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.

United States Office of Personnel Management
Strategic Human Resources Policy
RI 75-12
2008

Table of Contents

Page

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

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

What Types of Programs Are Offered by Medicare?

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

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

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

What Types of Expenses are covered by Medicare?

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

Part A (Hospital Insurance) helps pay for:

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

Part B (Medical Insurance) helps pay for:

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

Part C (Medicare Advantage):

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

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

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

Part D (Medicare Prescription Drug Coverage)

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

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

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

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

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

Medicare does not cover:

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

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

Am I Eligible for Medicare?

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

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

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

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

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

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

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

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

Do I Have to Take Part B Coverage?

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

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

How Much Does Part B Coverage Cost?

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

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

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

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

Does the FEHB Program Offer Medigap Policies?

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

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

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

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

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

When is My FEHB Plan the Primary Payer?

Your FEHB Plan must pay benefits first when you are an active Federal employee or reemployed annuitant and either you or your covered spouse has Medicare. (There is an exception if your reemployment position is excluded from FEHB coverage or you are enrolled in Medicare Part B only.)
Your FEHB Plan must also pay benefits first for you or a covered family member during the first 30 months of eligibility or entitlement to Part A benefits because of End Stage Renal Disease (ESRD), regardless of your employment status, unless Medicare (based on age or disability) was your primary payer on the day before you became eligible for Medicare Part A due to ESRD.

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

When is Medicare the Primary Payer?

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

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

If I Continue to Work Past Age 65, is My FEHB Coverage Still Primary?	Your FEHB coverage will be your primary coverage until you retire.
I am Retired With FEHB and Medicare Coverage. I am Also Covered Under My Spouse's Insurance Policy Through Work. Which Plan is Primary?	Since you are retired but covered under your working spouse's policy, your spouse's policy is your primary coverage. Medicare will pay secondary benefits and your FEHB plan will pay third.
Do My FEHB Premiums Change When Medicare Becomes Primary?	No. You will continue to pay the same premiums, unless you change to another plan or option.

Medicare & FEHB Primary Payer Chart

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

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

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

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

Should I Change Plans?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How Can I Get More Information About Medicare?

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

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

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

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

Terms Used in This Booklet

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

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

	and may charge a monthly premium and require copayments.
Medigap:	A supplemental private insurance policy that you can buy for extra benefits either not covered or not fully covered by Medicare. There are 12 standard Medigap plans in most states, ranging from a basic benefits package to ones that cover expenses such as the Part A deductible, Part B deductible, prescription drugs, and/or the skilled nursing coinsurance.
Original Medicare:	The traditional fee-for-service arrangement that covers Part A and Part B services. Medicare pays its share of the Medicare approved amount and you pay your share (deductibles and coinsurance).
Out-of-Pocket Costs:	Health care costs that you must pay because they are not covered by insurance, such as deductibles, coinsurance, copayments, and non-covered expenses.
Outpatient Care:	Health services that do not require an overnight hospital stay.
Preferred Provider Organization (PPO):	A fee-for-service option under Medicare Advantage Plans where you pay less if you use providers who have agreements with the plan. You may use providers outside of the PPO network but the services may cost you more.
Premium:	The amount you pay monthly or biweekly for insurance.
Preventive Care:	Care to keep you healthy or to prevent illness, such as routine checkups and flu shots, and some tests like colorectal cancer screening and mammograms.
Primary Payer:	When coordinating benefits, the health plan that pays benefits first for a claim for medical care.
Private Fee-For- Service Plan:	A traditional type of insurance you can choose under Medicare Advantage Plans that lets you use any doctor or hospital, but you usually must pay a deductible and coinsurance or copayment. The insurance plan, rather than the Medicare program, decides how much it will pay the provider and how much you will pay for the services you receive. You may pay more or less for Medicare covered benefits but, you may get extra benefits not found in Original Medicare.
Referral:	Your primary care doctor's written approval for you to see a certain specialist or to receive certain services. Most FEHB

	HMOs and some Medicare health plans may require referrals. **Important:** If you either see a different doctor from the one on the referral, or if you see a doctor without a referral and the service isn't for an emergency or urgently needed care, you may have to pay the entire bill.
Secondary Payer:	When coordinating benefits, the health plan that pays benefits after the primary payer has paid its full benefits. When an FEHB fee-for-service plan is the secondary payer, it will pay the lesser of a) its benefits in full, or b) an amount that when added to the benefits payable by the primary payer, equals 100% of covered charges.
Service Area:	The geographic area where a health plan accepts members. For plans that provide coverage only when you use their doctors and hospitals, it is also the area where services are administered.
Skilled Nursing Facility:	A facility that specializes in skilled nursing care performed by or under the supervision of licensed nurses, skilled rehabilitation services, and other related care, and which meets Medicare's special qualifying criteria, but not an institution that primarily cares for and treats mental diseases. **Important:** Medicare does not cover long term care so this skilled nursing facility coverage is limited.
Suspension of FEHB Enrollment:	When you notify your retirement system that you are suspending your FEHB coverage to enroll in a Medicare Advantage plan, you retain the right to reenroll in FEHB if your enrollment in the Medicare Advantage plan ends. Otherwise, if you cancel your FEHB coverage as an annuitant, you will probably never be eligible to reenroll.