FEHB

Federal Employees
Health Benefits

# The Federal Employees Health Benefits Program and Medicare

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

OPM

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

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

### What Are the New Provisions of Medicare?

The Balanced Budget Act of 1997 (P.L. 105-33) expanded Medicare's health plan options with the creation of Medicare+Choice. Beginning in 1999, Medicare beneficiaries may remain in Original Medicare or choose to get their Medicare benefits from an array of Medicare+Choice managed care plan options. Depending on where you live, your options may include Medicare managed care plans such as Medicare Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs). Future Medicare+Choice options can include private fee-for-service plans (PFFS) and Medical Savings Accounts (MSAs).

Medicare beneficiaries received information about these new choices this fall in *Medicare & You 2000*, a reference handbook. Medicare's web site **(www.medicare.gov)** also has information on Medicare+Choice. You should contact your retirement system before making any change to your coverage, especially if you are considering suspending your FEHB coverage to enroll in a Medicare managed care plan. If you are a CSRS or FERS annuitant, you may call OPM's Retirement Information Office at 1-88USOPMRET (1-888-767-6738) or 202-606-0500 from the metropolitan Washington area, or you may write to:

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

## What Does Medicare Cover?

Original Medicare has two parts:

**Part A (Hospital Insurance) helps pay for:**

- inpatient hospital care
- skilled nursing facility care
- home health care
- hospice care

**Part B (Medical Insurance) helps pay for:**

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

**Medicare does not cover:**

- your monthly Part B premium ($54.00 in 2002)
- deductibles, coinsurance or copayments when you get health care services
- outpatient prescription drugs (with only a few exceptions)
- routine or yearly physical exams
- custodial care (help with bathing, dressing, toileting, and eating) at home or in a nursing home
- most dental care and dentures
- routine foot care
- hearing aids
- routine eye care
- health care you get while traveling outside of the United States (except under limited circumstances)
- cosmetic surgery
- some vaccinations
- orthopedic shoes

## Am I Eligible for Medicare?

You are eligible for Medicare if you are age 65 or over. Also, certain younger disabled persons and persons with permanent kidney failure (or End Stage Renal Disease) are eligible.

You are entitled to Part A without having to pay premiums if you or your spouse worked for at least 10 years in Medicare-covered employment. (You automatically qualify if you were a Federal employee on January 1, 1983.) If you don't qualify for premium-free Part A, and you are age 65 or older, you may be able to buy it; contact the Social Security Administration.

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

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

Generally, plans under the FEHB Program help pay for the same kind of expenses as Medicare. FEHB plans also provide coverage for prescription drugs, routine physicals, emergency care outside of the United States and some preventive services that Medicare doesn't cover. Some FEHB plans also provide coverage for dental and vision care.

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

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

If you can get Part A premium-free, you should take it, even if you are still working. This will help cover some of the costs that your FEHB plan may not cover, such as deductibles, coinsurance, and charges that exceed the plan's allowable charges. There are other advantages to enrolling in Part A, such as being eligible to enroll in a Medicare managed care plan.

## Do I Have to Take Part B Coverage?

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

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

## How Much Does Part B Coverage Cost?

The monthly premium for Part B coverage is $54.00.

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

You must wait for the general enrollment period (January 1-March 31 of each year) to enroll, and Part B coverage will begin the following July 1. Your Part B premiums will go up 10 percent for each 12 months that you could have had Part B but didn't take it.

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

## Does the FEHB Program Offer Medigap Policies?

FEHB is not one of the 10 standardized Medicare supplemental insurance policies - known as Medigap (and Medicare SELECT) policies. However, FEHB plans and options will supplement Medicare by paying for costs not covered by Medicare, such as the required deductibles and coinsurance, and by providing additional benefits not provided under Medicare, such as prescription drugs, routine physicals and additional preventive care.

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

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

## Does My FEHB Plan or Medicare Pay Benefits First?

Medicare law and regulations determine whether Medicare or FEHB is primary (pays benefits first).

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

## When is My FEHB Plan the Primary Payer?

Your FEHB Plan must pay benefits first when you are an active Federal employee or reemployed annuitant and either you or your covered spouse have Medicare, unless your reemployment position is excluded from FEHB coverage or you are enrolled in Medicare Part B only.

Your FEHB Plan must also pay benefits first for you or a covered family member during the first 30 months of eligibility or entitlement to Part A benefits because of End Stage Renal Disease (ESRD), regardless of your employment status.

**When is Medicare the Primary Payer?**

Medicare must pay benefits first when you are an annuitant, and either you or your covered spouse have Medicare. This includes when you or your covered spouse are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C.

Medicare must pay benefits first when you are receiving Workers' Compensation and the Office of Workers' Compensation has determined that you're unable to return to duty.

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

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

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

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

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

**Do My FEHB Premiums Change When Medicare Becomes Primary?**

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

| Medicare & FEHB Primary Payer Chart | |
|---|---|
| **When Either You or Your Covered Spouse are Age 65 or Over, Have Medicare and FEHB, and You are:** | **The Primary Payer is:** |
| An active employee with Federal government (including when you or a family member are eligible for Medicare solely because of a disability). | FEHB |
| An annuitant | Medicare |
| A reemployed annuitant with Federal government | FEHB, if position not excluded from FEHB (ask your employing office) |
| A Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (Or your covered spouse is this type of judge.) | Medicare |
| Enrolled in Part B only, regardless of your employment status | Medicare, for Part B services |
| A former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation has determined that you are unable to return to duty | Medicare, except for claims related to the Workers' Compensation injury or illness |
| **When You or a Covered Family Member Have Medicare Based on End Stage Renal Disease (ESRD) and FEHB, and:** | **The Primary Payer is:** |
| Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD | FEHB |
| Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD | Medicare |
| Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision | Medicare |
| **When You or a Covered Family Member have FEHB and:** | **The Primary Payer is:** |
| Are eligible for Medicare based on disability | Medicare, if you are an annuitant.<br>FEHB, if you are an active employee |

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

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

**Should I Change Plans?**

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

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

Not always. A managed fee-for-service plan's payment is typically based on reasonable and customary charges, not on billed charges. In some cases, Medicare's payment and the plan's payment combined will not cover the full cost.

Your out-of-pocket costs for Part B services will depend on whether your doctor accepts Medicare assignment. When your doctor accepts assignment, you can be billed only for the difference between the Medicare-approved amount and the combined payments made by Medicare and your FEHB plan.

When your doctor doesn't accept assignment, you can be billed up to 115 percent of the Medicare-approved amount (the "limiting charge") when your FEHB plan's payment and Medicare's payment don't cover the full cost.

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

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

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

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

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

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

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

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

**I Want to Join a Medicare Managed Care Plan. Should I Drop My FEHB Coverage?**

When you enroll in a Medicare managed care plan, you may not need FEHB coverage because the Medicare managed care plan provides you with many of the same benefits. You should review their benefits carefully before making a decision. You should contact your retirement system to discuss suspension and reenrollment.

**Can I Reenroll in FEHB If I Disenroll From the Medicare Managed Care Plan?**

If you provide documentation to your retirement system that you are suspending your FEHB coverage to enroll in a Medicare managed care plan, you may reenroll in FEHB if you later lose or cancel your Medicare managed care plan coverage.

If you voluntarily cancel your Medicare managed care plan coverage, you must wait until the next open season to reenroll in FEHB. If you involuntarily lose your coverage under the Medicare managed care plan, you don't have to wait until the open season to reenroll in FEHB. You may reenroll from 31 days before to 60 days after you lose the Medicare managed care plan coverage, and your reenrollment in FEHB will be made effective the day after the Medicare managed care plan coverage ends. An involuntary loss of coverage includes when the Medicare managed care plan is discontinued or when you move outside its service area.

## How Can I Get More Information About Medicare?

During the fall of each year, you will receive a copy of the *Medicare & You* handbook, which is also available by calling 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048. Other useful publications, such as the *Guide to Health Insurance for People with Medicare,* are also available from this toll-free number or from your State Health Insurance Assistance Program (SHIP) counseling office. You can find SHIP counseling office telephone numbers in the *Medicare & You* handbook. Medicare information and publications are also available on the Internet at **www.medicare.gov**. If you do not have a personal computer, your local library or senior center may be able to help you access this web site.

Your FEHB plan brochure provides specific information on how its benefits are coordinated with Medicare. Some HMOs participating in the FEHB will coordinate to your greater advantage if you enroll in both their FEHB HMO and their Medicare managed care plan.

## Terms Used in This Booklet

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

**Health Maintenance Organization (HMO)**

A type of health benefits plan that provides care through a network of doctors and hospitals in particular geographic or service areas. HMOs coordinate the health care services you receive. Your eligibility to enroll in an HMO is determined by where you live or, for some plans, where you work. Some FEHB HMOs have agreements with providers in other service areas for non-emergency care if you travel or are away from home for lengthy periods.

**Inpatient Care**

All types of health services that require an overnight hospital stay.

**Managed Fee-For-Service Plan**

A traditional type of insurance that lets you use any doctor or hospital, but you usually must pay a deductible and coinsurance or copayment. These plans are called fee-for-service because doctors and other providers are paid for each service, such as an office visit or test. They help control costs by managing some aspects of patient care. Most FEHB managed fee-for-service plans also provide access to preferred provider organizations (PPOs).

**Medicare**

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

**Medicare-Approved Amount**

The amount Medicare determines to be reasonable for a service that is covered under Part B of Medicare. It may be less than the actual charge.

**Medicare+Choice**

A new Medicare program that provides more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (ESRD).

**Medicare Managed Care Plan**

An HMO that contracts with Medicare to enroll Medicare beneficiaries. Services must be obtained from the HMO's network of doctors and hospitals to receive full plan benefits. The HMO may charge a monthly premium and require copayments.

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|---|---|
| **Medigap** | A supplemental private insurance policy that you can buy for extra benefits either not covered or not fully covered by Medicare. There are 10 standard Medigap plans, ranging from a basic benefits package to ones that cover expenses such as the Part A deductible, Part B deductible, prescription drugs, and/or the skilled nursing coinsurance. |
| **Original Medicare** | The traditional fee-for-service arrangement that covers Part A and Part B services. |
| **Out-of-Pocket Costs** | Health care costs that you must pay because they are not covered by insurance, such as deductibles, coinsurance, copayments, and noncovered expenses. |
| **Outpatient Care** | All types of health services that do not require an overnight hospital stay. |
| **Preferred Provider Organization (PPO)** | A fee-for-service option where you can choose plan-selected providers who have agreements with the plan. When you use a PPO provider, you pay less money out-of-pocket for medical services than when you use a non-PPO provider. |
| **Premium** | The amount you pay monthly or biweekly for insurance. |
| **Preventive Care** | Care to keep you healthy or to prevent illness, such as routine checkups and flu shots, and some tests like colorectal cancer screening and mammograms. |
| **Primary Payer** | When coordinating benefits, the health plan that pays benefits first on a claim for medical care. |
| **Referral** | Your primary care doctor's written approval for you to see a certain specialist or to receive certain services. Most FEHB HMOs and some Medicare health plans may require referrals. **Important:** If you either see a different doctor from the one on the referral, or if you see a doctor without a referral and the service isn't for an emergency or urgently needed care, you may have to pay the entire bill. |

**Secondary Payer**

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

**Service Area**

The geographic area where a health plan accepts members. For plans that make you use their doctors and hospitals, it is also the area where services are given.

**Suspension of FEHB Enrollment**

When you notify your retirement system that you are giving up your FEHB coverage to enroll in a Medicare managed care plan, but still retain the right to reenroll in FEHB if your enrollment in the Medicare managed care plan ends. Otherwise, if you cancel your FEHB coverage as an annuitant, you probably may never reenroll.