A. ***PART I. General Payment Setup Options***

B. *1) Application ID*

C.

D. 2) If applicable, identify a Designee with payment request privilege for this application. Enter an existing Designee or enter the following information to establish a new Designee: (Optional)

E. 2a) Name: _____

F. 2b) E-mail Address: _____

G. 2c) Phone: _____ ***2d) FAX (optional):*** _____

H. 2e) Address: _____
Street

I. _____
City ***State*** ***Zip Code***

The following information (items 3 through 6) must be completed for each benefit option in the plan.

3) Unique Benefit Option Identifier _____

4) Method of submission of interim payment cost report data:

Not submitting payment request (selected payment frequency = annual) _____
OR
Enter cost report on the secure RDS website _____
OR
Upload file on the secure RDS website (may be available in the future) _____
OR
Transmit file to the RDS mainframe _____
(The mainframe option is only available for plan sponsors that have established mainframe to mainframe connectivity with the RDS Center.)

Please provide the following information (4a-4d) about your technical contact if selecting to transmit to the mainframe:

4a) Name: _____
4b) E-mail Address: _____
4c) Phone: _____ *4d) FAX (optional):* _____

5) Method of submission of reconciliation cost report file:

Upload file on the secure RDS website

OR

Transmit file to the RDS mainframe

(The mainframe option is only available for plan sponsors that currently transmit files to the RDS center.)

Please provide the following information (6a-6d) about your technical contact when selecting the option to transmit to the mainframe:

5a) Name:

5b) E-mail Address:

5c) Phone: *5d) FAX (optional):*

6) If applicable, enter an existing Designee as Cost Reporter for this Benefit Option or enter the following information to establish a new Designee as the Cost Reporter (Optional):

6a) Name:

6b) E-mail Address:

6c) Phone: *6d) FAX (optional):*

6e) Address:

Street

City *State* *Zip Code*

PART IIA. Cost Data (Use if entering data into RDS Center secure website)

1. Application ID

2. Unique Benefit Option number

A	B	C	D	E	F
Month	Premium Cost	Gross Retiree Cost	Threshold Reduction	Limit Reduction	Estimated Cost Adjustment
Plan Month 1					
Plan Month 2					
Plan Month 3					
Plan Month 4					
Plan Month 5					
Plan Month 6					
Plan Month 7					
Plan Month 8					
Plan Month 9					
Plan Month 10					
Plan Month 11					
Plan Month 12					

PART IIB. Cost Data File (File elements required for upload or transfer to mainframe).

If a Plan Sponsor chooses to report Rx cost data by transmitting the data file to the secure RDS website mainframe (or, if

available in the future, by uploading the data to the secure RDS website) the file must contain the following data. For instructions and information on file specifications, please go to the RDS website at http\\rds.cms.hhs.gov.

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 on the RDS application.

Vendor ID or Plan Sponsor ID

Submitter Type (Plan Sponsor or Vendor)

Month/Year of Rx Cost incurred (YYYYMM)

Estimated Premium

Gross Retiree Cost

Threshold Reduction

Limit Reduction

Estimated Cost Adjustment

Timestamp (date and time of file creation in timestamp format)

PART III. Reconciliation File Layout

1. A. Reconciliation File

Plan Sponsors must submit a reconciliation file within 15 months of the end of the plan year. This file may be uploaded to the RDS secure website or transmitted to the RDS Center mainframe. For instructions and information on file specifications, please go to the RDS Center website at http\\rds.cms.hhs.gov. The reconciliation file must contain the following data elements:

1. Application ID (assigned to you by the RDS Center)
2. Unique Benefit Option Identifier – This should be the same as the Unique Benefit Option Identifier entered on the RDS application for this retiree's plan.
3. Qualified Covered Retiree SSN

OR

4. Qualified Covered Retiree HICN
5. Year and Month of Rx Cost incurred. (YYYYMM)
6. First name of retiree or dependent
7. Middle Initial of retiree or dependent
8. Last name of retiree or dependent
9. Date of birth
10. Gender
11. Gross Retiree Cost
12. Threshold Reduction
13. Limit Reduction
14. Cost Adjustment
15. Timestamp (date and time of file creation in timestamp format)

The reconciliation file will also require an additional record with file totals: I.E. total number of records on the file, total retirees.

J. PART IV. Interim Payment Request Agreement and Electronic Signature

K. PAYMENT Agreement

L. (The Designee of the Plan Sponsor MUST agree to each clause under this section by providing an electronic signature in Part IV (B).)

1.	Payment is contingent on compliance with the plan sponsor agreement and with RDS program requirements, including the applicable laws and regulations.
2.	Authorized Payment Designee, on behalf of the plan sponsor, agrees that: a. Once they become aware that an overpayment has occurred, the Designee of plan sponsor will promptly notify the RDS Center of the overpayment within 30 days of the discovery of the overpayment; b. CMS is authorized to initiate payment, credit entries and other adjustments, including offsets and requests for payment, in accordance with the provisions of 42 CFR 423 Subpart R and 45 CFR 30 Subpart B, to the account at the financial institution (hereinafter the "Depository") indicated in Part IV(A)(1) of the plan sponsor application; and c. Sponsor will promptly notify CMS of any changes in its Depository information and submit an updated Electronic Funds Transfer (EFT) Authorization.

B. Authorization

Signature of Authorized Payment Designee

I, the undersigned Authorized Payment Designee, on behalf of the Plan Sponsor, declare that I have examined this Payment Request and certify that the information contained in this Payment Request is true, accurate and complete to the best of my knowledge and belief. 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.

☐ Electronic Signature

M. PART V. Reconciliation Request Agreement and Electronic Signature

N. RECONCILIATION Agreement

O. (The Authorized Payment Designee MUST agree to each clause under this section by providing an electronic signature in Part V (B).)

1.	In order to receive subsidy payments, Sponsor agrees to comply with all of the terms and conditions of the Plan Sponsor Agreement that was signed by the Authorized Representative of the Plan Sponsor and submitted with the application. Sponsor will promptly notify CMS of any changes to the information submitted in its Plan Sponsor Agreement.
2.	**Obtaining Federal Funds:** Sponsor acknowledges that the information furnished in its retiree drug subsidy reconciliation payment request 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 as described in the Department of Health and Human Services overpayment regulations at 45 C.F.R. 30 Subpart B. Sponsor agrees that once it becomes aware that an overpayment has occurred, it will promptly take action to repay the overpayment to the RDS Center within 30 days of the discovery of the overpayment. Sponsor 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. 423 Subpart R and 45 C.F.R. 30 Subpart B to the account at the financial institution (hereinafter the "Depository") indicated in Part IV(A)(1) of the Plan Sponsor Application. Sponsor agrees to promptly notify CMS of any changes in its Depository information and submit an update Electronic Funds Transfer (EFT) Authorization.
B. Authorization	
Signature of Authorized Payment Designee I, the undersigned Authorized Payment Designee, on behalf of the Plan Sponsor, declare that I have examined this Reconciliation Payment Request and certify that the information contained in this Reconciliation Payment Request is true, accurate and complete to the best of my knowledge and belief; that the Sponsor agrees to comply with all RDS program requirements (including 42 C.F.R. Subpart 423 R and 45 C.F.R. 30 Subpart B) and other applicable laws and regulations. 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. ☐ Electronic Signature	

Part I. Payment PRA

Section A. Payment Setup - User Selects Plan Sponsor and Application for which to complete payment setup.

1. Account Manager Privileges
   a) *Privilege
      (1) Report Costs
      (2) Request Payment
      (3) View Only
   b) Cost Reporting Method
      (1) Mainframe
      (2) Data Entry
      (3) RDS Secure Web Site Upload
      (4) Not Applicable
   c) Benefit Options assigned for cost reporting
      (1) Unique Benefit Option ID
      (2) Not Applicable

2. Vendor Privileges and Assignments
   a) *Do you want to specify one or more Vendors to report costs for this application? Yes/No
   b) Vendor ID
   c) Benefit Options assigned to Vendor
      (1) Unique Benefit Option ID

3. Designee Privileges and Assignments
   a) *Do you want to assign Payment Request or Cost Reporting Privileges to Designee(s)? Yes/No
   b) Does the Designee exist on the application?
      (1) Yes: Designee Name
      (2) No: E-mail address

c) Provide the following Designee Information if the Designee is not currently a RDS Secure Web Site user.
   (1) First Name
   (2) Middle Initial
   (3) Last Name
   (4) E-mail Address
   (5) Pass Phrase
d) Designee Privilege
   (1) Report Costs
   (2) Request Payment
   (3) View Costs
   (4) View Payment Requests
   (5) View All
e) Vendor ID
f) Designee Cost Reporting Method
   (1) Mainframe
   (2) Data Entry
   (3) RDS Secure Web Site Upload
   (4) Not Applicable
g) Benefit Options assigned to the Designee for cost reporting
   (1) Unique Benefit Option ID

4. Authorized Representative Verification form
   a) *Reason for Submission
   b) *Authorized Representative's Name
   c) *Authorized Representative's Title
   d) *Plan Sponsor Name
   e) *Plan Sponsor ID
   f) *Verifier's Name
   g) *Verifier's Job Title
   h) *Verifier's E-mail Address
   i) *Verifier's Telephone Number
   j) *Verifier's Company Address
   k) *Date that the form was completed
   l) *Verifier's Signature
5. Vendor and Plan Sponsor Mainframe Registration
   a) Which of the following best describes your role in the RDS program?
      (1) Plan Sponsor
      (2) Vendor submitting on behalf of the Plan Sponsor
   b) Plan Sponsor or Vendor ID:
   c) *Application Number:
   d) *Technical Contact Name
   e) *Technical Contact E-mail Address
   f) *Technical Contact Telephone Number
   g) SNA or IP AGNS Account Information
      (1) *Account ID
      (2) *Network ID or NODEID
      (3) *APPLID or Registered IP Address
      (4) *NDM NodeID or Subnet Mask
   h) Retiree List
      (1) Production File Name
      (2) Production Instructions
      (3) Test File Name

(4) Test Instructions
i) Weekly Retiree Notification Files
(1) Production File Name
(2) Production Instructions
(3) Test File Name
(4) Test Instructions
j) Cost Reporting Method
(1) Mainframe
(2) Data Entry
(3) RDS Secure Web Site Upload

Section B. Cost Data

1. Cost Data Submitted via data entry on the RDS Secure Website.
a) User selects
(1) *Plan Sponsor ID
(2) *Application ID
(3) *Unique Benefit Option ID
(4) *Plan Month
b) The following data elements are entered
(1) Estimated Premium Costs
(2) Gross Retiree Costs
(3) Threshold Reduction
(4) Limit Reduction
(5) Estimated/Actual Cost Adjustment

2. Cost Data Submitted in a File Format
a) *File Header
(1) Record Type
(2) Submitter Type
(3) Plan Sponsor ID or Vendor ID
(4) File Creation Date
(5) File Creation Time
b) *Application Header
(1) Record Type
(2) Application ID
c) *Benefit Option Detail
(1) Record Type
(2) Unique Benefit Option Identifier
(3) Plan Month
(4) Estimated Premium Costs
(5) Gross Retiree Costs
(6) Threshold Reduction
(7) Limit Reduction
(8) Estimated Cost Adjustment
(9) Actual Cost Adjustment
d) *Application Trailer
(1) Application ID
(2) Record Count for the Application
(3) Total Estimated Premium Costs
(4) Total Gross Retiree Costs
(5) Total Threshold Reduction
(6) Total Limit Reduction

(7) Total Estimated Cost Adjustment
(8) Total Actual Cost Adjustment

e) *File Trailer
(1) Record Type
(2) Plan Sponsor ID or Vendor ID
(3) Application Count
(4) Grand Total Estimated Premium Costs
(5) Grand Total Gross Retiree Costs
(6) Grand Total Threshold Reduction
(7) Grand Total Limit Reduction
(8) Grand Total Estimated Cost Adjustment
(9) Grand Total Actual Cost Adjustment

P. Interim Payment Request

3. Select
a) *Plan Sponsor ID
b) *Application ID
4. For each Unique Benefit Option ID(within the Application) with reported costs:
a) *Has a Payment Requester Reviewed Costs for the Benefit Option? Yes/No
b) *Should this Benefit Option be Included in the Payment Request? Yes/No
5. Payment Agreement (Reference Part I Section D.)
6. *Do you accept the Payment Agreement? Yes/No
7. *Electronic Signature

Section C. Payment Agreement

Payment is contingent on compliance with the Plan Sponsor Agreement and with Retiree Drug Subsidy (RDS) program requirements, including the applicable laws, regulations and guidance issued by CMS.

Authorized Payment Requester, on behalf of the Plan Sponsor, agrees that:
1. CMS is authorized to initiate payment, credit entries and other adjustments, such as offsets and requests for payment, in accordance with the provisions of 42 CFR § 423 Subpart R and applicable provisions of 45 CFR Part 30, to the account at the financial institution (hereinafter the "Depository") indicated under the Electronic Funds Transfer (EFT) section of the Plan Sponsor application. Plan Sponsor agrees to immediately pay back any overpayment or debt upon notification from CMS of the overpayment or debt. , Plan Sponsor agrees to promptly update any changes in its Depository information.

2. Under authority of 42 CFR §423.888(c), officers, employees and contractors of the U.S. Department of Health & Human Services (DHHS), including the Office of Inspector General (OIG), may use information collected under the RDS Program only for purposes of, and to the extent necessary in, carrying out their responsibilities under 42 C.F.R. § 423 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 necessary for purposes of 42 C.F.R. §423 Subpart R or other authority.

3. Under authority of 42 CFR §423.888(d) the Plan Sponsor or its designee, must maintain and furnish to CMS or the OIG upon request, the records enumerated in 42

CFR 423.888(d)(3) and (4) (Records). The Records must be maintained for 6 years after the expiration of the plan year in which the costs were incurred for the purposes of audits or other oversight activities conducted by CMS to assure the accuracy of the actuarial attestation and the accuracy of payments. Plan Sponsor acknowledges that CMS or the OIG may extend the 6-year Record retention requirement in the event of an ongoing investigation, litigation, or negotiation involving civil, administrative or criminal liability. Plan Sponsor agrees that it must maintain the Records longer than 6 years if it knows or should know that the Records are the subject to ongoing investigation, litigation or negotiation involving civil, administrative or criminal liability.

I, the undersigned Authorized Payment Requester, on behalf of the Plan Sponsor, declare that I have examined this Interim Payment Request and certify that the information contained in this Interim Payment Request is true, accurate and complete to the best of my knowledge and belief, and I authorize CMS 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 applicable Federal and/or State law.

Section D. Reconciliation and Single Annual Payment

1. Select
   a) *Plan Sponsor ID
   b) *Application ID

2. Step 1: Initiate Reconciliation
   a) *Are you ready to proceed with reconciliation for final payment determination? Yes/No
   b) *Do you acknowledge the instructions and warning? Yes/No
   c) *Confirmation

3. Step 2: Review Payment Setup
   a) *Do you accept the Payment Setup Options? Yes/No

4. Step 3: Request List of Covered Retirees
   a) *Request Covered Retiree List? Yes/No

5. Step 4: Finalize Covered Retirees
   a) *Select Download Covered Retiree List? Yes/No
   b) *Select File Name to download
   c) *Acknowledge PHI Agreement? Yes/No
   d) *Do you agree with the list of covered retirees and their associated coverage periods? Yes/No
   e) *Confirmation

6. Step 5: Start Preparation of Reconciliation Payment Request
   a) *Do you want to open final cost reporting? Yes/No

7. Step 6: Manage Submission of Final Cost Reports
   a) *Do you want to close final cost reporting? Yes/No
   b) *Confirmation

8. Step 7: Review Final Costs
   a) *Mark Benefit Option Review complete individually or may select all.

b) *Have you completed reviewing costs for all Benefit Options? Yes/No
c) *Confirmation

9. Step 8: Enter Revisions to Final Cost Data
   a) *Do you have revisions to make? Yes/No
   b) Select Benefit Option with Revised Cost Data and provide:
      (1) Reason for Revisions
         (a) *Coordination of Individual Retiree Costs? Yes/No
         (b) *Direct Rebates? Yes/No
         (c) *Other? Yes/No
         (d) *Explanation
      (2) Revised Gross Retiree Cost
      (3) Revised Threshold Reduction
      (4) Revised Limit Reduction
      (5) Revised Actual Cost Adjustment
   c) Confirmation

10. Step 9: Finalize Reconciliation Payment Request
   a) *Are you ready to finalize the reconciliation payment request? Yes/No
   b) *Do you acknowledge the instructions and warnings? Yes/No
   c) *Confirmation

11. Step 10: Review Electronic Funds Transfer (EFT) Information (Change necessary elements or confirm existing data)
   a) *Do you agree to the existing EFT banking information? Yes/No
   b) Account Information
      (1) Bank Name
      (2) Account Type
      (3) Company Name Associated with Account
      (4) Account Number:
      (5) Bank Routing Number:
   c) Bank Contact
      (1) First Name
      (2) Middle Initial
      (3) Last Name
      (4) Telephone
      (5) Fax
      (6) E-mail Address
   d) Bank Address
      (1) Street Line 1
      (2) Street Line 2
      (3) City
      (4) State
      (5) Zip Code
   e) *Confirmation

12. Step 11: Approve Electronic Funds Transfer (EFT) Information
   a) Do you accept or reject the EFT information entered in Step 10? Accept/Reject

13. Step 12: Review and Submit Reconciliation Payment Request
   a) Payment Request Review
      (1) *Do you acknowledge the instructions and warnings? Yes/No

(2) *Do you want to approve or reject the Final Payment Request? Approve/Reject

b) Payment Authorization

(1) *Reconciliation Agreement (Reference Part I Section F.)

(2) *Do you accept the Reconciliation Agreement? Yes/No

(3) *Electronic signature

c) *Confirmation

Section E. Reconciliation Agreement

Payment is contingent upon compliance with the Plan Sponsor Agreement and with Retiree Drug Subsidy (RDS) program requirements, including the applicable laws, regulations and guidance issued by CMS.

The Authorized Representative, on behalf of the Plan Sponsor, agrees that:

1. CMS is authorized to initiate payment, credit entries and other adjustments, such as offsets and requests for payment, in accordance with the provisions of 42 CFR §423 Subpart R and applicable provisions of 45 CFR Part 30, to the account at the financial institution (hereinafter the "Depository") indicated under the Electronic Funds Transfer (EFT section) of the plan Sponsor application. Plan sponsor agrees to immediately pay back any overpayment or debt upon notification from CMS of the overpayment or debt. Plan Sponsor agrees to promptly update any changes in its Depository information.

2. Under authority of 42 CFR §423.888(c), officers, employees, and contractors of the U.S. Department of Health & Human Services (DHHS), including the Office of Inspector General (OIG), may use information collected under the RDS Program only for purposes of, and to the extent necessary in, carrying out their responsibilities under 42 C.F.R. §423 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 necessary for purposes of 42 C.F.R. §423 Subpart R or other authority.

3.Under authority of 42 CFR 423.888(d) the Plan Sponsor or its designee must maintain and furnish to CMS or the OIG upon request, the records enumerated in 42 CFR 423.888(d)(3) and (4) (Records). The Records must be maintained for 6 years after the expiration of the plan year in which the costs were incurred for the purposes of audits or other oversight activities conducted by CMS to assure the accuracy of the actuarial attestation and the accuracy of payments. Plan Sponsor acknowledges that CMS or the OIG may extend the 6-year Record retention requirement in the event of an ongoing investigation, litigation, or negotiation involving civil, administrative or criminal liability. Plan Sponsor agrees that it must maintain the Records longer than 6 years if it knows or should know that the Records are the subject to ongoing investigation, litigation or negotiation involving civil, administrative or criminal liability.

Obtaining Federal Funds: Plan Sponsor acknowledges that the information furnished in its retiree drug subsidy Reconciliation Payment Request is being provided to obtain Federal funds. Plan 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. Plan Sponsor acknowledges that payment of a subsidy is conditioned on the submission of accurate information. Plan Sponsor agrees that it will not knowingly present or cause to be presented a false or fraudulent claim. Plan Sponsor acknowledges that any overpayment made to the Plan Sponsor under the RDS program, or any debt that arises from such overpayment, may be recovered by CMS

1. I, the undersigned Authorized Representative of Plan Sponsor, declare that I have examined this Plan Sponsor Reconciliation Payment Request and certify that the information contained in this Reconciliation Payment Request is true, accurate and complete to the best of my knowledge and belief, and I authorize CMS to verify this information. My signature legally and financially binds the Plan Sponsor to the laws, regulations and other guidance applicable to the RDS program (including, but not limited to, 42 C.F.R. §423 Subpart R) and all other applicable laws and regulations. . 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 applicable Federal and/or State law.

Part II. Appeals

Section A. Reconsideration and Subsequent Appeal Levels

1. Informal Written Reconsideration
   a) *Application number
   b) *Findings or issues the Plan Sponsor disagrees with (i.e., the initial determination).
   c) *Reason(s) for disagreement
   d) *Refer to the "sent" date on the e-mail notification of the adverse initial determination. Is the "sent" date within 15 calendar days of today's date? Yes/No
   e) *Will you be sending additional documentary evidence? Yes/No
   f) Additional Documentary Evidence
   g) Additional Documentary Evidence Cover Sheet
2. Informal Hearing
   a) *Provide copy of CMS' RDS Center's reconsideration decision
   b) *Specify the findings or issues in the decision with which the Plan Sponsor disagrees and the reasons for the disagreements
   c) *Plan Sponsor’s Supporting Statement
3. Review by the Administrator
   a) *Request for review by administrator

Section B. Reopening

1. *Application number
2. *Initial Determination that is the subject of the request for reopening
3. *Reason for the Request
4. Additional documentary evidence
5. Additional documentary evidence cover sheet