligible for Part B before you enrolled during the GEP. If you have been receiving Social Security Disability Insurance (SSDI) for 24 months, then you are automatically enrolled in Medicare in the 25th month you receive SSDI.

Q: Do I receive a notice about Medicare when I turn 65?

A: If you are already receiving Social Security benefits, you will get information about Medicare in the mail three months before you turn 65. If you are not receiving Social Security benefits, you must actively enroll in Medicare yourself by contacting your local Social Security office. You will not receive a notice in the mail letting you know that you are eligible for Medicare.

Q: If I wait to take Part B, will I face a penalty?

A: You will have to pay a monthly Part B late enrollment penalty if you do not sign up for Part B when you first become eligible for Medicare or during a Special Enrollment Period (SEP). If you do have insurance from a current employer, you must enroll within eight months of retiring or losing coverage, or you will have to pay a penalty.

Q: Will money be taken out of my Social Security check for Medicare?

A: Part A is free for most people. You only have to pay a premium for Part A if you or your spouse have not worked and contributed to Social Security for 40 work quarters (10 years). Most people pay a monthly premium for Part B. You can either write a check to Social Security or have the Part B premium automatically taken out of your Social Security check. If you have a Medicare Savings Program (MSP) that pays your Part B premium, your state pays the premium and it should not be deducted from your Social Security check.

Medicare Q&A

Q: How do I pay for Medicare if it is not automatically taken out of my Social Security check?

A: If your Part B premium is not automatically taken out of your Social Security check, you can mail a check to your local Social Security office. However, it is a good idea to have your Part B premium taken out of your Social Security check automatically.

Q: I'm thinking of not taking Part B. Who do I need to talk to?

A: Before making any decisions about enrolling in or opting out of Part B, talk to the Social Security Administration. You may not have any medical coverage if you do not have other primary insurance. If you do have another form of health insurance, contact the plan's benefits administrator to find out how that plan works with Medicare. Then, contact Social Security to confirm the plan's guidance. Make sure keep detailed notes of who you spoke with, when, and what they told you.

Q: My income is low. Are there programs that can help me afford my Medicare premiums?

A: Yes. Every state has Medicare Savings Programs (MSPs) that can help pay your Part B premium. A Medicare Savings Program may also pay Medicare copays and deductibles. You can also see if you are eligible for Extra Help. Extra Help is a federal program that can help pay your Part D prescription drug costs.

Q: Is there additional insurance I can buy to pay for the deductibles and coinsurance that Medicare does not pay for?

A: Yes. Supplemental insurance called Medigap policies can help pay for your Medicare copays and deductibles. Medigap policies only work with Original Medicare. You can only buy Medigap policies at certain times in some states. Check with your state insurance department to find out when you have the right to buy a Medigap plan.

Q: I'm 65, but my spouse is 60. Can my spouse get Medicare, too?

A: Your spouse cannot get Medicare based on your eligibility. To qualify for Medicare, an individual must be:

- age 65,
- or have received Social Security Disability Insurance (SSDI) for 24 months,
- or have End-Stage Renal Disease (ESRD),
- or have ALS (Lou Gehrig's disease).

Medicare Q&A

Q: I'm 63 and I just lost my job. Can I get Medicare early?

A: Unlike Social Security retirement benefits, you cannot take Medicare early. Unless you have been receiving Social Security Disability Insurance benefits (SSDI) for 24 months or have ESRD or ALS, you must wait until you are 65 to receive Medicare.



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Getting Medicare right



Equitable Relief: Navigating the process

Equitable relief is an administrative process created under federal law that allows people with Medicare to request relief from the Social Security Administration (SSA) in the form of:

- Immediate or retroactive enrollment into Medicare Part B, and/or
- The elimination of your Part B premium penalty

Who can obtain equitable relief?

For SSA to grant equitable relief, it must determine that your failure to enroll in Part B was:

- "Unintentional, inadvertent, or erroneous" and
- Was the result of "error, misrepresentation or inaction of a federal employee or any person authorized by the federal government to act in its behalf"

For example, if you did not enroll in Part B because a Social Security representative told you that you did not need to enroll, you may have grounds for equitable relief.

How can you request equitable relief?

In order to request equitable you should write a letter to Social Security explaining that you received misinformation from a federal employee (someone at 800-Medicare, Social Security, or someone acting on the federal government's behalf such as a Medicare private health plan). You can find the address of your local Social Security office by calling 800-772-1213 or visiting www.ssa.gov.

Be as specific as possible in your letter. Make sure to include the dates and times you spoke with the federal employee or representative and their name if possible. Also be sure to describe the outcome of the conversation. You must also state whether you want coverage going forward or retroactive coverage, and/or the elimination of your Part B penalty. Remember, if you are granted retroactive coverage, *you will have to pay premiums back to the time your coverage begins.*

You should always keep copies of the documents you send to Social Security. You should also follow up with your local office one month after you submit your letter. If you are having trouble contacting SSA, contact your Senator or Congressperson and ask them to follow up with SSA for you.

Problems with equitable relief

SSA is not required to respond to your request within any set timeframe, nor is there a formal decision letter that they will send you in response to your request. In the equitable relief process you have no formal rights and you do not have the right to appeal if your request is denied.

Equitable relief is not a formal legal process, but this should not deter you from filing for equitable relief. *Many people have been successful in their pursuit of relief.*

(see reverse side for a sample letter to SSA)



Medicare Coverage for People with Disabilities

www.medicareadvocacy.org/medicare-info/medicare-coverage-for-people-with-disabilities/

- I'm not 65 yet, but I am disabled. Can I get Medicare coverage?
 - I heard that I had to collect disability for 24 months to be eligible. Is this ALWAYS true?
 - I have trouble getting private insurance. Can my illness disqualify me for Medicare coverage, too?
 - Are the benefits the same for me as for those who qualify by virtue of age?
 - Okay, I qualify. How do I enroll in Medicare?
 - If I go back to work, can I keep my Medicare coverage?
 - Articles and Updates
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Medicare is available for certain people with disabilities who are under age 65. These individuals must have received Social Security Disability benefits for 24 months or have End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS, also known as Lou Gehrig's disease). There is a five month waiting period after a beneficiary is determined to be disabled before a beneficiary begins to collect Social Security Disability benefits. People with ESRD and ALS, in contrast to persons with other causes of disability, do not have to collect benefits for 24 months in order to be eligible for Medicare.

The requirements for Medicare eligibility for people with ESRD and ALS are:

- ESRD – Generally 3 months after a course of regular dialysis begins or after a kidney transplant
- ALS – Immediately upon collecting Social Security Disability benefits.

People who meet all the criteria for Social Security Disability are generally automatically enrolled in Parts A and B. People who meet the standards, but do not qualify for Social Security benefits, can purchase Medicare by paying a monthly Part A premium, in addition to the monthly Part B premium.

HOW DO PEOPLE WITH DISABILITIES ENROLL IN MEDICARE?

People who qualify for Social Security Disability benefits should receive a Medicare card in the mail when the required time period has passed. If this does not happen or other questions arise, contact the local Social Security office.

WHAT MEDICARE BENEFITS ARE AVAILABLE FOR PEOPLE WITH DISABILITIES?

Medicare coverage is the same for people who qualify based on disability as for those who qualify based on age. For those who are eligible, the full range of Medicare benefits are available. Coverage includes certain hospital, nursing home, home health, physician, and community-based services. The health care services do not have to be related to the individual's disability in order to be covered.

PEOPLE WITH DEMENTIA, MENTAL ILLNESS, AND OTHER LONG-TERM AND CHRONIC CONDITIONS CAN OBTAIN COVERAGE

There are no illnesses or underlying conditions that disqualify people for Medicare coverage.

Beneficiaries are entitled to an individualized assessment of whether they meet coverage criteria.

Although there are criteria that must be met to obtain coverage for particular kinds of care, Medicare should not be denied based on the person's underlying condition, diagnosis, or other "Rules of Thumb." For example:

- Beneficiaries should not be denied coverage simply because they will need health care for a long time.
- Beneficiaries should not be denied coverage simply because their underlying condition will not improve.

COVERAGE SHOULD NOT BE DENIED SIMPLY BECAUSE THE SERVICES ARE "MAINTENANCE ONLY" OR BECAUSE THE PATIENT HAS A PARTICULAR ILLNESS OR CONDITION

Physical therapy and other services can be covered even if they are only expected to maintain or slow deterioration of the person's condition, not to improve it.

People with certain conditions are at particular risk for being unfairly denied access to Medicare coverage for necessary health care.

People with these and other long-term conditions are entitled to coverage if the care ordered by their doctors meets Medicare criteria:

- Alzheimer's Disease
- Mental Illness
- Multiple Sclerosis
- Parkinson's Disease

If it seems that Medicare enrollment or coverage has been unfairly denied, ask the individual's doctor to help.

Medicare Coverage for Working People with Disabilities

Medicare eligibility for working people with disabilities falls into three distinct time frames. The first is the trial work period, which extends for 9 months after a disabled individual obtains a job. The second is the seven-and-three-quarter years (93 months) after the end of the trial work period. Finally, there is an indefinite period following those 93 months. (See the statute at 42 U.S.C. § 422(c), and regulation at 20 C.F.R. § 404.1592).

Keep in mind that Medicare eligibility during each of these periods applies only while the individual continues to meet the medical standard for being considered disabled under Social Security rules.

• Trial Work Period (TWP)

An individual who is receiving Social Security disability benefits is entitled to continue receiving Medicare as well as Social Security income during a maximum 9 month "trial work" period during any rolling 5 year time period. To qualify, an individual must have gross earnings of at least \$770 per month in 2014, or work more than 80 hours of self-employment per month. The nine months of the trial work period do not necessarily have to be consecutive. During the trial work period, the ability to perform such work will not disqualify the individual from being considered disabled and receiving Social Security and Medicare benefits. However, independent evidence that the individual is no longer disabled could end benefits during the trial work period. After the nine month trial work period has ended, the work performed during it may be considered in determining whether the individual is no longer disabled, and thus no longer eligible for Social Security income and Medicare benefits.

• Extended Period of Eligibility (EPE)

Individuals who still have the disabling impairment but have earned income that meets or exceeds the "Substantial Gainful Activity" level can continue to receive Medicare health insurance after successfully completing a trial work period. The Substantial Gainful Activity level for 2014 is \$1070 a month, or \$1,800 for the blind. This new period of eligibility can continue for as long as 93 months after the trial work period has ended, for a total of eight-and-one-half years including the 9 month trial work period. During this time, though SSDI cash benefits may cease, the beneficiary pays no premium for the hospital insurance portion of Medicare (Part A). Premiums are due for the supplemental medical insurance portion (Part B). If the individual's employer has more than 100 employees, it is required to offer health insurance to individuals and spouses with disabilities, and Medicare will be the secondary payer. For smaller employers who offer health insurance to persons with disabilities, Medicare will remain the primary payer.

- **Indefinite Access to Medicare**

Even after the eight-and-one-half year period of extended Medicare coverage has ended, working individuals with disabilities can continue to receive benefits as long as the individual remains medically disabled. At this point the individual – who must be under age 65 – will have to pay the premium for Part A as well as the premium for Part B. The amount of the Part A premium will depend on the number of quarters of work in which the individual or his spouse have paid into Social Security. Individuals whose income is low, and who have resources under \$4,000 (\$6,000 for a couple), can get help with payment of these premiums under a state run buy-in program for Qualified Disabled and Working Individuals.

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- For more information on services available for those with disabilities, Disability.gov has developed a series of 14 guides about topics such as disability benefits, housing assistance, job training programs, and financial help for families with low incomes. Other guides cover services that promote independence for people with disabilities such as home health care, programs for caregivers, assistive technology, and more.
 - For more on Chronic Conditions, visit our [Coverage for People with Chronic Conditions](#) page.
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Articles and Updates

- What Would Work Better for You? Deciding Between Traditional Medicare and a Medicare Advantage Plan November 9, 2016
- Barriers to Medigap Coverage for Beneficiaries Under Age 65 October 26, 2016
- Medicare Annual Enrollment Period Has Begun – Ends December 7 October 19, 2016
- Transition of Coverage: The Affordable Care Act and Medicare September 21, 2016
- Center for Medicare Advocacy Presents at National SHIP and SMP Conference about Medicare for Beneficiaries Under 65 August 10, 2016
- CMA Survey on Access for SHIPs and SMPs April 29, 2016
- New IRS guidance will impact people eligible for Medicare based on End Stage Renal Disease (ESRD) and those who must pay a premium for Part A January 8, 2014

For older articles, please see our [article archive](#).