Centers for Medicare & Medicaid Services – National Training Program

Glossary: Coordination of Benefits with Medicare Mini-Lesson & Podcast Series

- **Benefits Coordination & Recovery Center (BCRC)**—The company that acts on behalf of Medicare to collect and manage information on other types of insurance or coverage that a person with Medicare may have, and determine whether the coverage pays before or after Medicare. This company also acts on behalf of Medicare to obtain repayment when Medicare makes a conditional payment, and the other payer is determined to be primary.
- **Catastrophic coverage**—The level of coverage you get after you spend the annual maximum out-of-pocket amount for drugs covered under your Medicare drug plan (Part D). It assures that you only pay a small coinsurance percentage or copayment for covered drugs for the rest of the year.
- **Claim**—A request for payment that you submit to Medicare or other health insurance when you get items and services that you think are covered.
- **COBRA (Consolidated Omnibus Budget Reconciliation Act)**—A federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee, or another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee. In general, COBRA only applies to employers with 20 or more employees.
- **Conditional payment**—A payment made by Medicare for services for which another payer is responsible.
- **Coordination of benefits (COB)**—A process for determining which plan or insurance policy will pay first if 2 or more health plans or insurance policies cover the same benefits. If one of the plans is a Medicare health plan, federal law may decide who pays first.
- **End-Stage Renal Disease (ESRD)**—Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.
- **Explanation of Benefits (EOB)**—An enrollee communication provided by Medicare Advantage Plans and Medicare drug plans that give enrollees clear and timely information about their medical and/or drug claims.
- **Federal Black Lung Benefits Program**—A program authorized by the Black Lung Benefits Act, which provides monthly payments and medical benefits to coal miners totally disabled from pneumoconiosis (black lung disease) arising from their employment in or around the nation's coal mines. The Act also provides monthly benefits to a miner’s dependent survivors.
- **Federal Employees Health Benefits (FEHB)**—A type of group health plan. It covers participating current and retired federal employees.
- **Formulary**—A list of prescription drugs covered by a drug plan or another insurance plan offering drug benefits. Also called a drug list.

- **Group health plan (GHP)**—In general, a health plan offered by an employer or employee organization that provides health coverage to employees and their families.
- **Indian Health Service (IHS)**—An agency within the Department of Health & Human Services that's responsible for providing federal health services to American Indians and Alaska Natives.
- **Liability insurance**—Insurance that protects against claims for negligence or inappropriate action or inaction, which results in injury to someone or damage to property.
- **Medicaid**—A joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid Programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
- **Medicare**—The federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).
- **Medicare Advantage Plan**—A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of your Part A and Part B benefits, with a few exclusions, for example, certain aspects of clinical trials which are covered by Original Medicare even though you're still in the plan. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan; most Medicare services aren't paid for by Original Medicare; and most Medicare Advantage Plans offer prescription drug coverage.
- **Medicare drug coverage (Part D)**—Optional benefits for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare.
- **Medicare Summary Notice (MSN)**—A notice you get after the doctor, other health care provider, or supplier files a claim for Part A or Part B services in Original Medicare. It explains what the doctor, other health care provider, or supplier billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.
- **Medigap**—Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage.
- **No-fault insurance**—Insurance that may pay for health care services you get if you're injured or your property gets damaged in an accident, regardless of who's at fault for causing the accident. Some types of no-fault insurance include automobile plans, homeowners' plans, and commercial insurance plans.
- **Original Medicare**—A fee-for-service health plan that has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).
- **Part A (Hospital Insurance)**—Covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.
- **Part B (Medical Insurance)**—Covers certain doctors' services, outpatient care, home health care, medical supplies, and preventive services.
- **Part D (Medicare drug coverage)**—See "Medicare drug coverage (Part D)."
- **Primary payer**—The insurance policy, plan, or program that has primary responsibility for paying a claim.

- **State Pharmaceutical Assistance Program (SPAP)**—A state program that provides help paying for drug coverage based on financial need, age, or medical condition.
- **Secondary payer**—The insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance, depending on the situation.
- **TRICARE for Life (TFL)**—TRICARE is a health care plan for uniformed service members, military retirees, and their families. TFL provides expanded medical coverage to Medicare-eligible uniformed services retirees 65 or older, to their eligible family members and survivors, and to certain spouses.
- **True out-of-pocket (TrOOP) costs**—Expenses that count toward your Medicare drug plan's out-of-pocket threshold.
- **Veterans Affairs (VA**)—An agency of the federal government that provides benefits, health care and cemetery services to military Veterans.
- **Veterans coverage**—Veterans of the U.S. Armed Forces may be eligible for a broad range of programs and services provided by the U.S. Department of Veterans Affairs (VA). Eligibility for most VA benefits is based on the service member's discharge from active military service under other than dishonorable conditions. Active service means full-time service, other than active duty for training, as a member of the Army, Navy, Air Force, Marine Corps, Coast Guard, or as a commissioned officer of the Public Health Service, Environmental Science Services Administration, or National Oceanic and Atmospheric Administration.
- **Workers' Compensation**—An insurance plan that employers are required to have to cover employees who get sick or injured on the job.

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March 2023

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