Your Guide To The Disability Process

Patient Advocate Foundation

Solving Insurance and Healthcare Access Problems | since 1996

The Patient Advocate Foundation is a national non-profit organization that serves as an active liaison between the patient and their insurer, employer and/or creditors to resolve insurance, job retention, and/or debt crisis matters relative to their diagnosis through case managers and attorneys. Patient Advocate Foundation seeks to safeguard patients through effective mediation assuring access to care, maintenance of employment and preservation of their financial stability.

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Your Guide To The Disability Process

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Centers for Medicare and Medicaid, *"Medicare and Other Health Benefits: Your Guide to Who Pays First"*; ***www.cms.gov and www.medicare.gov***
The Patient Advocate Foundation's *"National Financial Resource Guide"*; *"The Managed Care Answer Guide, Second Edition 2004"*; *"Your Guide to the Appeals Process"*; *"Greater Understanding Brochure Series"*; ***www.patientadvocate.org***

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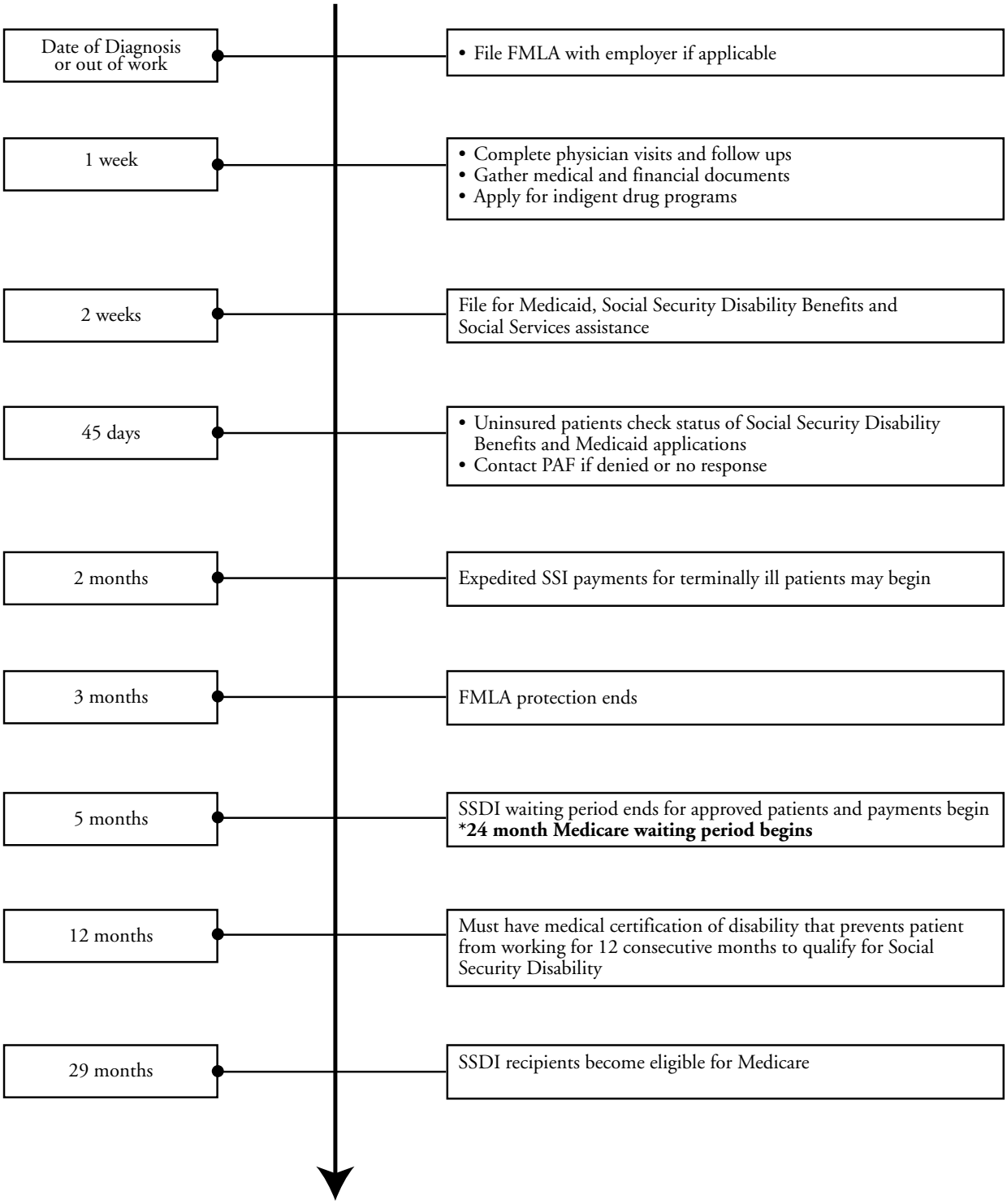

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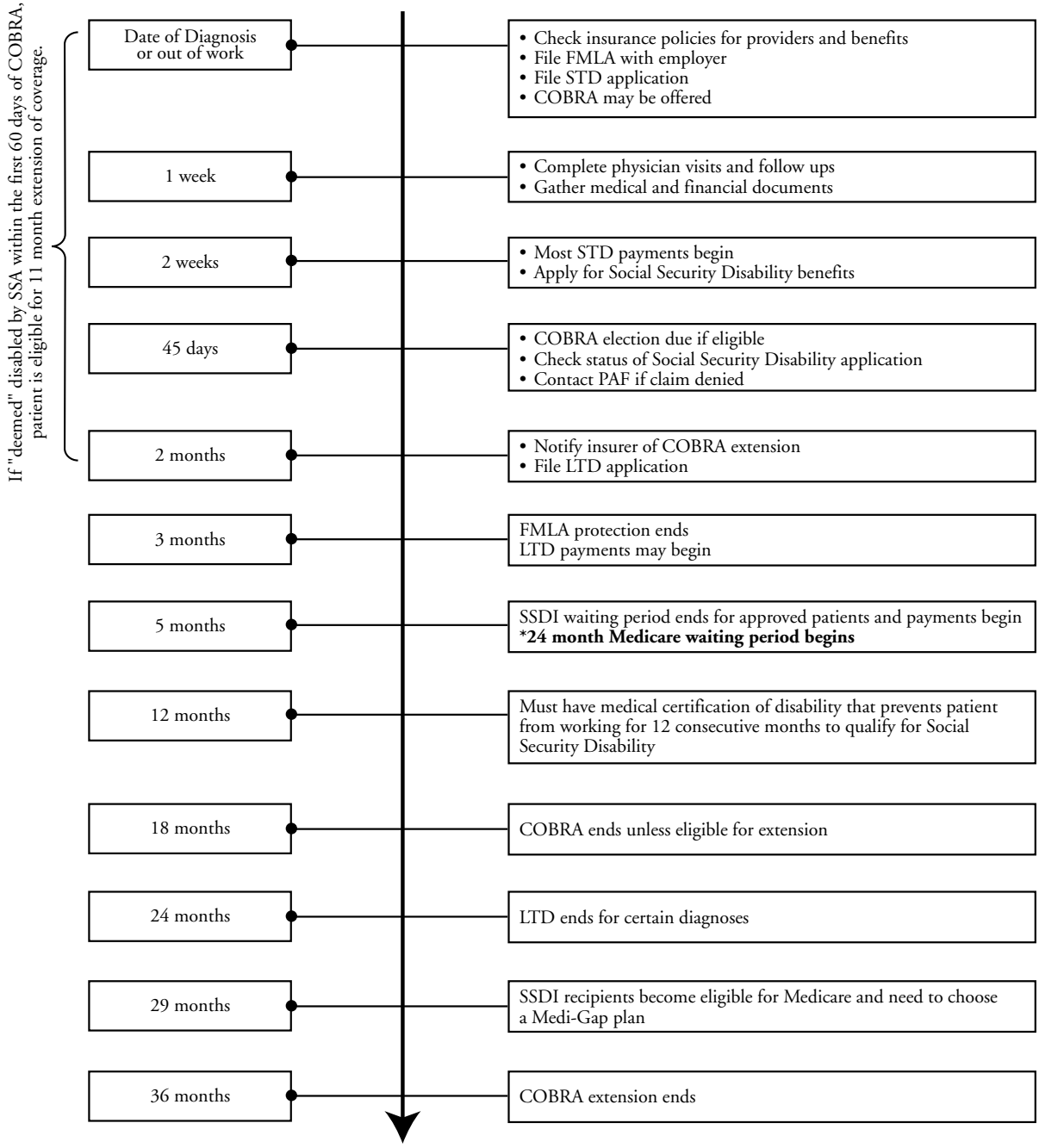

INTRODUCTION

This guide was written in response to the many issues that have been identified by the Patient Advocate Foundation, as they have assisted patients who were faced with disabilities and subsequent access difficulties. Many of those patients would have benefited from the information contained in a comprehensive guide to navigating the overwhelming process of filing for Disability benefits. Whether you are filing a claim through an insurance policy or through the Social Security Administration, the process is rife with red tape and confusion. PAF feels that the more information you have, the more capable you will be to make decisions that can ultimately impact your long-term insurability and financial stability. It is our hope that Your Guide to the Disability Process will provide you with the necessary tools to anticipate the steps you need to take to make your disability claim problem free.

There are five chapters in ***Your Guide to the Disability Process***:

Chapter 1 – Short Term and Long Term Disability
This chapter describes the differences between Short Term and Long Term policies and how to understand how they work and what you need to do maximize your benefits.

Chapter 2 – Social Security Disability
This chapter describes the Social Security Disability process and the difference between the programs offered by Social Security. Tips on filing and what you need to do are included.

Chapter 3 – Health Insurance Issues Before and After Medicare
This chapter explains Medicare and Medicaid eligibility issues disabled patients often have. It also contains guidance for disabled patients enrolled in group health insurance programs.

Chapter 4 – Appeals Process
This chapter addresses the process through which you can file an appeal should your claim be denied.

Chapter 5 – Financial Resources
This chapter lists resources that can assist disabled patients with health care alternatives and financial assistance.

CHAPTER 1
SHORT TERM AND LONG TERM DISABILITY

Many working adults are enrolled in programs or have insurance policies that protect their income in the event a disease or medical condition prevents them from engaging in gainful employment. Disability insurance can be obtained through an employer group program or purchased as an individual policy.

DISTINCTION BETWEEN INDIVIDUAL AND GROUP POLICIES

Disability insurance is intended to replace income lost due to a medical disability. This coverage may be purchased by individuals on their own "individual policy," or provided as a benefit by employers at no or low cost to employees "group policy." Income replacement benefits paid under a group policy are taxable. Benefits paid under an individual policy are not taxable, under the rationale that the policy premiums were totally paid with after-tax dollars. Adequate income protection should include both an STD and LTD policy. Your STD policy should match the length of the LTD waiting period to ensure there is no lapse in coverage.

Every plan is different. Policy language governs.
Read your contract.

SHORT TERM DISABILITY (STD)

Group Plans

A typical group policy will pay short term disability benefits for 90-180 days. Sometimes these benefits are funded and administered by an insurer and sometimes funded by the employer and administered by a third party administrator. The employer is usually very involved with the short term disability claim.

The plan usually will pay 60-100% of pre-disability income, depending on the policy. A cap on benefits is common – for example, a plan may pay 60% of salary up to a maximum salary of $50,000.00 per year, or may declare a maximum benefit of $500.00 per week. Certain conditions may be excluded from coverage, or coverage may be limited – for example, a disability that is the result of a pre-existing condition may not be covered until the employee has been covered by the plan for 12-24 months. Disability resulting from elective surgery is a common exclusion.

STD plans are usually more lenient than LTD plans in the type of medical documentation that needs to be submitted to support the claim, since the length of the claim is limited to 90-180 days. **It is almost always necessary for the employee to be under the care of a doctor who will provide satisfactory evidence of disability.** Policy language usually states that an employee may receive STD benefits if medically unable to perform his or her usual job.

Income from other sources usually offsets STD benefits – for example, workers' compensation wage loss benefits. Since workers' compensation pays 66% of pre-disability earnings, no STD benefits may be payable.

Individual Plans

Short term disability policies are not typically purchased on an individual basis. Individuals instead purchase long term disability insurance through an insurance company and the individual deals directly with the insurance company.

LONG TERM DISABILITY (LTD)

Group Plans

Large employers may self-insure and self-administer these plans, but it is much more common for an insurer to be the sole administrator of the claim, and for the requirements for proof of disability to be more stringent. For this reason, it is not unusual for an employee to receive STD benefits for the maximum period and then be abruptly denied LTD benefits. Patients **must** apply for their LTD benefits. STD benefits do not automatically roll-over into LTD benefits.

Most group LTD plans pay 60-80% of pre-disability earnings for a specified period of years or until age 65. **In order to qualify for benefits detailed medical information must be provided to the LTD carrier at the onset of the claim and periodically throughout the life of the claim as requested. Failure to do so results in denial or termination of benefits.**

Usually there is a 60-180 day elimination or waiting period following the onset of disability to qualify for benefits. STD policies are usually written to provide benefits during the waiting period of an LTD policy. It is a good idea to have both an STD and LTD policy. Your STD policy should be for the same length of time that your LTD policy elimination or waiting period is. Check your policies to ensure that when the STD plan benefits end that the LTD benefits would begin.

Certain conditions may be excluded or limited as discussed above in the STD section. Often the policy will limit coverage for so-called "mental-nervous" conditions to a maximum or 24 months. Policy language governs and there is much variation from plan to plan.

Most policies have two definitions of disability –**"Own Occupation" and "Any Occupation."** During the **"Own Occupation" period**, benefits are payable if the employee is unable to perform his or her regular job or a similar job. The Own Occupation period is at the beginning of the claim and is usually two years in length. After that, benefits are payable only if the employee is unable to perform any occupation.

During the **"Any Occupation" period**, benefits are only payable if an employee is unable to perform any occupation for which he or she is or becomes reasonably fitted by education, training or experience. Some policies state that if the employee is unable to perform work that pays at least 60-80% of pre -disability earnings, the person will be considered disabled, while others do not take earning potential into account. Income from other sources offsets LTD benefits. For this reason, most LTD carriers require claimants to file for **Social Security Disability** as soon as possible. Often the LTD carrier will pay attorney's fees for the employee who is represented by an attorney at the hearing level.

Some LTD carriers assign rehabilitation professionals to try to help the employee transition back to work. Failure to cooperate with rehabilitation usually results in termination of benefits. Some carriers will continue to pay full or partial LTD benefits for a specified period of time while the employee is returning to work.

Individual Policies

Individual LTD policies are available from insurance carriers and can be tailored to the individual's needs. The benefits payable are generally a percentage of pre-disability earnings as evidenced by income tax returns. Premiums and coverages vary greatly, depending on the age, health and usual occupation of the individual. The same general principles are applied for the policies as outlined above.

APPEALS

It is important to consult the plan summary or policy to determine how to appeal a denied claim and to file appeals in a timely manner. Most policies do make allowances for late appeals if an individual is incapacitated or is otherwise unable to file an appeal. Please refer to Chapter 4 of this publication for guidance on filing an appeal if your claim is denied.

STATE SPONSORED DISABILITY PROGRAMS

There are some states that offer state sponsored disability income protection for state residents. These programs are state-mandated and funded through employee payroll deductions. They provide short-term wage-replacement benefits to eligible workers who experience a loss in wages when they are unable to work for a **NON-WORK RELATED** illness, injury or medically disabling condition. Residents of states that offer these programs should contact their State Department of Labor or Employment for more information.

CHAPTER 2
SOCIAL SECURITY DISABILITY

How does the Social Security Administration (SSA) Define Disability?

According to the Social Security Act, the definition of disability is the "inability to engage in any substantial or gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 month" *(www.ssa.gov).*

Social Security Disability Insurance (SSDI)

SSDI is a federal disability insurance program designed for individuals who have worked enough to earn sufficient "work credits." Under this program, monthly payments are based on the individual's earning record, which is on file with the Social Security Administration. SSDI provides monthly cash benefits and Medicare entitlement to those who are blind or disabled.

SSDI benefits can be paid retroactive back to the original date of a disability, if a claim was filed at that time. If you do not have enough work credits to qualify for SSDI then you maybe eligible for SSI.

Supplemental Security Income (SSI)

SSI is federal financial assistance program which provides monthly payments to individuals who either never worked or have insufficient credits on their earnings record to qualify for SSDI. SSI recipients are typically required to have limited financial resources and assets that do not exceed $2,000 for one person and $3,000 for a couple. In 2004, the basic SSI benefit program will pay according to Federal Poverty Guidelines which are re-calculated each fiscal year.

These programs are administered by the Social Security Administration and the disability criteria are the same for both. In order to qualify for SSI or SSDI, an individual must have impairment or a combination of impairments that preclude substantial gainful work activity that is expected to last **continuous period of 12 months or longer or that is expected to result in death.**

Each individual who applies for SSDI is also screened for SSI benefits. **SSI payments may be available during the usual 5-month waiting period before SSDI cash benefits begin.** Benefits become payable the month after the application is filed regardless of when the disability began. There is no retroactive benefit under SSI. Those eligible for SSI may also be automatically eligible for Medicaid benefits. For those who receive SSDI approval, they will begin receiving monthly cash benefits after **five full months of waiting.**

The SSA can make a determination of "presumptive disability" for SSI benefits. **Presumptive Disability** allows SSA to pay up to six months of SSI payments before they make their disability determination, based on the finding that there is a high probability that the applicant is disabled. SSA does not provide for presumptive payments to individuals applying for SSDI benefits *(www.alsa-stl.org).*

The SSA has an expedited procedure for processing terminally ill cases to ensure that a favorable decision can be made expeditiously. The code word for this type of case is "**TERI**" case. This type of case needs to be flagged or noted some way by the claim representative so that the case can move expeditiously to the Disability Determination Section (DDS). There is no cash benefits paid to the family if the claimant expires during the waiting period or while a disability decision is being established. The individual's medical records or pathology report must reflect that the claimant is terminally ill or about to expire in six months or less ***(www.alsa.stl.org).***

THE DISABILITY PROCESS

Most Social Security disability claims are initially processed through a network of local Social Security Administration (SSA) field offices and State agencies called **Disability Determination Services (DDS)**. The field offices obtain applications for disability benefits in person, by telephone, by mail or by filing online. The application and related forms ask for a description of the claimant's impairment(s), treatment sources and other information related to alleged disability. The field office is responsible for verifying non-medical eligibility requirements, which may include age, employment, marital status or Social Security coverage information. The field office then sends the case to the **DDS** for evaluation of disability.

The DDS office is fully funded by the Federal Government, but the State agency is responsible for developing medical evidence criteria and rendering the initial determination as to whether or not a claimant is disabled or blind under the law ***(www.ssa.gov/disability/determination.htm).***

Usually, the DDS tries to obtain evidence from the claimant's own medical source first. If that evidence is unavailable or insufficient to make a determination, the DDS will arrange for a Consultative Examination (CE) to obtain additional information needed. After, all the medical evidence is compiled, the **Adjudicator/Claims Examiner** is the person that makes the disability decision, and he/she determines if the claimant will be approved or denied. Then, the DDS returns the case to the field office for appropriate action. If the DDS found the claimant to be disabled, SSA computes the benefit amount and will began paying cash benefits to the claimant.

DDS takes into account the age, education and work experience of the claimant in addition to the medical records and the residual functional capacity to determine whether the claimant is "disabled" under the SSA's rules.

It is much more likely that a claimant over age 55 will be approved for SSDI/SSI because it is assumed that a claimant over age 55 cannot adjust or be retrained to a completely different line of work.

HOW DO YOU FILE YOUR DISABILITY CLAIM?

If you become disabled, you should file for disability benefits right away. You can do this by calling or visiting your local Social Security office. There are federal government listings in your local phone book or you can call a toll free number from any where in the United States by calling **1-800-772-1213** or if you have access to the internet by visiting Social Security Online at ***www.ssa.gov***.

You can shorten the time it takes to process your claim if you have the following medical vocational information when you apply:

- Medical records from your doctors, therapists, hospitals, clinics, and caseworkers
- Your laboratory and test results
- The names, addresses, phone and fax numbers of your doctors, clinics and hospitals
- The names of all medications you are taking
- The names of your employers and job duties for the last 15 years
- Submit a copy of your most recent tax return along with a recent pay check stub
- A letter from your attending physician that includes this phrase as written: "...will be unable to work for 12 months or longer"

Be aware that many disability applications, up to 60% of all filed, are denied the first time. Do not give up! You have the right to appeal this denial and can do so very effectively with the proper medical documentation(s) such as: physician's notes, history and physicals, consultations, MRI's, cat scans and pathology reports. Include other pertinent information that would indicate a decline in your condition as well as any side effects to medications (memory loss, fatigue, nausea, etc.). Do not file a new application after a denial, appeal the original decision.

THE APPEALS PROCESS

If you wish to appeal, you must make your request **in writing within 60 days** from the date you receive your SSA denial letter. Please refer to *Chapter 4 - The Appeals Process* for more information.

CHAPTER 3
HEALTH INSURANCE ISSUES BEFORE AND AFTER MEDICARE

Once you are approved for SSDI, it is very important that you consider your health insurance options carefully before and after becoming eligible for Medicare. Once you have been receiving SSDI payments for 24 months you will become eligible for Medicare.

WHAT ARE MY HEALTH INSURANCE OPTIONS BEFORE I AM ELIGIBLE FOR MEDICARE?

FAMILY MEDICAL LEAVE ACT (FMLA)

FMLA entitles eligible employees to take up to 12 weeks of unpaid, job-protected leave in a 12-month period for specified family and medical reasons. The employer may elect to use the calendar year, a fixed 12-month leave or fiscal year, or a 12-month period prior to or after the commencement of leave as the 12-month period. For more information on this Federal Law visit the Department of Labor website at ***www.dol.gov***.

FMLA applies to all:

- Public agencies, including state, local and federal employers, local education agencies (schools)
- Private-sector employers who employed 50 or more employees in 20 or more workweeks in the current or preceding calendar

To be eligible for FMLA benefits, an employee **must**:

- work for a covered employer
- have worked for the employer for a total of 12 months
- have worked at least 1,250 hours over the previous 12 months
- work at a location in the United States or in any territory or possession of the United States where at least 50 employees are employed by the employer within 75 miles

A covered employer must grant an eligible employee up to a total of 12 work weeks of **unpaid** leave during any 12-month period for one or more of the following reasons:

- For the birth and care of the newborn child of the employee
- For placement with the employee of a son or daughter for adoption or foster care
- To care for an immediate family member (spouse, child, or parent) with a serious health condition
- To take medical leave when the employee is unable to work because of a serious health condition

Under some circumstances, employees may take FMLA leave intermittently — which means taking leave in blocks of time, or by reducing their normal weekly or daily work schedule. Also, subject to certain conditions, employees **or** employers may choose to use accrued **paid** leave (such as sick or vacation leave) to cover some or all of the FMLA leave.

The employer is responsible for designating if an employee's use of paid leave counts as FMLA leave, based on information from the employee.

A covered employer is required to maintain group health insurance coverage for an employee on FMLA leave whenever such insurance was provided before the leave was taken and on the same terms as if the employee had continued to work. If applicable, arrangements will need to be made for employees to pay their share of health insurance premiums while on leave.

Upon return from FMLA leave, an employee must be restored to the employee's original job, or to an equivalent job with equivalent pay, benefits and other terms and conditions of employment. Employees seeking to use FMLA leave are required to provide 30-day advance notice of the need to take FMLA leave when the need is foreseeable and such notice is practicable.

Employers may also require employees to provide:

- Medical certification supporting the need for leave due to a serious health condition affecting the employee or an immediate family member
- Second or third medical opinions (at the employer's expense) and periodic recertification
- Periodic reports during FMLA leave regarding the employee's status and intent to return to work

When intermittent leave is needed to care for an immediate family member or the employee's own illness, and is for planned medical treatment, the employee must try to schedule treatment so as not to unduly disrupt the employer's operation. Covered employers must post a notice approved by the Secretary of Labor explaining rights.

It is unlawful for any employer to interfere with, restrain or deny the exercise of any right provided by FMLA. It is also unlawful for an employer to discharge or discriminate against any individual for opposing any practice, or because of involvement in any proceeding, related to FMLA.

(*Compliance Guide to the Family and Medical Leave Act,* U.S. Department of Labor Employment Standards Administration Wage and Hour Division, WH Publication 1421, December 1996)

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) contains provisions giving certain former employees, retirees, spouses, former spouses and dependent children the right to temporary continuation of health coverage at group rates. Group health coverage is usually more expensive than health coverage for active employees, since usually the employer pays a part of the premium for active employees while COBRA participants generally pay the entire premium themselves. It is ordinarily less expensive than individual health coverage.

Who is entitled to benefits under COBRA?

There are three elements to qualifying for COBRA benefits. COBRA establishes specific criteria for plans, qualified beneficiaries and qualifying events.

Plan Coverage

Group health plans for employers with 20 or more employees on more than 50 percent of its typical business days in the previous calendar year are subject to COBRA. Both full and part-time employees are counted to determine whether a plan is subject to COBRA.

Qualified Beneficiaries

A qualified beneficiary generally is an individual covered by a group health plan on the day before a qualifying event who is an employee, the employee's spouse or an employee's dependent child. In certain cases, a retired employee, the retired employee's spouse and the retired employee's dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary. Agents, independent contractors and directors who participate in the group health plan may also be qualified beneficiaries.

Qualifying Events

Qualifying events are certain events that would cause an individual to lose health coverage. The following are defined as "qualifying events:"

- Voluntary or involuntary termination of employment for reasons other than "gross misconduct"
- Reduction in the number of hours of employment

The qualifying events for **spouses** are:

- Voluntary or involuntary termination of employment for reasons other than "gross misconduct"
- Reduction in the hours of employment worked by the covered employee
- Divorce or legal separation of the covered employee
- Death of the covered employee

The qualifying events for **dependent children** are the same as for the spouse with one addition:

- Loss of "dependent child" status under the plan rules

(*U.S. Department of Labor, Pension and Welfare Benefits Administration,* ***www.dol.gov.pwba***, "Frequently Asked Questions")

Special rules for disabled individuals and certain family members may extend the maximum periods of coverage. If a qualified beneficiary is determined to be disabled under the Social Security Act within the first 60 days of COBRA coverage, then the qualified beneficiary and all of the qualified beneficiaries in his or her family may be able to extend COBRA coverage for an additional 11 months. However, you may lose all rights to the additional COBRA coverage, if the Notice of the Determination is not provided to the COBRA carrier within 60 days of the date of the determination and before the expiration of the 18 month COBRA period. The qualified beneficiary who is disabled or any qualified beneficiaries in his or her family may notify the plan administrator of the Social Security Determination (*US Department of Labor Pension and Welfare Benefits Administration " COBRA"* pages 13-14).

SPOUSE'S POLICY

If you are married at the time you become disabled and your spouse has an employer group health policy, you maybe eligible to elect coverage under your spouse's policy. You will not be subjected to a pre- existing condition clause, as long as you sign up for your spouse's policy within 63 days of losing your coverage.

RISK POOL COVERAGE

Some states offer Risk Pool coverage which provides health insurance options for high risk individuals. These are state programs that serve people who have pre-existing health conditions, and often are denied or find it difficult to obtain affordable coverage in the private market. Contact your State Insurance Commissioner for further information.

VETERANS OR FORMER MILITARY SERVICE PERSONNEL

The Veteran's Administration (VA) may be able to help you with your medical expenses. The VA provides hospital care covering a full range of medical services. Outpatient treatment is available for all service connected conditions, or a non-service connected conditions in some cases. Questions regarding health care benefits should be directed to 1-800-733-8387 (*HHA-SSA Publication* No. 05-10029).

MEDICAID

If you become disabled and cannot afford health insurance, you may be eligible for Medicaid. Medicaid is state administrated health insurance program for those people who cannot afford to pay for some or all of their medical bills.

What are the requirements for getting Medicaid?

To get Medicaid due to disability you must be disabled and meet state income and resource standards and certain other requirements. In addition you must be a resident of the state, and be a citizen or a qualified immigrant. Legal immigrants can also qualify under certain circumstances depending on their date of entry into the country. Illegal aliens cannot qualify, except for emergency care (***www.cms.gov*** "Medicaid FAQ").

How do I apply for Medicaid?

To find contact information about Medicaid in your state, contact your local Department of Social Services or visit ***http://www.cms.hhs.gov/medicaid/statemap.asp*** and select your state.

What does Medicaid cover?

Medicaid is a state administered program. Each state sets its own guidelines subject to federal rules and guidelines. Certain services must be covered by the states in order to receive federal funds. Other services are optional and are elected by the states (***www.cms.gov*** "Welcome to Medicaid Site for Consumer Information").

If you are in need of assistance with daily activities such as bathing, dressing, light housekeeping, transferring, etc., contact social services to request a community based care screening. If approved, you may be able to get an aide in your home to assist you with your daily needs. Depending on what is offered in your state, community based care participation might also include incontinence supplies, transportation and medications. Check with your local Medicaid office for state specific information.

How much money can you make and still get Medicaid?

It varies depending on the eligibility group you fall into. Each state sets an income limit for each Medicaid eligibility group and determines what income counts towards that limit. You will need to contact your local Medicaid office or your state to find out what the income limits are and how much of your income counts.

Keep in mind that you may lose your Medicaid upon receipt of your first disability check. The amount of your disability may put you over the income guidelines. Check with your caseworker to see if a spend-down program is available. A spend-down will allow you to keep your Medicaid benefits, but you will have to pay a determined dollar amount in medical expenses, determined by your caseworker, for your medical care.

MEDICAID versus MEDICARE

You may think that Medicaid and Medicare are two different names for the same program. Actually, they are two different programs. Medicaid is a state-run program designed primarily to help those with low income and little or no resources. The federal government helps pay for Medicaid, but each state has its own rules about who is eligible and what is covered under Medicaid. Some people qualify for both Medicare and Medicaid (*SOCIAL SECURITY- "Medicare",* page 4-5, SSA Publication No 05-10043 March 2001).

WHAT ARE MY HEALTH INSURANCE OPTIONS AFTER I AM ELIGIBLE FOR MEDICARE?

WHAT IS MEDICARE?

Medicare is our national health insurance program for people with disabilities, people of any age who have permanent kidney failure, amyotrophic lateral sclerosis (ALS/Lou Gehrig's Disease) and people who are 65 or older. It provides basic protection against the cost of health care, but it does not cover all medical expenses or the cost of most long-term care. Medicare has two Parts: **Medical Insurance, Part A** which helps pay for care in a hospital and skilled nursing facility, home health care and hospice care; and **Medical insurance, Part B** which helps pay for doctors, out-patient hospital care and other medical services (SOCIAL SECURITY – *"Medicare"*, page 4, SSA Publication No 05-10043 March 2001).

Depending on where you live you may be able to get your health care coverage in several ways. Medicare offers the following types of Medicare health plans:

The Traditional Plan is a "fee for service" plan. You are charged a fee for each health care service or supply you get. This plan managed by the Federal Government, is available nationwide. You will stay in the Traditional Plan unless you choose to join a Medicare + Choice Plan. Many people in the Traditional Medicare Plan also buy a Medigap (Medicare Supplement Insurance) policy to help pay health care costs that this plan does not cover.

Medicare + Choice Plans provide care under contract to Medicare. There are two types of Medicare + Choice Plans. They are available in many parts of the country. Medicare + Choice Plans include Medicare Managed Care Plans (like HMOs and PPOs) and Medicare Private Fee-for-Service Plans. To inquire about changes in your Medicare coverage contact your nearest Social Security office.

(CMS Choosing a Medigap Policy 2003 Guide to Health Insurance for People with Medicare)
S*OCIAL SECURITY DISABILITY BENEFITS, SOCIAL SECURITY ADMINISTRATION PUBLICATION NO. 05-10029* (2/2003 PAGES 11-12)

When am I eligible for Medicare?

For those who receive SSDI approval they will begin receiving monthly payments only after **five full months of disability** and will be entitled to Medicare coverage **24 months after the entitlement date**, which is the date that a person becomes eligible for payments. Please recognize that it actually takes **29** months from your disablement date until you are eligible for Medicare coverage, not 24 months which is a common point of confusion for recipients.

The Centers for Medicare and Medicaid, CMS, is the agency in charge of the Medicare program. However, the Social Security offices actually enroll you in the program and provide general Medicare information (*SOCIAL SECURITY- "Medicare"*, page 4, SSA Publication No 05-10043 March 2001).

How much does Medicare cost?

If you are under 65 and have been receiving Social Security disability benefits for 24 months, you are eligible for premium-free Medicare hospital insurance Part A. Anyone who is eligible for free Medicare hospital insurance Part A, can enroll in Medicare medical insurance Part B by paying a monthly premium. In addition to the monthly premiums you pay, there are other "out of pocket" costs for Medicare. These are the amounts you pay when you actually received medical services, known as "deductibles" and "co-insurance." For example, if you are hospitalized you will be required to pay a deductible amount, and may have to pay co-insurance amounts, depending on how long you stay. If you receive medical services from a doctor, you pay a yearly deductible amount as well as a co-insurance amount for each visit. The monthly premiums, deductibles and co-insurance for Medicare change each year. You can find out the current amount of these Medicare charges by contacting your local Social Security office or calling Social Security's toll-free number (*SOCIAL SECURITY- "Medicare"*, page 5-7, SSA Publication No 05-10043 March 2001).

Help for some low-income Medicare beneficiaries

If you cannot afford to pay your Medicare premiums and other costs, you may be able to get help from your state. You may qualify for a Medicare assistance program as a "Qualified Medicare Beneficiary" (QMB), "Specified Low-Income Medicare Beneficiary" (SLMB) or "Qualifying Individual" (QI). These programs are for certain people who are entitled to Medicare and have low income. They may pay some or all of Medicare's premiums and may also pay Medicare deductibles and co-insurance. Only your state can decide if you qualify for help under one of these programs. To find out if you qualify, contact your state or local medical assistance (Medicaid) agency, social service or welfare office (*SOCIAL SECURITY- "Medicare"*, page 8, SSA Publication No 05-10043 March 2001).

Options for Medicare eligible persons with access to Employer Group Health Plans (EGHP)

If you are disabled, eligible for Medicare and are insured through your spouse's employment, you may have several choices as to health coverage:

- You may opt for both the employer group health plan and Medicare
- You may opt for Medicare only and decline the employer group health plan
- You may opt for the employer group health plan and decline Medicare Part B, (remember Medicare Part A is provided automatically).

Each of these options has different consequences which should be considered carefully before deciding which option to choose.

A person may decide to have both the EGHP and Medicare. This will usually give a person dual coverage for many types of services, expand the scope of types of medical care, services and items that may be covered and may provide extra flexibility in obtaining covered health care. Both the EGHP and Medicare should be analyzed to determine if there is additional benefit to having both sets of coverage. For further assistance with these issues contact your State Health Insurance Assistance Program by calling **1-800-Medicare** or visit them online at ***www.medicare.gov***.

What is Medicare Supplemental Insurance or a Medigap Policy?

A Medigap policy s a health insurance policy sold by private insurance companies to fill the "gaps" in a Traditional Medicare Plan. There are ten standardized Medigap plans called "A" through "J." Each plan A through J has a different set of benefits. Plan A only covers the basic benefits, while Plan J offers the most benefits (***www.cms.gov*** "Choosing a Medigap Policy 2003 Guide to Health Insurance for People with Medicare").

When am I eligible to purchase Medicare Supplemental Insurance?

Generally, the only time that an insurance company is required to sell a Medicare supplemental policy without medical underwriting, is within the first six months that a person begins coverage Medicare Part B. After this six-month period, companies usually refuse to sell Medigap policies to people who are disabled. After the first six months of starting Medicare Part B, the next opportunity a disabled person has to purchase a Medigap policy may not be until age 65.

For further assistance with these issues contact your State Health Insurance Assistance Program by calling **1-800-Medicare** or go to ***www.medicare.gov***.

FOR FURTHER INFORMATION REGARDING WHO PAYS FIRST IF YOU HAVE OTHER HEALTH INSURANCE OR COVERAGE, PLEASE SEE THE TABLE IN APPENDIX A.

CHAPTER 4
THE APPEALS PROCESS

Whether a patient is enrolled in an insurance program, applying for benefits with a Social Services program or have filed for Social Security Disability benefits, there is always a possibility that your application will be denied. If you do not agree with the denial you have received, you will need to appeal the decision. To begin the appeal process, you must first inquire what the process is within the program you have applied to. No one organization, program or policy will require the same procedures. For assistance please refer to the Patient Advocate Foundation publication *"Your Guide to the Appeals Process"* available online at ***www.patientadvocate.org*** or by contacting the Patient Advocate Foundation for individualized assistance by a patient liaison representative.

The following information will be necessary to file your appeal, especially to have the denial reversed:

- An appeal letter from the patient stating why you feel the decision is incorrect
- A copy of your denial
- A letter from your attending physician supporting your claim of disability
- Medical documentation to support your diagnosis, course of treatment and disability

INSURANCE POLICY APPEALS

All insurance policies are different and unique. It is important to consult the plan summary or policy to determine how to appeal a denied claim and where to file appeals in a timely manner. Most disability policies do make allowances for late appeals if an individual is incapacitated or is otherwise unable to file an appeal.

SOCIAL SECURITY APPEALS

If you wish to appeal, you must make your request **in writing within 60 days** from the date you receive your SSA denial letter. There are four levels of appeal, and they are:

- Reconsideration
- Hearing by an administrative law judge
- Review by the Appeals Council
- Federal court review

Reconsideration:

The **reconsideration** process occurs when the claimant appeals the initial denial. DDS reviews the previously considered information along with any new information that becomes available. The majority of these appeals are denied unless new materials or medical evidence is documented in the medical records by your treating physician. A written decision is issued with instructions on how to appeal if the claim is denied. **Again, an appeal must be filed within 60 days of receipt of the denial.**

Hearing:

If you disagree with the reconsideration decision, you may ask for a hearing. The hearing will be conducted by an **Administrative Law Judge** (**ALJ**). The **ALJ** conducts an informal hearing and has a chance to see the claimant in person. The **ALJ** takes a fresh look at all of the evidence and issues an independent decision based on the merit of the claim. It is helpful for the claimant to have an attorney

assisting them when they are at the hearing level. If the **ALJ** denies, the claimant can start the whole process over by filing a "new" claim for Social Security Disability benefits, which may be filed while an appeal is pending at the Appeals Council.

Appeals Council Review:

Appeals Council Review most often occurs when the claimant appeals an unfavorable decision by the ALJ. The Appeals Council may take no action on the case, affirm the ALJ's decision, reverse the ALJ's decision or remand the case back to the ALJ with specific instructions on how to proceed. Currently, there is a 24 months backlog at the Appeals Council.

Federal Court:

If you disagree with the Appeals Council's decision or if the Appeals Council decides not to review your case, you may file a lawsuit in a federal district court that can take up to three years to resolve a case at this level. An appeal may be made all the way to the United States Supreme Court.

MEDICARE APPEALS

Medicare beneficiaries must call the number on their Medicare Summary Notice or 1-800-Medicare. You will need to know the reason the claim is denied to know how to appeal. Patients are encouraged to contact their State Health Insurance Assistance Program or the Patient Advocate Foundation for assistance with Medicare claims denials.

MEDICAID APPEALS

Each state handles appeals for Medicaid benefits differently. If you have been denied Medicaid coverage or any Social Services benefits, you must contact the department where you initially filed your application. Your caseworker or other staff member can provide you with the contact information for the Appeals Department. Keep in mind that there is a short time limit after your application is denied to file an appeal, you must act quickly. If you do not have the necessary documents available, file your appeal and submit additional documentation at a later date. Patients that need assistance with Medicaid appeals are encouraged to contact the Patient Advocate Foundation for assistance.

CHAPTER 5
FINANCIAL ASSISTANCE

Financial instability leads to stress, which can affect your health as well as your mental well-being. When a person becomes disabled, they are faced with so many uncertainties in regards to their future. Without the knowledge of what resources may be available, the thought of the long road ahead can oftentimes be unbearable. This publication has been designed to provide you with the necessary information to provide a smoother transition from being in a work environment into an unplanned retirement or extended period of disability. Any incident, inquiry or issue may vary according to the specific and unique circumstances surrounding each individual patient.

You have been diagnosed with an illness that is going to, or already has, interrupted your ability to work, provide for yourself and your family and robbed you of your independence. You are now going to be faced with issues that you never thought you would have to face. Patients can deplete an entire life's savings in a short amount of time. What will you do? How will you keep your home? How will you buy food, pay your utilities and other bills? Will you be left with no income for a period of time? How can you access the benefits that you may be entitled to? Are you uninsured and do not know how you are going to even afford your treatment?

Through research conducted by the Patient Advocate Foundation's Patient Services Department, we have identified resources that may be helpful to you. Having knowledge of the disability process will empower you as a patient and hopefully leave you feeling less overwhelmed. Patient Advocate Foundation hopes to assist you with avoiding a financial crisis by giving you the resources and information to plan ahead. If you have any questions that are not answered in this guide, please contact Patient Advocate Foundation at **1-800-532-5274**.

ARE YOU UNINSURED?

How can you get the care you need?

If you are in need of medical care, but do not have insurance, don't panic. There are facilities that offer charity care and/or financial assistance programs. You will have to find a hospital/provider that offers such assistance, by calling and speaking with a social worker, patient advocate or financial counselor. Ask for an application for charity care/financial assistance. The determination will be based on the area they assist individuals in, your income/assets and household size. Each facility will have their own specific eligibility requirements for charity care, but these are the main demographics that will be evaluated. Some may offer 100% charity care and others might use a sliding fee scale based on your income.

When applying for charity care, keep in mind that any hospital charges will be covered, but there will be providers that bill separately. You will need to make separate arrangements with them. Occasionally, if the hospital is doing a charity write-off for your care, the physicians will follow suit. If charity care is not available, discuss making reasonable payment arrangements with the provider

Most states have Hill-Burton facilities. These facilities provide care to uninsured Americans. To locate a Hill-Burton facility in your area, call **1-800-638-0742** or visit their website at ***www.hrsa.gov***.

How will you get your medications?

There are many programs available to assist you with getting your medications. Most medications are available through patient assistance programs offered by the pharmaceutical companies. Each company has their own eligibility requirements to obtain your medication free of charge or at a discounted rate.

A very user friendly website, ***www.needymeds.com,*** is available to find out if your medications are available through a patient assistance program. They are not able to accept calls, so the internet is the only way you can access this information. If you do not have the internet, a friend, family member or healthcare provider may be able to assist you with obtaining the information.

Pharmaceutical Research and Manufacturers' of America (PhRMA) publishes a "Directory of Prescription Drug Indigent Programs." This is a list of drug manufacturers that offer medications to people who are unable to afford them. You must submit a written request to receive a free copy. The request must be received on a physician, healthcare professional or agency letterhead. Their address is:

Manufacturers' Indigent Drug Program
1100 15th Street, NW
Washington, DC 20005
1-800-762-4636

Or you can visit them online at ***www.phrma.org***. PhRMA also offers ***www.helpingpatients.org***, which allows the patient to answer a series of questions and automatically fills out the appropriate applications for programs offered by one of the 48 participating pharmaceutical companies.

You may also qualify for assistance with obtaining your diabetic supplies. Call Crystal Home Health Care & Medical Equipment at 1-800-493-4902 for more information. They provide assistance with obtaining other types of medical equipment/supplies as well.

How can you get Medicare?

Medicare is a health insurance program for the elderly or disabled and is administered by the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services Department (DHHS). Most patients over 65 and some people who have been receiving Social Security disability payments are eligible for Medicare benefits. Benefits vary and patients should determine, as early as possible, which benefits they are qualified to receive (*HHA-SSA* Publication No. 05-10029). CMS can explain coverage and eligibility requirements by calling the Medicare Hotline at **1-800-MEDICARE** or **1-800-633-4227**. You can speak to a Customer Service Representative in English or Spanish. TTY users should call **1-877-486-2048** (*Medicare & You*, 2004).

You will need to apply for Social Security Disability Income (SSDI) or Social Security Income (SSI) and Medicaid. Once approved, you will receive your first check five months later. Twenty-four months after receiving your first check, you will have the option of enrolling in Medicare. Check with your Social Security Office to determine what benefits you would qualify for and the length of your waiting period. The national number for the Social Security Administration is **1-800-772-1213**. After you have been disabled for 24 months, you may qualify for Medicare. The Medicare national phone number is **1-800-633-4227**.

Were you a member of the armed forces?

If so, the Veteran's Administration may be able to help with your medical expenses. The VA provides hospital care covering a full range of medical services. Outpatient treatment is available for all service connected conditions, or a non-service connected conditions in some cases. Questions regarding health care benefits should be directed to **1-800-733-8387** (*HHA-SSA* Publication No. 05-10029).

What is Medicaid and how can you find out if you qualify?

Medicaid is a federally funded, state regulated program to provide financial assistance in regards to medical expenses for children, the elderly and disabled and pregnant women. Individuals must qualify based on their household income, assets and other limits established by each state. Medicaid can act as a Medicare supplement as well as primary coverage. Information about coverage is available at your local public health or welfare office, State Medical Assistance or State Medicaid office.

Keep in mind that you may lose your Medicaid upon receipt of your first disability check. The amount of your disability may put you over the income guidelines. Check with your caseworker to see if a spend-down program is available. A spend down will allow you to keep your Medicaid benefits, but you will have to pay an amount, determined by your caseworker, for your medical care.

If you are in need of assistance with daily activities such as bathing, dressing, light housekeeping, transferring, etc., contact social services to request a community based care screening. If approved, you may be able to get an aide in your home to assist you with your daily needs. Depending on what is offered in your state, community based care participation might also include incontinence supplies, transportation and medications. Check with your local Medicaid office for state specific information.

Financial Assistance Programs

When applying for financial assistance, please recognize that many organizations have specific criteria that must be met in order to qualify for financial assistance and that some organizations may have assistance in an area that you do not need. Be creative in your approach in how to utilize this assistance. For example, you may need financial assistance to pay your health insurance premium, and an organization will provide assistance for your utility bill. Take advantage of the financial assistance for the utility bill and reallocate your money to pay your health insurance premium, if the program permits reallocation.

What should you do about your secured debt?

In general, most organizations will not provide financial assistance for secured debt, such as a mortgage or an automobile. Your best option for this type of debt would be to work direct with the creditor and ask for alternative payment arrangements for the loan, such as refinancing, deferring payments or paying only the interest due. If you cannot get the creditor to work with you, you may consider selling the item. A home mortgage is usually at risk of foreclosure after three months of delinquency. Typically, mortgage lenders are more cooperative when they are approached prior to foreclosure status.

Do you have credit card bills?

If you find yourself unable to pay your credit card bill(s), contact the creditor to make payment arrangements that involve the most minimal payment you can afford. Be specific in the amount that you are able to afford. If you are unable to establish payment arrangements, contact Consumer Credit Counseling Services for assistance. You can always give them more money each month, but want to make sure you are at least paying the minimal amount due. Charitable organizations are not likely to assist you with making these payments.

It might be in your best interest to contact a credit counseling center for debt consolidation. They are able to negotiate lower interest rates and payment arrangements. Only contact those companies that are non-profit.

If you have mounting medical bills, do not allow them to go into collections. Contact the billing office of the provider that you owe money, and offer the most minimal payment you are realistically able to make. When negotiating a payment, keep in mind that you are making a binding agreement. You cannot default on your payments, so make sure the monthly amount is feasible for you and your family. You must also realize, when negotiating payment arrangements, that the facility/provider is a business and must be able to collect a reasonable amount. If you are able to make a lump sum payment, the facility may be willing to write a portion of the balance off.

Don't forget your medical bills while filing your taxes. Medical expenses are tax deductible. Keep all receipts and records of payment. Examples of tax deductible expenses include mileage for trips to and from medical appointments, out-of-pocket costs for treatment, prescription drugs and/or equipment and the cost of meals during medical visits *(**http://usovinfo.about.com/library/weekly/aa061800b.htm***).

Having trouble paying your utilities?

Check to see if your state has a Low Income Heating Energy Assistance Program (LIHEAP). Ask the utility company if they have any charity programs available. Call the Department of Social Services in your area to see if they have any information about a Community Action Agency, an organization who canusually assist when a shutoff or eviction notice is given. Ask your doctor to write a letter of medical necessity to the utility company, as they may be more willing to work with you relative to your condition. Lastly, you may contact the State Utilities Commissioner to request their review of a compassionate appeal. For more information on the LIHEAP program, call **1-202-783-5594**.

Your electric company may also have a fuel fund. This is the fund that your neighbors contribute to. Look on your electric bill for the number in your area.

HeatShare is administered by the Salvation Army and provides emergency energy assistance on a year-round basis. Funds are used to natural gas, oil, propane, wood, electricity and emergency furnace repairs. For more information, call **1-800-842-7279**.

Have prescription coverage, but still can't afford medications?

Managed RX is a program that accepts most major medical insurance as full payment for prescribed medications. If your prescription benefit pays a minimum of 70%, Managed RX accepts that as full payment for the medication and waives the co-pay. Medications are shipped at no cost to you. Call **1-800-799-8765** for an application.

The PAF Patient Assistance Program provides financial assistance to patients who meet certain qualifications to help them pay for the prescriptions and/or treatments they need. This assistance lets patients who have chronic, life-threatening and/or debilitating diseases afford the out-of-pocket costs for these items that their insurance companies require.

What is the PAF Patient Assistance Program?

The PAF Patient Assistance Program helps patients with insurance including Medicare and Medicaid. Once approved for the program and depending on the level of help needed, payments are made:

- To the doctor
- To the pharmacy
- To the patient directly

Who is eligible and how to apply

The PAF Patient Assistance Program offers personal service to all patients through the use of program call counselors. These counselors screen for eligibility by collecting financial and medical information from everyone who calls to apply for the program. Once eligibility has been determined, a comprehensive application will be completed and processed. Patients will be assigned their own call counselor who will be available to answer any questions during the process. For more information, please call **1-866-512-3861**.

What type of assistance can your community offer?

Civic, religious and fraternal organizations also might offer financial aid or services to assist the patient and family. Groups such as the Salvation Army, United Way, Lutheran Social Services, Jewish Social Services and the Associated Catholic Charities can be found in the yellow pages under "Social Service Organizations." Also, churches and synagogues sometimes provide financial help to their members; however, you do not have to be a member to qualify for assistance with many religious organizations (*HHA-SSA* Publication No. 05-10029).

If financial aid is not available, these and other organizations may be able to provide transportation to and from the treatment centers, babysitting services and special equipment and dressings for home care. Services are sometimes available from the Red Cross, Salvation Army, labor unions to which any family member belongs and other social organizations. Counseling and assistance is usually available through organizations that are specific to your diagnosis (*HHA-SSA* Publication No. 05-10029).

Local charities are often willing to provide financial assistance for such needs as clothing, utilities, rent, furniture and other necessities while funding is available. Check your local listings for charitable organizations in your area.

Could you use help with getting food?

If you are having a difficult time affording an adequate amount of food, there are places to turn. Contact your local social services office to apply for food stamps. Food stamps will allow you to purchase food at the grocery store. The stigma of using food stamps has been removed by the implementation of the food stamp debit card program. Those who are eligible for the program will receive a plastic card that is swiped just like a debit or credit card. Almost every community in America has a food bank program. Check your phone book for a list of local food banks.

IMPORTANT NUMBERS

- **American Cancer Society: 1-800-227-2345**
  Offers numerous resources, including printed materials, counseling for patients and their families and information on lodging for people who may require treatment far from home. Contact your local chapter to find out about resources that may be available in your community. Local ACS office may offer reimbursement for expenses related to cancer treatment including transportation, medicine and medical supplies. Financial assistance is available in some areas.

- **Credit Counseling Centers of America: 1-800-493-2222 or www.cccamerica.org**
  A non-profit organization that provides a wide array of consumer and creditor services for individuals and families experiencing financial distress.

- **Hardin Benefits Group, Inc.: 1-800-248-6188**
  The Hardin Benefits Group is not an insurance company itself, but rather a consulting firm and agency specializing in helping clients whose medical conditions have made it difficult for them to find a life insurer. Call for a free ten-minute consultation.

- **HeatShare: 1-800-842-7279**
  Administered by the Salvation Army, HeatShare provides emergency energy assistance on a year-round basis. Funds are used for natural gas, oil, propane, wood, electricity and emergency furnace repairs.

- **Hill-Burton Program: 1-800-638-0742**
  A program run by the U.S. Government that can arrange for certain medical facilities or hospitals to provide free or low-cost care. Low income/uninsured persons should inquire about the possibility of free services before entering the hospital, as many have fulfilled or are very close to fulfilling their requirements.

- **Managed RX: 1-800-799-8765**
  Accepts most major medical insurance as full payment for medications. If your prescription benefit pays a minimum of 70%, Managed RX will accept that as full pay and waive your co-pay. Medications are shipped for free. Call for application.

- **Medical Information Resources: 1-888-203-6062**
  Provides tips and resources for medical fundraising.

- **Medicare: 1-800-Medicare or 1-800-633-4227; www.medicare.gov**
  Federal health insurance program for those who receive Social Security Benefits. Eligible individuals include those who are 65 and/or individuals deemed disabled and have received Social Security payments for 24 months. To receive information on eligibility, explanation of coverage and to enroll, call the Social Security Administration.

- **National Association for the Terminally Ill: 1-888-847-0390**
  Assists individuals with terminal diseases with financial aid.

- **National Association of Hospital Hospitality Houses, Inc.: 1-800-542-9730 or www.nahhh.org**
  Provides information on free or low-cost temporary lodging to families or patients who are undergoing treatment away from home.

- **Needy Meds: www.needymeds.com**
  Informational website that has up-to-date contact and instructions about various pharmaceutical manufacturers' drug assistance programs.

- **Patient Advocate Foundation's Patient Assistance Program: 1-866-512-3861**
  The PAF Patient Assistance Program provides financial assistance to patients who meet certain qualifications to help them pay for the prescriptions and/or treatments they need. This assistance lets patients who have chronic, life-threatening and/or debilitating diseases afford the out-of-pocket costs for these items that their insurance companies require.

- **www.patienttravel.org: 1-800-296-1217**
  Provides information about all forms of charitable, long-distance medical air transportation and provides referrals to all appropriate sources of help to patients who cannot afford travel for medical care.

- **Salvation Army National Headquarters: 1-800-378-7272**
  Provides assistance on a case-by-case basis.

- **U.S. Department of Health & Human Services: 1-877-696-6775**
  United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. The office of the Inspector General U.S. Government Hotline is for individuals to call for complaints regarding Medicare or Medicaid, as well as providing assistance with entitlements, benefits, insurance and resources.

- **Utility Assistance (LIHEAP): 1-202-783-5594**
  Assist eligible low-income households in meeting the heating or cooling portion of their residential energy needs. LIHEAP dollars are distributed by local community action agencies, usually at the county level. The Salvation Army processes applications in many states. To fin the number of your community action agency, call your state's energy assistance director.

- **Veterans' Administration: 1-877-222-VETS or www.va.gov/vbs/health/index**
  Provides a broad spectrum of medical, surgical and rehabilitative care to its qualified veterans and their dependents. Treatment for services is based on the veteran's financial need.

For more information on both local and national resources, visit our online resource guide at www.patientadvocate.org.

APPENDIX A
A QUICK LOOK: KNOW WHO PAYS FIRST IF YOU HAVE OTHER HEALTH INSURANCE OR COVERAGE

If you have Medicare and other health insurance or coverage, be sure to tell your doctor and other providers. This will help them send your bills to the correct payer to avoid delas. Whether Medicare pays first or second depends on a number of things. You should consider those listed in the hcart below and on the following page to help find who pays first. However, this chart doesn't cover every situation. If you have questions about who pays first or if your insurance changes, call the Medicare Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782.

If You . . .	Condition	Pays First	Pays Second
Are age 65 or older and covered by a *group health plan* because you are working or are covered by a *group health plan* of a working spouse of any age	Entitled to Medicare	Group Health Plan	Medicare
	The employer has 20 or more employees		
	The employer has less than 20 employees	Medicare	Group Health Plan
Have an *employer retiree plan* and are age 65 or older	Entitled to Medicare	Medicare	Retiree Coverage
Are disabled and covered by a *large group health plan* from your work or from a family member who is working	Entitled to Medicare	Large Group Health Plan	Medicare
	The employer has 100 or more employees		
	The employer has less than 100 employees	Medicare	Group Health Plan

If You . . .	Condition	Pays First	Pays Second
Have End-Stage Renal Disease (permanent kidney failure) and group health plan coverage (including a retirement plan)	First 30 months of eligibility or entitlement to Medicare	Group Health Plan	Medicare
	After 30 months	Medicare	Group Health Plan
Have End-Stage Renal Disease (permanent kidney failure) and COBRA coverage	First 30 months of eligibility or entitlement to Medicare	COBRA	Medicare
	After 30 months	Medicare	COBRA
Have been in an accident where no-fault or liability insurance is involved	Entitled to Medicare	No-fault or Liability insurance, for accident related services	Medicare
Are covered under workers' compensation because of a job-related illness or injury	Entitled to Medicare	Worker's compensation, for works' compensation claim related services	Usually doesn't apply. However, Medicare may make a conditional payment
Are a Veteran and have Veterans' benefits	Entitled to Medicare and Veterans' benefits	Medicare pays for Medicare-covered services	Usually doesn't apply
		Veterans' Affairs pays for VA authorized services	
		NOTE: Medicare and VA can't pay for the same service	
Are covered under TRICARE	Entitled to Medicare and TRICARE	Medicare pays for Medicare-covered services	TRICARE may pay second
		TRICARE pays for services from a military hospital or any other federal provider	
Have black lung disease and covered under the Federal Black Lung Program	Entitled to Medicare and Federal Black Lung Program	Federal Black Lung Program, for black lung related services	Medicare
Are age 65 or over OR disabled and covered by Medicare and COBRA coverage	Entitled to Medicare	Medicare	COBRA

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NOTES

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