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BENEFITS COMPLIANCE GUIDE

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COVERAGE WHILE ON LEAVE OF ABSENCE

FAMILY MEDICAL LEAVE (FMLA)

The Family and Medical Leave Act allows a member to take unpaid family/medical leave within any 12-month period; the member is restored to the same or an equivalent position upon their return from leave if they meet the following conditions:

- Worked for the employer for at least 12 months
- Worked for the employer for at least 1,250 hours in the previous 12 months prior to leave
- Worked at a location in the United States or in a US territory where at least 50 employees are employed by the employer within a 75-mile radius

Stipulations:

- The member may be required to use accrued Vacation Time/Paid Time Off for their FMLA leave of absence.

- FMLA can run concurrently with Short Term or Long Term Disabilty or Worker's Compensation Benefits if your FMLA leave is due to the member's own illness or injury. Use of the compensation benefits will not extend the maximum allowable FMLA timeframe of 12 weeks.

Impacts to Benefits:

- Member may elect to suspend or continue participation in their benefit options, except for Dependent Care FSA, which is suspended as of the date the FMLA leave begins. (All benefits are protected during the duration of FMLA leave of absence except Dependent Care FSA).

- If the member continues their benefit participation, the employee must arrange pre-payment ahead of their leave of absence OR premiums are billed to the employer and collected from the member upon their return to work after leave. If the member does not return to work at the end of their leave period, they will be required to reimburse the employer for its portion of the premiums paid towards maintaining their coverage during leave.

- If benefit participation is voluntarily suspended, benefit expenses incurred while on leave of absence will not be covered under the group health plan. However, the member will have the right to reinstate coverage upon returning from their FMLA leave of absence.

MILITARY LEAVE OF ABSENCE

A member is absent from work due to military obligation, on a voluntary or involuntary basis for a uniformed service of the United States when under the following conditions:

- Active Duty
- Active Duty for training
- Initial Active Duty for training
- Inactive Duty training
- Full-Time National Guard Duty
- A period in which you are absent from a position of employment for the purpose of an examination to determine the members' fitness to perform any such duty

Military Leave <31 Days for the purpose of benefit eligibility:

- Dependent Care FSA contributions are suspended as of the first day of leave
- HSA contributions are suspended as of the first day of leave
- Benefits remain in effect for the 31-day period
- Premiums remain under EE/ER; member responsible for arrears payments upon return from military obligation

Military Leave >31 Days for the purpose of benefit eligibility:

- Benefits remain active through the end of the current month in which the leave begins. This applies to health care coverages and spending accounts
- Short Term Disability, Long Term Disability, and Life Insurance discontinue as of the first day of leave
- Benefits continuation is extended through COBRA where applicable

NON-QUALIFIED LEAVES OF ABSENCE (NON-FMLA)

If the member is absent from work due to a non-qualified leave of absence, the following guidelines apply:

- Member will lose benefits beginning the first day of the month following their non-qualified leave of absence

- If the member returns to work within the same calendar month in which the leave commenced, benefits will not terminate, or the member will be reinstated with no gap in coverage

- If benefits are terminated due to a non-qualified leave of absence, coverages will not be automatically reinstated upon return to work unless the return to work occurs within the same month of leave start

- The member must contact FrankCrum to re-enroll in coverage, effective the first day of the following month. Note: This coverage termination is considered an event for the continuation of coverage under COBRA.

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AFFIDAVIT OF DOMESTIC PARTNERSHIP

Name: _____ Center Name: _____

Address: _____

I. DECLARATION

We, _____ and _____ certify that we are Domestic Partners
Print Employee Name Print Partner Name
in accordance with the Domestic Partner Criteria listed below, and we affirm that we have met all such criteria for at least twelve (12) continuous months and, as such, are eligible for benefits coverage as Domestic Partners under FrankCrum benefits programs.

II. DOMESTIC PARTNER CRITERIA

1. We live in a spouse-like relationship and have lived in this relationship for a period of twelve continuous months or more. Further, we intend to remain each other's Domestic Partner indefinitely.
2. We live in the same permanent residence, and we have lived in the same permanent residence together for a period of twelve continuous months or more. Further, we intend to live together in the same residence indefinitely. (Same permanent residence allows for relocations or moves, which are made together).
3. In states or municipalities recognizing Domestic Partner relationship through registration (currently Alaska, California, Hawaii, New Jersey, Oregon, Washington, and the District of Columbia) for same-sex and opposite-sex domestic partners, we have or will register.
4. Neither of us is legally married nor the Domestic Partner of anyone else.
5. We are not related by blood in a way that would bar marriage to each other under applicable law in effect where we reside; and
6. We are both at least eighteen (18) years of age and are mentally competent to enter into a legal contract.

III. CHANGE IN DOMESTIC PARTNER STATUS

We acknowledge that in the event we no longer meet the criteria set forth in section II above, we will no longer be considered Domestic Partners, and the Partner will no longer be eligible for FrankCrum benefits.

We agree to immediately notify FrankCrum if there is any change in our status as Domestic Partners, as attested to in this Affidavit, which would change our eligibility for FrankCrum benefits (for example, if we cease to maintain the same permanent residence). We each agree to notify the other in writing if and when such a change in Domestic Partner status is reported to FrankCrum. We understand that failure to notify FrankCrum will neither prevent nor delay the termination of eligibility for benefits based on our previous enrollment under the Domestic Partner relationship.

FRANKCRUM BENEFITS

We understand that an Affidavit of Domestic Partnership must be filed in order for a Domestic Partner to be eligible for coverage under FrankCrum benefit plans and that filing this affidavit does not enroll us for any benefits.

We acknowledge that filing this Affidavit does not automatically result in the naming of the Partner as a beneficiary for the employee's life insurance, retirement, or any other potential benefit. The employee must

complete the appropriate forms for enrollment and the appropriate beneficiary designation forms for applicable benefits. We understand that we will need to complete other enrollment procedures in order to enroll a Domestic Partner in any FrankCrum benefit plan for which the Domestic Partner is eligible.

IV. OTHER ACKNOWLEDGEMENTS

1. We certify that the information we have provided on this form is true and correct. Any statements on this form that are known to be false may be cause for disciplinary action, including loss of benefits or termination of employment.
2. We understand that any person/employee/company who suffers any loss due to any false statement contained in this Affidavit may bring a civil action against either or both of us to recover their losses, including reasonable attorney's fees.
3. We have provided the information in this Affidavit for use by FrankCrum or its agent for the sole purpose of determining our eligibility for FrankCrum benefits as Domestic Partners. No other parties shall have any rights under this Affidavit.
4. We understand that the Employee may be taxed on applicable imputed income from the premium paid by FrankCrum on behalf of the Partner and the Partner's eligible covered children (if any), and the Employee may not be eligible to pay the portion of covered benefits attributable to the Partner on a pre-tax basis.

V. SIGNATURE AND IMPORTANT INFORMATION

Note: You are urged to seek appropriate advice before signing this Affidavit. Please be advised that some courts have recognized non-marriage relationships as the equivalent of marriage for the purpose of establishing and dividing joint property. There may also be other implications to signing this document. Finally, you are also urged to seek independent tax advice.

EMPLOYEE INFORMATION

Name (Print)

Address

City, State, Zip

Social Security Number

Daytime Phone Number

Signature Date

PARTNER INFORMATION

Name (Print)

Address

City, State, Zip

Social Security Number

Date of Birth

Signature Date

Sworn to and subscribed before me this ____ day of _____, 20____

Notary Public _____

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STATEMENT OF TERMINATION OF DOMESTIC PARTNERSHIP

Name: _____ Center Name: _____

I. REASON FOR TERMINATION:

- ☐ Relationship Dissolved
- ☐ Marriage
- ☐ No longer meet all the required criteria
- ☐ Other

II. NOTICE REQUIRED TO PARTNER AND FRANKCRUM

In accordance with the previously signed Affidavit, I acknowledge that my Domestic Partner and I each agreed to notify the other in writing if and when there was a change in our Domestic Partner status, which needed to be reported to FrankCrum. I further acknowledge that it is understood that failure to notify FrankCrum will neither prevent nor delay the termination of eligibility for benefits based on our previous enrollment under the Domestic Partner relationship.

III.REMINDERS

In the event of the termination of your Domestic Partner relationship, you may want to consider reviewing your beneficiary designations, as the completion of this form does not change your beneficiary designation for applicable benefit programs. Changes to benefit elections must be made within 60 days of completion of this form. The FrankCrum employee must take action to complete appropriate forms to make necessary benefit changes.

EMPLOYEE INFORMATION	PARTNER INFORMATION
Name (Print)	Name (Print)
Address	Address
City, State, Zip	City, State, Zip
Social Security Number	Social Security Number
Daytime Phone Number	Date of Birth
Signature Date	Signature Date

Sworn to and subscribed before me this ____ day of _____, 20 ____

Notary Public _____

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AFFIDAVIT OF TAX-QUALIFIED DEPENDENT STATUS

Name: _____ Center Name: _____

Address: _____

I. DECLARATION

We, _____ and _____ certify that we have reviewed
Print Employee Name Print Partner Name
the criteria for IRS tax-qualified dependent status and understand that all criteria must be satisfied in order to qualify for tax-qualified dependent status. Further, we acknowledge that in order to be treated as having a tax-qualified dependent status for benefits, this Affidavit must be completed and returned at the time of application for benefits. Otherwise, the benefits will be taxed in accordance with Internal Revenue Service Regulations for Domestic Partners.

The following dependents qualify as either "qualifying child" or "qualifying relative" as defined below. Please complete the dependent section indicating under which statutory definition the individual qualifies as a dependent. It must be one or the other, as an individual may never be both a "qualifying child" and a "qualifying relative."

II. DEPENDENTS

Name	SSN	Relationship	Qualifying Child	Qualifying Relative
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

III. DEFINITIONS:

Qualifying Child: Must be under age 26.

Qualifying Relative: The taxpayer (FrankCrum employee) must provide more than one-half of the individual's support for the year. A Domestic Partner must have lived with the taxpayer for the entire calendar year, and the relationship cannot be in violation of any local laws.

III. ACKNOWLEDGMENTS

1. We certify that the information we have provided on this form is true and correct. Any statements on this form that are known to be false may be cause for disciplinary action, including loss of benefits or termination of employment.
2. We understand that any person/employee/company who suffers any loss due to any false statement contained in this Affidavit may bring a civil action against either or both of us to recover their losses, including reasonable attorney's fees.
3. We have provided the information in this Affidavit for use by FrankCrum or its agent for the sole purpose of determining our eligibility for FrankCrum benefits as Domestic Partners. No other parties shall have any rights under this Affidavit.
4. We understand that we are stating that all parties listed qualify under Internal Revenue Service Regulations as dependents and that, as defined, all parties are eligible to have the premium paid by FrankCrum on behalf of the Partner and the Partner's eligible covered children (if any), as tax-free, and the portion of covered benefits paid by the employee can be processed on a pre-tax basis.
5. We acknowledge full tax liability and penalties on both employee and employer will be our responsibility for either knowingly or unknowingly misrepresenting an individual as either a "qualifying child" or "qualifying relative."
6. We affirm, under pain and penalty of perjury, that the assertions in this Affidavit are true to the best of our knowledge.
7. We acknowledge that we are required to notify FrankCrum within thirty days if any of the dependents listed herein cease to meet the criteria for tax-qualified dependents. We further acknowledge that in the event a tax-qualification ceases mid-year (dependent no longer meets the criteria but remains under the employee's coverage), the employee will be liable for imputed income beginning the first of the month following the status change and through the remainder of the coverage election period, or until the dependent again meets tax-qualified status. In the event that a tax-qualified dependent was improperly classified at the time of or after the initial enrollment period, the employee agrees to be liable for imputed income that would have resulted had the dependent been properly classified.

IV. SIGNATURE AND IMPORTANT INFORMATION

Note: You are urged to seek appropriate advice before signing this Affidavit. Please be advised that some courts have recognized non-marriage relationships as the equivalent of marriage for the purpose of establishing and dividing joint property. There may also be other implications to signing this document. Finally, you are also urged to seek independent tax advice.

EMPLOYEE INFORMATION

Name (Print)

Address

City, State, Zip

Social Security Number

Daytime Phone Number

Signature

Date Signed

PARTNER INFORMATION ☐ Male ☐ Female

Name (Print)

Address

City, State, Zip

Social Security Number

Date of Birth

Signature

Date Signed

Sworn to and subscribed before me this ____ day of _____, 20 ____

Notary Public _____

GROUP TERM LIFE INSURANCE & IMPUTED INCOME FAQS

TOTAL AMOUNT OF COVERAGE

IRC section 79 provides an exclusion for the first $50,000 of Group Term Life Insurance coverage provided under a policy carried directly or indirectly by an employer. There are no tax consequences if the total amount of such policies does not exceed $50,000. The imputed cost of coverage in excess of $50,000 must be included in income, using the IRS Premium Table, and are subject to social security and Medicare taxes.

IMPUTED INCOME FAQS

Q: What is the "Imputed Income" line on my pay stub?

A: You may see a line for "Imputed Income" in the earnings section of your pay stub if Arlington Public Schools is covering you under the Group Term Life Insurance policy (and if the coverage exceeds $50,000). Group Term Life Insurance is a taxable fringe benefit. The IRS requires that you pay tax on the value of this taxable fringe benefit when it exceeds $50,000 of value. Therefore, the line for imputed income on your pay stub is a figure that is your "taxable premium" for life insurance that is paid for any insurance over $50,000 of value. The imputed income figure is displayed only to reflect your taxable earnings. It does not affect your gross pay; it only affects your gross taxable earnings. Previously, you would see this figure only on your W-2 in box 12A Code C. You will now see this figure for each pay period on your pay stub.

How do you know the exact amount of net pay you will receive this period? Don't think of the imputed income as "real money;" think of it as the value of a benefit you are paying taxes upon. Looking at the SUMMARY section in the middle right of your pay stub, if you take the Current Period "Earnings" and subtract the Imputed Income Current Earnings figure, you will come up with true Gross Pay. Next, subtract your Current Period "Pre-Tax Deductions," "Tax Deductions" and "Other Deductions," and the result will be the actual Net Pay that you will receive. This will match the "Net Pay" you see for the Current Period in the SUMMARY section of your pay stub.

EARNINGS DESCRIPTION	
Res S Salary	1,118.14
Inputed Income	22.72
DEDUCTIONS	
FIT	296.01
SS	131.49
MEDICARE	30.75

In this example, take the "Earnings" from the Current Period Summary section (2,140.86) and subtract the Imputed Income Current Earnings (22.72). Subtract the Current Period "Pre-Tax Deductions," "Tax Deductions" and "Other Deductions" (458.25), and the result will be the actual Net Pay as you see in the "Net Pay" for the Current Period in the SUMMARY section of your pay stub (1,659.89). The amount of $1,659.89 is what you will actually receive in your bank account.

SUMMARY	CURRENT PERIOD	YTD
Earnings:	2,140.86	17,502.40
Pre-Tax Deductions:	0.00	0.00
Tax Deductions:	458.25	4,633.89
Other Deductions:	0.00	0.00
Net Pay:	1,659.89	12,868.51

Q: How do I compute my own imputed income based upon my own situation?

A: For IRS tax regulations on Group Term Life Insurance, click here. For taxable and non-taxable items, click here. Use the following worksheet to figure the amount to include in your income.

WORKSHEET 1. FIGURING THE COST OF GROUP TERM LIFE INSURANCE TO INCLUDE IN INCOME

1. Enter the total amount of your insurance coverage from your employer(s)	1. _____
2. Limit on exclusion for employer-provided group term life insurance coverage	2. 50,000
3. Subtract line 2 from line 1	3. _____
4. Divide line 3 by $1,000. Figure to the nearest tenth	4. _____
5. Go to Table 1. Using your age on the last day of the tax year, find your age group in the left column, and enter the cost from the column on the right for your age group	5. _____
6. Multiply line 4 by line 5	6. _____
7. Enter the number of full months of coverage at this cost	7. _____
8. Multiply line 6 by line 7	8. _____
9. Enter the premiums you paid per month	9. _____
10. Enter the number of months you paid the premiums	10. _____
11. Multiply line 9 by line 10.	11. _____
12. Subtract line 11 from line 8. Include this amount in your income as wages	12. _____

Q: Does the State Group Life Insurance Program affect my income tax responsibilities?

A: The State Basic Group Life Plan is a pre-tax employee benefit plan, and the premiums are not subject to federal income tax or Social Security taxes. However, some employees are subject to the imputed income provisions of Section 79 of the Internal Revenue Code. Employees have imputed income added to their regular wages for the portion of group life insurance coverage that exceeds $50,000. The imputed income is added to regular wages to determine taxable income. The amount of imputed income is determined from value tables published by the IRS based on the employee's age and cost of the coverage.

Age	Cost
Under 25	$ .05
25 - 29	.06
30 - 34	.08
35 - 39	.09
40 - 44	.10
45 - 49	.15
50 - 54	.23
55 - 59	.43
60 - 64	.66
65 - 69	1.27
70 & up	2.06

QUALIFYING EVENTS

Elections for pre-tax group health insurance are generally irrevocable for the plan year under Section 125 of the Internal Revenue Code. However, the Internal Revenue Service (IRS) provides specific instances when an employee can make mid-year election changes (or "permitted change in election events"):

- Change in marital status
- Change in number of dependents
- Change in employment
- Change in dependent eligibility due to plan requirements (e.g., loss of student status, age limit reached)
- Change in residence (e.g., employee or dependent moves out of plan service area)
- Significant cost changes in coverage
- Significant curtailment of coverage
- Addition or improvement to benefits package option
- Change in coverage of spouse or dependent under another employer plan (e.g., spouse's employer had no insurance coverage before but now offers a plan)
- Loss of certain other health coverage (e.g., plans provided by governmental or educational institutions)
- Health Insurance Portability and Accountability Act (HIPAA) special enrollment rights
- Judgments, decrees, or orders
- Entitlement to Medicare or Medicaid
- Change in hours worked to less than 30-hours per week on average if the employee and covered family members enroll in another plan providing minimum essential coverage
- Enrollment in a marketplace exchange plan during an exchange special or open enrollment period; employees and others covered must enroll in the exchange plan by the first day after coverage ends under the employer plan. See IRS Notice 2014-55 for details.

Additional Information:

- Employers do not have to allow employees to make mid-year election changes except those under the HIPAA special enrollment rights. An employer should include in the plan documents and summary plan description which events, if any, would allow for an employee to make mid-year election changes.
- If a change in status does occur, the election changes should be consistent with that event. For example, if an employee divorces, the employee may drop coverage for the spouse but not for themselves or other covered dependents.
- The amount of time an employee has to request a change to his or her group health coverage is defined by the employer's plan rules, often 30 or 60 days, and may not be too far removed to ensure the change is clearly consistent with the event.

WHAT IS HIPAA?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes provisions of Federal law governing health coverage portability, health information privacy, administrative simplification, medical savings accounts, and long-term care insurance. The responsibility of the Department of Labor and the subject of these FAQs are the law's portability and nondiscrimination requirements.

HIPAA's provisions affect group health plan coverage in the following ways:

- Provide certain individuals special enrollment rights in group health coverage when specific events occur, e.g., the birth of a child (regardless of any open season)
- Prohibit discrimination in group health plan eligibility, benefits, and premiums based on specific health factors
- While HIPAA previously provided for limits with respect to preexisting condition exclusions, new protections under the Affordable Care Act now prohibit preexisting condition exclusions for plan years beginning on or after January 1, 2014. For plan years beginning on or after January 1, 2014, plans are no longer required to issue the general notice of preexisting condition exclusion and individual notice of period of preexisting condition exclusion. Plans are also no longer required to issue certificates of creditable coverage after December 31, 2014. These amendments were made because plans are prohibited from imposing preexisting condition exclusions for plan years beginning on or after January 1, 2014.

SPECIAL ENROLLMENT

Group health plans are required to provide special enrollment periods during which individuals who previously declined health coverage for themselves and their dependents may be allowed to enroll regardless of any open enrollment period. In addition to HIPAA special enrollment rights, the Children's Health Insurance Program Reauthorization Act (CHIPRA) added additional special enrollment rights under ERISA. Rights related to CHIPRA special enrollment are discussed in this section.

Special enrollment rights can occur when:

- An individual loses eligibility for coverage under a group health plan or other health insurance coverage (such as an employee and his/her dependents' loss of coverage under the spouse's plan) or when an employer terminates contributions toward health coverage
- An individual becomes a new dependent through marriage, birth, adoption, or being placed for adoption
- An individual loses coverage under a State Children's Health Insurance Program (CHIP) or Medicaid or becomes eligible to receive premium assistance under those programs for group health plan coverage. Employees must receive a description of special enrollment rights on or before the date they are first offered the opportunity to enroll in the group health plan.
- Special enrollment due to pregnancy (State of Rhode Island residents only).

In addition, employers that maintain a group health plan in a state with a CHIP or Medicaid program that provides for premium assistance for group health plan coverage must provide a notice (referred to as the Employer CHIP Notice) to all employees to inform them of possible opportunities in the state in which they reside.

Some individuals losing coverage under an employment-based group health plan may want to consider enrolling for coverage in the Marketplace. For more information on the Marketplace, visit healthcare.gov

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QUALIFYING EVENT FORM

We must receive this form and your Enrollment/Change form(s) within 60 calendar days of the event.
IRS rules dictate that employee's enrolled in the medical, dental, vision, and flexible spending accounts cannot enroll in or change enrollment options during the plan year except during an open enrollment period or in the event of a "change in status" life event. Employees are encouraged to provide documentation prior to 60 days and, except as noted below, under no circumstance will a change be permitted to the employee's benefits during the plan year beyond 60 days of the life event.

Employee Name (please print): _____ Effective Date: _____

Employer Name: _____ Date of Qualifying Event: _____

Changes for these events are effective on the date of event:

☐ **Birth, Adoption, or Placement for Adoption** – Provide documentation of birth date or copy of the adoption agreement or pre-adoptive placement agreement.

Removal of ineligible dependents is effective the first of the month following receipt of your request:

☐ **Divorce** – Copy of final divorce decree must be attached.
Provide address of former spouse: _____

☐ **Child no longer eligible dependent:** date of 26th birthday _____
Provide child's address, if different: _____

☐ **Death** – Provide documentation of date of death.

These changes are also effective the first of the month following receipt of your request:

☐ **Marriage**
Copy of marriage certificate must be attached.

☐ **Custody or guardianship**
Attach a copy of custody order.

☐ **Change in eligibility for Medicare, Medicaid, or other government-sponsored health care***
(Retro changes are permitted.)

☐ **Change of dependent's employment status***
Benefit Eligibility Change Date: _____

☐ **Special enrollment due to pregnancy**
(State of Rhode Island resident only)

☐ **Significant change in dependent's employer-provided coverage***
(NOTE: This event is not a qualifying event for Health Care Flexible Spending Account changes)

☐ **Dependent's employer has a different Open Enrollment period and Plan Year***
Date of coverage change on Spouse's employer-provided plan: _____
(NOTE: This event is not a qualifying event for Health Care Flexible Spending Account changes)

☐ **Gain/Loss of coverage due to:**
_____

IMPORTANT – READ CAREFULLY BEFORE SIGNING.

This is to certify that I incurred the family status change checked above, and therefore, wish to change my plan benefits as indicated on the enrollment/change form(s) attached. I understand that the change requested must be consistent with the family status change event, and the effective date of the change to the coverage will be as indicated above. I further understand that documentation of status change must be received by the FrankCrum Benefits department no later than 60 days from the date of the life event.

Employee Signature: _____ Date: _____

QUALIFYING EVENTS
Additional Documentation

Qualifying Event	Documentation Needed
Change in eligibility for Medicare, Medicaid, or other government-sponsored health care	HIPAA Certificate from former plan OR Letter on prior employer's/government entities letterhead stating: • Date letter is prepared • Name of employer/government entity that provided coverage • Name of employee/dependents losing coverage • Date coverage ends • Name of prior carrier
Change of dependent's employment status	HIPAA Certificate from former plan OR Letter on employer's letterhead stating: • Date letter is prepared • Name of employee and covered dependents • Name of employer providing coverage • Date coverage ended (if adding spouse/dependents to your coverage) OR Date coverage will begin (if dropping spouse/dependents from your coverage) • Name of carrier • Employer contact name, phone number, address
Significant change in dependent's employer-provided coverage	Letter on spouse's employer's letterhead stating: • Date prepared • Name of employer providing coverage • Name of employee and covered dependents • Name of current carrier • Description of significant change in coverage • Effective date of significant change in coverage • Employer contact name, phone number, address
Dependent's Employer's Open Enrollment and Benefits Plan Year is different from FrankCrum	Letter on spouse's employer's letterhead stating: • Date letter is prepared • Name of spouse's employer • Name of spouse/dependents changing coverage • Date coverage change is effective • Employer contact name, phone number, address
Gain/Loss of Coverage	HIPAA Certificate from former plan OR Letter on prior employer's letterhead stating: • Date letter is prepared • Name of employer that provided coverage • Name of employee/dependents losing coverage • Date coverage ends • Name of prior carrier • Employer contact name, phone number, address
Special enrollment due to pregnancy (State of Rhode Island residents only)	Documentation from a medical professional confirming pregnancy

AETNA NEWBORN COVERAGE RULE

If a newborn's date of birth is anything other than the first of the month, Aetna will not begin billing until the first of the following month.

For example, the waiver period for a child born on January 20 extends to February 20. Billing for the newborn would begin on March 1.

The 30-day automatic coverage applies to the newborn whether or not they are added to the plan.

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DEPENDENT COVERAGE LAWS BY STATE

STATE	LAWS
Colorado	Colo. Rev. Stat. § 10-16-104.3 states that a child is considered a dependent for insurance purposes up to age 25 (even if they are not enrolled in an educational institution) as long as they are unmarried and are financially dependent or share the same permanent address as the insurance provider.
Connecticut	C.G.S.A. § 38a-497 requires that group comprehensive and health insurance policies extend coverage to unwed children until the age of 26 provided they remain residents of Connecticut or are full-time students.
Delaware	Del. Code Ann. Tit. 18, § 3354 requires insurance providers to cover policyholder's dependent children until age 24. Dependents must be unmarried and a resident of Delaware or, if living outside the state, a full-time student. Insurance companies may charge more for dependent coverage past age 18, but it may not exceed 102 percent of the policyholder's cost before the child turned 18.
Florida	Florida 627.6562 allows for dependent children up to 26, who live with their parent or are a student, and up to **30 years old**, who are also unmarried and have no dependent child of their own, to remain on their parents' insurance.
Georgia	Ga. Code § 33-30-4 allows dependent children up to age 25 who are enrolled as full-time students at least five months during the year or are eligible to enroll but are prevented due to illness or injury to remain on their parents' insurance. Ga. Code § 33-24-28 requires that a health services plan or health insurer exempt dependent children incapable of self-sustaining employment due to disability from dependent age limits.
Idaho	Idaho Stat. § 41-2103 allows for any unmarried dependents to remain on their parents' health insurance until age 21; any full-time, unmarried student until age 25; or a dependent with a disability without regard to age.
Illinois	215 ILCS 5/356z.12 provides parents with the option of keeping unmarried dependents on their health care insurance up to age 26. Parents with dependents who are veterans can keep them on their plans up to age 30.
Indiana	IC 27-8-5-2,28 and IC 27-13-7-3 require commercial health insurers and health maintenance organizations to cover children until age 24 or without regard to age if they are incapable of self-sustaining employment due to disability.
Iowa	Iowa Code § 509.3 and Iowa Code § 514E.7 requires that health insurance providers continue to cover unmarried children under their parents' coverage provided that the child 1) is under the age of 25 and a current resident of Iowa, 2) is a full-time student, or 3) has a disability.
Kentucky	Ky. Rev. Stat. § 304.17A-256 allows parents to keep their unmarried children on their health plans until the age of 25. Parents may have to pay extra for their adult children.
Louisiana	La. Rev. Stat. Ann. § 22:1003 allows an unmarried, dependent child to remain on parent's insurance up to age 24 if they are a full-time student.

STATE	LAWS
Maine	24-A MRSA § 2742-B requires individual and group health insurance policies to continue coverage for a dependent child up to 25 years of age if the child is dependent upon the policyholder and the child has no dependents of the his/her own.
Maryland	MD Code, Insurance § 15-418 requires that health insurance be extended to, at the request of the policyholder, unmarried dependents under the age of 25.
Massachusetts	Mass. Gen. Laws Ann. Ch. 175 § 108 allows dependents to stay on their parent's coverage for two years past the age of dependency or until age 26, whichever occurs first, or without regard to age if they are incapable of self-sustaining employment due to disability. Young adults ages 19-26 are eligible for lower-cost insurance coverage, tailored to meet their needs, offered through the Commonwealth Health Insurance Connector.
Minnesota	Minnesota Chapter 62E.02 defines "dependent" as a spouse or unmarried child under age 25, or a dependent child of any age who is disabled.
Missouri	Mo. Rev. Stat. § 354-536 defines dependent as an unmarried child up to age 26. If a health maintenance organization plan provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children, such coverage shall continue while the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the enrollee for support and maintenance.
Montana	MCA 33-22-140 provides insurance coverage under a parent's policy for unmarried children up to age 25.
Nevada	NRS 689C.055 allows an unmarried, dependent child who is a full-time student to remain on his or her parent's insurance up to age 24 if the parent is covered by a small group policy. NRS 689B.035 requires that dependents retain coverage beyond age of policy termination if they are incapable of self-sustaining employment due to disability.
New Hampshire	N.H. Rev. Stat § 420-B:8-aa defines dependent as those who are unmarried up to age 26 and either a full-time student or resident of New Hampshire for purposes of health insurance coverage. 2009 SB 115 allows those up to age 26 to buy-in to coverage through the state's CHIP program, Healthy Kids.
New Jersey	N.J.S.A. 17B:27-30.5 states that, at the option of the insured person, a dependent may be covered up to the age of 31, as long as they are unmarried and have no dependents of their own.
New Mexico	NM Stat. Ann. § 13-7-8 states that health insurance for dependents may not be terminated based on age up to age 25.
New York	N.Y. Insurance Code, sec. 3216. (2009 AB 9038) allows an unmarried adult child to remain on parent's insurance through age 29 (up to age 30) if they are a resident of New York. [link updated 4/2015]
North Dakota	N.D. Cent. Code § 26.1-36-22 allows an unmarried, dependent child to remain on parent's insurance up to age 22 if they live with parents. If they are full-time students, they can remain on parent's insurance from age 22 up to age 26.
Ohio	Ohio Rev. Code § 1751.14, as amended by 2009 OH H 1 allows an unmarried, dependent child that is an Ohio resident or a full-time student to remain on parent's insurance up to age 23, or without regard to age if they are incapable of self-sustaining employment due to disability.

STATE	LAWS
Oregon	O.R.S. § 735.720 defines dependent as an unmarried child up to 23, elderly parents and disabled adult children for the purpose of insurance coverage.
Pennsylvania	2009 SB 189 states that an unmarried child may remain on parent's insurance up to age 30 if they have no dependents and are residents of PA or are enrolled as full-time students. 51 Pa.C.S.A. § 7309 states that full-time students whose studies are interrupted by service in the reserves or the National Guard must be extended health care benefits as a dependent of their parent beyond the terminating age equal to the length of their deployment.
Rhode Island	R.I. Gen. Laws § 27-20-45 and Gen. Laws § 27-41-61 requires insurance plans which cover dependent children to cover unmarried dependent children until age 19 or, if a student, until age 25. If the dependent child is mentally or physically impaired, the plan must continue their coverage after the specified age.
South Carolina	S.C. Code Ann. § 38-71-1330 allows an unmarried, dependent child who is a full-time student to remain on parent's insurance up to age 22 if parent is covered by small group policy. S.C. Code Ann. § 38-71-350 requires that a dependent child who is not capable of self-sustaining employment be allowed to remain on his or her parent's insurance, without regard to age.
South Dakota	SD Codified Laws Ann. § 3-12A-1 states that any insurance provider offering benefits to a dependent may not terminate those benefits by reason of age before the dependent's 19th birthday. If the dependent is enrolled in an educational institution, they are not to be terminated until they reach age 24 and not terminated if unable to seek self-support due to disability. SD Codified Laws § 58-17-2.3 states that if the dependent remains a full-time student upon attaining age 24 but not exceeding age 29, the insurer shall provide for the continuation of coverage for that dependent at the insured's option.
Tennessee	Tennessee Code Ann. § 56-7-2302 allows for dependent coverage for children under their parents' health insurance plan up to age 24 provided the child is unmarried and financially dependent on the parents.
Texas	V.T.C.A. Insurance Code § 846.260 and V.T.C.A. Insurance Code § 1201.059 make dependent status available for an unmarried child up to age 25 for insurance purposes.
Utah	Utah Code Ann. tit. 31A § 22-610.5 requires that coverage for unmarried dependents continue up to age 26, regardless of whether or not the dependent is enrolled in higher education.
Virginia	Va. Code Ann. § 38.2-3525 makes dependent status available to any child up to age 19 or who is a dependent up to age 25 who resides with the parent or is a full-time student.
Washington	West's RCWA 48.44.215 states that, at the option of the insured person, an unmarried dependent may be covered up to age 25.
West Virginia	W. Va. Code § 33-16-1a defines dependent for health insurance coverage as a child or stepchild up to age 25.
Wisconsin	Wis. Stat. § 632.885 requires that coverage for unmarried dependents through a parent's insurance be offered up to age 27 if they are not offered insurance through an employer. Full-time students called to active duty in the armed forces can be covered beyond age 26 depending on various factors.
Wyoming	Wyo. Stat. § 26-19-302 states that if child is unmarried and a full-time student, they can remain on parent's insurance up to age 23 if the parent is covered by a small group policy.

COVERAGE BEYOND THE FEDERAL ACA | 2016 UPDATE

Six states, including Florida, Illinois, New Jersey, Pennsylvania, South Dakota, and Wisconsin, have enacted laws that require or authorize carriers to cover young adults beyond age 26. New York and Ohio previously enacted such laws. However, those provisions are no longer in effect.

STATE	REQUIRED COVERAGE AGE CUT-OFF	CITATION
Florida	30 (must be unmarried and have no dependents of their own)	West's F.S.A. § 627.6562
Illinois	30 (applies to veterans only)	215 ILCS 5/356z.12
New Jersey	31	N.J.S.A. 17B:27-30.5
New York	29* (unmarried and not eligible for employer-based insurance)	McKinney's Insurance Law § 3216
Pennsylvania	30	40 P.S. § 752.1
South Dakota	29*	SDCL § 58-17-2.3
Wisconsin	Full-time students, regardless of age	Wis. Stat. § 632.885

WHO PAYS?

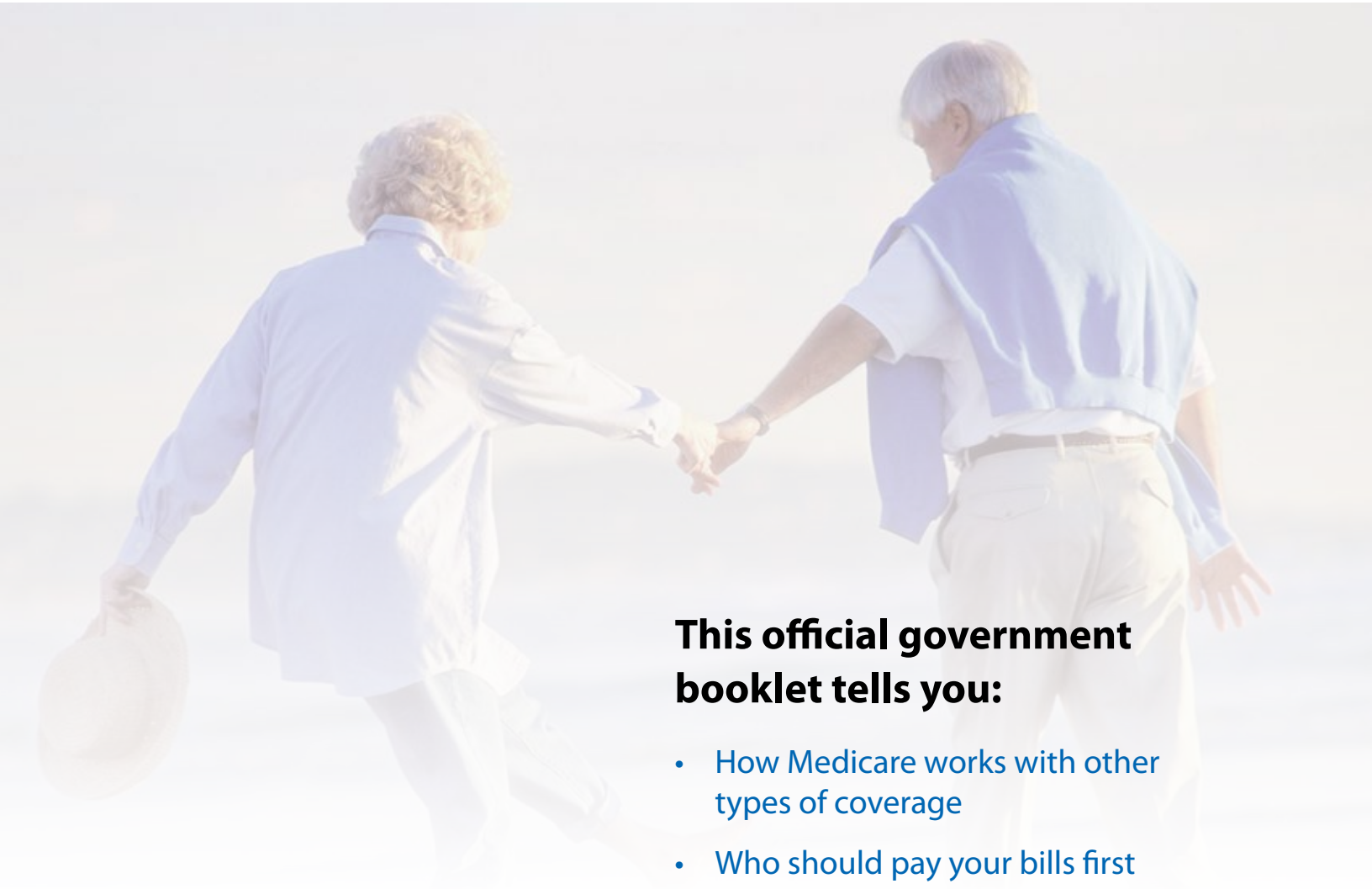
The cost of notifying families about new enrollment opportunities is shared between insurance providers and employers. The cost of covering the young adults who take advantage of the extension is shared between employers and the families of newly covered young adults. For families with no employer health coverage, the cost may fall on the parents. Those families that qualify for States, as sponsors of coverage plans for state employees, also share the costs with families. A qualified young adult cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage due to the loss of dependent status.

IRS Notice 2010-38 provides guidance to extend the general exclusion from gross income for the reimbursements for medical care under an employer-provided accident or health plan to any employee's child who has not yet attained age 27 as of the end of the taxable year, making the benefit tax-free.

Medicare & Other Health Benefits:

Your Guide to
Who Pays First

CENTERS FOR MEDICARE & MEDICAID SERVICES



This official government booklet tells you:

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

The information in this booklet describes the Medicare Program at the time this booklet was printed. Changes may occur after printing. Visit Medicare.gov, or call 1-800-MEDICARE to get the most current information.

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

SECTION

1

When you have other health coverage

Coordination of benefits

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

Whether Medicare pays first depends on a number of things, including the situations listed in the chart on the next 3 pages. However, this chart doesn't cover every situation. Be sure to tell your doctor and other providers if you have health coverage in addition to Medicare. This will help them send your bills to the correct payer to avoid delays.

Where to go with questions

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

The BCRC is the contractor that acts on behalf of Medicare to collect and manage information on other types of insurance or coverage that a person with Medicare may have, and determines whether the coverage pays before or after Medicare. This contractor also acts on behalf of Medicare to get repayment when Medicare makes a conditional payment, and another payer is determined to be primary.

When you call the BCRC, have your Medicare Number ready—you can find it on your red, white, and blue Medicare card. The BCRC may also ask for information like your Social Security Number (SSN), your address, the date you were first eligible for Medicare, and whether you have Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance).

How Medicare works with other coverage–find your situation

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

I've got Medicaid (page 11)

Medicare pays first, and Medicaid pays second.

I'm 65 or older and have group health plan coverage based on my own current employment status or the current employment status of my spouse (pages 11–13).

- If the employer has 20 or more employees, then the group health plan pays first, and Medicare pays second.
- If the employer has less than 20 employees and isn't part of a multi-employer or multiple employer group health plan (see page 18), then Medicare pays first, and the group health plan pays second. See page 13.

I'm in a Health Maintenance Organization (HMO) Plan or Preferred Provider Organization (PPO) Plan through my employer and get services outside the employer plan's network (page 16)

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

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

If your spouse's employer has 20 or more employees, your spouse's plan pays first and Medicare pays second.

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

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

I'm under 65, disabled, retired and have group health plan coverage based on my family member's current employer (page 18)

- If the employer has 100 or more employees, then the large group health plan pays first, and Medicare pays second. See page 13.

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

I'm under 65, disabled, retired and have group health plan coverage based on my family member's current employer (page 18) (continued)

- If the employer has less than 100 employees, and isn't part of a multi-employer or multiple employer group health plan (see page 18), then Medicare pays first, and the group health plan pays second. If the employer is part of a multi-employer or multiple employer group health plan, the group health plan pays first and Medicare pays second.

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

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

I have group health plan coverage, I first got Medicare due to turning 65 or because of a disability (other than ESRD), and now I have ESRD. Who pays first? (Page 19)

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

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

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

When you're eligible for or entitled to Medicare due to ESRD, during a coordination period of up to 30 months, COBRA pays first. Medicare pays second, to the extent COBRA coverage overlaps the first 30 months of Medicare eligibility or entitlement based on ESRD.

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

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

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

I've been in an accident where no-fault or liability insurance is involved (pages 19–21)

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

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

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

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

Generally, Medicare and VA can't pay for the same service or items. Medicare pays for Medicare-covered services or items. Veterans' Affairs pays for VA-authorized services or items.

I'm covered under TRICARE (page 27)

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

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

I'm covered under TRICARE (page 27) (continued)

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

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

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

I have COBRA continuation coverage (page 29)

- If you have Medicare because you're 65 or over or because you have a disability other than End-Stage Renal Disease (ESRD), Medicare pays first.
- If you have Medicare based on ESRD, COBRA pays first. Medicare pays second to the extent COBRA coverage overlaps the first 30 months of Medicare eligibility or entitlement based on ESRD.

How will Medicare know I have other coverage?

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

You can also report your coverage information by calling the Benefits Coordination & Recovery Center (BCRC) toll-free at 1-855-798-2627. TTY users can call 1-855-797-2627.

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

What happens if my health coverage changes?

Insurers must report these changes to Medicare, but the changes can take some time to be posted to Medicare's records.

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

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

Tell your doctor and other health care providers about changes in your coverage when you get care. Also, contact your health plan to make sure they reported these changes to Medicare. Medicare uses your answers to help keep your file correct so your claims get paid correctly.

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

Check your insurance policy—it may include the rules about who pays first. You can also call the BCRC.

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

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

On the other hand, if you don't yet have Medicare but have coverage through the Marketplace, you can choose to keep your Marketplace plan after your Medicare coverage starts. But once your Medicare Part A coverage starts and you've been getting premium tax credits or other savings on a Marketplace plan, these savings will end. If you keep your Marketplace plan, you would have to pay full price. For this reason, in most cases you'll want to end your Marketplace coverage once you're eligible for Medicare. If you age into Medicare and decide to keep your Marketplace plan, then Medicare pays first.

SECTION

2 Medicare & other types of health coverage

The situations on pages 6–8 can help you find your type(s) of coverage and situation to see which payer pays first.

This section provides detailed information on how Medicare works with your other health coverage.

Medicare & Medicaid

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

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

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

If you have Medicare and you're offered coverage under a group health plan, you can choose to accept or reject the plan. The group health plan may be a fee-for-service plan or a managed care plan, like an HMO or PPO.

Medicare & group health plan coverage (continued)

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

If your or your spouse's employer has 20 or more employees, the group health plan pays first and Medicare pays second.

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

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

   Note: For this situation, "spouse" includes both opposite-sex and same-sex marriages where 1) you're entitled to Medicare as a spouse based on Social Security's rules; and 2) the marriage was legally entered into in a U. S. jurisdiction that recognizes the marriage—including one of the 50 states, the District of Columbia, or a U.S. territory—or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction.

   An employer, insurer, third party administrator, group health plan, or other plan sponsor may choose to have a more inclusive definition of spouse than described above. Under these circumstances, the plan **may** pay, but isn't required to pay, first for someone it considers a spouse under its definition. Contact your employer or insurer if you have a question about their definition of "spouse" and how claims will be paid.

2. The employer has 20 or more employees and covers any of the same services as Medicare (this means the group health plan pays first on your hospital and medical bills).

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

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

Medicare & group health plan coverage (continued)

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

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

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

However, your plan may ask for an "exception" and request not to be part of a multi-employer group health plan. Check with your plan first and ask whether it will pay first or second for your claims.

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

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

Medicare & group health plan coverage (continued)

If I don't accept coverage from my employer, how will this affect what Medicare will pay?

Medicare pays its share for any Medicare-covered health care service you get, even if you don't take group health plan coverage from your employer, and you don't have coverage through an employed spouse.

What happens if I drop coverage from my employer?

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

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

Medicare & group health plan coverage after you retire

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

It depends on the terms of your specific plan. Your employer or union or your spouse's employer or union might not offer any health coverage after you retire. If you can get group health plan coverage after you retire, it might have different rules and might not work the same way with Medicare.

Can I continue my employer coverage after I retire?

When you have retiree coverage from an employer or union, it manages this coverage. Employers aren't required to provide retiree coverage, and they can change benefits or premiums, or even cancel coverage (a premium is the periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage).

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

What are the price and benefits of the retiree coverage, and does it include coverage for my spouse?

Your employer or union may offer retiree coverage that limits how much it will pay. It might only provide "stop loss" coverage, which starts paying your out-of-pocket costs only when you reach a certain maximum amount of coverage.

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

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

What effect will my continued coverage as a retiree have on both my health coverage and my spouse's health coverage?

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

How does retiree coverage compare with a Medigap policy?

Medigap is optional insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage. Since Medicare pays first after you retire, your retiree coverage is likely to be similar to coverage under a Medigap policy. Sometimes retiree coverage includes extra benefits, like coverage for extra days in the hospital.

Retiree coverage isn't the same thing as a Medigap policy but, like a Medigap policy, it usually offers benefits that fill in some of Medicare's gaps in coverage, like coinsurance and deductibles. (Coinsurance is an amount you may be required to pay as your share of the cost for services, after you pay any deductibles. It's usually a percentage—for example, 20%. A deductible is the amount you must pay for health care or prescriptions, before Original Medicare, your prescription drug plan, or your other insurance begins to pay.)

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

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

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

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 may pay based on what the group health plan paid, what the group health plan allowed, and what the doctor or health care provider charged on the claim. You may have to pay any costs Medicare or the group health plan doesn't cover.

I'm under 65, disabled, retired and I have group health plan coverage from my former employer.

If you get group health plan coverage through your own former employer and you're not currently employed:

- Medicare pays first for your health care bills.
- Your group health plan (retiree) coverage pays second.

I'm under 65, disabled, retired and I have group health plan coverage from my family member's current employer.

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

- You retire but your spouse is still working, and
- You're covered by your spouse's group health plan coverage, and
- Your spouse's employer has 100 or more employees, or the employer employs less than 100 employees but is part of a multi-employer plan or multiple employer plan (see page 18).

Medicare & Medigap

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

The best time is during your 6-month Medigap Open Enrollment Period, because you can buy any Medigap policy sold in your state, even if you have health problems. This period automatically starts the month you're 65 **and** enrolled in Part B, and once it's over, you can't get it again.

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

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

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

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

If your former employer goes bankrupt or out of business, federal COBRA rules may protect you if any other company within the same corporate organization still offers a group health plan to its employees. That plan is required to offer you COBRA continuation coverage. See pages 26–27. If you can't get COBRA continuation coverage, you may have the right to buy a Medigap policy even if you're no longer in your Medigap Open Enrollment Period

Medicare & group health plan coverage for people who are disabled (non-ESRD disability)

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

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

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

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

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

However, your plan may ask for an "exception" and request not to be part of a multi-employer group health plan. Check with your plan first and ask whether it will pay first or second for your claims.

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

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

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

When you're eligible for Medicare due to End-Stage Renal Disease (ESRD), permanent kidney failure requiring dialysis or a kidney transplant, the group health plan pays first and Medicare pays second on your hospital and medical bills during a coordination period of up to 30 months, regardless of how many employees the employer has or whether you're currently employed or retired. This is also true in dual entitlement situations—like if you were previously entitled to Medicare on the basis of age or disability and Medicare wasn't the first payer for you, and now you've become eligible or entitled to Medicare on the basis of ESRD.

If you're eligible for Medicare only because of ESRD, the coordination period begins when you become eligible for Medicare. Medicare pays second during this period even if your employer's plan says its policy is to pay second to Medicare, or otherwise rejects or limits its payments to people with Medicare. During the 30-month coordination period, your plan is billed first for services you get as a person with Medicare due to ESRD.

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

Medicare & Indian Health Services (IHS)

Medicare pays first for your health care bills, before the IHS. However, if you have a group health plan through an employer, and the employer has 20 or more employees, then generally the plan pays first and Medicare pays second. If your employer has less than 20 employees, Medicare generally pays first and the plan pays second. If you have a group health plan through tribal self-insurance, Medicare generally pays first and the plan pays second.

Medicare & no-fault or liability insurance

What's no-fault insurance?

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

- Automobile
- Homeowners'
- Commercial insurance plans

Medicare & no-fault or liability insurance (continued)

What's liability insurance?

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

Some types of liability insurance include:

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

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

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

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

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

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

Medicare & no-fault or liability insurance (continued)

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

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

What's a conditional payment?

A conditional payment is a payment Medicare makes for services another 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.

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

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

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

Medicare & no-fault or liability insurance (continued)

How does Medicare get repaid for the conditional payment?

If you file a no-fault insurance or liability insurance claim, you or your representative should call the Benefits Coordination & Recovery Center (BCRC) toll-free at 1-855-798-2627. TTY users can call 1-855-797-2627. The BCRC will set up and work on your recovery case, using information from you or your representative.

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

Where can I get more information?

If you have questions about a no-fault or liability insurance claim, call the insurance company. If you have questions about who pays first, call the BCRC.

Medicare & workers' compensation

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

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

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

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

If you have Medicare and get injured on the job, workers' compensation pays first on health care items or services you got because of your work-related illness or injury. There can be a delay between when a bill is filed for the work-related illness or injury and when the state workers' compensation insurance decides if they should pay the bill. Medicare can't pay for items or services that workers' compensation will pay for promptly (generally within 120 days).

Medicare & workers' compensation (continued)

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

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

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

What if workers' compensation denies payment?

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

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

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

In some cases, workers' compensation insurance may not pay your entire bill. If you had an injury or illness before you started your job (called a "pre-existing condition"), and the job made it worse, workers' compensation may not pay your whole bill because the job didn't cause the original problem. In this case, workers' compensation insurance may agree to pay only a part of your doctor or hospital bills. You and workers' compensation insurance may agree to share the cost of your bill. If Medicare covers the treatment for your pre-existing condition, then Medicare may pay its share for part of the doctor or hospital bills that workers' compensation doesn't cover.

Medicare & workers' compensation (continued)

How does Medicare get repaid for the conditional payment?

If Medicare makes a conditional payment, and you or your lawyer haven't reported your worker's compensation claim to Medicare, call the Benefits Coordination & Recovery Center (BCRC) toll-free at 1-855-798-2627. TTY users can call 1-855-797-2627. The BCRC will work on your case using information from you or your representative, to see that Medicare gets repaid for the conditional payments.

The BCRC will gather information about any conditional payments Medicare made relating to your workers' compensation claim. If you get a settlement, judgment, award, or other payment, you or your lawyer should call the BCRC. The BCRC will calculate the repayment amount (if any) on your case and issue a letter requesting repayment.

You or your lawyer should contact the BCRC if you have a pending claim for workers' compensation benefits and then contact the BCRC again if your claim is settled, abandoned or dismissed.

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

If you settle your workers' compensation claim and have money in a Worker's Compensation Medicare Set-aside Arrangement, you must use the settlement money to pay for related medical care before Medicare will begin again to pay for related care. In many cases, the workers' compensation agency contacts Medicare before a settlement is reached to ask Medicare to approve an amount to be set aside to pay for future medical care. Medicare will look at certain medical documentation and approve an amount of money from the settlement that must be used up first before Medicare starts to pay for related care that's otherwise covered and reimbursable by Medicare.

You and the workers' compensation agency aren't required to set up a WCMSA—it's completely voluntary. However, if you set up a WCMSA, you must make sure the settlement money is used only for related medical care.

If you prefer to request approval of a proposed WCMSA amount yourself or if you'd like more information about WCMSAs, visit go.cms.gov/wcmsa.

Medicare & workers' compensation (continued)

What if I have a Medicare-approved WCMSA amount? How am I allowed to use the money if I manage the account myself?

Keep these in mind if you manage your WCMSA account:

- Money placed in your WCMSA is for paying future medical expenses, including prescription drug expenses related to your work injury or illness/disease that otherwise would've been paid by Medicare.

  You should also use WCMSA funds to pay for these medical services and items, as well as prescription drug expenses, if you're enrolled in a Medicare Advantage Plan (Part C), a type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits (most Medicare Advantage Plans also offer prescription drug coverage).

  Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare.
- You can't use the WCMSA to pay for any other work injury, or any medical items or services that Medicare doesn't cover (like dental services).
- Medicare won't pay for any medical expenses related to the injury until after you've used all of your set-aside money appropriately.
- If you aren't sure what type of services Medicare covers, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227) for more information, before you use any of the money that was placed in your WCMSA account. TTY users can call 1-877-486-2048.
- Keep records of your workers' compensation-related medical expenses, including prescription drug expenses. These records show what items and services you got and how much money you spent on your work-related injury, illness, or disease. You need these records to prove you used your WCMSA money to pay your workers' compensation-related medical expenses, including prescription drug expenses.
- After you use all of your WCMSA money appropriately, Medicare can start paying for Medicare-covered and otherwise reimbursable items and services related to your workers' compensation claim.

To find out how to manage (self-administer) your WCMSA, visit go.cms.gov/WCMSASelfAdm.

Medicare & Veterans' benefits

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

If you have or can get both Medicare and Veterans' benefits, you can get treatment under either program. 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. Also, Medicare is never the secondary payer after the Department of Veterans Affairs (VA).

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

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

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

Example: Bob, a Veteran, goes to a non-VA hospital for a service authorized by the VA. While at the non-VA hospital, Bob gets other non-VA authorized services that the VA won't pay for. Some of these services are Medicare-covered services. Medicare may pay for some of the non-VA authorized services that Bob got.
Bob will have to pay for services that Medicare or the VA doesn't cover.

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

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

Where can I get more information on Veterans' benefits?

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

Medicare & TRICARE

What's TRICARE?

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

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

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

Can I have both Medicare and TRICARE?

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

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

I have Medicare and TRICARE. Who pays first?

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

Who pays if I get services from a military hospital?

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

Where can I get more information?

- Visit Tricare.mil/tfl.
- Call the health benefits advisor at a military hospital or clinic.
- Call TRICARE For Life at 1-866-773-0404.

Medicare & the Federal Black Lung Benefits Program

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

The Federal Black Lung Benefits Program pays first for any health care for black lung disease covered under that program. Medicare won't pay for doctor or hospital services covered under the Federal Black Lung Benefits Program. Your doctor or other health care provider should send all bills for the diagnosis or treatment of black lung disease to:

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

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

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

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

Where can I get more information?

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

Medicare & COBRA

What's COBRA?

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

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

Medicare & COBRA (continued)

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

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

It can be a very complicated decision to decide if and when you should elect COBRA coverage. When you lose employer coverage and you have Medicare, you need to be aware of your COBRA election period, your Part B enrollment period, and your Medigap Open Enrollment Period. These may all have different deadlines that overlap, so be aware that what you decide about one type of coverage (COBRA, Part B, and Medigap) might cause you to lose rights under one of the other types of coverage.

Where can I get more information about COBRA?

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

CMS Accessible Communications

To help ensure people with disabilities have an equal opportunity to participate in our services, activities, programs, and other benefits, we provide communications in accessible formats. The Centers for Medicare & Medicaid Services (CMS) provides free auxiliary aids and services, including information in accessible formats like Braille, large print, data/audio files, relay services and TTY communications. If you request information in an accessible format from CMS, you won't be disadvantaged by any additional time necessary to provide it. This means you'll get extra time to take any action if there's a delay in fulfilling your request.

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

1. **Call us:**
   For Medicare: 1-800-MEDICARE (1-800-633-4227)
   TTY: 1-877-486-2048
2. **Email us:** altformatrequest@cms.hhs.gov
3. **Send us a fax:** 1-844-530-3676
4. **Send us a letter:**

   Centers for Medicare & Medicaid Services Offices of Hearings and Inquiries (OHI)

   7500 Security Boulevard, Mail Stop S1-13-25

   Baltimore, MD 21244-1850

   Attn: Customer Accessibility Resource Staff

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

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

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

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

1. **Online:**
   hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.
2. **By phone:**
   Call 1-800-368-1019. TDD user can call 1-800-537-7697.
3. **In writing:** Send information about your complaint to:

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

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

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

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