# PART I. General Contact Information

## A. Plan Sponsor Information

1) Sponsor's Name:

2) Sponsor's Classification:

- □ Government
- □ Union
- □ Religious
- □ Commercial
- □ Non-profit

3) Employer Identification Number (EIN):

4) Phone: _____ 5) FAX (optional): _____

6) Company Address (must be associated with the EIN provided above):

_____
Street

_____
City State Zip Code

7) Plan Sponsor Website Address (optional): _____

## B. Authorized Representative

1) Name: _____ 2) Title: _____

3) Date of Birth: _____ 4) Social Security Number: _____

5) E-mail Address: _____

6) Phone: _____ 7) FAX (optional): _____

8) Address:
(If different from Sponsor Address) Street

_____
City State Zip Code

9) Is this individual authorized to view HIPAA PHI? Yes/No

## C. Account Manager

1) Name: _____ 2) Title: _____

3) Date of Birth: _____ 4) Social Security Number: _____

5) E-mail Address: _____

6) Phone: _____ 7) FAX (optional): _____

8) Address: _____

Street

_____

City State Zip Code

9) Is this individual authorized to view HIPAA PHI? Yes/No

## D. Application Designee(s)

1a) Name: _____ 1b) Title: _____

1c) Date of Birth: _____ 2d) Social Security Number: _____

1e) E-mail Address: _____

1f) Phone: _____ 1g) FAX (optional): _____

1h) Address: _____
Street

_____
City State Zip Code

1i) Is this individual authorized to view HIPAA PHI? Yes/No

1j) Check the following Parts of the Application that this Designee can edit and/or submit:

- □ Part I – General Contact Information
- □ Part II – Plan Information
- □ Part IV – Electronic Funds Transfer (EFT)
- □ Part V – Payment Frequency
- □ Part VI – Retiree List Submission

1k) Does this Designee have the authority to change and/or submit payment requests? Yes/No

1l) Does this Designee have the authority to request an extension for application submission? Yes/No

1m) Does this Designee have the authority to withdraw this application? Yes/No

1n) Does this Designee have the authority to delete this application? Yes/No

1o) Does this Designee have the authority to request an appeal? Yes/No

2a) Name: _____ 2b) Title: _____

2c) Date of Birth: _____ 2d) Social Security Number: _____

2e) E-mail Address: _____

2f) Phone: _____ 2g) FAX (optional): _____

2h) Address: _____
Street

_____
City State Zip Code

2i) Is this individual authorized to view HIPAA PHI? Yes/No

2j) Check the following Parts of the Application that this Designee can edit and/or submit:

□ Part I – General Contact Information

□ Part II – Plan Information

□ Part IV – Electronic Funds Transfer (EFT)

□ Part V – Payment Frequency

□ Part VI – Retiree List Submission

2k) Does this Designee have the authority to submit and change payment requests? Yes/No

2l) Does this Designee have the authority to request an extension for application submission? Yes/No

2m) Does this Designee have the authority to withdraw this application? Yes/No

2n) Does this Designee have the authority to delete this application? Yes/No

2o) Does this Designee have the authority to request an appeal? Yes/No

Click here for additional Designees □

## PART II. Plan Information

### A. Plan Information

1) Plan Name: _____ 2) Plan Year - Start Date:_____ End Date: _____

3) Are you combining two or more benefit options (listed in Part II(B)) for the purpose of demonstrating that the plan meets the actuarial equivalence Net Test? Yes/No

### B. Benefit Option(s) Provided Under This Plan

1a) Benefit Option Name: _____
1b) Unique Benefit Option Identifier: _____
1c) Benefit Option Type: Self-Funded _____ Fully Insured _____ Both _____
1d) Benefit Administrator Company Name: _____
1e) Name of Attesting Actuary: _____ 1f) AAA Membership Number: _____
1g) Job Title: _____
1h)Actuary Company Name (optional): _____ 1i) E-mail Address:_____
1j) Phone: _____ 1k) FAX (optional): _____
1l) Address: _____
Street
_____
City State Zip Code

2a) Benefit Option Name: _____
2b) Unique Benefit Option Identifier: _____
2c) Benefit Option Type: Self-Funded _____ Fully Insured _____ Both _____
2d) Benefit Administrator Company Name: _____
2e) Name of Attesting Actuary: _____ 2f) AAA Membership Number: _____
2g) Job Title: _____
2h) Actuary Company Name (optional): _____ 2i) E-mail Address: _____
2j) Phone: _____ 2k) FAX (optional): _____
2l) Address: _____
Street
_____
City State Zip Code

Click here to add more benefit options □

### C. Contact Information for the Actuary Attesting to the Net Value of the Combined Benefit Options

1) Name: _____ 2) AAA Membership Number: _____

3) Company Name: _____

4) E-mail Address: _____

5) Phone: _____ 6) FAX (optional):_____

7) Address: _____

Street

_____

City State Zip Code

# PART III. Attestation of Actuarial Equivalence

## A. Actuarial Attestation Used When Benefit Options are Combined

### (A)(i). Actuarial Attestation for the Gross Value Test

I hereby attest to the following:

I am a qualified actuary and a member of the American Academy of Actuaries. I am familiar with the requirements for, and am qualified to prepare, a Retiree Drug Subsidy (RDS) Actuarial Attestation.

The actuarial Gross Value of the benefit option(s) is at least equal to the actuarial Gross Value of the defined standard prescription drug coverage under Part D for the Part D eligible individuals who are participants and beneficiaries of the sponsor's plan for the subject plan year.

The Gross Value of the option listed in section II(B) of this application was determined using a methodology consistent with the requirements set forth at 42 C.F.R. 423.884(d)(5) and all relevant actuarial guidelines issued by CMS, and the data and assumptions used in the development of this attestation are reasonable and are based on generally accepted actuarial principles, including the appropriate actuarial standards of practice.

I understand and acknowledge that the information being provided in this attestation is being used to obtain Federal funds.

I agree to maintain and make available reports, working documents and other records as required under 42 C.F.R. 423.888(d). This includes information about data and/or assumptions I may have relied upon.

I certify that this attestation is true and accurate to the best of my knowledge and belief.

Electronic Signature □

### (A)(ii). Actuarial Attestation for the Net Value Test

I hereby attest to the following:

I am a qualified actuary and a member of the American Academy of Actuaries. I am familiar with the requirements for, and am qualified to prepare, a Retiree Drug Subsidy (RDS) actuarial attestation.

The actuarial Net Value of the Plan Sponsor's prescription drug plan (consisting of the combined benefit options listed in section II(B)) is at least equal to the actuarial Net Value of the defined standard prescription drug coverage under Part D for the Part D eligible individuals who are participants and beneficiaries of the Sponsor's Plan for the subject plan year.

The Net Value of the Plan Sponsor's prescription drug coverage was determined using the methodology consistent with the requirements set forth at 42 C.F.R. 423.884(d)(5) and all relevant actuarial guidelines issued by CMS, and the data and assumptions used in the development of this attestation are reasonable and are based on generally accepted actuarial principles, including the appropriate actuarial standards of practice.

I understand and acknowledge that the information being provided in this attestation is being used to obtain Federal funds.

I agree to maintain and make available reports, working documents and other records as required under 42 C.F.R. 423.888(d). This includes information about data and/or assumptions I may have relied upon.

I certify that this attestation is true and accurate to the best of my knowledge and belief.

Electronic Signature □

## B. Actuarial Attestation for the Gross Value and Net Value Tests When the Benefit Options are Not Combined

I hereby attest to the following:

I am a qualified actuary and a member of the American Academy of Actuaries. I am familiar with the requirements for, and am qualified to prepare, a Retiree Drug Subsidy (RDS) Actuarial Attestation.

The actuarial Gross Value and Net Value of the benefit option is at least equal to the actuarial Gross Value and Net Value of the defined standard prescription drug coverage under Part D for the Part D eligible individuals who are participants and beneficiaries of the sponsor's plan for the subject plan year.

The Gross Value and Net Value of the option listed in section II(B) of this application was determined using a methodology consistent with the requirements set forth at 42 C.F.R. 423.884(d)(5) and all relevant actuarial guidelines issued by CMS, and the data and assumptions used in the development of this attestation are reasonable and are based on generally accepted actuarial principles, including the appropriate actuarial standards of practice.

I understand and acknowledge that the information being provided in this attestation is being used to obtain Federal funds.

I agree to maintain and make available reports, working documents and other records as required under 42 C.F.R. 423.888(d). This includes information about data and/or assumptions I may have relied upon.

I certify that this attestation is true and accurate to the best of my knowledge and belief.

Electronic Signature □

## PART IV. Electronic Fund Transfer (EFT) Information

1) Bank Name: _____

2) Bank Address: _____
Street

_____ _____
City State Zip Code

3) Account Number: _____ 4) Name on Account: _____

5) ☐ Checking Account ☐ Savings Account

6) Bank Routing Transit Number: _____

7) Bank Contact Person: _____

8) E-mail address: _____ 9) Phone: _____

## PART V. Payment Frequency

Please select one of the following payment frequencies:

1) ☐ Monthly
2) ☐ Quarterly
3) ☐ Interim Annual
4) ☐ Annual

## PART VI. Retiree List Submission

### A. Retiree List File Submission Method

1) ☐ Hypertext Transfer Protocol Secure (HTTPS) to RDS Center
2) ☐ Plan Sponsor Mainframe to RDS Center Mainframe (Please note that if you elect this option a representative from the RDS Center will contact the Plan Sponsor Technical Contact.)
   - 2a) Plan Sponsor Technical Contact Name: _____
   - 2b) Plan Sponsor Technical Contact Phone Number: _____
   - 2c) Plan Sponsor Technical Contact Email Address: _____
3) ☐ Voluntary Data Sharing Agreement (VDSA) via the Coordination of Benefits (COB) Contractor

### B. Retiree List

Plan Sponsors must submit an electronic list of retirees for whom they are seeking subsidy payments. For each retiree the following data elements must be provided:

- Application ID (assigned to you by the RDS Center)
- Unique Benefit Option Identifier – This should be the same as the Unique Benefit Option Identifier entered in Part II(B).
- Effective Date – This should either be the first day of the Plan Year, or the first date of coverage for the Retiree under the Plan, whichever is later.
- Termination Date – The last date of coverage for the Retiree under the Plan, if known. If unknown, leave it blank.
- First name
- Last name
- Middle initial (optional)
- Social Security Number (SSN)
- Medicare Health Insurance Claim Number (HICN)
- Date of Birth
- Gender
- Relationship to the Retiree (self, spouse, dependent)
- Type of record (add, update, delete)

## PART VII. Plan Sponsor Agreement

| | |
|---|---|
| 1. | Compliance. In order to receive subsidy payment(s), Sponsor agrees to comply with all of the terms and conditions for obtaining the retiree drug subsidy and as outlined in 42 C.F.R. 423.880 et. seq., (Subpart R) and in other guidance issued by CMS, including the conditions for submission of cost data for obtaining payment and the record retention requirements. |
| 2. | Notice of Creditable Coverage: Sponsor certifies that it has provided or will provide prior to the beginning of the plan year, creditable coverage notices in accordance with 42 C.F.R. 423.56 to Part D eligible individuals covered under the Sponsor's plan. |
| 3. | Written Agreement: Sponsor certifies that it has executed a written agreement with its health insurance issuer or group health plan regarding disclosure of information to CMS, and the issuer or plan agrees to disclose to CMS, on behalf of the Sponsor, the information necessary for the Sponsor to comply with the requirements of the RDS Program. (For year one of the RDS program Sponsor certifies that it will execute the written agreement prior to January 1, 2006.) |
| 4. | Use of Records: Sponsor understands and agrees that officers, employees and contractors of the Department of Health and Human Services, including the Office of Inspector General (OIG), may use information collected under the RDS Program only for the purposes of, and to the extent necessary in, carrying out their responsibilities under 42 C.F.R. Subpart R including, but not limited to, determination of payments and payment-related oversight and program integrity activities, or as otherwise required by law. This restriction does not limit OIG authority to conduct audits and evaluations under 42 C.F.R. Subpart R or other authority. |
| 5. | Obtaining Federal Funds: Sponsor acknowledges that the information furnished in its retiree drug subsidy application is being provided to obtain Federal funds. Sponsor certifies that it requires all subcontractors, including plan administrators, to acknowledge that information provided in connection with the subcontract is used for purposes of obtaining Federal funds. Sponsor acknowledges that payment of a subsidy is conditioned on the submission of accurate information. Sponsor agrees that it will not knowingly present or cause to be presented a false or fraudulent claim. Sponsor acknowledges that any overpayment made to the Sponsor under the RDS program may be recouped by CMS/RDS Contractor. Sponsor will promptly notify CMS of any changes to the information submitted in its Plan Sponsor Agreement. |
| 6. | Data Security: Sponsor agrees to establish and implement proper safeguards against unauthorized use and disclosure of the data exchanged under this RDS Application. Sponsor recognizes that the use and disclosure of protected health information is governed by the Health Insurance Portability and Accountability Act (HIPAA) and accompanying regulations. Plan Sponsor certifies that its retiree group health plan(s) has established and implemented appropriate safeguards in compliance with 45 C.F.R. Parts 160, 162 and 164 (HIPAA administrative simplification, privacy and security rule) in order to prevent unauthorized disclosure of such information or data. Sponsor also agrees that if it participates in the administration of the plan(s),then it has also established and implemented the same safeguards in compliance with the above HIPAA citations. Any and all Sponsor personnel interacting with this data shall be advised of (1) the confidential nature of the information; (2) safeguards required to protect the information, and (3) the administrative, civil and criminal penalties for noncompliance contained in applicable Federal laws. |
| 7. | Depository Information: Sponsor hereby authorizes CMS to initiate payment, credit entries and other adjustments, including offsets and requests for payment, in accordance with the provisions of 42 C.F.R. Subpart R to the account at the financial institution (hereinafter the "Depository") indicated in Part IV(A)(1) of the Plan Sponsor Application. When Sponsor know of, and agrees to, an overpayment it must pay that amount back to CMS. Sponsor agrees to promptly notify CMS of any changes in its Depository information and submit an update EFT Authorization. |
| 8. | Change of Ownership: The Sponsor shall provide written notice to CMS/RDS Contractor at least 60 days prior to a change in ownership. When a change of ownership results in a transfer of the liability for prescription drug |

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|---|---|
| | costs, this Plan Sponsor Agreement is automatically assigned to the new owner, who shall be subject to the terms and conditions of this Plan Sponsor Agreement. |

## PART VIII. Plan Sponsor Electronic Signature

Signature of Plan Sponsor Authorized Representative

I, the undersigned Authorized Representative of Sponsor, declare that I have examined this Application and Plan Sponsor Agreement. My signature legally and financially binds the Sponsor to the laws, regulations, and other guidance applicable to the RDS program (including 42 C.F.R. Subpart R) and all other applicable laws regulations. I certify that the information contained in this Application and Plan Sponsor Agreement is true, accurate and complete to the best of my knowledge and belief, and I authorize CMS/RDS Contractor to verify this information. I understand that, because payment of a subsidy will be made from Federal funds, any false statements, documents, or concealment of a material fact is subject to prosecution under any applicable Federal and/or State law. If I become aware that information in this application is not (or is no longer) true, accurate and complete, I agree to notify CMS/RDS Contractor promptly of this fact.

□ Electronic Signature