MEDICARE SECONDARY PAYER
INSURER VOLUNTARY DATA SHARING AGREEMENT

This Voluntary Data Sharing Agreement (the "Agreement") for the exchange of health care coverage enrollment information is entered into between [*insert Insurer name*] and related entities as identified herein, a [*insert State name if appropriate*] Corporation, with its principal address at [*insert Insurer address*] (the "Insurer") and the United States Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services ("CMS") (together, the "Parties") on this ___ day of _____, 20__(the "Effective Date").

RECITALS

I. THE MEDICARE SECONDARY PAYER PROGRAM

The sections of the Social Security Act known as the Medicare Secondary Payer (MSP) provisions were originally enacted in the early 1980s. Since then, MSP law has been repeatedly amended by Congress and CMS has promulgated several sets of regulations concerning the MSP laws. The current MSP regulations, codified at 42 C.F.R. § 411.20 et seq., created a change in the administration of Medicare program secondary payer determinations. In certain cases the regulations have shifted primary payment responsibility from Medicare to another insurer. The term "MSP Laws" as used in this Agreement refers to the MSP provisions found at 42 U.S.C. § 1395y(b), as amended, excepting 42 U.S.C. § 1395y(b)(2)(A)(ii), and the regulations related to the statute, as amended and currently found at 42 C.F.R. § 411.20-.37, 411.100-.130, 411.160-.175, and 411.200-.206.

II. THE MEDICARE MODERNIZATION ACT AND VDSAs

The Medicare Prescription Drug, Improvement, and Modernization Act (the Medicare Modernization Act, or MMA) was enacted in 2003. Included in the MMA is a new prescription drug benefit, referred to as Medicare Part D. Under provisions found in § 1860D-2(a) (4) of the MMA, the Medicare Secondary Payer (MSP) rules have been incorporated in the MMA and apply to prescription drug coverage in the same manner as they apply to hospital and medical coverage. Part D establishes access through beneficiary enrollment in coverage provided by private sector Prescription Drug Plans (PDPs) and through beneficiary enrollment in Medicare Advantage plans that include a prescription drug benefit (MA-PDs). The MMA also contains a new retiree drug subsidy that is designed to encourage employers and unions to continue providing prescription drug coverage for their retirees. Under the new law, employers and unions that offer drug coverage that is as good as or better than Medicare's defined standard prescription drug benefit under Part D will be eligible for a retiree drug subsidy. Finally, the MMA introduces a requirement that PDPs and MA-PDs keep track of the TrOOP – "true out-of-pocket" spending – made by Part D beneficiaries.

Insurers that enter into a Voluntary Data Sharing Agreement (VDSA) can use it to determine the Medicare program eligibility of individuals who are enrolled in health insurance plans that include prescription drug benefits authorized by the MMA. VDSA data exchange procedures can quickly clarify appropriate participation, coverage and payment responsibility determinations. Participation in a VDSA will also help the Insurer assist in the accurate and timely calculation and tracking of beneficiary True Out-of-Pocket (TrOOP) spending. Finally, current regulations specifically authorize the use of a VDSA as an alternative method of providing retiree drug subsidy enrollment files to the Retiree Drug Subsidy (RDS) Contractor.

III. PURPOSE OF THIS AGREEMENT

The CMS and the Insurer seek to more efficiently coordinate health care benefit payments between them in accordance with the MSP, MMA and other Medicare-related laws. The purpose of this Agreement is to establish and describe conditions under which the Insurer and CMS agree to exchange health care coverage enrollment data. To facilitate better and more efficient coordination of benefits in accordance the MSP, MMA and other Medicare related laws, the Insurer agrees to provide CMS with specified data describing its covered individual population. CMS agrees to provide the Insurer with Medicare entitlement data. Examples of the data to be exchanged are more specifically described in the Input and Response File Layouts, Attachments A through G. The process through which these data will be exchanged is described in TERMS AND CONDITIONS, Sections A through O, below. The Insurer further agrees that a completed copy of Attachment M, the Insurer VDSA Implementation Questionnaire, will accompany the copy (s) of this agreement delivered to CMS.

IV. VDSA USER GUIDE

A “VDSA User Guide” has been produced to accompany this Agreement. The VDSA User Guide is designed to accommodate the ordinary process changes and revisions that result from ongoing program operations. Current operational versions of all input and response data files can be found in the VDSA User Guide. Instructions for preparing a VDSA for signature are given in Section A of the VDSA User Guide.

V. DEFINITIONS

NOTE: These definitions are informational. While they accurately describe the terms being defined, they should not be construed as incorporating the force of regulation.

1. "Active Employee" shall mean an individual who satisfies the requirements of current employee status as explained at 42 C.F.R. § 411.104.

2. "Active Covered Individuals" are, for the purpose of this Agreement, defined as those Active Employees and their spouses and dependents who are enrolled in an employer Group Health Plan ("GHP") and who are, at a minimum, no younger than 55 years of age.

3. “Agent” shall mean an individual or entity authorized by the Insurer to act on the Insurer’s behalf for purposes of administering this Agreement. For purposes of this Agreement, all actions undertaken by the agent in administering this Agreement on behalf of the Insurer shall be binding on the Insurer.

4. “Coordination of Benefits Agreement (COBA)” refers to the standardized agreements between the CMS and other health insurers, and Medicaid State Agencies and their fiscal agents, for the electronic exchange of eligibility and paid claims data used to coordinate correct health claim benefit payments by Medicare and other insurers. Insurers that have signed a COBA with CMS have the option of reporting drug coverage information using either the VDSA process or the COBA process.

5. “Covered Individual” shall mean any individual enrolled in a health plan or policy, including but not limited to a group health plan or policy, for which the Insurer or its Subsidiary acts as an insurer, third party administrator, health plan sponsor or any combination thereof.

6. “Customer” shall mean any person or entity for whom, or for which, an Insurer or one of its Subsidiaries (defined below) provides health care financing or third-party administrator (“TPA”) services, including insured employer groups and self-insured groups.

7. “Employer” is defined in 42 C.F.R. § 411.101 for purposes of this Agreement.

8. “Group Health Plan (GHP)” is defined in 42 C.F.R. § 411.101 for purposes of this Agreement. Generally, a GHP is a health insurance benefit program made available to employees (and, often, their dependents) by an Employer.

9. "Inactive Covered Individuals" are, for the purpose of this Agreement, defined as any “Covered Individuals” – individuals enrolled in a health plan or policy, including but not limited to a group health plan or policy, for which the Insurer or its Subsidiary acts as an insurer, third party administrator, health plan sponsor or any combination thereof – and who cannot be classified as Active Covered Individuals. See, generally, 42 C.F.R § 411.104.

10. “MSP Input File” is a data set transmitted from an Insurer to CMS that consists of data elements pertaining to health care coverage information of the Insurer’s Active Covered Individuals.

11. “MSP Response File” is a data set transmitted from CMS to an Insurer after the data supplied in the Insurer’s MSP Input File has been processed. The MSP Response File is the CMS reply to the data supplied or information sought in the MSP Input File.

12. “Non-MSP Input File” is a data set transmitted from an Insurer to CMS that consists of data elements pertaining to health care coverage information of the Insurer’s Inactive Covered Individuals.

13. "Non-MSP Response File" is a data set transmitted from CMS to an Insurer after the data supplied in the Insurer's Non-MSP Input File has been processed. The Non-MSP Response File is the CMS reply to the data supplied or information sought in the Non-MSP Input File.

14. "Query Only HEW Input File" shall mean a Non-MSP File that does not contain information about drug coverage. This Non-MSP Query Only File will be submitted to CMS wrapped into a HIPAA-compliant 270 Format.

15. "Query Only HEW Response File" shall mean a Non-MSP Query Response File returned from CMS wrapped into a HIPAA-compliant 271 Format.

16. "Retiree" shall mean Qualifying Covered Retiree, a Part D eligible individual who is not enrolled in a Part D plan, and who is a participant (or the spouse or dependent of a participant) covered under employment-based retiree health coverage that is a "qualified retiree prescription drug plan" (a subsidy-eligible employer pharmacy benefit plan).

17. "Subsidiary" shall mean those subsidiaries and affiliate licensees of the Insurer.

18. "TIN Reference File" is a data set transmitted from an insurer to CMS containing required Insurer, group health plan, third party administrator, other plan sponsor and claims processor Tax Identification Number information.

TERMS AND CONDITIONS

In consideration of the mutual promises and representations set forth in this Agreement, the Parties agree as follows:

A. PREPARATORY PERIOD AND TEST PROCEDURES FOR COVERED INDIVIDUALS

Within ten (10) business days or as soon as is practicable after the effective date of this Agreement, CMS, the CMS Coordination of Benefits Contractor (COBC) and the Insurer will discuss the operational terms of the Agreement. Issue areas covered during this Preparatory Period shall include data requirements, file submissions, review of error codes, and other matters, as necessary. All parties will endeavor to resolve problems identified during Preparatory Period discussions within thirty (30) business days following the effective date of the Agreement.

The Insurer acknowledges that the parties to this Agreement cannot proceed to full production file exchange until test file exchanges have been completed to the satisfaction of both CMS and the Insurer. Prior to submitting its Initial MSP and Non-MSP Input Files, the Insurer shall submit a Test Initial MSP Input File and a Test Initial Non-MSP Input File to CMS, receive a Test MSP Response File and a Test Non-MSP Response File in return, correct errors identified by CMS in the Test Initial MSP and

Non-MSP Input Files, and add new Enrollees in Test Ongoing MSP and Non-MSP Input Files. The Test process is described in detail in the User Guide.

After successfully completing the Test process, the Initial Input File shall be submitted in accordance with provisions in Sections C and D, below.

B. PRIMARY PAYER DETERMINATION FOR COVERED INDIVIDUALS

The Insurer shall identify those Covered Individuals, as defined in Section V. of this Agreement, in accordance with the process described in "C" and "D" below. In accordance with the process described in "C" below, CMS shall identify those Active Covered Individuals who are Medicare beneficiaries for whom Medicare assumes primary or secondary payment responsibility, based on coverage enrollment information received from the Insurer. In accordance with the process described in "D" below, CMS shall identify those Inactive Covered Individuals for whom Medicare assumes primary payment responsibility.

C. CONTINUING ELECTRONIC DATA EXCHANGE FOR MEDICARE SECONDARY PAYER REPORTING

1. Within forty-five (45) days of the completion of the process described in Section A (the "Preparatory Period"), the Insurer shall provide to CMS a file containing the data elements included in the record layout found at Attachment A, with respect to Active Covered Individuals ("MSP Input File"). The data provided by the Insurer in this initial MSP Input File shall cover all the periods of coverage for the above-mentioned Active Covered Individuals from **[*insert date*]** through the last day of the month in which the MSP Input File ("MSP Input File Date") is submitted to CMS.

   The Insurer may opt to require its Pharmaceutical Benefit Manager (PBM) to submit files containing the prescription drug coverage of Active Covered Individuals, in a format provided by CMS for PBM use in data sharing. Using the VDSA Implementation Questionnaire found at Attachment M of this Agreement, the Insurer shall indicate whether its PBM will submit prescription drug coverage of its Active Covered Individuals on the Employer's behalf.

2. On the same date as the Insurer's MSP Input File submission as described in C.1 above, the Insurer shall submit a File containing the data elements in the Attachment B record layout titled "TIN Reference File." This file contains required Insurer, group health plan, third party administrator, other plan sponsor and claims processor TIN information. The Insurer shall submit an updated TIN Reference File every quarter in which additional TIN records need to be added to the TIN Reference File or when corrections to previously submitted TIN records are required.

3. CMS shall search its Medicare enrollment files for the Active Covered Individuals identified on the Insurer's MSP Input File. Where a match occurs and according to the MSP Laws the GHP is primary, CMS shall annotate its Medicare enrollment files to identify the GHP as a primary payer and Medicare as a secondary payer for the Active Covered Individuals.

4. Within forty-five (45) days of CMS's receipt of the Insurer's MSP Input File, for individuals identified under the electronic match conducted pursuant to C.3. CMS shall provide to the Insurer a file containing the data elements listed in Attachment C, labeled "MSP Response File."

5. By (i), the 15th day of the 2nd month following the end of the calendar quarter in which the MSP Input File is delivered to CMS, or (ii) within forty-five (45) days after the Insurer's receipt from CMS of the MSP Response File for the preceding quarter, whichever is later (in either case the "MSP Update File Date"), the Insurer shall provide CMS with an MSP Input File containing the data elements listed in Attachment A, effective through the last day of the month in which the MSP Input File ("MSP Update File Date") is submitted to CMS.

   This new submission of the MSP Input File will function as the MSP Update File. The MSP Update File shall list (1) the Insurer's new reported Active Covered Individuals who now, due to age or Active Employee status, meet the criteria for inclusion in the continuing electronic data exchange ("adds"); (2) previously reported Active Covered Individuals for whom the Insurer has not yet received confirmation of Medicare entitlement via the previous CMS Response File ("adds"); (3) changes in status as an Active Employee or in GHP coverage for Covered Individuals identified in earlier submissions ("updates"); and (4) deletions of individuals who were erroneously included on earlier files ("deletes") but for which the insurer subsequently received confirmation of Medicare entitlement via a CMS Response File. (Definitions of the terms "adds," "updates" and "deletes" can be found in the accompanying VDSA User Guide.) For individuals included as "adds" on an MSP Update File, CMS shall conduct the matching process set out in C.3., and provide Medicare entitlement data to the Insurer on the matches as required by C.6.

6. Within forty-five (45) days of CMS's receipt of the MSP Update File, CMS shall provide the Insurer with the MSP Response File for individuals identified under the electronic match conducted pursuant to C.3.

D. CONTINUING ELECTRONIC DATA EXCHANGE FOR NON-MEDICARE SECONDARY PAYER REPORTING

The Non-MSP File serves three purposes. First, for Inactive Covered Individuals as defined in Section V, the Insurer shall use the Non-MSP File to report prescription drug coverage that is secondary to Medicare Part D coverage. Second, the Insurer may use the Non-MSP File to report the prescription drug coverage of retirees for whom an

Insurer's employer client is claiming the Part D employer subsidy. Third, the CMS shall provide Medicare entitlement information to the Insurer for all Covered Individuals (as defined in Section V) who are included in the Non-MSP File. The electronic data file submission processes described in Sections D.1. through D.4., below, shall be referred to as the Non-MSP File submission processes.

Insurers will have the option of submitting Non-MSP Input Files in the record layout found at Attachment D, containing D, S and N records described below, and receiving Non MSP Response Files on a quarterly or monthly basis in the record layout found at Attachment E. Using the VDSA Implementation Questionnaire found at Section P, Attachment M of this Agreement, the Employer shall indicate whether it will submit Non-MSP Input Files on a quarterly or monthly basis. The User Guide that accompanies this Agreement contains the specific file submission protocols for each process described below.

1. Continuing electronic reporting of prescription drug coverage that is secondary to Medicare Part D: D Records.

   If an Insurer is providing coverage for a Medicare beneficiary who is classified as an Inactive Covered Individual, and the Insurer is not claiming the subsidy for that individual, on a quarterly/monthly basis the Insurer shall submit this beneficiary information to CMS via a Non-MSP Input File. When a match is found, the coverage information will be applied to CMS's systems and used for prescription drug coordination of benefits. Within forty-five (45)/fifteen (15) days of CMS's receipt of the Non-MSP Covered Individual Input File, CMS shall provide the Insurer with Medicare entitlement data regarding individuals identified through the electronic data match. CMS shall provide these data to the Insurer in a file containing the data elements listed in the record layout prescribed in Attachment E, labeled Non-MSP Response File. In cases when a match does not occur (that is, Part D enrollment is not confirmed), the information contained on the Non-MSP Input File record will be sent back to the Insurer using the same Non-MSP Response File layout, without Medicare entitlement information.

   Following the initial Non-MSP Input File, the Insurer shall submit regularly scheduled file transfers of ongoing changes in its Non-MSP data, consisting of adds, updates and deletes.

   If the Insurer has entered into a Coordination of Benefits Agreement (COBA) with CMS, it may opt to submit secondary prescription drug coverage using either the COBA or a VDSA. Using the VDSA Implementation Questionnaire found at Section P, Attachment M of this Agreement, the Insurer shall indicate whether it will submit secondary prescription drug coverage as a part of this Agreement or via its COBA. The Insurer may also opt to require its Pharmaceutical Benefit Manager (PBM) to submit files containing the prescription drug coverage of Inactive Covered Individuals, in a format provided by CMS for PBM use in data sharing. Using the Questionnaire at Attachment M of this Agreement, the Insurer

shall indicate whether its PBM will submit prescription drug coverage of its Inactive Covered Individuals on the Insurer's behalf.

2. Continuing electronic reporting of retiree prescription drug coverage for the administration of the Employer Subsidy: S Records.

   Employers wishing to participate in the Employer Subsidy for retiree drug coverage must submit an application to the Retiree Drug Subsidy (RDS) Contractor. The application includes an attestation of the actuarial equivalence of the employer's retiree drug plan to the Medicare Part D drug coverage benefit.

   For all retirees for whom it wishes to claim the subsidy, the Employer will be required to submit to the RDS Contractor an initial enrollment file of all those individuals. This first enrollment file will be followed by regularly scheduled subsequent file transfers containing adds, updates and deletes, using a Web portal maintained by the RDS Contractor.

   Current regulations specifically authorize the use of a VDSA as an alternative method of providing retiree drug subsidy enrollment files to the RDS Contractor. VDSA partners submitting initial enrollment files and subsequent update files for the Employer Subsidy may opt to do so as part of their regular quarterly/monthly VDSA filing using S records. The Insurer shall indicate whether it intends to use this process using the VDSA Implementation Questionnaire, found at Attachment M of this Agreement.

   If the Non-MSP Covered Individuals submitted by the Insurer for the Employer Subsidy on behalf of its customers are found by CMS to be enrolled in Medicare Part D, CMS shall convert the records of those individuals into secondary prescription drug coverage reporting – D Records – as described in D.1., above. The Insurer will be notified in the Non-MSP Response File that the records were converted. In subsequent Non-MSP Input File submissions the Insurer shall submit adds, updates and deletes for the records converted, as though the records were originally submitted as D records. Note that this provision does not preclude the Employer from re-submitting the original S records in an attempt to claim the subsidy on those individuals previously rejected because they were enrolled in a Part D Plan when the previous file was submitted.

3. Non-Reporting process: N Records.

   Using the N action type the Insurer may submit records for any Covered Individuals via the Non-MSP Input File. CMS shall search its files for the individuals identified on this Non-MSP Input File. Within forty-five (45)/fifteen (15) days of CMS's receipt of the Non-MSP Input File, CMS shall provide the Insurer with Medicare entitlement data regarding individuals identified through the electronic data match. CMS shall provide these data to the Insurer in a file containing the data elements listed in the record layout prescribed in Attachment

E, labeled the Non-MSP Response File. Where a match does not occur, the information on the Non-MSP Input File record will be sent back to the Insurer using the same Non-MSP Response File layout, without Medicare entitlement information.

4. Continuing electronic exchange of Medicare entitlement information for Covered Individuals, and the HIPAA Eligibility Wrapper (HEW) software.

   The Insurer may use the Non-MSP Input File to find the Medicare entitlement of Covered Individuals only when it submits files that include either secondary prescription drug coverage or retiree prescription drug coverage. Whenever it is available, CMS will include Medicare entitlement information as part of the Non-MSP Response File.

   If the Insurer does not use the Non-MSP Input file to report either secondary to Medicare prescription drug coverage, described in Section D.1., above, or retiree prescription drug coverage, described in Section D.2., above, the Insurer shall use the HIPAA Eligibility Wrapper (HEW) software provided by CMS to submit the VDSA Query Only HEW Input File (for queries of Medicare entitlement) using the record layout found in Attachment F. After receiving the response file from CMS, the HEW software will generate the VDSA Query Only HEW Response File in the record layout found in Attachment G.

E. CORRECTION OF RECORDS CONTAINING ERRORS

Upon receipt of the Insurer's Covered Individuals Initial and Update Files, CMS shall analyze the files to identify any errors and defects in the data provided (such as unreadable entries or data that do not comply with the terms of this Agreement). When it detects errors and/or defects, CMS shall provide to the Insurer an MSP Response File and a Non-MSP Response File, containing the data elements in the record layout prescribed in Attachment C or E, identifying the errors detected on the Initial or Update Files. Recognizing that all Voluntary Data Sharing Agreement data is submitter-driven information, the Insurer agrees to correct any record errors identified in a Response File, provided such records can be corrected, and to resubmit those records as "add" or “update” records on the next Update File.

F. BASIS - THE BENEFICIARY AUTOMATED STATUS AND INQUIRY SYSTEM APPLICATION

The BASIS application: When the Insurer has a more immediate need to know Medicare entitlement, BASIS allows the Insurer to make a limited number of on-line queries of Medicare entitlement of its Covered Individuals through a private web-based host. Access to BASIS is contingent on the Insurer having submitted its Initial MSP and Non-MSP Input Files and its most recent MSP and Non-MSP Update Files during the last quarterly production cycle. Refer to the User Guide for more detail about the BASIS process, outlined as follows:

1. CMS shall (through its designated contractor) assign an Insurer personal identification number ("IPIN") to the Insurer. The IPIN information shall be received by the designated Insurer Contact Person within 30 days of submission of the initial MSP and Non-MSP Input Files, as described in Sections A – D above, along with information concerning the designated telephone line to be used for the BASIS application.

2. CMS shall notify the Insurer when the BASIS application is operational and shall provide detailed instructions to assist the Insurer in using the BASIS application.

3. The Insurer shall dial a designated telephone line to access the BASIS application using its assigned IPIN. For each Covered Individual for whom the Insurer is requesting Medicare entitlement information, the Insurer shall enter the following data elements that the Insurer maintains in its system concerning that individual:

   - Social Security Number
   - Last Name
   - First Initial
   - Date of Birth
   - Sex

4. The CMS will post the results of the above referenced inquiry(s) to BASIS immediately after the Insurer submits its inquiry(s) to the BASIS application.

G. Rx BIN AND PCN CODES

Both the Rx BIN and PCN are numbers used in the electronic routing of pharmacy benefit reimbursement information. The prescription Benefit International Number (Rx BIN) and the Pharmacy Benefit Processor Control Number (PCN) are assigned to network pharmacy payers by the American National Standards Institute or by the National Council for Prescription Drug Programs, respectively. All network pharmacy payers have an Rx BIN. Many, though not all, also have a PCN. The four data input and response files used by the VDSA program (Attachments A, C, D, and E in the User Guide) include data fields for both Rx BIN and PCN reporting.

To participate in the TrOOP Facilitation process, Insurers must designate a unique Rx BIN or PCN number to code for coverage that is secondary to Medicare Part D. This unique coding will assure that the secondary paid claim is captured by the TrOOP Facilitation contractor in the claim response sent from the payer to the pharmacy provider. The "TrOOP Facilitation" Rx BIN(s) or PCN(s) will be separate and distinct from the Insurer's standard Rx BIN(s) and PCN(s). The regular Rx BIN(s) and PCN(s) shall be provided in MSP File Input Records. <u>The TrOOP Facilitation Rx BIN or PCN are the required routing codes for use with Non-MSP Input Records.</u>

When CMS identifies an Inactive Covered Individual on the Non-MSP File as a Medicare Part D beneficiary, the prescription drug coverage and TrOOP Facilitation Rx

BIN and PCN routing information will be provided to the Part D plan and the TrOOP Facilitation contractor. By signing this Agreement, the Insurer agrees to obtain a TrOOP Facilitation Rx BIN or PCN (if necessary). In addition, the Employer must provide CMS with a list of all its standard and TrOOP facilitation BINs and PCNs no later than ten (10) business days prior to submitting its first production files. (See Number 10, "Miscellaneous: VDSA Implementation Questionnaire, Attachment M," in Section P of this Agreement.)

H. DUTY TO OBTAIN DATA

The Insurer may be in possession of some, but not all, of the data elements identified in Attachments A, B, C, D and E in the VDSA User Guide. With respect to data not originally in its possession, the Insurer shall use commercially reasonable efforts to obtain these data as soon as possible. These data should be obtained no later than the first practical enrollment, re-enrollment or renewal date in the Group Health Plan (GHP) as long as this date is no later than six (6) months after the CMS' receipt of the MSP and/or Non MSP Input File required by paragraphs C.1 and D.1 respectively. If necessary data cannot be obtained because an enrollment, re-enrollment or renewal date of the GHP will not occur in the next six (6) months, the Insurer shall individually contact each Covered Individual to obtain or correct such data within thirty (30) days of becoming aware, or being notified, that the necessary information about the Covered Individual is missing or is incorrect. The Insurer shall include the data corrections received as an "update" in the next Update File delivered to CMS following the collection of the necessary data.

The Insurer shall also modify, when necessary, its GHP enrollment, re-enrollment and renewal procedures to routinely capture the data elements identified in Attachments A, B, C, D and E before the next enrollment, re-enrollment, or renewal cycle, unless the Insurer has an alternative method of capturing this information that is acceptable to CMS. The Insurer attests that once the data elements are captured, it will provide this information to CMS when it submits its next update file.

If, following the procedures outlined above for the collection of new and correction of existing data, the Insurer is still unable to obtain a particular data element, the Insurer should submit to CMS as much of the remaining information for the Covered Individual as it is able to provide. The Insurer shall continue to seek any data for which a request is more than thirty (30) days old.

I. TERM OF AGREEMENT

The Insurer and CMS are dedicated to developing and implementing a process for exchanging data that provides CMS and the Insurer with quarterly updates on a regular and consistent basis with minimal interruption to the administration and operations of the Insurer and CMS. Accordingly, the initial term of this Agreement shall be twenty-four (24) months from the Effective Date unless earlier terminated as set forth below, and shall automatically renew for successive twelve (12) month terms unless, not less than

ninety (90) days prior to the end of any term, a Party provides the other Party with written notice of its intent not to renew the Agreement. During the initial term of the Agreement, the parties shall diligently and in good faith evaluate the data exchange process and discuss and endeavor to implement modifications to the process in order to achieve the efficiency described in Section II hereof as a principal purpose of the agreement.

During the initial term or any succeeding term of this Agreement, CMS may terminate this Agreement upon sixty (60) days prior written notice to the Insurer of the Insurer's repeated failure to perform its obligations pursuant to this Agreement, and the Insurer's failure during such sixty (60) day period to cure such breach of its obligations by satisfying the conditions set forth in such notice.

During the initial term or any succeeding term of this Agreement, the Insurer may terminate this Agreement upon sixty (60) days prior written notice to CMS of CMS's repeated failure to perform its obligations pursuant to this Agreement, and CMS's failure during such sixty (60) day period to cure such breach of its obligations by satisfying the conditions set forth in such notice.

Except as the parties may otherwise agree, this Agreement shall terminate in the event of enactment of any new MSP legislation which contradicts or is inconsistent with the terms of the data exchange portions of this Agreement.

J. SAFEGUARDING & LIMITING ACCESS TO EXCHANGED DATA

The Parties agree to establish and implement proper safeguards against unauthorized use and disclosure of the data exchanged under this Agreement. Proper safeguards shall include the adoption of policies and procedures to ensure that the data obtained under this Agreement shall be used solely in accordance with Section 1106 of the Social Security Act [42 U.S.C. § 1306], Section 1874(b) of the Social Security Act [42 U.S.C. § 1395k(b)], Section 1862(b) of the Social Security Act [42 U.S.C. § 1395y(b)], and the Privacy Act of 1974, as amended [5 U.S.C. § 552a]. The Insurer shall establish appropriate administrative, technical, procedural, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized access to the data provided by CMS. The Insurer agrees that the authorized representatives of CMS shall be granted access to premises where the Medicare data is being kept for the purpose of inspecting security arrangements confirming whether the Insurer is in compliance with the security requirements specified above.

Access to the records matched and to any records created by the matching process shall be restricted to authorized CMS and Insurer employees, agents and officials who require access to perform their official duties in accordance with the uses of the information as authorized in this Agreement. Such personnel 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.

CMS and the Insurer agree to limit access to, disclosure of and use of all data exchanged between the Parties. The information provided may not be disclosed or used for any purpose other than to implement MMA and MSP provisions and related laws, and coordinate benefit payments between the Insurer and CMS, and as is necessary to prevent or recover mistaken payments. The Parties agree that the eligibility files exchanged by the Parties shall not be duplicated or disseminated beyond updating the Parties current eligibility files.

K. PRIVACY ACT

Data that are protected in a Privacy Act System of Records (SOR) shall be released from CMS in accordance with the Privacy Act (5 U.S.C. §552a) and CMS data release policies and procedures. The appropriate Privacy Act disclosure exception for these releases is found in System No. 09-70-0536 (Medicare Beneficiary Database).

The parties agree and acknowledge that they are performing "covered functions" as that term is defined in the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule") under the HIPAA at 45 C.F.R. § 164.501. The parties further agree that the use and disclosure of Protected Health Information between the parties pursuant to this Agreement is for payment as defined in the Privacy Rule. The Parties further agree that the Protected Health Information be used or disclosed pursuant to this Agreement is the minimum necessary to accomplish the intended purposes of this Agreement. The parties agree to abide by all requirements of the Privacy Rule with respect to Protected Health Information used or disclosed under the Agreement.

All data contained in the MSP Input File and all data contained in any Update File (excluding any Medicare data which are provided by CMS to the Insurer on a MSP Response File) shall not be subject to the use and disclosure data requirements found in the regulations described in this Section.

L. RESTRICTION ON USE OF DATA

All data and information provided by the Parties shall be used solely for the purposes outlined in Section III of the Recitals. If the Insurer wishes to use the data and information provided by CMS under this Agreement for any purpose other than those outlined above, the Insurer shall make a written request to CMS describing the additional purposes for which it seeks to use the data. If CMS determines that the Insurer's request to use the data and information provided hereunder is acceptable, CMS shall provide the Insurer with written approval of the additional use of the data.

The terms of this section shall not apply to the insurer with respect to data contained in any MSP or Non-MSP Input files, excluding any Medicare data which are provided by CMS to the Insurer in any MSP or Non-MSP Response files.

M. PENALTIES FOR UNAPPROVED USE OR DISCLOSURE OF DATA

The Insurer acknowledges that criminal penalties under section 1106(a) of the Social Security Act [42 U.S.C. § 1306 (a)], including possible imprisonment, may apply with respect to any disclosure of data received from CMS that is inconsistent with the purposes and terms of the Agreement. The Insurer further acknowledges that criminal penalties under the Privacy Act [5 U.S.C., § 552a(I)(3)] may apply if it is determined that the Insurer, or any individual employed or affiliated therewith, knowingly and willfully obtained the data under false pretenses.

N. INSURER CONTACTS

Administrative Contact: The Insurer designates the individual listed below as the contact person for administrative or other implementation coordination issues under this Agreement. The contact person shall be the point of contact for the CMS for any administrative questions that may arise during the term of this Agreement. If the Insurer changes its administrative contact person, the Insurer shall notify the CMS in writing within thirty (30) working days of the transfer and provide the information listed below for the new contact person.

Name:	(Insert Name)
Address:	(Insert mailing address)
Phone #:	(Insert Phone #)
Fax #:	(Insert Fax #)
E-mail:	(Insert E-mail address)

Technical Contact: The Insurer designates the individual listed below as the contact person for technical or other implementation coordination issues under this Agreement. The contact person shall be the point of contact for the CMS for any technical questions that may arise during the term of this Agreement. If the Insurer changes its technical contact person, the Insurer shall notify the CMS in writing within thirty (30) working days of the transfer and provide the information listed below for the new contact person.

Name:	(Insert Name)
Address:	(Insert mailing address)
Phone #:	(Insert Phone #)
Fax #:	(Insert Fax #)
E-mail:	(Insert E-mail address)

O. CMS CONTACTS

Administrative Contacts: The CMS designates the individual listed below as the contact for administrative or other implementation coordination issues under this Agreement. The contact shall be the point of contact for the Insurer for any administrative questions that may arise during the term of this Agreement. If the CMS changes the administrative

contact person(s), the CMS shall notify the Insurer in writing within thirty (30) working days of the transfer and provide the information listed below for the new contact person.

Name: William Decker
Phone #: (410) 786-0125
Fax #: (410) 786-7030
E-mail: william.decker@cms.hhs.gov

Address: Centers for Medicare and Medicaid Services
Office of Financial Management
Financial Services Group
Division of Medicare Secondary Payer Policy and Operations
Mail Stop: C3-14-16
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CMS Technical Contact: Upon signature of this agreement by both parties, the CMS will designate a Coordination of Benefits Contractor Electronic Data Interchange (EDI) Representative as the contact for technical or other implementation coordination issues under this Agreement. The EDI Representative contact shall be the point of contact for the Insurer for any technical questions that may arise during the term of this Agreement. If the CMS changes the technical contact person, the CMS shall notify the Insurer within thirty (30) working days of the transfer.

P. MISCELLANEOUS

1. The Parties agree that their respective representatives, whose signatures appear below, have the authority to execute this Agreement and to bind each of the Parties, respectively, to every promise or covenant contained in this Agreement. The Effective Date of this Agreement shall be the last date of execution by the Parties.

2. No alteration, amendment, modification or other change to the Agreement shall be effective without the written consent of the affected Party or Parties. No waiver of this Agreement or of any of the promises, obligations, terms, or conditions contained herein shall be valid unless it is written and signed by the Party against whom the waiver is to be enforced. However, the Parties agree that the VDSA User Guide which accompanies this Agreement is not, and is not represented to be, a part of this Agreement.

3. The Parties agree that this Agreement contains all material representations, understandings, and promises of the Parties with respect to this Agreement. The Parties agree that Attachments A through E are representative of the data sets required by this Agreement, but are not necessarily the exact data sets that are to be or will be used by the Parties for the term of this Agreement. This Agreement shall be binding upon the Parties, their successors, and assigns.

4. In the interest of working to protect the confidentiality of MSP Covered Individual and Non-MSP Covered Individual data, information received by the Parties hereto that does not result in a match relevant to this Agreement shall be destroyed within six (6) months following a Party's completion of the matching process. If requested by either Party, each Party to this Agreement shall provide written confirmation to the other Party that all data and information that does not result in a match has been destroyed within that time frame. The Parties further agree that the medium by which the Parties exchange stored data (e.g., round reel tapes, cartridges, CDs) shall be destroyed within one (1) year of receipt.

5. The Parties may transmit the data required to be exchanged under this Agreement electronically, provided the Parties agree on a methodology and format within which to exchange such documentation, and the actual transmission of data is secure.

6. If either Party cannot submit its respective file in a timely manner, at least one week prior to the scheduled release of the file it must notify the other Party that the submission will be late. At that time the date the file will be submitted shall also be provided.

7. The Insurer agrees it will inform its related entities, claims processors, third party administrators, and GHPs, to the extent necessary to pay claims, in accordance with the MSP and MMA provisions. The Insurer shall share with these entities the MSP and Medicare entitlement information identified as a result of this data exchange for their use in paying claims, in accordance with the MSP provisions.

8. There are no fees payable by either party with respect to this Agreement.

9. Except as specifically provided herein, the rights and/or obligations of either party to this Agreement may not be assigned without the other party's written consent. This Agreement shall be binding upon and shall inure to the benefit of and be enforceable by the successors, legal representatives and permitted assigns of each party hereto.

IN WITNESS WHEREOF, the Parties have signed this Agreement on the date indicated below.

Centers for Medicare & Medicaid Services

By: GERALD WALTERS DATE
Director, Financial Services Group
Office of Financial Management

Duly Authorized Representative

(*Insert Insurer Name*)

By: (*Insert Insurer Representative Name*) DATE
(*Insert Title*)

Duly Authorized Representative

[08/05 – 11/05 – 12/06 – 11/07 – 4/08]