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Subscriber eligibility

Defining a group

A group must have an “employer-employee” relationship to establish a health care program. This relationship allows the group to do the following for the employee:

- Make payroll deductions for federal withholding taxes
- Contribute to Michigan Unemployment Insurance for workers
- Provide worker’s compensation for workers as required by law
- Withhold payroll taxes or wages paid to employees

Categories of eligibility

The several categories of eligible employees within a group are detailed in the chart on the following page.

Eligible Employees	Eligibility Defined
Employers/Owners	• Have a direct and active interest in the group • Derive at least 50 percent of their employment income from the business • Physically report to the place of business at least once a week • Have a direct voice in all major decisions • Live in the BCN service area a minimum of nine months of the year
Full-time workers	Must work a minimum of 30 hours per week to be eligible, unless otherwise specified in the Group Enrollment and Coverage Agreement.
Part-time workers	Must work 17½ to 30 hours per week to be eligible, unless otherwise specified in the Group Enrollment and Coverage Agreement.
Retirees	Can participate only if the group has an established retiree segment with a documented retirement benefit program. The group can establish a retiree segment if there is a corresponding active segment with a minimum of five active, nonretiree, non-COBRA medical contracts (employees) enrolled with BCN. Individuals who retire must be transferred to the retiree segment when they begin receiving pension benefits from the group. Retirees may or may not be eligible for Medicare at the time of retirement, and their eligibility for Medicare will determine the type of coverage they receive.

Enrollment Guidelines

Effective date of coverage

The effective date of coverage for individuals who signed up during initial enrollment is the date specified in Part B of your Group Enrollment and Coverage Agreement.

New hires

Eligible new hires may enroll for coverage for themselves and their eligible dependents according to the provisions of your Group Enrollment and Coverage Agreement. If your health care plan contains a new-hire wait period, coverage will begin following this period, usually 30, 60 or 90 days following the date of hire. Coverage will usually begin on the first day of your billing cycle after the wait period has ended.

If your organization covers part-time workers, they may have different enrollment guidelines, depending on your personnel policy and provisions in the Group Enrollment and Coverage Agreement.

Rehires

Individuals who are rehired or who return to work after a layoff or leave of absence may be readmitted to coverage based on your rehire wait period as stated in Part B of the Group Enrollment and Coverage Agreement.

Transfers from Blue to Blue

Individuals who were covered by a Blue Cross Blue Shield of Michigan or Blue Care Network plan through another employer may transfer into your Blue plan when they are hired. The effective date of coverage must be the date of hire. Depending on your personnel policy, you may allow coverage immediately or following a new-hire wait period.

Transfers from other carriers

Loss of coverage

New hires and their eligible dependents who were covered by another carrier through a spouse may request a transfer to your plan after the new-hire wait period if they lost their coverage. Application must be made within 30 days of the loss of coverage or be delayed until your next open enrollment. Coverage is effective on the date coverage is lost. A letter from the previous health insurance carrier or other group verifying loss of eligibility for coverage is required.

Other reasons

New hires who elect to change carriers may transfer only during an open enrollment period.

Veterans

An employee returning from military service and his or her covered dependents are entitled to immediate reinstatement of health coverage — provided that the service in uniform services does not exceed five years.

The health plan may not impose a wait period or exclude preexisting conditions — except for illnesses and injuries determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the military.

To qualify for reinstatement of coverage, BCN requires that the member:

- Must have been covered under a BCN contract immediately prior to being called to active duty
- Must reapply for employment within 90 days of discharge. Note: Coverage will be effective as of the date of re-employment
- Include proof of discharge with the application

Dependent eligibility

Defining dependents

Eligible dependents of individuals with BCN coverage include:

- Spouse
- Dependent children
- Principally supported children
- Incapacitated/disabled children (over 26 years of age)
- Surviving spouse or dependent
- Domestic partners (if this rider is included)
- Other eligible adults (if this rider is included)

Dependent eligibility

Eligibility for dependents is defined in the chart on the following page.

Dependent eligibility (continued)

Eligible Dependents	Eligibility Defined
Spouse	A dependent who is legally married to the subscriber
Dependent children	Children of the subscriber or subscriber's spouse by birth, marriage, legal adoption or legal guardianship who are: • Under 26 years of age
Principally supported children	Children related to the subscriber by blood or marriage who: • Are under 26 years of age • Are unmarried • Have legal residence with the subscriber • Are claimed as a dependent on the subscriber's most recent federal income tax return or qualify in the current tax year for dependency tax status • Are dependent on the subscriber for principal support in accordance with Internal Revenue Service standards and have met these standards for at least six months prior to applying for coverage (coverage begins three months after the subscriber's application) • Are not eligible for Medicare
Incapacitated/ Disabled children over 26 years of age	Children who became permanently disabled — either mentally or physically — prior to age 26 and: • Are incapable of self-sustaining employment • Are disability-certified by a physician, and BCN was notified before the end of the year in which the dependent turns 26 years of age • Reside in a BCN service area • Are unmarried and dependent on subscriber for main support and care as defined by the U.S. Internal Revenue Code
Spouse or dependent due to survivorship clause	A surviving spouse or dependent is eligible if the group offers a survivorship clause and the subscriber elects it prior to or at retirement. A surviving spouse or dependent must reside within the BCN service area a minimum of nine months of the year.

Exclusions

Ineligible workers

The following categories of employees are not eligible for BCN health care coverage:

- Temporary workers, students in training, co-ops and foreign exchange students
- Independent contractors and commissioned personnel

Documents required for dependent eligibility verification

Eligibility documents

To ensure that you are only paying premiums for eligible dependents, we may request documentation to verify the eligibility of dependents. These are as follows:

Dependent	Required Documents
Spouse	• Enrollment/Change of Status form*
Dependent Child	• Enrollment/Change of Status form*
Child adopted or guardianship by subscriber	• Enrollment/Change of Status form* • Court order or documentation verifying legal guardianship, or intent to adopt, or petition for guardianship
Principally supported child (after nine months of support)	• Enrollment/Change of Status form* • Notarized statement or tax return verifying support

**Always required. To view this form, see Section 6.*

Complying with document requests

Always submit supporting documentation with the Enrollment/Change of Status form. If we request additional documentation, you will have only 10 days to comply.

If BCN does not receive documentation to verify the dependent's eligibility, the dependent will not be added. The subscriber will have to wait until the next open enrollment period to add the dependent.

Enrollment/ Change of Status

Members should submit an Enrollment/Change of Status form for themselves or their dependents within 30 calendar days of a qualifying event (date subscriber or member became eligible for enrollment into the group). This will allow BCN to process the form and request additional documentation as required.

Sponsored dependent continuation coverage

Sponsored dependent coverage defined

A sponsored dependent is any adult dependent over 25 (or the age specified by the Group Enrollment and Coverage Agreement) who is a family member of the subscriber.

Coverage effective dates are one of the following:

- Initial enrollment of the subscriber
- First of the month in which qualifying event occurs
- Annual open enrollment effective date

Sponsored dependent coverage applies only to groups of 100 or more eligible subscribers that have selected the Sponsored Dependent rider.

There is an added premium for this coverage.

Sponsored dependent eligibility guidelines

A dependent is eligible for continuation coverage if he or she:

- Is related to the subscriber by blood or marriage within the terms of the Internal Revenue Code for dependents
- Qualified as a dependent on the subscriber's last federal tax return filed under the Internal Revenue Code
- Receives more than half of his or her support from the subscriber
- Resides in the subscriber's household
- Is ineligible for or not enrolled in Medicare or Medicaid

Form requirements

The following documentation must be filed with BCN:

- Enrollment/Change of Status form (See Section 6 for more about the Enrollment/Change of Status form.)
- Subscriber's most recent tax return

Domestic partner coverage

Domestic partner coverage defined

Domestic partner coverage provides eligibility for same-sex domestic partners and for their children. Coverage is available to groups that request the Domestic Partner rider.

Coverage effective dates are one of the following:

- Initial enrollment of the subscriber
- First of the month in which qualifying event occurs
- Annual open enrollment effective date

Guidelines for a same-sex domestic partner

A domestic partner is eligible for coverage if:

- The individual is 18 years of age or older
- The individual is not related by blood to the subscriber
- Neither the subscriber nor the domestic partner is legally married to any other party
- The parties are financially interdependent
- The parties intend to reside together permanently and have resided together for at least 12 consecutive months prior to enrollment in BCN

Form requirements

The following documentation must be filed with BCN:

- Enrollment/Change of Status form (See Section 6 for more about the Enrollment/Change of Status form.)
- A signed and notarized affidavit of domestic partnership
- Proof of financial interdependence (joint bank account, joint title to a home)

Other eligible adult coverage

Other eligible adult coverage defined

Other eligible adult coverage provides eligibility for persons of the opposite-sex and their children. Coverage is available to groups with 100 or more eligible subscribers that request the Other Eligible Adult rider.

Coverage effective dates are one of the following:

- Initial enrollment of the subscriber
- First of the month in which qualifying event occurs
- Annual open enrollment effective date

Guidelines other eligible adult coverage

An adult is eligible for coverage under the Other Eligible Adult rider if:

- The individual is 26 years of age or older
- The individual is not related by blood to the subscriber
- Neither the subscriber nor the domestic partner is legally married to any other party
- The parties are financially interdependent
- The parties intend to reside together permanently and have resided together for at least 18 consecutive months prior to enrollment in BCN

Form requirements

The following documentation must be filed with BCN:

- Enrollment/Change of Status form (See Section 6 for more about the Enrollment/Change of Status form.)
- A signed and notarized affidavit of other eligible adult partnership
- Proof of financial interdependence (joint bank account, joint title to a home)

Continuing Coverage — COBRA and Group Conversion

When members leave the group

Subscribers or dependents who leave your group or are no longer eligible for benefits can purchase their own BCN benefits without a lapse in coverage. They may qualify for one of two types of continuing coverage:

- COBRA (Consolidated Omnibus Budget Reconciliation Act) extends coverage through your plan for a specified length of time, provided you have 20 or more full- or part-time employees.
- BCN Group Conversion Coverage

The member can choose coverage through COBRA for the length of time determined by his or her particular situation and then choose Group Conversion once COBRA coverage has exhausted, or the member can choose Group Conversion coverage immediately.

About COBRA
This explanation is not intended to replace the group's need to consult its own counsel.

The Consolidated Omnibus Budget Reconciliation Act is a federally mandated, employer-sponsored and administered health care plan for covered employees and dependents who lose their group health insurance. COBRA applies only to employer groups with 20 or more employees (except for church plans defined in Section 414(e) of the Internal Revenue Code and government employers who have similar rules under a different law).

COBRA allows the "qualified beneficiary" (the eligible person) to continue coverage through your group plan for a specific length of time. You continue to administer the coverage, but the qualified beneficiary or others connected to the qualified beneficiary pay you directly for the cost of the coverage.

For more information on COBRA administration, call 202-219-8776.

Or write:

Division of Technical Assistance and Inquiries — Room N-5625
The U.S. Department of Labor, Pension and Welfare Benefits
200 Constitution Avenue NW
Washington, D.C. 20210

Who qualifies for COBRA

Anyone covered under your organization's plan the day before a COBRA qualifying event is eligible for COBRA and is called a qualified beneficiary.

A COBRA qualifying event could include but is not limited to:

- Employment termination
- Divorce
- Layoff
- Reduction in hours
- Dependents who lose eligibility

Group Conversion

Group Conversion is a second option for members whose coverage has been terminated. It provides basic medical coverage only; prescription drugs and ancillary benefits are not covered.

Group Conversion premium rates are billed directly to the subscriber or dependent. Enrollees may continue their coverage indefinitely, provided they do not become eligible for other coverage. Subscribers or dependents interested in Group Conversion must enroll within 30 days of the date of termination or the date of notification, whichever is later.

For information

Call BCN Customer Service at 1-800-662-6667 for more information about Group Conversion, COBRA or other BCN nongroup products.

Frequently asked questions about continuing coverage

	COBRA	Group Conversion
When group coverage ends, what health care coverage is available? How is it activated?	• Groups with 20 or more full- or part-time employees must offer COBRA. (Groups exempt from the requirement: churches defined in Section 414(e) of the IRS code and government employers who have similar rules under a different law.) • The group must notify all members in writing about their specific COBRA rights within 14 calendar days of the date of the qualifying event, or the date the group learned of the event from the subscriber. • The qualified beneficiary or his or her representative must sign up within 60-calendar days from the date of notification.	Coverage is NOT automatic. • The group must notify group members of their group conversion coverage options within 14 days after group coverage termination date. • The subscriber or dependent must request coverage by calling Customer Service at 1-800-662-6667. • A subscriber must elect group conversion coverage within 30 calendar days of loss of group coverage. The subscriber's coverage must be in effect continuously.

	COBRA	Group Conversion
How long can a subscriber or eligible dependent keep the coverage?	• COBRA eligibility ends: ✓ When the qualified beneficiary reaches the allowed time limit: ✓ 18 months from when the employee or eligible dependents lose coverage due to termination or reduction of work hours ✓ 29 months from when employees who are disabled stopped working; the disability can have occurred within 60 days of their stopping work. Subscriber must provide a Certificate of Disability from the Social Security Administration during the initial 18-month COBRA period or within 60 calendar days of receiving the certificate ✓ 36 months for eligible dependents from the date the subscriber dies, is legally divorced or separated, or when a dependent becomes ineligible for coverage • Your group stops offering any group health BCN plan. • The qualified beneficiary or representative does not make premium payments. • The qualified beneficiary becomes covered under another health plan without limits for pre-existing conditions or becomes entitled to Part A or Part B Medicare benefits.	• Coverage remains in effect as long as the member makes payments on time and does not become eligible for any other coverage.

FAQs about Continuing Coverage (continued)

How much does coverage cost?

COBRA	Group Conversion
COBRA coverage costs the same as the group premium rate for months 0-18. The group can include an additional 2 percent administration fee.	Contact Customer Service 1-800-662-6667 for the current group conversion premium or online at **MiBCN.com/extended coverage**.

How are premiums paid?

COBRA	Group Conversion
The group collects and submits premiums to BCN. Enrollees, or their representatives, must pay any retroactive premiums and current premiums within 45 calendar days from date of COBRA election.	A two-month premium must be submitted with the coverage application. Subscribers or dependents are billed for premiums.

FAQs about Continuing Coverage (continued)

How do individuals sign up for coverage?

COBRA	Group Conversion
• Tell BCN of subscriber termination by submitting Enrollment/Change of Status form to BCN within 30 calendar days of termination date. • Individual election must take place within 60 calendar days of their being notified of their group coverage ending. • Group forwards application to BCN within 30 calendar days of election. • The COBRA effective date must be the day following the termination date. There can be no lapse in coverage.	• Contact Customer Service for enrollment form and coverage information. • Complete and mail in the application with premium payment to BCN within 30 calendar days of loss of group coverage. • The group conversion effective date must be the day following the group coverage termination date. There can be no lapse in coverage.

Does the subscriber keep the same BCN benefits?

COBRA	Group Conversion
Yes	• Provides basic medical coverage only; prescription drugs and ancillary benefits are not covered. Contact Customer Service for information.

Uniformed Services Employment and Reemployment Rights Act

USERRA explained

USERRA requires group health plans to offer up to 24 months of continuation coverage to persons absent from employment due to military service. USERRA applies to all employers, including groups with fewer than 20 employees who are not subject to COBRA.

USERRA runs concurrent with COBRA.

The employer may charge up to 102 percent of the full premium cost for continuation coverage unless the employee is called to active duty for fewer than 31 days; those individuals are only required to pay the applicable employee share of the premium

Certificates of Creditable Coverage

HIPAA requires health plans to provide Certificates of Creditable Coverage to any individual who loses health care coverage. These certificates must also be provided to members with active coverage who request them.

The certificates:

- Identify prior or active coverage.
- May be used to reduce or eliminate any preexisting condition periods that may apply when a member changes coverage.
- Must show each period of continuous coverage within the 24-month period prior to the date of request. A separate certificate may be provided for each period of continuous coverage.
- Must be generated 60 days after an individual loses coverage.
- Can be requested up to 24 months after an individual loses coverage.

Note: If coverage ended more than 24 months prior to the date of request, the individual is not eligible for a Certificate of Creditable Coverage.

Eligibility audits

Member audits

BCN periodically conducts membership audits to ensure accuracy. The group is responsible for reviewing the audit reports received from BCN and reporting discrepancies immediately to BCN.

The table below describes the types of audits BCN conducts.

Audit Type	When	Members	BCN
COBRA	Monthly	COBRA members exhausting eligibility period	• Notifies member by mail when COBRA will be exhausted and gives member their options for continued coverage
TEFRA (Tax Equity Fiscal Responsibility Act) working aged	Every year (Spring)	Members over age 65 with active coverage	• Sends surveys to members over 65 to determine whether Medicare status has changed.
Medicare*	Monthly	✓ Members who are approaching age 65: ✓ Retirees ✓ Dependents	• Sends surveys to members 4 months prior to their 65th birthday to determine Medicare status

*Contact Blues sales representative or agent to establish formal retiree classification or to cancel coverage.

Membership Collection System (eMCS)

Submit membership data electronically

We offer a Web-based membership collection system to help groups and agents manage their Blues coverage. eMCS is available at no charge to groups with 10 or more members and requires very few system or programming changes.

How eMCS works

Users log in to the secured Web portal through their personal computer.

You designate authorized users for your group and receive specific logon and password identification.

Control over membership records

eMCS offers these advantages:

- Less paperwork
- Instant information on your membership
- More control over your membership records

To enroll

Visit us on the web at **MiBCN.com**. Select *I am an Employer* and then log in to Secured Services to register your Blue Care Network group with eMCS.

Medicare Coverage

About Medicare

Medicare is a federal health insurance program for individuals age 65 and older, certain disabled people and those with end stage renal disease. The Centers for Medicare and Medicaid Services, not BCN, determines eligibility (entitlement) for Medicare coverage.

See Section 10 of this manual for detailed information about Medicare coverage.

Medicare eligibility

The Medicare Secondary Payer law defines when Medicare will be the primary payer for services covered under a group health plan. According to the law, a group may not offer Medicare complementary coverage to an individual who is eligible for group health coverage and should only have Medicare as the secondary carrier.

See the chart on the following page for how the Medicare Secondary Payer law defines eligibility.

Medicare Eligibility/Enrollment Grid — Page 1

If Subscriber ...	AND/OR...If Dependent...	IF Group has under 20 full time/part time and seasonal employees...	IF Group has 20 to 99 full time/part time and seasonal employees...	IF group has 100+ full time/part time and seasonal employees...
Is age 65 or over, still working and has Medicare Parts A and B	Is age 65 or over and has Medicare Parts A and B	New or Existing Member(s) May enroll in a Medicare primary plan (not to be confused with a retiree class) until Subscriber retires.	New or Existing Member(s) Subscriber and spouse in BCN plan.	New or Existing Member(s) Subscriber and spouse in BCN plan.
Is age 65 or over, still working and does not have Medicare Part B	Is age 65 or over and does not have Medicare Part B	New Member(s) NOT Eligible Existing Member(s) Coverage terminated.	New or Existing Member(s) BCN Primary Subscriber and spouse in BCN plan.	New or Existing Member(s) BCN Primary Subscriber and spouse in BCN plan.
Is age 65 or over, retired and group does not have a retiree segment		New Member(s) NOT Eligible Existing Member(s) Coverage terminated.	New Member(s) NOT Eligible Existing Member(s) Coverage terminated.	New Member(s) NOT Eligible Existing Member(s) Coverage terminated.
Is age 65 or over, retired and group has a retiree segment		New or Existing Member(s) Medicare Primary Member must have Medicare Part A&B. Member(s) will be placed in a Retiree Class.	New or Existing Member(s) Medicare Primary Member must have Medicare Part A&B. Member(s) will be placed in a Retiree Class.	New or Existing Member(s) Medicare Primary Member must have Medicare Part A&B. Member(s) will be placed in a Retiree Class.
Is age 65 or over, not actively working and does not have Medicare Part B		New Member(s) NOT Eligible Existing Member(s) Coverage terminated.	New Member(s) NOT Eligible Existing Member(s) Coverage terminated.	New Member(s) NOT Eligible Existing Member(s) Coverage terminated.
Is age 65 or over, not actively working and does not have Medicare Part A		New Member(s) NOT Eligible Existing Member(s) Coverage terminated.	New Member(s) NOT Eligible Existing Member(s) Coverage terminated.	New Member(s) NOT Eligible Existing Member(s) Coverage terminated.
Is age 65 or over, not actively working and has Medicare Parts A and B	Is age 65 or over, and has Medicare Parts A and B	New Member(s) NOT Eligible Existing Member(s) Coverage terminated.	New Member(s) NOT Eligible Existing Member(s) Coverage terminated.	New Member(s) NOT Eligible Existing Member(s) Coverage terminated.
Is under age 65 and working	Is age 65 or over and does not have Medicare Part B	New Member(s) NOT Eligible Existing Member(s) Coverage terminated.	New or Existing Member(s) BCN Primary Subscriber and spouse in BCN plan.	New or Existing Member(s) BCN Primary Subscriber and spouse in BCN plan.
Is under age 65, retired and covered under retiree segment	Is under age 65	New or Existing Member(s) BCN Primary, Medicare not available until age 65. Member(s) placed in a retiree class.	New or Existing Member(s) BCN Primary, Medicare not available until age 65. Member(s) placed in a retiree class.	New or Existing Member(s) BCN Primary, Medicare not available until age 65. Member(s) placed in a retiree class.
Is under age 65, retired and covered under retiree segment	Is over age 65 and has Medicare Parts A and B	New or Existing Member(s) BCN Primary for SUBSCRIBER. Medicare not available until age 65. Subscriber placed in a Retiree Class. Medicare Primary for DEPENDENT Dependent must have Medicare Parts A and B.	New or Existing Member(s) BCN Primary for SUBSCRIBER. Medicare not available until age 65. Subscriber placed in a Retiree Class. Medicare Primary for DEPENDENT Dependent must have Medicare Parts A and B.	New or Existing Member(s) BCN Primary for SUBSCRIBER. Medicare not available until age 65. Subscriber placed in a Retiree Class. Medicare Primary for DEPENDENT Dependent must have Medicare Parts A and B.

Medicare Eligibility/Enrollment Grid — Page 2

If Subscriber ...	AND/OR...If Dependent...	IF Group has under 20 full time/part time and seasonal employees...	IF Group has 20 to 99 full time/part time and seasonal employees...	IF group has 100+ full time/part time and seasonal employees...
Is *under age 65*, *still working* and *disabled* (as specified by Social Security guidelines)	Is *under age 65* and *disabled* (as specified by Social Security guidelines)	*New or Existing Member(s)* **Medicare Primary.** Member(s) must have Medicare Parts A and B.	*New or Existing Member(s)* **Medicare Primary.** Member(s) must have Medicare Parts A and B.	*New or Existing Member(s)* **BCN primary.** Member(s) has BCN plan.
Is *under age 65*, *disabled* (as specified by Social Security guidelines) *and not currently employed* (as specified by 1993 COBRA guidelines.	Is *under age 65* and *disabled* (as specified by Social Security guidelines) and *not currently employed* (as specified by 1993 COBRA guidelines.)	*New or Existing Member(s)* **Medicare Primary.** **BCN NOT available.** Member(s) must have Medicare Parts A and B to enroll in BCN nongroup coverage.	*New or Existing Member(s)* **Medicare Primary.** **BCN NOT available.** Member(s) must have Medicare Parts A and B to enroll in BCN nongroup coverage.	*New or Existing Member(s)* **Medicare Primary.** **BCN NOT available.** Member(s) must have Medicare Parts A and B to enroll in BCN nongroup coverage.
Is age *65 or over*, actively *working*, *has Medicare Parts A and B* and *ESRD*	Is age *65 or over*, *has Medicare Parts A and B* with *ESRD*	*New or Existing Member(s)* *Medicare Primary* Must have Medicare Parts A and B *ESRD* NO 30-month coordination period	*New or Existing Member(s)* *Has Medicare A OR B, or Both* *ESRD, BCN Primary* Required 30-month coordination period beginning with the first date of dialysis or transplant date. *ESRD Medicare Primary* Must complete the 30-month coordination period regardless of date of transplant.	*New or Existing Member(s)* *Has Medicare A OR B, or Both* *ESRD, BCN Primary* Required 30-month coordination period beginning with the first date of dialysis or transplant date. *ESRD Medicare Primary* Must complete the 30-month coordination period regardless of date of transplant.
Is *under age 65* *with ESRD* and *has Medicare Parts A and B*	Is *under age 65* *with ESRD* and *has Medicare Parts A and B*	*New or Existing Member(s)* *Medicare Parts A and B* *ESRD, BCN Primary* Required 30-month coordination period beginning with the first date of dialysis or transplant date. *ESRD Medicare Primary* Must complete the 30-month coordination period regardless of date of transplant.	*New or Existing Member(s)* *Medicare Part A& B* *BCN Primary* Required 30-month coordination period beginning with the first date of dialysis or transplant date. *Medicare Primary* Must complete the 30-month coordination period regardless of date of transplant.	*New or Existing Member(s)* *Medicare Part A& B* *BCN Primary* Required 30-month coordination period beginning with the first date of dialysis or transplant date. *Medicare Primary* Must complete the 30-month coordination period regardless of date of transplant.
Is *under age 65* *with ESRD* and *has Medicare Part A*, but **NOT Medicare Part B**	Is *under age 65* *with ESRD* and *has Medicare Part A*, but **NOT Medicare Part B**	*New or Existing Member(s)* *Medicare Part A, NO Part B* *BCN Primary* Required 30-month coordination period for all A & B benefits. After 30th month, BCN primary for Part B benefits only. *Medicare Primary, for Part A Benefits only* Must complete the 30-month coordination period regardless of date of transplant.	*New or Existing Member(s)* *Medicare Part A, NO Part B* *BCN Primary* Required 30-month coordination period for all A & B benefits. After 30th month, BCN primary for Part B benefits only. *Medicare Primary, for Part A Benefits only* Must complete the 30-month coordination period regardless of date of transplant.	*New or Existing Member(s)* *Medicare Part A, NO Part B* *BCN Primary* Required 30-month coordination period for all A & B benefits. After 30th month, BCN primary for Part B benefits only. *Medicare Primary, for Part A Benefits only* Must complete the 30-month coordination period regardless of date of transplant.