Note: Contractor must accept this DCH Medicare Advantage Prescription Drug Plan Agreement as presented, with the understanding that equivalent contract clauses and other technical changes to language, may be substituted as part of the amendment process through which final Attachments are added to the Agreement, if such contract clauses and technical changes are mandated by federal law.

Medicare Advantage Prescription Drug Plan Agreement

Exhibit 6 to Contract # _____ between the Georgia Department of Community Health and **[Contractor]** for a fully-insured In-Network Only Plan with an Integrated HRA and Medicare Advantage Plan.

This Medicare Advantage Group Agreement (hereinafter "Agreement") is entered into this _____ day of, 2013 by and between the Georgia Department Of Community Health (hereinafter "DCH"), located at 2 Peachtree Street, Atlanta, Georgia 30303 and **[Contractor]** sponsor of the Medicare Advantage and the Part D Prescription Drug Program (hereinafter "Contractor"), located at **[address]** upon the following terms and conditions:

ARTICLE 1 – PURPOSE

NOW THEREFORE, in consideration of the application of DCH for the medical and prescription drug benefits provided under this Agreement, in accordance with the Medicare Laws and Regulations and in consideration of the periodic payment of MA-PD Plan Beneficiary Premiums on behalf of Members, Contractor agrees to provide coverage for Covered Services to Group Plan participants enrolled as Members in the Contractor Medicare Advantage with Part D Plan, subject to all terms and conditions of this Agreement.

This Agreement is made a part of the Contract between the Georgia Department of Community Health and Contractor for a fully-insured In-Network Only Plan with an Integrated HRA and Medicare Advantage Plans (the "Contract"). A capitalized term used herein but not defined herein will have the meaning ascribed to it in the Contract. Except as otherwise provided herein, the terms of the Contract apply to this Agreement. In the event of a conflict between the provisions of this Agreement and the Contract with respect to the MA-PD Plan, this Agreement will prevail, except to the extent pre-empted by federal law, or as otherwise required by Medicare Laws and Regulations.

ARTICLE 2 - DEFINITIONS

For purposes of this Agreement and any addenda or schedules to this Agreement, the following words and terms have the following meanings unless the context or use clearly indicates another meaning or intent. Capitalized words and terms not defined below are defined in the Evidence of Coverage.

A. **AGREEMENT.** This Medicare Advantage with Prescription Drug Benefit Plan Group Agreement, including, but not limited to, the Evidence of Coverage and Disclosure Information, Summary of Benefits, Enrollment Files, Contractor administrative practices and procedures, Limitations and Exclusions, other Attachments and any amendments thereto. The parties agree to promptly amend this Agreement to include the Evidence of Coverage and Disclosure Information, Summary of Benefits, Limitations and Exclusions, and other Attachments and any amendments thereto and to incorporate such documents by reference into this Agreement at such time as they become available.

B. **ATTACHMENTS.** Attachments to this Agreement include:

Attachment A, Rates for Coverage
Attachment B, Disclosure Form
Attachment C, Evidence of Coverage and Disclosure Document
- C.1 Annual Notice of Change
- C.2 Evidence of Coverage excerpts (Standard A and B, Premium A and B; Standard B only, Premium B only)
- C.3 Benefits Charts (Standard A and B, Premium A and B; Standard B only, Premium B only)
- C.4 Georgia Wrap Certificate Excerpts
- C.5 Georgia Medical Directory Excerpts
- C.6 Georgia Pharmacy Directory Excerpts

C. **CENTERS FOR MEDICARE & MEDICAID SERVICES ("CMS").** Federal Agency within the United States Department of Health and Human Services and is responsible for administering various Medicare programs.

D. **CONTRACTOR ENROLLMENT PACKET.** The packet of information supplied by Contractor to prospective Members which discloses plan policy and procedure and provides information about the MA-PD Plan medical and prescription drug benefits and exclusions.

E. **COVERED PART D DRUGS.** The prescription drugs covered under the MA-PD Plan.

F. **COVERED SERVICE.** Any hospital, medical, prescription or other health care service rendered to Members for which benefits are provided pursuant to the Evidence of Coverage.

G. **DEPENDENT.** Any Subscriber's spouse or unmarried child (including a step-child, adopted child, or child who is in the custody of the Subscriber for purposes of adoption) of a Subscriber who is enrolled hereunder, who meets all the eligibility requirements of DCH and the MA-PD Plan in his or her own right, and who is eligible, in his or her own right, to enroll in a Medicare Advantage with Prescription Drug Benefit Plan under the Medicare Laws and Regulations.

H. **EFFECTIVE DATE.** The Effective Date of coverage and rates for this Agreement is set forth in Attachment A.

I. **ELIGIBLE RETIREE.** An SHBP Member formerly employed by an entity participating in the State Health Benefit Plan who has met the minimum required Retiree participation conditions as determined by DCH, who is eligible to enroll in a Medicare Advantage with Prescription Drug Benefit Plan under the Medicare Laws and Regulations, who resides in the Service Area, and who meets the Subscriber eligibility and enrollment requirements of the MA-PD Plan.

J. **ENROLLMENT.** The enrollment of DCH's Eligible Retirees and their eligible Dependents into the MA-PD Plan by DCH pursuant to and in accordance with Medicare Laws and Regulations. Enrollment and its effective date are conditioned upon acceptance of the Eligible Retiree or eligible Dependent by CMS.

K. **EVIDENCE OF COVERAGE AND DISCLOSURE INFORMATION.** The Evidence of Coverage and Disclosure Information ("EOC") are the documents issued to prospective and enrolled Subscribers disclosing and setting forth the health care and prescription drug benefits and terms and conditions of coverage to which Members of the Premium Option MA-PD Plan or the Standard Option MA-PD Plan are entitled. These documents are set forth in Attachment C to this Agreement and are incorporated fully into this Agreement by reference.

L. **GRACE PERIOD.** Premium payment is due and payable on the 1st of the month. However, there is a thirty (30) day Grace Period. The payment amount must equal the “TOTAL DUE” amount shown on the billing cover sheet, less any payment previously remitted but not reflected on the current billing statement. Once DCH exceeds their Grace Period, Contractor shall provide Notice to DCH and DCH must pay 100% of the “TOTAL DUE” to avoid termination as set forth in the termination provisions of the Contract and Article 8 of this Agreement.

M. **LOW INCOME SUBSIDY ELIGIBLE INDIVIDUAL.** A Medicare beneficiary who is eligible for a low-income subsidy for coverage under a Medicare Advantage with Prescription Drug Benefit Plan, as described in the Medicare Laws and Regulations.

N. **MA-PD PLAN BENEFICIARY PREMIUMS.** Amounts established by Contractor and approved by CMS to be paid to Contractor by or on behalf of each Member enrolled in the MA-PD Plan for coverage under the MA-PD Plan. The amount is set forth in Attachment A. The MA-PD Plan Beneficiary Premiums may include late enrollment penalties as assessed by CMS for those beneficiaries who did not have creditable prescription drug coverage for a period that exceeds 63 days from or after eligibility for Medicare Part D.

O. **MEDICARE LAWS AND REGULATIONS.** Collectively, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the "MMA"), the regulations implementing the Medicare Advantage provisions at 42 CFR Part 422, together with guidance, instruction and other directives from CMS relating to Medicare Advantage Plans, and the regulations implementing the Part D Plan provisions of the MMA at 42 CFR Part 423, together with guidance, instruction and other directives from CMS relating to Medicare Part D Prescription Drug Benefit Plans.

P. **MEMBER.** An Eligible Retiree or his or her Eligible Dependent who has elected MAPD Plan coverage and who has satisfied the eligibility conditions specified in this Agreement, and the Evidence of Coverage. Although Members are not parties to this Agreement, the information provided in the DCH eligibility file described in Section 5.1 of the Contract is used to determine eligibility for coverage and benefits.

Q. **RETIREE OPTION CHANGE PERIOD.** The annual period established by DCH, or the Open Enrollment Period as promulgated by CMS or another period required by CMS, during which all eligible and prospective Subscribers and their eligible Dependents may enroll in the MAPD Plan

R. **SERVICE AREA.** The Service Area for MAPD Plan is the Atlanta Service Area, as defined in the Contract.

S. **SUBSCRIBER.** An Eligible Retiree who is enrolled under this Agreement and is eligible to receive benefits under the terms and conditions of the Evidence of Coverage.

ARTICLE 3 - ELIGIBILITY AND ENROLLMENT

A. Eligibility. Members eligible to be covered under this Agreement shall be as specified in this Agreement, the Evidence of Coverage and Contractor Policies.

B. Initial enrollment of Members. Those individuals initially enrolled shall be those Members included on DCH's initial eligibility file, which reflect elections made during the Retiree Option Change Period. The initial eligibility file may be modified by Contractor based on acceptance or rejection of enrollment by CMS. Upon acceptance of such enrollment by Contractor and CMS, or modification thereof, and payment of the applicable premiums, such Members and dependents shall become enrolled under this Agreement for the type of coverage elected in such enrollment file on the Effective Date.

The premium rates calculated for DCH are as provided in Attachment A.

Notice of Eligibility. DCH or Contractor. if so directed by DCH shall provide a written notice prepared by Contractor to Eligible Retirees and eligible Dependents at the commencement of applicable enrollment periods and throughout the year to persons who become eligible at times other than during the Retiree Option Change Period. The written notice shall provide notice of the availability of coverage under the MAPD Plan

C. Addition of New, Transferred and Newly Eligible Members. DCH shall have the opportunity to update the eligibility file to add new, transferred and newly eligible Members to the group of Members initially enrolled under this Agreement. However, before qualifying for enrollment, the new, transferred or newly eligible Member must meet all of the applicable eligibility requirements as set forth in the Evidence of Coverage, CMS rules and Plan Documents. Addition of the Members and their eligible dependents shall be made in accordance with the following procedures:

1. The eligibility files are submitted by DCH on behalf of all new, transferred or newly eligible Members who wish to enroll at the time of retirement, transfer or eligibility. The eligibility files shall specify the effective date for those who became eligible after the initial enrollment date.

2. The effective date of coverage for any such additional Member whose enrollment is approved by CMS shall be in accordance with the Evidence of Coverage, Plan Documents, and CMS regulations in effect at the time the Member's enrollment is approved.

3. At any time eligibility files may include Members who are enrolled in another benefit plan or alternate delivery system offered by DCH.

D. Commencement of Coverage. Coverage hereunder for Subscribers and their eligible dependents that are enrolled on or before the Effective Date of this Agreement shall commence as of such Effective Date, subject to the provisions of the Evidence of Coverage. Thereafter, coverage for any eligible Member or his/her Eligible Dependent, whose enrollment is submitted on subsequent DCH eligibility files, shall begin on the date determined in accordance with Contractor Policies and Medicare Advantage regulations.

E. Retroactive Changes. Contractor reserves the right to limit retroactive changes to enrollment or terminations to a maximum of ninety (90) days from the date notice is received. Acceptance of payments from DCH or the payment of benefits to persons no longer eligible will not obligate Contractor to provide benefits. Premium bills will be adjusted to reflect such retroactive changes.

F. Termination of coverage. A Member who is determined by the DCH to be ineligible for benefits shall be reported on the monthly listing as a deletion from the listing of Members. Upon the DCH's direction to Contractor, the coverage of such Member shall terminate after providing notice to such Member in accordance with the Contractor Policies, the Evidence of Coverage and the Medicare Advantage regulations.

In the case of a Member who no longer meets SHBP's eligibility requirements for participation in the MA-PD Plan or in the case of termination of this Agreement, DCH or, if so directed by DCH, will issue prospective notice to Member(s) of the termination. Such notice must advise Member(s) of other coverage options that may be available under the SHBP. DCH, or Contractor if so directed by DCH, will also advise such Member that the disenrollment action means the Member will not have Medicare drug coverage. Notice must include information about the potential for late-enrollment penalties that may apply in the future.

The effective date of disenrollment always falls on the last day of a month. In the case of a Member no longer meeting SHBP's eligibility requirements, DCH or Contractor if so directed by DCH, will issue notice of a Member's termination from the MA-PD Plan by the 1st of the month for an effective date of the end of that month. All notifications received after that date will result in a termination effective date of the last day of the following month. To disenroll from the MA-PD Plan, each Member must submit a signed, written notice according to the Medicare Laws and Regulations. DCH cannot request a voluntary disenrollment of an enrolled Member.

The DCH shall give Contractor reasonable advance notice of any Member terminations in order to enable Contractor to remove the Member from Contractor's list of Members.

Retroactive disenrollment is not allowed except in specific situations approved by CMS. CMS may approve a retroactive disenrollment of a Member if there are unusual facts or situations meeting all of the following criteria:

1. The Member alleges not having understood that he/she was enrolling into a lock-in Medicare Advantage Plan. A written statement signed by the Member is required.

2. The Member has not used plan services.

3. There are other indications that the Member did not understand the lock-in provision.

Retroactive disenrollment must be submitted to the Contractor, so that the Contractor can submit the retroactive disenrollment request to CMS. The DCH shall be responsible for providing Contractor with applicable data or information required to substantiate Contractor's request for retroactive disenrollment.

G. COBRA continuation Coverage. To the extent that the continuation coverage requirements of Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") or any other applicable state law apply to Contractor, Contractor shall allow continued coverage under this Agreement only for those qualified beneficiaries under COBRA or such state law who have been timely notified of their continuation rights and have timely elected and paid for the continued coverage, and only to the extent required by COBRA or applicable state law. It is further understood and agreed that any notice, collection of premium, or communication regarding continuation of coverage shall be the responsibility of the Employer and not Contractor.

ARTICLE 4 - OBLIGATIONS OF CONTRACTOR

A. Contractor shall provide health care benefits to Members who receive Covered Services under the terms of this Agreement and the Evidence of Coverage. However, in no event will Contractor provide benefits for services rendered prior to the Effective Date or after the termination of this Agreement or for any period for which full premium payment has not been paid to Contractor, except as provided in the Evidence of Coverage and applicable Medicare Advantage regulations.

B. Contractor shall furnish an identification card as set forth in Section 5.4 of the Contract, except that the identification card will not contain date of birth. Contractor also shall furnish the Evidence of Coverage and other disclosure

documents required by CMS for each Member enrolled in the applicable plans covered by this Agreement in accordance with the deadlines of CMS.

C. Contractor shall furnish material necessary and appropriate for the enrollment of Members and shall provide such assistance as may reasonably be necessary to the DCH for enrollment purposes. Contractor shall maintain current eligibility status records on all Members as submitted by DCH for the adjudication of claims.

D. Contractor shall provide DCH Data to DCH or its designee pursuant to the Contract upon DCH's completion of the form set forth in Attachment B or a similar form mutually agreed to by the Parties.

ARTICLE 5 - OBLIGATIONS OF DCH

A. Premium payments shall be due and payable in full by DCH for each Member in the amounts and at the time specified in Attachment A to this Agreement or in subsequent modifications thereto. Contractor shall not have any obligation to accept partial premium payment. DCH shall make such payments as reflected on the bill regardless of whether DCH has made arrangements to receive from, or otherwise charge to, its subscribers any part of such amounts. DCH shall have the responsibility for collecting and remitting payments to Contractor as they come due, even if the DCH has not received premiums from Members. Contractor shall not assume any liability for Members enrolled hereunder by reason of any delay or failure of DCH to remit applicable payments.

B. DCH will, within a reasonable time period, provide Contractor with any information as may reasonably be required by Contractor for the purposes of determining eligibility for coverage, enrolling and disenrolling Members, determining the amount of premium payable by DCH or any other purpose reasonably related to the administration of this Agreement. DCH will give notification of eligibility to each Member who is or will become eligible for enrollment, and will collect and submit to Contractor an enrollment record for each Member desiring to enroll.

C. DCH will forward to Contractor the eligibility file in accordance with Sections 3.11 and 5.1 of the Contract. DCH shall, within a reasonable time period, forward to Contractor notices or other writings submitted to DCH by Members that relate to coverage under the MAPD Plan.

D. All communications created by DCH referencing the Contractor name, Contractor benefits and/or MAPD branding, will be submitted to the Contractor before communication is mailed or distributed to the DCH's Retirees.

E. DCH hereby acknowledges, agrees and certifies its compliance with the following requirements as they relate DCH's Contractor(s).

1. Premium – DCH hereby agrees and certifies, as to waiver premium, that:

Different amounts can be subsidized for different classes of Members in an MAPD Plan, provided such classes are reasonable and based upon objective business criteria (i.e., years of service, business location, job category, nature of compensation). Accordingly, DCH hereby certifies that such classes (if any) are reasonable and based upon objective business criteria.

The premium within a given class does not vary by Member.

Members are not charged more than the premium an individual would pay if they purchased the applicable Contractor individually (i.e., Members are not charged more than 100% of the premium for the standard coverage plus any supplemental coverage added by DCH; thereby, passing along to the Member the CMS subsidy payment).

The foregoing certifications shall be based upon DCH's best knowledge, information, and belief at the time such information is submitted or provided. To the extent any material information is discovered or changes occur after such certification that impact the accuracy, completeness and/or truthfulness of such certifications or data, DCH agrees to make Contractor immediately aware of such change or discovery.

2. Low Income Subsidy – DCH hereby agrees and certifies, as to Members who are Subsidy Eligible Individual pursuant to, but not limited to, 42 C.F.R. 423.773, that:

a) DCH agrees that the low income premium subsidy amount will first be used to reduce the portion of the monthly MAPD Plan Beneficiary Premium attributable to basic prescription drug coverage paid by the Member, with any remaining portion of the premium subsidy amount then applied toward the portion of the monthly MAPD Plan Beneficiary Premium attributable to basic prescription drug coverage paid by DCH; and

b) if the low income premium subsidy amount for which a Member is eligible is less than the portion of the monthly MAPD Plan Beneficiary Premium paid by the Member, to the extent required by applicable law, Contractor shall communicate to the Member

the financial consequences for the Member of enrolling in the Group MAPD Plan as compared to enrolling in another Medicare Advantage with Prescription Drug Benefit Plan with a monthly beneficiary premium equal to or below the low income premium subsidy amount.

Contractor agrees that it will refund any low-income subsidy amounts due to beneficiaries within forty-five (45) days of receipt.

3. Prescription Drug Plan (Part D) Late Enrollment Penalty – Consistent with, but not limited to, 42 CFR 423.46 & 423.286(d)(3), DCH hereby agrees and certifies, as to late enrollment penalty, that:

a) The late enrollment penalty for a Member shall be assessed when the Member has a break in creditable coverage or a gap in creditable coverage of more than 63 days since their initial Part D eligibility.

i. Creditable coverage includes, but is not limited to: qualifying - group based prescription drug coverage, the Federal Employees Health Benefits Program; qualified State Pharmaceutical Assistance Programs (SPAPs); military-related coverage (e.g., VA, TRICARE); and certain Medicare supplemental (Medigap) policies.

b) Contractor shall send a creditable coverage attestation form to applicable Members. Contractor must send the creditable coverage attestation to Members within 7 calendar days of receipt of the Beneficiary Eligibility Query (BEQ) if the results indicate that (1) the potential Member was not enrolled in a Part D plan or covered by a DCH receiving the retiree drug subsidy (RDS) since the Part D eligibility end date, or (2) the potential Member was enrolled in such coverage but a gap in creditable coverage of 63 or more days occurred. Beneficiaries shall be instructed to return the creditable coverage attestation form within 30 calendar days of the date on the form. The Contractor shall retain the attestation form as part of the Member's permanent records.

c) The Contractor shall be responsible for reporting the creditable coverage period determinations to CMS. Normally, CMS requires Contractor to make these reports within 14 calendar days of receiving the completed attestation form. If an incomplete attestation form is received, the Contractor shall attempt to obtain complete information within 21 calendar days of receipt of the incomplete form. If the beneficiary fails to return the attestation form by the stated deadline, the Contractor will determine the applicable number of

uncovered/non-creditable months based upon the available information received.

d) The late enrollment penalty is based on the national average Part D bid amount set by CMS and is assessed for each month a beneficiary has not enrolled in a Medicare Part D drug plan, when eligible or a beneficiary does not have creditable coverage (coverage containing a prescription drug benefit that is equivalent to or better than the standard Medicare prescription drug coverage). The process for receiving notifications of late enrollment penalty and the payment of the late enrollment penalty by DCH or the Member will be mutually agreed upon during Implementation.

ARTICLE 6 - NOTICES

It shall be the responsibility of DCH to notify all Members of the termination of the Agreement. In the case of either changes in or termination of the Agreement, notice to the DCH shall be deemed to constitute notice to all Members in order to effectuate any change in or termination of the Agreement or coverage under the Evidence of Coverage; however, Contractor reserves the right to provide such notice if required by CMS.

ARTICLE 7 - CHANGES IN THE AGREEMENT

A. Covered Services, as set forth in the EOC, as well as other terms of coverage under the MA- PD Plan may be modified by Contractor at the direction of CMS. Any such modification shall take effect on such date as is specified by CMS. DCH shall give Contractor at least forty-five (45) days advance written notice of the proposed effective date of any DCH request to change benefits provisions under this Agreement.

B. Contractor also reserves the right to change the premium rates by giving written notice to DCH not less than thirty (30) days prior to the effective date of such change in the event a change in benefits is made pursuant to Section 7A. Any change in premium rates must be completed through an Amendment to the Contract.

ARTICLE 8 - TERMINATION AND/OR SUSPENSION OF PERFORMANCE

A. The Termination provisions of the Contract shall apply; provided, however, with respect to this Agreement DCH shall provide Contractor at least sixty (60) days

notice before the effective date of termination. If this Agreement is terminated, DCH shall be liable for all premiums due to Contractor up to the date of termination.

B. In the event Contractor decides, in its sole discretion to discontinue offering a particular Medicare Advantage product, Contractor has the right to terminate such product as permitted by federal and state law, by giving written notice of termination to DCH at least ninety (90) days before the effective date of termination of the discontinued product.

C. Upon termination of this Agreement, Contractor shall cease to have any liability for benefits incurred after the effective date of termination (except as otherwise provided in the Evidence of Coverage) and shall have no liability to offer continuation or conversion coverage to Members under the terminated Agreement.

ARTICLE 9 - LIABILITY

Contractor does not undertake to furnish any health care services but shall pay for such services furnished to Members as provided and limited by this Agreement, including the Evidence of Coverage issued hereunder. Nothing contained in this Agreement shall confer upon DCH or Members any right or cause of action either at law or in equity, against Contractor for acts or omissions of any hospital or other health care providers from which any Members receive service.

ARTICLE 10 - TERMINATION OF COVERED PERSONS

Contractor reserves the right to cancel or rescind any health care benefits provided hereunder to any Member who engages in misrepresentation and/or fraudulent conduct, as determined by Contractor and with the concurrence of CMS, in relation to any claims made for coverage or any election of coverage under this Agreement. In addition, Contractor reserves the right to cancel or terminate coverage provided hereunder to any Member in accordance with cancellation and termination provisions in their Evidence of Coverage.

ARTICLE 11 - NO WAIVER

A. The failure of either party to enforce or insist upon compliance with any provision of this Agreement shall not be construed as or constitute a waiver of the right to enforce or insist upon compliance with such provision in the future.

B. No failure or delay by either Party to exercise any right or to enforce any obligation herein, and no course of dealing between DCH and Contractor, shall operate as a

waiver thereof. No single or partial exercise of any right or failure to enforce any obligation hereunder shall preclude any other or further exercise thereof or the right to exercise any other right or enforce any other obligation.

ARTICLE 12 - COORDINATION OF BENEFITS WITH OTHER BENEFITS

A. General.

1. This coordination of benefits ("COB") provision applies when a Member has health care coverage under more than one plan. For purposes of this provision, "Plan" is defined below.

2. If this COB provision applies, the parties should look first at the order of benefit determination rules. Those rules determine whether the benefits of Contractor are determined before or after those of another Plan. The benefits of Contractor:

   a) Shall not be reduced when, under the Order of Benefit Determination Rules, Contractor determines its benefits before another Plan; but

   b) May be reduced when, under the Order of Benefits Determination Rules, another Plan determines its benefits first. The above reduction is described in Section (D) "Effect on the Benefits of Contractor."

B. Definitions. Notwithstanding any other provision or definition in this Agreement, for purposes of this Article 20:

1. "Plan" - includes any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

   a) Individual insurance, group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

   b) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grant to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

   c) "Plan" does not include school accident-type coverage or some supplemental sickness and accident policies.

Each Agreement or other arrangement for coverage under (a) or (b) is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two, each part is a separate plan.

2. "Primary Plan/Secondary Plan" - the Order of Benefit Determination rules state whether MAPD Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

   When MAPD Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

   When MAPD Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

   When there are more than two Plans covering the person, MAPD Plan may be Primary Plan as to one or more other Plans and may be Secondary Plan as to a different Plan or Plans.

3. "Allowable Expense" - means a necessary and reasonable item of expense for health care or prescription drugs, as determined by Contractor, when the item or expense is covered by the MAPD Plan. However, Contractor is not required to pay for an item, service, or benefit which is not a due under the terms of the Plan Documents.

   When a Plan provides benefits in the form of services, the reasonable cash value, as determined by Contractor, of each service rendered will be considered both an Allowable Expense and a benefit paid.

C. Order of Benefit Determination Rules.

1. When there is a basis for a claim under MAPD Plan and another Plan, MAPD Plan and the other Plan payment order shall be determined in accordance with the applicable Medicare Secondary Payer statute (42 U.S.C. 1395y(b), applicable amendments and implementing regulations). Specifically, MAPD Plan shall be treated as if it were Original Medicare for purposes of determining payment order and the other Plan’s benefits shall be coordinated in accordance with Medicare Secondary Payer requirements.

D. Effect on the Benefits of this MAPDPlan.

1. This section applies when, in accordance with Section (C) "Order of Benefit Determination Rules," MAPD Plan is a Secondary Plan as to one or more

other Plans. In that event, the benefits of MAPD Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in (2) below.

2. Reduction in MAPDPlan's benefits. The benefits of MAPD Plan will be reduced to the extent that the sum of:

a) The benefits that would be payable for the allowable expense under Contractor in the absence of this COB provision; and

b) The benefits that would be payable for the allowable expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses.

E. Right to Receive and Release Needed Information. Certain facts are needed to apply these COB rules. Contractor has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Contractor need not tell, or get the consent of, any person to do this. Each person claiming benefits under Contractor must give Contractor any facts it needs to pay the claim.

F. Facility of Payment. A payment made under another Plan may include an amount which should have been paid underMAPD Plan. If it does, Contractor may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid underMAPD Plan. Contractor will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right to Recovery. If the amount of the payments made by Contractor is more than it should have paid under this COB provision, it may recover the excess from one or more of the following:

1. The persons it has paid or for whom it has paid;

2. Another Plan; or

3. The provider of service.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

ARTICLE 13 - AGREEMENT ADMINISTRATION

A. Contractor shall have all the powers necessary and appropriate to enable it to carry out its duties in connection with the operation and administration of this Agreement. This includes, without limitation, the discretion to construe the terms and conditions of the benefits to be provided pursuant to this Agreement and the Evidence of Coverage and Plan Documents, to determine all questions arising under the Evidence of Coverage, and to make, establish and amend rules, and procedures, all of which shall be Plan Documents, with regard to the interpretation and administration of this Agreement and the Evidence of Coverage. Contractor shall have discretion to determine an individual's eligibility for benefits and to construe the terms and conditions of the benefits to be provided pursuant to this Agreement and the Evidence of Coverage. Contractor's construction of the Agreement and Evidence of Coverage and Plan Document provisions shall be binding upon Members except when such construction is arbitrary and capricious.

B. Notwithstanding any other terms of this Agreement, Contractor shall have the authority to waive or modify any referral, authorization, certification requirement or other process contained in the Evidence of Coverage if, in the sole discretion of Contractor, such requirement is not efficiently or effectively managing the cost of care under the Agreement.

C. Notwithstanding any other terms of this Agreement, Contractor shall have the authority, to institute or terminate from time to time, pilot or test programs regarding disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in the Evidence of Coverage. Contractor shall obtain the permission of DCH prior to including Members in such programs. Contractor reserves the right to discontinue a pilot or test program at any time. Contractor shall provide thirty (30) days advance written notice to DCH of the initiation or discontinuance of any such program.

D. DCH agrees to refer all questions and complaints about claims and benefit administration under this MAPD Plan to Contractor. Contractor agrees to provide DCH status updates and notification of resolution. Contractor shall retain the ultimate authority and responsibility for resolving appeals from claims adjudications.

ARTICLE 14 - RELATIONSHIP OF THE PARTIES

DCH is not responsible for the services and benefits of Contractor, but is simply agreeing that its eligible Members have the option of enrolling in this fully-insured MAPD Plan offered by Contractor. In holding itself out to provide services under this Agreement, Contractor does not act as an agent for, or for the benefit of, DCH.

ARTICLE 15 - MISCELLANEOUS

A. Contractor shall have authority to pursue recovery of benefits provided on behalf of Members under this Agreement. Such authority includes subrogation recoveries, as well as other available recoveries or refunds. Contractor shall have authority to establish recovery policies, determine which recoveries are to be pursued, and compromise recovery amounts. Contractor will not pursue recoveries for overpayments if the cost of collection would exceed the overpayment amount. If Contractor would recover the overpayment amount through an automatic recoupment mechanism, Contractor will not pursue such recovery if the overpayment was in the amount of ten dollars ($10.00) or less. If Contractor would recover the overpayment amount through manual recovery, Contractor will not pursue such recovery if the overpayment was in the amount of seventy-five dollars ($75.00) or less.

B. Certain facts are needed to process subrogation recoveries. Contractor has the right to decide which facts are needed. It may get necessary facts from or give them to any other organization or person. Contractor need not tell, or get the consent of, any Member to do this. Each Member claiming benefits under this Agreement must give Contractor any facts it needs to process the claim and pursue any subrogation recovery. For benefits paid pursuant to this Agreement, the authority granted pursuant to this provision shall survive termination of this Agreement.

C. Contractor hereby informs DCH that Contractor or its vendors may have reimbursement contracts with certain providers for the provision of and payment for health care services and supplies provided to, among others, Members under this Agreement. Under some of these contracts, there may be settlements which require Contractor to pay the providers or vendors additional money (which may or may not be solely funded by Contractor) or which require the providers or vendors to return a portion of volume discounts, rebates, or excess money paid. Such providers or vendors may include entities affiliated with Contractor. Under many provider or vendor contracts, the negotiated reimbursement does not contemplate any type of settlement between Contractor and the provider or vendor. DCH has no responsibility for additional payment to vendors nor any right to discounts, rebates, or excess money received from vendors.

D. All Members enrolled under this Agreement shall have only the rights and benefits as set forth in Plan Documents, and shall be subject to the terms and conditions, set forth herein.

E. The parties acknowledge that Contractor is not engaged in the practice of medicine; it merely makes decisions regarding the coverage of services. Contracted physicians acknowledge and agree within the provisions of their participation agreements that they must exercise independent medical judgment regarding the treatment of their patients, regardless of Contractor's coverage determinations.

F. This Agreement supersedes any and all prior agreements between the Parties, whether written or oral, and other documents, if any, addressing the subject matter contained in this Agreement.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed in duplicate by affixing the signatures of duly authorized officers.

Georgia Department of Community Health	**[Contractor]** sponsor of the Medicare Advantage and the Part D Prescription Drug Program
By_____	By_____
Title_____	Title_____
Date_____	Date_____