



Wellmark Blue Cross and Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.

MEDICARE COMPLIANCE

The purpose of this communication is to notify employers of the mandatory reporting requirements of the Medicare, Medicaid, and SCHIP Extension Act of 2007 which were passed into law in July 2008. Your cooperation in providing the necessary employer data and data for each employee and dependent is needed in order to comply with the requirements.

The Section 111 mandates of the law help payers identify when the Centers for Medicare and Medicaid Services (CMS) should pay secondary to employer group health coverage. The goal includes reducing the amount CMS may pay as primary when they should have paid as secondary.

Under the requirements, all health plan, liability, no fault and workers compensation coverages must register with CMS as a Responsible Reporting Entity (RRE) and must report to CMS employer and member information. In order to fulfill the mandated requirements and report accurately to CMS, Wellmark, as a RRE, must gather and groups must provide the following information:

- Employer Tax Identification Number (ETIN)
- Evidence of status as a Commonly Owned/Controlled Group of Organizations, Multi/Multiple Employer Group health plan (such as an Association or Trust), Hour Bank or Union health plan
- Total number of group employees/group size
- Social Security Numbers (SSNs) or Health Insurance Claim Numbers (HICNs) of active employees, spouses, domestic partners
- SSNs or HICNs for those dependents with end stage renal disease (ESRD) or disabled
- Status of all employees and effective date of that status (i.e. active, COBRA, retired)
- Disability information begin or end dates, if known

Please take a moment to complete the Confirmation of Medicare Secondary Payer (MSP) Addendum form. This will allow us to capture your employer data for reporting to CMS. Member data is gathered through the use of the group's existing enrollment and eligibility data collection channels, which may include paper applications or electronic data exchanges and should be provided through those processes.

Failure to provide the group information requested on the attached Confirmation of MSP Addendum can result in penalties being assessed to the group including, but not limited to, \$1,000 per day per member for not accurately reporting to CMS and/or an excise tax equivalent to 25 percent of the employer's group health plan expenses for the relevant year.



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FOR ADMINISTRATIVE USE ONLY
New Group: Group # _____
Coverage Effective Date: ____/____/____

CONFIRMATION OF MSP ADDENDUM

ALL NEW AND RENEWAL GROUPS ARE REQUIRED TO SUBMIT A COMPLETED FORM. FAILURE TO SUBMIT A COMPLETED FORM WILL DELAY THE INITIAL ENROLLMENT OR RENEWAL PROCESS UNTIL THIS FORM IS SUBMITTED.

Part A - Employer Information

Please complete a separate confirmation form for each Employer Tax Identification Number you use to report employee earnings to the Internal Revenue Service (IRS). See the Medicare Secondary Payer Definitions page (M-1756) for more information on terms shown in italics.

Employer Tax Identification Number: [] [] [] [] [] [] [] [] [] []

Group Number (Renewing Groups Only): _____

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____

Telephone Number: _____ E-mail Address (optional): _____

- 1. Did your organization make contributions on behalf of any employee who was covered under a collectively bargained Health and Welfare Fund (i.e., union plan) during the previous calendar year?
2. Did you have 20 or more employees for 20 or more calendar weeks (this includes all full-time, part-time, intermittent, leased and/or seasonal employees, not just those eligible or enrolled employees) during the previous or current calendar year?
3. Did you have 100 or more employees during 50 percent of your business days (this includes all full-time, part-time, intermittent, leased and/or seasonal employees, not just those eligible or enrolled employees) during the previous calendar year?
4. Did your organization participate in a multi or multiple employer group health plan (more than one employer in group, i.e., Multiple Employer Welfare Association) during the previous calendar year?
5. Was your organization part of a commonly owned or commonly controlled group of organizations during the previous calendar year?

Name: _____ Address: _____ City: _____ State: _____ Zip: _____

Part B - Employer Certification

I certify that the information provided is accurate and truthful. All information will be used to identify the Medicare Secondary Payer status of Medicare-enrolled employees.

Signature _____ Date ____/____/____

Table with 4 columns: Send completed MSP form based on following: IA & SD Large Groups (new or renewal), IA & SD Small Groups (new or renewing with benefit changes), IA Small Groups renewing with no benefit change - send this form to: Wellmark, Inc., SD Small Groups renewing with no benefit change: Wellmark, Inc.

Required Federal Accessibility and Nondiscrimination Notice



Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Wellmark does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, निःशुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deutsch schwetze duscht, kansch du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တၢ်ဒုးသ့ၣ်ညါ-နမ့ၢ်ကတိၢ်ကညိၣ်န့ၢ်. န့ၢ်တၢ်မၤစၢၤတၢ်ဝဲးတၢ်မၤတၢ်ဝဲး, လၢတၢ်ဝဲးလၢတၢ်ဝဲးလၢ. နီၣ်လၢနီၣ်ဝဲၤ. ဝဲးတၢ်နီၣ်ဆူၣ် ၈၀၀-၅၂၄-၉၂၄၂ မ့ၢ်တမ့ၢ် (TTY: ၈၈၈-၇၈၁-၄၂၆၂) တတ့ၢ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: ከግርግር ገጥሞች ለሆነ፣ የቋንቋ አገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም በ(TTY: 888-781-4262) ደውሎ ያነጋገሩ።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maada. Hebir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quonnaamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'éhjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojí' hóline' 800-524-9242 doodaii' (TTY: 888-781-4262)