

Medicare Information Sheet

When a Blue Cross Blue Shield of Michigan (BCBSM) subscriber, their spouse or dependent is entitled to Medicare, determining the primary carrier can seem a bit complex. Here are some tips for simplifying the process. Should the group have any questions on the following, they should consult their legal counsel because the Medicare Secondary Payor and TEFRA laws are for employers, not insurance companies.

First, you need answers to two basic questions; then refer to the chart below.

1. Why is the employee, spouse or dependent entitled to Medicare?

Because they are...

Over age 65?

Under age 65 and disabled?

End-stage renal disease?

2. How many employees are on the group's payroll? (Include full and part time employees in the count.)

Reason for Medicare eligibility (Employee or Dependent)	If the group employs...	Primary Carrier is...
Over age 65	Less than 20 (This includes full and part-time employees regardless of their eligibility for group coverage)	Medicare
Over age 65	20 or more (This includes full and part-time employees regardless of their eligibility for group coverage)	BCBSM - when this applies Medicare does NOT pick up what BCBSM doesn't pay.
Under age 65, disabled	Less than 100	Medicare
Under age 65, disabled	100 or more	BCBSM
Retirees	Not applicable	Medicare
End-stage renal disease (regardless of age or reason for Medicare)	All Groups (Active & Retired)	<ul style="list-style-type: none"> BCBSM is primary for the first 30 months after the person is entitled to Medicare. Medicare is primary after the initial 30-month eligibility period.

Here are some things to keep in mind when Medicare is the primary carrier.

- The individual MUST sign up for Part A and Part B of Medicare in order to get BCBSM's Supplemental product.
- The individual cannot have BCBSM regular coverage.

Special Information regarding groups enrolled in POS or Community Blue PPO

BCBSM Medicare Supplemental coverage is not available with either Point of Service (POS) or the Community Blue PPO. In situations where a group has one of these plans and group members need Supplemental coverage, we can enroll the Medicare eligibles in a Traditional plan. To accomplish this, you must submit Coverage agreements, Part A, B and C, a Group Roster, A Traditional Group Subscriber Application form and a Medicare Information Form.

If the employee/subscriber is the person who needs Medicare Supplemental coverage, both the employee and any dependents on the contract will be enrolled under the Traditional suffix.

If the dependent needs Medicare Supplemental coverage, but the employee/subscriber does not, only the dependent will be enrolled under the Traditional group, using his or her own Social Security number. The subscriber and any other dependents can still enroll in POS or Community Blue.