EXHIBIT 1

DECLARATION OF TRUST

This DECLARATION OF TRUST is made this 8th day of May, 1997 by Springhill, Inc.

ARTICLE I
NAME OF THE TRUST

The name of the Trust established under this instrument is The Pooled Accounts Trust of Springhill, Inc. (herein referred to as the "Trust"). This Trust is intended to be a pooled accounts trust established under 42 U.S.C. § 1396p (d)(4)(C). All provisions of this trust shall be interpreted to qualify this Trust under 42 U.S.C. § 1396p(d)(4)(C). Any provision of this Trust which prevents this Trust from qualifying under 42 U.S.C. § 1396p(d)(4)(C) shall be null and void.

ARTICLE II
DEFINITIONS

1. "Beneficiary" shall mean a disabled person, as defined in Section 1614(a)(3) of the Social Security Act (42 U.S.C. § 1396p, amended August 10, 1993, by the Revenue Reconciliation Act of 1993), to be a recipient of services and benefits under this Trust. If the Social Security Administration or any authorized governmental entity has not made a determination that the Beneficiary is a disabled person, the Trustee is authorized to accept such Beneficiary within its discretion if it has made a determination that the Beneficiary is a disabled person, as defined in 42 U.S.C. § 1382c(a)(3).

2. "Government assistance" shall mean all services, benefits and financial assistance that may be provided by any state or federal agency to or on behalf of a Beneficiary. Such benefits

include, but are not limited to, the Supplemental Security Income (SSI) program, the Old Age Survivor and Disability Insurance (OASDI) program, the Supplemental Security Disability Income (SSDI) program and the Medicaid program, together with any additional, similar, or successor public programs.

3. "Grantor" shall mean a parent, grandparent, agent acting under a power of attorney, or guardian of a Beneficiary, a Beneficiary himself or herself, or any court. The term "Grantor" shall also include any person or entity that contributes his, her, or its own assets or property to the Trust for the benefit of a Beneficiary, by gift, will, contract, or agreement.

4. "Guardian" shall mean a legal guardian, conservator, agent acting under a durable power of attorney, trustee, representative payee, or other legal representative or fiduciary of a Beneficiary.

5. Payments for "supplemental needs" or for "supplemental care" shall mean non-support disbursements. It is not the Grantor's intention to displace public and private financial assistance that may otherwise be available to any Trust Beneficiary. It is the intention of the Grantor to limit the Trustee's contribution to a Beneficiary's supplemental needs only. The following illustrates the kinds of supplemental, non-support disbursements that are appropriate for the Trustee to make from this Trust to or for the benefit of a Trust Beneficiary. The following examples are not exclusive. Non-covered medical, dental and diagnostic work and treatment for which there are no private or public funds, and medical procedures that are desirable in the Trustee's discretion, even though they may not be medically necessary or life saving may be paid by the Trustee. Differentials in cost between housing and shelter

for shared and private rooms may be paid by the Trustee in its discretion for Beneficiaries of the Trust. Care appropriate for a Beneficiary that assistance programs may not or do not otherwise provide may be paid by the Trustee, as well. Expenditures for recreation, social, travel, companionship, cultural experiences, and expenses in bringing a Beneficiary's siblings and others for visitation with him or her are appropriate expenditures. Supplemental care needs shall also include items of a similar nature specified in a Joinder Agreement if approved by the Trustee.

6. "Trustee" shall mean Springhill, Inc., a non-profit organization, its successor or successors and shall include any Co-Trustee or Co-Trustees. "Co-Trustee" shall mean a person or entity, or both, selected by the Trust to assist with the management, administration, allocation, and disbursement of Trust assets and property.

ARTICLE III
ESTABLISHMENT OF SUPPLEMENTAL NEEDS TRUST

1. It is the intention of Springhill, Inc. to establish a supplemental fund pursuant to 42 U.S.C. § 1396p, as amended August 10, 1993 by the Revenue Reconciliation Act of 1993, for the benefit of Beneficiaries under this Trust. This Trust shall not be reduced in value by the Beneficiaries' creditors. Their public and private assistance benefits shall not be made unavailable to them or be terminated because of this Trust. Assets held in this Trust and sub-accounts are not for the Beneficiaries' primary support. They are to supplement their care needs only. There is no obligation of support owing to the Beneficiaries by the Grantor nor by the Trustee; the Beneficiaries have no entitlement to the income or corpus of this Trust, except as the Trustee, in its complete and

unfettered discretion, elects to disburse, and the Trustee may act unreasonably in exercising discretion. The Trustee's judgment should not be substituted for the judgment of any other person or entity.

2. The Trustee shall pay or apply for the supplemental needs of each Beneficiary, such amounts from the principal or income, or both, of the Trust sub-account maintained for such Beneficiary, up to the whole thereof, as the Trustee, in its sole discretion, may from time to time deem necessary or advisable for the satisfaction of that Beneficiary's supplemental care needs, if any. Any income not distributed shall be added annually to the principal in the Trust sub-account maintained for the respective Beneficiary.

3. Disbursements from this Trust should not be made to or for the benefit of a Beneficiary if the effect of such distribution replaces government assistance benefits of any kind. The Trust corpus and income are not available to any Beneficiary except to the extent of distributions made by the Trustee to a Beneficiary. No distributions should be made by the Trustee to or for the benefit of a Beneficiary in excess of resource and income limitations of any public benefit program to which the Beneficiary is entitled. The Beneficiary's future needs may be considered by the Trustee in connection with disbursements made. The interests of the remainder Beneficiary is of only secondary importance.

4. The Trustee should refuse any request for payments from this Trust for services that any public or private agency has the obligation to provide to Beneficiaries who otherwise qualify for such assistance. The Trustee may not be familiar

with the federal, state and local agencies that have been created to assist persons financially such as the Trust Beneficiaries, and the Trustee should seek assistance in identifying public and private programs that are or may be available to the Trust's Beneficiaries so that the Trustee may better serve them.

5. No part of this Trust, principal or income, shall be subject to anticipation or assignment by the Beneficiaries nor shall it be subject to attachment or control by any public or private creditor of the Beneficiaries; nor may it be taken by any legal or equitable process by any voluntary or involuntary creditor, including those that have provided for the Beneficiary's support and maintenance. Further, under no circumstances may any Beneficiary compel a distribution from a Beneficiary's sub-account.

ARTICLE IV
TRUST FUNDING

Springhill, Inc. shall initially fund this Trust with a lump-sum payment of Fifty Dollars and No Cents ($50.00). The Trust estate shall consist of this initial contribution and any additional contributions in cash or property made to the Trust estate at any time by any Grantor in accordance with the provisions of Article V. By execution hereof, Springhill, Inc. assigns, conveys, transfers and delivers the above-described funds to the Trust on the date of this instrument.

ARTICLE V
GRANTORS' CONTRIBUTIONS

1. The Trust shall be effective as to any Beneficiary upon execution of a Joinder Agreement by a Grantor, or by court order, subject to the

approval of the Trustee. Upon delivery to and acceptance by the Trustee of property acceptable to the Trustee, the Trust, as to the Grantor of such property and the designation of the respective Beneficiary, shall be irrevocable and the contributed property shall not be refundable, except as is otherwise provided in Article XI Paragraph (3)

2. Property or interests in property can be designated for future transfer by a Grantor as a contribution. Such designation may be revocable and can be revoked by the Grantor as to such property at any time during that Grantor's life and continued competence, upon prior written notice from the Grantor to the Trustee. Examples of such contributions include a policy of life insurance on a Grantor's life in which the Trust is designated as a beneficiary, or the Trust being named as a beneficiary of any future interest in property, such as that which would pass by way of a Grantor's Last Will.

ARTICLE VI
ADMINISTRATIVE PROVISIONS

1. A separate Trust sub-account shall be maintained for each Beneficiary, but, for purposes of investments and management of funds, the Trust shall pool these Trust sub-accounts. The Trustee, or its authorized agents, shall maintain records for each Trust sub-account in the name of, and showing the property contributed for, each Beneficiary.

2. The Trustee shall report, at least annually, to each Beneficiary (or to his or her guardian), who is eligible to receive discretionary distributions of the net income or principal from a Trust sub-account maintained for such Beneficiary, all of the

receipts, disbursements and distributions to or from such Trust sub-account occurring during the reporting period. In addition, a complete statement of the Trust sub-account resources shall be furnished. Further, the Trustee shall furnish, at least annually, to each Beneficiary or to his or her guardian, a financial statement concerning the Trust.

3. The Trust sub-account records of the Trustee, along with all Trust sub-account documentation, shall be available and open at all reasonable times for the inspection of the Beneficiary, or his or her guardian, or both.

4. The Trustee shall not be required to furnish Trust records or documentation to any individual, corporation, or other entity who is not a Beneficiary, or does not have the express written approval of the Beneficiary to receive such information, or who is not the fiduciary of the Beneficiary.

5. Except as otherwise provided in this instrument, and so long as the Trustee is prudent in administering the Trust, the Trustee may serve without bond, and may exercise all powers contained in Article VIII.

6. The Trustee, in its sole discretion, may make any payment under the Trust (a) directly to a Beneficiary, (b) in any form allowed by law, (c) to any person deemed suitable by Trustee, or (d) by direct payment of a Beneficiary's expenses.

7. No authority described in this instrument or available to trustees pursuant to applicable law shall be construed to enable the Trustee to purchase, exchange or otherwise deal with or dispose of the principal or income of any Trust

sub-account for less than an adequate or full consideration in money or money's worth, or to enable any person to borrow the principal or income of any Trust sub-account, directly or indirectly, without adequate interest or security.

8. Costs and expenses of defending the Trust from any claim, demand, legal or equitable action, suit, or proceeding may, in the sole discretion of the directors of Springhill, Inc. either (a) be apportioned on a pro rata basis to all Trust sub-accounts, or (b) be charged only against the Trust sub-account as to the affected Beneficiary.

ARTICLE VII
DESIGNATION OF CO-TRUSTEES

The Trustee may designate a Co-Trustee or Co-Trustees to serve at its pleasure.

ARTICLE VIII
POWERS AND AUTHORITY OF TRUSTEE

Subject to the restrictions contained in Article III and Article VI, the Trustee has the following continuing, absolute, and discretionary powers to deal with any property, real or personal, held in the Trust. Trustee may exercise these powers independently and without the approval of any court or judicial authority. No person dealing with Trustee need inquire into the propriety of any of its actions or in to the application of any funds or other property. Trustee shall, however, exercise all powers in a fiduciary capacity for the best interest of any Beneficiary of this Trust Agreement. Without in any way limiting the generality of the foregoing, Trustee is given the following specific powers in addition to any other powers conferred by law:

1. Except as otherwise provided to the contrary, to hold funds uninvested in amounts that Trustee deems appropriate, and to invest in any assets Trustee deems advisable even though they are not technically recognized as legal investments for fiduciaries, without responsibility for depreciation or loss on account of those investments, or because those investments are nonproductive.

2. To retain the original assets it receives for as long as it deems best, and to dispose of those assets as and when it deems advisable.

3. If no personal representative of Grantors' estates is then serving, and to the extent permitted by law, to perform in a fiduciary capacity any act and make any and all decisions or elections under state law.

4. To expend whatever funds it deems proper for the preservation, maintenance, or improvement of assets. In its absolute discretion, Trustee may pay premiums on all insurance policies that it holds, and may elect any options or settlements or exercise any rights under those policies. However, no Trustee who is the insured of any insurance policy that is subject to the terms of this Agreement may exercise any rights or have any incidents of ownership with respect to the policy, including the power to change the beneficiary, to surrender or cancel the policy, to assign the policy, to revoke any assignment, to pledge the policy for a loan, or to obtain from the insurer a loan against the surrender value of the policy.

5. To employ and compensate attorneys, accountants, managers, agents, assistants, and advisors without liability for any act of those

persons, so long as they are selected and retained with reasonable care.

6. To execute deeds, leases, contracts, bills of sale, notes, and other written instruments.

7. To make distributions, whether of principal or income, to any minor child or incompetent person according to the terms of this Trust Agreement by making distributions directly to that person whether or not that person has a guardian; to the parent, guardian, or spouse of that person; to a custodial account established for that person under an applicable Uniform Transfers to Minors Act; to any adult who resides in the same household with that person or who is otherwise responsible for the care and well-being of that person; or by applying any distribution for the benefit of that person in any manner Trustee deems proper. The receipt of the person to whom payment is made will constitute full discharge of Trustee with respect to that payment.

8. To make any division or distribution in money or in kind, or both, without allocating the same kind of property to all shares or distributees, and specifically without regard to the income tax basis of the property. Any division will be binding and conclusive on all parties. Trustee is excused from any duty of impartiality with respect to any division or distribution.

9. To borrow money from any source (including Trustee in its non-fiduciary capacity) for the benefit of any trust created by this Agreement, and to secure the loan by mortgage or other collateral.

10. To compromise, arbitrate, or otherwise adjust claims in favor of or against any trust created by this Agreement and to agree to any rescission or modification of any contract or Agreement.

11. To participate in any type of liquidation or reorganization of any enterprise.

12. To vote and exercise all rights and options, or empower another to vote and exercise those rights and options, concerning any corporate stock, securities or other assets or to delegate those rights to an agent, and to enter into voting trusts and other Agreements or subscriptions that Trustee deems advisable.

13. To buy, sell, exchange, or lease any real or personal property, publicly or privately, for cash or credit, without order of court and upon the terms and conditions that Trustee deems advisable. Any lease so made will be valid and binding for its full term even though it extends beyond the duration of any trust. Specifically, the Trustee may invest the Trust principal in residential real estate suitable for occupancy by a Beneficiary, and may permit occupancy or use without charge in such manner as, in the opinion of the Trustee, best serves the Trust's interest without the necessity of turning such property (whether complete or a shared interest with others) into cash or gaining an income therefrom. Furthermore, the Trustee is authorized to pay out of the income or principal of this Trust the taxes, insurance and maintenance expenses to keep the residential or replacement property in suitable repair, or any portion thereof as the Trustee deems proper.

14. To exercise all its powers by this Agreement, even though it may also be acting individually, or on behalf of any other person or entity interested in the same matters. Trustee, however, shall exercise these powers at all times in a fiduciary capacity, primarily in the interest of the beneficiaries of any trust created by this Trust Agreement.

15. To treat premiums and discounts on bonds and other obligations for the payment of money in accordance with generally accepted accounting principles and to hold nonproductive assets without allocating any portion of the Trust principal to income, notwithstanding the provisions of any applicable principal and income.

16. To incorporate any business or venture forming a part of the Trust estate and to continue any incorporated business throughout the term of the Trust.

17. To employ any investment management service, financial institution, or similar organization to advise it, handle all Trust investments, and render all accounting of funds held on its behalf under custodial, agency, or other Agreements and if no Trustee is corporate, to pay the costs of those services as an expense of administration in addition to fees and commissions.

18. To hold, manage, and develop real estate. To grant easements and make dedications as it deems advisable. To retain unproductive property, as determined appropriate by the Trustee.

19. To buy, sell, and trade in securities of any nature, including short sales, on margin or otherwise. To maintain and operate margin accounts with brokers, and to pledge any securities held or purchased by Trustee with such brokers as security or loans or advances made to Trustee.

20. To disclaim any assets otherwise passing or any fiduciary powers pertaining to any Trust created thereunder, by execution of an instrument of disclaimer meeting the requirements of applicable law generally imposed upon individuals executing disclaimers. No notice to, or consent of, any

beneficiary, other interested person, or any court is required for any such disclaimer, and Trustee is to be held harmless for any decision to make or not make such a disclaimer.

21. To transfer the situs of any Trust property to any other jurisdiction as often as Trustee deems it advantageous to the Trust, appointing a substitute Trustee to act with respect to that property. Trustee may delegate to the substitute Trustee any or all of the powers given to Trustee; may elect to act as advisor to the substitute Trustee and shall receive reasonable compensation for so acting; and may remove any acting substitute Trustee and appoint another, or reappoint itself, at will.

22. The Trustee, its agents, employees, successors, assigns, attorneys or any other representatives, shall be indemnified and held harmless, up to and including any amount held by this Trust, for any costs or expenses, including but not limited to identification, maintenance, administration, remediation, or litigation associated with any property, facility, vessel or other identifiable unit that is subject to environmental claims under the laws of this State or the laws of the United States.

23. To establish accounts of all kinds, including checking and savings, in the name of this Trust, with financial institutions of any kind, including but not limited to banks and thrift institutions; to modify, terminate, make deposits to and write checks on or make withdrawals from and grant security interests in all accounts in the Trust's name; to negotiate, endorse or transfer any checks or other instruments with respect to any such accounts; to contract for any services rendered by any bank or financial institution;

24. To contract with any institution for the maintenance of a safe-deposit box in the name of this Trust.

ARTICLE IX
INDEMNIFICATION

The Trustee and each of its agents and employees, as well as its agents' and employees' heirs, successors, assigns and personal representatives, are indemnified by the Trust and the Trust property against all claims, liabilities, fines, or penalties and against all costs and expenses (including attorney's fees and disbursements and the cost of reasonable settlements) imposed upon, asserted against or reasonably incurred thereby in connection with or arising out of any claim, demand, action, suit, or proceeding in which he, she, or it may be involved by reason of being or having been a Trustee or Advisor, whether or not he, she, or it shall have continued to serve as such at the time of incurring such claims, liabilities, fines, penalties, costs, or expenses or at the time of being subjected to the same. However, the Trustee and its agents and employees (and their heirs or personal representatives) shall not be indemnified with respect to matters as to which he, she, or it shall be finally determined to have been guilty of willful misconduct in the performance of any duty as such, by a court of competent jurisdiction. This right of indemnification shall not be exclusive of, or prejudicial to, other rights to which the Trustee, its agents or employees may be entitled as a matter of law or otherwise.

ARTICLE X
AMENDMENT OF TRUST

This Declaration of Trust shall be irrevocable,

except that it may be amended from time to time to conform to Article III to effectuate the terms of this instrument. In addition, the Trustee may amend this instrument with the approval of any court of competent jurisdiction in the State of Michigan, so that it conforms with any rules or regulations that are approved by any governing body or agency relating to 42 U.S.C. § 1396p or related statutes, including state statutes and regulations that are consistent with the provisions and purposes of the Revenue Reconciliation Act of 1993. Amendments may be made and approved by any court of competent jurisdiction in this state, by notice of such request for amendment to the Family Independence Agency, or its successor agency, of the State of Michigan.

ARTICLE XI
TERMINATION OF TRUST

1. Every reasonable attempt will be made to continue the Trust for the purposes for which it is established. However, it is recognized that the Trustee does not and cannot know how future developments in the law, including administrative agency and judicial decisions, may affect the Trust or any Trust sub-account. If the Trustee has reasonable cause to believe that the income or principal in a Trust sub-account maintained for any Beneficiary is or will become liable for basic maintenance, support, or care for that Beneficiary which has been or would otherwise be provided by local, state, or federal government, or an agency or department thereof, the Trustee, in its sole discretion, may (a) terminate the Trust sub-account as to the affected Beneficiary as though he or she had died, and the Trustee shall then treat the property in the Trust sub-account according to the provisions of Article XI Paragraph (2), (b) determine that the Trust has become impossible to

implement for the affected Beneficiary, and the Trustee shall then treat the property in the Trust sub-account according to the provisions of Article XI Paragraph (3), or (c) continue to administer the Trust sub-account under separate arrangement with the affected Beneficiary or his or her guardian. Before making any distribution of amounts retained in any Trust sub-account, the Trustee should consider the tax and Medicaid and other public benefit consequences to the Beneficiary of any particular distribution.

2. Upon the death of a Beneficiary, any amounts remaining in the Beneficiary's Trust sub-account shall be deemed to be surplus Trust property and shall be retained by the Trust and, in the Trustee's sole discretion, used (a) for the benefit of other Beneficiaries, (b) to aide persons who are indigent and disabled, as defined in 42 U.S.C. § 1382c(a)(3), or (c) to provide persons who are indigent and disabled, as defined in 42 U.S.C. § 1382c(a)(3), with housing or supplemental support services deemed suitable for such persons by the Trustee. Gifts or devises to the Trust shall be similarly treated unless the purpose for which the gift is made is specified by the donor.

3. The Trustee, in its sole discretion, may refund all or any portion of the property in a Trust sub-account to a Grantor (excluding any court) if it becomes impossible to fulfill the conditions of the Trust with regard to the respective Beneficiary for reasons other than the death of the Beneficiary. In the event such Grantor is not living at the time a refund is to be made, payment may be made to the estate of the Grantor.

4. If it becomes impossible, or impracticable, to carry out the Trust's purposes with respect to all Beneficiaries, the Trustee may terminate the Trust

and distribute the Trust property as set forth in Article XI Paragraph (2), provided, however, that if Springhill, Inc. has ceased to exist or has been dissolved, then any property remaining in the Trust shall be applied and paid over to such other organization or organizations as the Trustee, in its sole discretion, may determine then to be serving the interests and needs of people with disabilities in a manner consistent with the purposes of this Trust. Before action is taken under this Article XI Paragraph (4), a final accounting along with an application seeking approval of the action to be taken shall be filed in a court of competent jurisdiction in this state.

ARTICLE XII
RESIGNATION OF TRUSTEE

The Trustee may resign only with the approval of a court of competent jurisdiction in this state. A successor Trustee shall be selected and appointed by the court. Any successor Trustee shall act as such without any liability for the acts or omissions of any predecessor Trustee.

ARTICLE XIII
GENERAL MATTERS AND INSTRUCTIONS WITH REGARD TO THE TRUSTEESHIP

1. The Trustee shall not be required to furnish any bond for the faithful performance of the Trustee's duties. If bond is required by any law or court of competent jurisdiction, no surety shall be required on such bond.

2. The Trust established under this instrument shall be administered free from the active supervision of any court. Any proceedings to seek judicial instructions or a judicial determination may be initiated by the Trustee in any court having

jurisdiction of these matters relating to the construction and administration of the Trust.

3. The Trustee shall be entitled to reasonable compensation, commensurate with the services actually performed, and to reimbursement of costs and expenses properly incurred.

4. The validity of this Trust shall be determined by the laws, including valid regulations, of the United States and the State of Michigan. Questions of construction and administration of this Trust shall be determined by the laws of the situs of administration.

IN WITNESS WHEREOF, the undersigned hereby subscribes to the above Declaration of Trust on the date and year first above written. This Agreement extends to and is binding upon the personal representatives, successors, and assigns of the Trustee.

SIGNED:

Jim B Hoffman, President of Springhill, Inc.

WITNESSED:

Jim M Rose

Dawn H. Calnen

STATE OF MICHIGAN)
OAKLAND COUNTY)

On the 8th day of May, 1997, James B. Haeffner, President of Springhill, Inc., appeared before me, signed, acknowledged, and delivered the above Agreement.

Patricia E. Kefalas Dudek
Notary Public
Oakland County, Michigan
My commission expires:

PATRICIA E. KEFALAS DUDEK
Notary Public, Oakland County, MI
My Commission Expires Jan. 30, 2000

STATE OF MICHIGAN
MACOMB COUNTY PROBATE COURT

In the Matter of SPRINGHILL, INC. POOLED ACCOUNTS TRUST F/B/O DARYL C. WEIER

File Numbers: 98-158,095TT

SPRINGHILL, INC., Petitioner

Honorable: James F. Nowicki

_____/

PATRICIA E. KEFALAS DUDEK (P46408)
Attorney for Petitioner, SPRINGHILL, INC.
P.O. Box 721249
Berkley, Michigan 48072-1249
(248) 586-9820

_____/

ORDER TO AMEND THE SPRINGHILL, INC. POOLED ACCOUNTS TRUST AND JOINDER AGREEMENT

At a session of said Court, held in the City of
Mt. Clemens, County of Macomb, State of Michigan,
on the 17th day of May, 1999
Present: JAMES F. NOWICKI
PROBATE COURT JUDGE

THIS MATTER having come before the Court upon petition of SPRINGHILL, INC., Trustee of the SPRINGHILL INC., POOLED ACCOUNTS TRUST dated May 8, 1997, and the Court having determined that all interested parties have been notified; IT IS HEREBY ORDERED THAT the SPRINGHILL, INC. POOLED ACCOUNTS TRUST shall be amended in the following manner:

1. Delete Article II, Paragraph 5 and substitute the following in its place:

   Payments for "supplemental needs" or for "supplemental care" shall mean non-support disbursements. It is not the Grantor's intention to displace public and private financial assistance that may otherwise be available to any Trust Beneficiary. It is the intention of the Grantor to limit the Trustee's contribution to a Beneficiary's supplemental needs only. The following illustrates the kinds of supplemental, non-support disbursements that are appropriate for the Trustee to make from this Trust to or for the benefit of a Trust Beneficiary. The following examples are not exclusive: non-covered medical, dental and diagnostic work and treatment for which there are no private or public funds and medical procedures that are desirable in the Trustee's discretion, even though they may not be medically necessary or life saving may be paid by the Trustee; differentials in cost between housing and shelter for shared and private

rooms may be paid by the Trustee in its discretion for Beneficiaries of the Trust; care appropriate for a Beneficiary that assistance programs may not or do not otherwise provide; expenditures for dry-cleaning, laundry services, recreation, social, travel, cultural experiences and sporting events. Supplemental care needs shall also include items of a similar nature specified in a Joinder Agreement if approved by the Trustee.

2. Delete Article V, Paragraph 1 and substitute the following in its place:

   1. The Trust shall be effective as to any Beneficiary upon execution of a Joinder Agreement by a Grantor, or by court order, subject to the approval of the Trustee. Upon delivery to and acceptance by the Trustee of property acceptable to the Trustee, the Trust, as to the Grantor of such property and the designation of the respective Beneficiary, shall be irrevocable and the contributed property shall not be refundable.

3. Delete Article XI, Paragraph 1(b) in its entirety.

4. Delete Article XI, Paragraph 3 in its entirety.

5. Delete Article XI, Paragraph 4 and substitute the following in its place:

   3. If it becomes impossible, or impracticable, to carry out the Trust's purposes with respect to all Beneficiaries, the Trustee may terminate the Trust and distribute the Trust property as set forth in Article XI Paragraph (2), provided, however, that if Springhill, Inc. has ceased to exist or has been dissolved, then any property remaining in the Trust shall be applied and paid over to such other organization or organizations as the Trustee, in its sole discretion, may determine then to be serving the interests and needs of people with disabilities in a manner consistent with the purposes of this Trust. Before action is taken under this Article XI Paragraph (3), a final accounting along with an application seeking approval of the action to be taken shall be filed in a court of competent jurisdiction in this state.

Date: MAY 17 1999

JAMES F. NOWICKI
PROBATE COURT JUDGE

A TRUE COPY
Barbara P. Carracci
Probate Court

PATRICIA E. KEFALAS DUDEK
Attorney for Petitioner, SPRINGHILL, INC.
P.O. Box 721249
Berkley, Michigan 48072-1249
(248) 586-9820

STATE OF MICHIGAN
MACOMB COUNTY PROBATE COURT

In re SPRINGHILL, INC. POOLED ACCOUNTS TRUST F/B/O DARYL C. WEIER

File Number: 98 158 095 TT

SPRINGHILL, INC., Petitioner

Honorable:

_____/

PATRICIA E. KEFALAS DUDEK (P46408)
Attorney for Petitioner
P.O. Box 721249
Berkley, MI 48072-1249
(248) 586-9820

_____/

ORDER TO AMEND THE SPRINGHILL, INC. POOLED ACCOUNTS TRUST AND JOINDER AGREEMENT

At a session of said Court, held in the City of Mt. Clemens, County of Macomb, State of Michigan, on the 17th day of June, 1998

Present: JAMES P. NOWICKI
PROBATE COURT JUDGE

THIS MATTER having come before the Court upon petition of SPRINGHILL, INC., Trustee of the SPRINHILL, INC. POOLED ACCOUNTS TRUST dated May 8, 1997, and the Court having determined that all interested parties have been notified;

IT IS HEREBY ORDERED THAT:

1. The SPRINGHILL POOLED ACCOUNTS TRUST shall be amended in the following manner: Article XI, Paragraph 2 shall be deleted and the following substituted in it's place:

> 2. Upon the death of a Beneficiary, any amounts remaining in the Beneficiary's Trust sub-account shall be deemed to be surplus Trust property and shall be retained by the Trust and, in the Trustee's sole discretion, used (a) for the benefit of other Beneficiaries, (b) to aide persons who are indigent and disabled, as defined by 42 U.S.C. §-1382c(a)(3), or (c) to provide persons who are indigent and disabled, as defined by 42 U.S.C. § 1382c(a)(3) with housing or supplemental support services deemed suitable for such persons by the Trustee. To the extent that any amounts remaining in the Beneficiary's account upon the death of the Beneficiary are not so retained by the Trust, as required under 42 U.S.C. 1396p(d)(4)(C), or any regulations promulgated thereunder,

or the corresponding provisions of any subsequent Federal law, the Trustee shall pay from such remaining amounts in the account to any state an amount equal to the total amount of medical assistance paid on behalf of the Beneficiary under the State's plan under 42 U.S.C. 1396(a) *et seq*. Gifts or devises to the Trust shall be similarly treated unless the purpose for which the gift is made is specified by the donor.

2. DARYL WEIER'S JOINDER AGREEMENT dated May 8, 1997 shall be amended in the following manner:

> W. Distributions upon the Beneficiary's death: If, upon the Beneficiary's death, funds remain in his or her separate Trust sub-account, such funds shall be deemed to be surplus Trust property, such funds shall be retained by the Trust and, in the Trustee's sole discretion, used (a) for the benefit of the other Beneficiaries of the Trust, (b) to aide persons who are indigent and disabled, as defined in 42 U.S.C. sec. 1382c(a)(3), or (c) to provide persons who are indigent and disabled, as defined in 42 U.S.C. sec. 1382c(a)(3), with housing or supplemental support services deemed suitable for such persons by the Trustee. To the extent that any amounts remaining in the Beneficiary's account upon the death of the Beneficiary are not so retained by the Trust, as required under 42 U.S.C. 1396p(d)(4)(C), or any regulations promulgated thereunder, or the corresponding provisions of any subsequent Federal law, the Trustee shall pay from such remaining amounts in the account to any state an amount equal to the total amount of medical assistance paid on behalf of the Beneficiary under the State's plan under 42 U.S.C. 1396(a) *et seq*. Gifts or devises to the Trust shall be similarly treated unless the purpose for which the gift is made is specified by the donor.

3. The SPRINGHILL, INC. POOLED ACCOUNTS TRUST is a valid Exception C Trust as defined by 42 U.S.C. 1396p(d)(4)(C) and a valid Exception B trust as defined by the Family Independence Agency's (FIA) Program Eligibility Manual Item 401.

Date: JUN 17 1998

PROBATE COURT JUDGE

A TRUE COPY

BARBARA P. CAMMICCI
DEPUTY PROBATE REGISTRAR

PATRICIA E. KEFALAS DUDEK
Attorney for Petitioner
P.O. Box 721249
Berkley, MI 48072-1249
(248) 586-9820

STATE OF MICHIGAN
MACOMB COUNTY PROBATE COURT

In the matter of SPRINGHILL, INC. POOLED ACCOUNTS TRST

File No.: 98-158,095 TT

SPRINGHILL HOUSING CORPORATION, A NONPROFIT HOUSING CORPORATION, Petitioner

Honorable: James F. Nowicki

_____/

PATRICIA E. KEFALAS DUDEK (P46408)
Attorney for Petitioner, SPRINGHILL HOUSING CORPORATION, A NONPROFIT HOUSING CORPORATION
P.O. Box 721249
Berkley, Michigan 48072-1249
(248)586-9820

_____/

ORDER TO AMEND THE SPRINGHILL, INC. POOLED ACCOUNTS TRUST DATED MAY 8, 1997

At a session of said Court, held in the City of Mount Clemens, County of Macomb, State of Michigan, on the 25th day of October, 1999.

Present: JAMES F. NOWICKI
PROBATE COURT JUDGE

THIS MATTER having come before the Court upon petition of SPRINGHILL HOUSING CORPORATION, A NONPROFIT HOUSING CORPORATION, Trustee of the SPRINGHILL, INC. POOLED ACCOUNTS TRUST, dated May 8, 1997, and the Court having determined that all interested parties have been notified;

IT IS HEREBY ORDERED THAT the SPRINGHILL, INC. POOLED ACCOUNTS TRUST dated May 8, 1997 be amended in the following manner:

1. Change the Declaration of Trust to read "This DECLARATION OF TRUST is made this 8th day of May, 1997 by Springhill Housing Corporation, a Nonprofit Housing [illegible]"

2. Article I shall be deleted and the following substituted in its place:

The name of the Trust established under this instrument is The Pooled Accounts Trust of Springhill Housing Corporation, a Nonprofit Housing Corporation, also known as The Pooled Accounts Trust of Springhill, Inc. (hereinafter referred to as the "Trust"). This Trust is intended to be a pooled accounts trust established under 42 U.S.C. §1396p(d)(4)(C). All provisions of this Trust shall be interpreted to qualify this Trust under 42 U.S.C. §1396p(d)(4)(C). Any provision of this Trust which prevents this Trust from qualifying under 42 U.S.C. §1396p(d)(4)(C) shall be null and void.

3. Article II, Paragraph 6 shall be deleted and the following substituted in its place:

   6. "Trustee" shall mean Springhill Housing Corporation, a Nonprofit Housing Corporation, also known as Springhill, Inc., a non-profit organization, its successor or successors and shall include any Co-Trustee or Co-Trustees. "Co-Trustee" shall mean a person or entity, or both, selected by the Trust to assist with the management, administration, allocation, and disbursement of Trust assets and property.

4. Article III, Paragraph 1 shall be deleted and the following substituted in its place:

   1. It is the intention of Springhill Housing Corporation, a Nonprofit Housing Corporation, to establish a supplemental fund pursuant to 42 U.S.C. §1396p, as amended August 10, 1993 by the Revenue Reconciliation Act of 1993, for the benefit of Beneficiaries under this Trust. This Trust shall not be reduced in value by the Beneficiaries' primary support. They are to supplement their care needs only. There is no obligation of support owing to the Beneficiaries by the Grantor nor by the Trustee; the Beneficiaries have no entitlement to the income or corpus of this Trust, except as the Trustee, in its complete and unfettered discretion, elects to disburse, and the Trustee may act unreasonably in exercising discretion. The Trustee's judgment should not be substituted for the judgment of any other person or entity.

5. Article VI, Paragraph 8 shall be deleted and the following substituted in its place:

   8. Costs and expenses of defending the Trust from any claim, demand, legal or equitable action, suit, or proceeding may, in the sole discretion of the directiors of Springhill Housing Corporation, a Nonprofit Housing Corporation, either (a) be apportioned on a pro rata basis to all Trust sub-accounts, or (b) be charged only against the Trust sub-account as to the affected Beneficiary.

6. Article IV shall be deleted and the following substituted in its place:

   Springhill Housing Corporation, a Nonprofit Housing Corporation, shall initially fund this Trust with a lump-sum payment of Fifty Dollars and No Cents ($50.00). The Trust estate shall consist of this initial contribution and any additional contributions in cash or property made to the Trust

estate at any time by any Grantor in accordance with the provisions of Article V. By execution hereof, Springhill Housing Corporation, a Nonprofit Housing Corporation, assigns, conveys, transfers and delivers the above-described funds to the Trust on the date of this instrument.

7. Article XI, Paragraph 3 shall be deleted and the following substituted in its place:

If it becomes impossible or impracticable, to carry out the Trust's purposes with respect to all Beneficiaries, the Trustee may terminate the Trust and distribute the Trust property as set forth in Article XI Paragraph (2), provided, however, that if Springhill Housing Corporation, a Nonprofit Housing Corporation, has ceased to exist or has been dissolved, then any property remaining in the Trust shall be applied and paid over to such other organization or organizations as the Trustee, in its sole discretion, may determine then to be serving the interests and needs of people with disabilities in a manner consistent with the purposes of this Trust. Before action is taken under this Article XI Paragraph (3), a final accounting along with an application seeking approval of the action to be taken shall be filed in a court of competent jurisdiction in this state.

Date: OCT 25 1999

PROBATE COURT JUDGE

A TRUE COPY

BARBARA ANN HECKMANN
DEPUTY PROBATE REGISTER

PATRICIA E. KEFALAS DUDEK
Attorney for Petitioner, SPRINGHILL HOUSING CORPORATION, A NONPROFIT HOUSING CORPORATION
P.O. Box 721249
Berkley, Michigan 48072-1249
(248)586-9820

N ENGLER, Governor

MEDICAL SERVICES ADMINISTRATION

400 SOUTH PINE
PO BOX 30479
LANSING MI 48909-7979

August 17, 1999

Ms. Patricia Kefalas Dudek
P.O. Box 721249
Berkley, Michigan 48072-1249

Dear Ms. Kefalas Dudek:

Thank you for your recent letter in follow-up to our meeting of July 22, 1999. My staff expects to convene a workgroup in the near future to develop prototype trust documents.

Since our meeting, my staff has advised the Family Independence Agency (FIA) that the Exception B trust documents for your clients, [redacted] and [redacted] are acceptable and that the Medicaid applications filed on or about June 1, 1999, should now be processed. Since the Assistant Attorney General Morris Klau has advised that the issue of retroactivity is not yet resolved, the effective dates for their eligibility will be the first day of the month of application, if they otherwise qualify. Once the retroactivity issue is resolved the eligibility begin dates will be changed, if appropriate.

Should you establish additional Exception B trust documents that are identical in wording to those of the above three individuals, the documents should be submitted with the Medicaid application to the local FIA office, as has always been the instruction. The local FIA office staff will continue to refer the documents to their central office for review and approval. The central office staff has been instructed to quickly review and approve such documents.

I trust that this information will be of assistance to you and appreciate your continued interest in the Medicaid Program.

Cordially,

Robert M. Smedes
Deputy Director for
Medical Services Administration

cc: Mr. Morris Klau

Resources - all income and assets of a person and the person's spouse. It includes any income and assets the person or spouse is entitled to but does not receive because of action:

- by the person or spouse; or
- by someone else (including a court or administrative body) with legal authority to act in place of or on behalf of the person or spouse; or
- by someone else (including a court or administrative body) acting at the direction or upon the request of the person or spouse.

Revocable trust - a trust which can be revoked or modified by:

- the grantor, or
- a court, or
- the trustee, or
- any other person or entity.

This includes a trust which allows for revocation or modification only when a change occurs such as the grantor leaves the LTC facility or the beneficiary becomes competent.

Modify means changing the beneficiaries or the availability of principal or income.

MEDICAID TRUST CRITERIA

A Medicaid trust is a trust that meets conditions 1 through 5 below:

1. The person whose resources were transferred to the trust is someone whose assets or income must be counted to determine MA eligibility, an MA post-eligibility patient-pay amount, a divestment penalty or an initial assessment amount. A person's resources include his spouse's resources (see definition).

2. The trust was established by:

   - the person, or
   - the person's spouse, or
   - someone else (including a court or administrative body) with legal authority to act in place of or on behalf of the person or the person's spouse, or
   - someone else (including a court or administrative body) acting at the direction or upon the request of the person or the person's spouse.

3. The trust was established on or after August 11, 1993

4. The trust was not established by a will.

5. The trust is not described in **"Exception A, Special Needs Trust"** or **"Exception B, Pooled Trust"** below.

Exception A, Special Needs Trust

A trust is not a Medicaid trust if it meets all the following conditions:

- The trust must be unchangeable with regard to the provisions that make it an Exception A, Special Needs Trust. This is necessary to ensure that a trust initially meeting the other conditions still meets those conditions when the person dies.

- The trust contains the resources of a person who is under age 65 and is disabled (not blind) per PEM 260. See **"Continuing Exception A"** when the person has attained age 65.

- The trust was established for the person described above. This means that the trust must ensure that none of the principal or income can be used for someone else during the person's lifetime, except for **"Trustee Fees"** per PEM 405.

- The trust was established by a court or by the person's:

  - parent, or
  - grandparent, or
  - legal guardian/conservator.

- The trust imposes on the trustee an automatic duty to repay Medicaid upon the person's death.

  When a person has lived in more than one state, the trust must provide that the funds remaining in the trust are distributed to each state in which the individual received Medicaid, based on the state's proportionate share of the total amount of Medicaid benefits paid by all of the states on the person's behalf.

  Examples of circumstances under which a trust **fails** this repay condition are:

  - Requiring a trustee to reimburse Medicaid only if Medicaid first submits a claim.

  - Failing to provide that repaying Medicaid has priority over all debts and expenses except those given higher priority by law.

Transfers to Exception A Trust

Treat assets and income transferred into an **"Exception A, Special Needs Trust"** as part of the trust for the entire month of transfer.

Continuing Exception A

A trust that is an **"Exception A, Special Needs Trust"** when the person was under age 65 continues being an **"Exception A, Special Needs Trust"** after the person attains age 65. However, any additions or augmentations to the trust after the person attains age 65 are not protected by the exception. The additions/ augmentations are subject to trust and divestment policies without regard to **"Exception A, Special Needs Trust."**

Countable Exception A Payments

Count as a person's unearned income any payment received from the trust.

Exception B, Pooled Trust

A trust is not a Medicaid trust if it meets all of the following conditions:

- The trust must be unchangeable with regard to the provisions that make it an Exception B, Pooled Trust. This is necessary to ensure that a trust initially meeting the other conditions still meets those conditions when the person dies.
- The trust contains the resources of a person who is disabled (not blind) per PEM 260.
- The trust is established and managed by a nonprofit association.
- A separate account is maintained for each beneficiary of the trust, but for purposes of investment and management of funds, the trust pools these accounts.
- Accounts in the trust are established for the benefit of persons who are disabled (not blind) per PEM 260. This means the trust must ensure that none of the principal or income attributable to a person's account can be used for someone else during the person's lifetime, except for **"Trustee Fees"** per PEM 405.
- Accounts in the trust are established by courts or by disabled persons':
  - parents, or
  - grandparents, or
  - legal guardians/conservators
- The trust says that if any funds are distributed from the trust after the person's death, the trustee has an automatic duty to repay Medicaid.

  When a person has lived in more than one state, the trust must provide that the funds remaining in the trust are distributed to each state in which the individual received Medicaid, based on the state's proportionate share of the total amount of Medicaid benefits paid by all of the states on the person's behalf.

JOINDER AGREEMENT

This is a legal document. You are encouraged to seek independent, professional advice before signing.

The undersigned hereby enrolls in and adopts the Declaration of Trust of Springhill Housing Corporation, a Non-Profit Housing Corporation, dated May 8, 1997, as subsequently amended by Orders of the Macomb County Probate Court dated the 17th day of June, 1998 and the 25th day of October, 1999, which is incorporated herein by reference.

A. Trust sub-account number: _____

B. Grantor's name: _____

C. Grantor's Social Security No.: _____

D. Address: _____

E. Telephone: _____

F. Grantor's birthdate: _____

G. Relationship to Beneficiary: _____

H. Beneficiary' s name: _____

I. Beneficiary' s Social Security No.: _____

J. Address: _____

K. Telephone: _____

L. Beneficiary's birthdate: _____

M. If the Beneficiary has a legal representative (e.g., legal guardian, conservator, representative payee, or agent), what is the name, address, and relationship of such person to the Beneficiary:

Name: _____
Address: _____
Relationship: _____

N. Does Beneficiary receive Supplemental Security Income? _____ If so, how much per month? _____

O. Does Beneficiary receive Social Security? _____ If so, how much per month?

P. If the Beneficiary receives Medicaid, what is the Medicaid card number?

Q. list all other forms of government assistance that the Beneficiary receives:

R. If the Beneficiary is covered under any policy of health insurance, what is the insurer's name and address, and what is the policy number?

Insurer: _____
Address: _____
Policy No.: _____

S. Is the Beneficiary covered under any prepaid funeral or burial insurance plan? _____ If so, what is the insurer's name and address, and what is the policy number?

Insurer: _____
Address: _____
Policy No.: _____

T. What is the nature of the Beneficiary's disability? _____
_____
_____

U. If the Beneficiary's condition has been medically diagnosed, what is the diagnosis?

_____
_____
_____

V. What is the prognosis at this time? _____
_____

W. Distributions upon the Beneficiary's death: If, upon the Beneficiary's death, funds remain in his or her separate Trust sub-account, such funds shall be deemed to be surplus Trust property, such funds shall be

retained by the Trust and, in the Trustee's sole discretion, used (a) for the benefit of other Beneficiaries of the Trust, (b) to aide persons who are indigent and disabled, as defined in 42 U.S.C. sec. 1382c(a)(3), or (c) to provide persons who are indigent and disabled, as defined in 42 U.S.C. sec. 1382c(a) (3), with housing or supplemental support services deemed suitable for such persons by the Trustee. To the extent that any amounts remaining in the Beneficiary's account upon the death of the Beneficiary are not retained by the Trust, as required under 42 U.S.C. 1396p(d)(4)(C), or any regulations promulgated thereunder, or the corresponding provisions of any subsequent Federal law, the Trustee shall pay from such remaining amounts in the account to any state an amount equal to the total amount of medical assistance paid on behalf of the Beneficiary under the State's plan under 42 U.S.C. 1396(a) *et seq.*

X. The Beneficiary specifically directs the Trustee to give priority in expending funds retained in Trust on behalf of any members of the Beneficiary's family who are indigent and disabled as defined in 42 U.S.C. §1382c(a)(3). Further, if there are no family members of the Beneficiary who qualify as disabled then the Trustee shall use the funds retained on behalf of a person with a disability who is indigent, who receives services through (name an agency for the Trustee to work with if you prefer):

_____

_____

Y. The Trust sub-account will be administered solely for the benefit of the Beneficiary.

Z. Any non-support items that are required for maintaining a Beneficiary's health, safety and welfare may be provided for the benefit of the Beneficiary when, in the discretion of the Trustee, such requirements are not being provided by any public agency, or are not otherwise being provided by any other source of income available to that Beneficiary.

AA. The Grantor recognizes that all distributions are at the Trustee's sole discretion. With this in mind, the Grantor expresses the following desires as to how funds in the Trust sub-account might be used:

1. Specific Supplemental Needs requested for the beneficiary:

_____
_____
_____
_____

2. General Supplemental Needs to be on going:

_____
_____
_____
_____

BB. Additional supplemental needs, including items of a similar nature to those specified above that are specified in an individualized supplemental needs plan established for the Beneficiary and updated from time to time, may be provided if approved by _____ and _____

CC. At any time, the Grantor may, in a non-fiduciary capacity, reacquire the funds in the Grantor's sub-account by substituting other property of an equivalent value. If the Grantor elects to substitute property, the determination of value is to be made by an independent appraiser.

DD. Trustee fees will be charged in accordance with reasonable costs incurred by the Trustee.

EE. Miscellaneous:

1. The provisions of this Joinder Agreement, as entered into on this _____ day of _____, 2007, may be amended as the Grantor and _____ may jointly agree, so long as any such amendment is consistent with the Declaration of Trust, and the then applicable law.

2. Taxes:

a. The Grantor acknowledges that Springhill Housing Corporation has made no representation to the Grantor that contributions to the Trust are deductible as charitable gifts, or otherwise.

b. Trust sub-account income, whether paid in cash or distributed in other property, may be taxable to the Beneficiary subject to applicable exemptions and deductions. Professional tax advice is recommended.

c. Trust sub-account income may be taxable to the Trust, and when this is the case, such taxes shall be payable from the Trust sub-account.

3. If the Grantor intends to enroll more than one Beneficiary under one Trust sub-account, an additional agreement is required between the Grantor and the Trustee.

4. The Trust administered by Springhill Housing Corporation is a pooled accounts trust, governed by the laws of the State of Michigan, in conformity with the provisions of 42 U.S.C. э 1396p, amended August 10, 1993, by the Revenue Reconciliation Act of 1993. To the extent there is conflict between the terms of this Trust and the governing law as from time to time amended, the law and regulations shall control.

5. Disclosure and Waiver of Potential Conflicts of Interest:

a. Individuals executing the Joinder Agreement are aware of the following potential conflicts of interest that are connected with Trustee's administration of the Trust:

1. The Trustee may appoint persons to assist in the carrying out of its Trustee duties who are associated with Springhill Housing Corporation, MORC, Inc., or Community Housing Network such as staff, board members, volunteers, etc. Additionally, Springhill Housing Corporation, MORC, Inc., or Community Housing Network may provide services and supports to individual sub-account Beneficiaries.

2. The Trustee may appoint Patricia E. Kefalas Dudek as its agent to assist in the carrying out of its Trustee duties. Additionally, Patricia E. Kefalas Dudek and other attorneys by and through Hafeli Staran Hallahan Christ & Dudek, P.C. may act as legal counsel for sub-account Grantors and/or Beneficiaries.

3. The Trustee is the remainder beneficiary of the sub-accounts created hereunder.

b. Any grantor executing a Joinder Agreement to this Trust hereby waives any and all claims against the Trustee on account of self-dealing, the above-listed conflicts of interest, or other conflicts of interest. The Trustee shall not be liable to any party for any self-dealing or conflicts of interest herein disclosed.

IN WITNESS WHEREOF, the undersigned Grantor has reviewed and signed this Joinder Agreement, understands it, and agrees to be bound by its terms, and has accepted and signed this Joinder Agreement this _____ day of _____, 2008.

Grantor:

_____

Witnessed:

_____ _____

STATE OF MICHIGAN)
COUNTY OF)

On the ____ day of _____, 2008, _____ appeared before me, signed, acknowledged, and delivered the above Agreement.

_____

Notary Public, _____ County, Michigan
Acting in _____ County, Michigan
My Commission Expires:

EXHIBIT 2

MEDIVEST®

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"Making a Difference"

TRUST ADVISOR SERVICES

When a Special Needs Trust is recommended and protection of Medicaid benefits is of utmost concern, our Trust Advisor Services are an invaluable resource to preserve, protect, and stretch Special Needs Trust funds. Medivest works in conjunction with the Trust Company of your choice to ensure that account funds are spent in the most cost efficient manner.

- Savings- This service is designed to stretch the funds held in your Special Needs Trust. Medivest works with preferred vendors, negotiates medical payments, and utilizes discounted fee schedules to **preserve the funds held in your trust account .**
- Patient Advocate- Our experienced customer service and claims department professionals **negotiate medical bills** with providers and work on your behalf to **preserve, protect, and stretch** your trust account through various cost containment methods. We exist to ensure that your bills are taken care of when care is needed most.
- Freedom To Choose- We allow you to **choose medical providers that serve you best.** Medivest works with your choice of providers to ensure cost efficient payment for any medical expenses incurred.
- Medical Claims Administration- Medical claims processing and cost efficient payment recommendations are made in a timely manner to your Trust Company. Upon request, Medivest will provide you with a Summary of Savings report so that you can monitor the savings generated from Medivest's Trust Advisor Services.
- Protection of Medicare Benefits— If a Medicare Set-Aside Account was established within a Special Needs Trust, Medivest is able to **separate and identify Medicare allowable expenses** to be paid from the trust account to ensure that future Medicare entitlement is protected.
- Extraordinary Customer Service- We are here to serve you. Your file is not assigned to an individual, but rather to our customer service department to ensure an **immediate response to your needs.**

Call us today toll free at 877.725.2467, extension 2. Our team of experienced professionals are ready to provide you with the extraordinary service that you deserve.

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Trust Advisor Referral Form

Please send completed referral form and necessary items to:
Medivest – 2100 Alafaya Trail, Suite 201 – Oviedo, FL 32765
Phone: 877.725.2467 Fax: 407.971.4742

Account Representative: _____ Referral Date: _____

Claimant Information

Claimant Name _____
Address _____
City, St, Zip _____
Phone # _____
SS# _____

Gender _____
Birth Date _____
Jurisdiction State _____
Injury Date _____

Parent and/or Guardian Name _____
Relationship to Claimant _____
Parent/Guardian Address _____
Parent/Guardian City, State Zip code _____
Parent/Guardian Phone number _____

Trust Co or Bank

Workers' Comp ☐ Liability ☐

Trust Officer or Account Manager _____
Bank Name _____
Bank Address _____
City, St, Zip _____

Phone # _____
Fax # _____
Email _____
Account # _____

Insurance/Payor

Adjuster's Name _____
Carrier/TPA Name _____
Carrier/TPA Address _____
City, St, Zip _____

Phone # _____
Fax # _____
Email _____
Claim # _____

Defense Attorney

Attorney's Name _____
Firm Name _____
Firm Address _____
City, St, Zip _____

Phone # _____
Fax # _____
Email _____

Applicant/Plaintiff Attorney

Attorney's Name _____
Firm Name _____
Firm Address _____
City, St, Zip _____

Phone # _____
Fax # _____
Email _____

Case Questions

Has the claimant applied for Social Security benefits?	Yes ☐	No ☐	Unknown ☐
Is the claimant receiving Social Security benefits?	Yes ☐	No ☐	Unknown ☐
Is the claimant receiving Medicare benefits?	Yes ☐	No ☐	Unknown ☐
Is the claimant receiving Medicaid benefits?	Yes ☐	No ☐	Unknown ☐

ACORD CERTIFICATE OF LIABILITY INSURANCE

OP ID CG
MEDIV-1

DATE (MM/DD/YYYY) 03/17/08

PRODUCER

Ogilvy-Hill Insurance
P. O. Box 929
Santa Barbara CA 93102
Phone: 805-966-4101 Fax: 805-966-7810

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURED

Medivest Benefit Advisors, Inc
and Medivest Allocation
Services, Inc.
Jim Johnson
351 Paseo Nuevo
Santa Barbara CA 93101

INSURERS AFFORDING COVERAGE	NAIC #
INSURER A: Indian Harbor Insurance Co.	36940
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
		GENERAL LIABILITY				EACH OCCURRENCE	$
		COMMERCIAL GENERAL LIABILITY				DAMAGE TO RENTED PREMISES (Ea occurence)	$
		CLAIMS MADE / OCCUR				MED EXP (Any one person)	$
						PERSONAL & ADV INJURY	$
		GEN'L AGGREGATE LIMIT APPLIES PER:				GENERAL AGGREGATE	$
		POLICY / PRO-JECT / LOC				PRODUCTS - COMP/OP AGG	$
		AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT (Ea accident)	$
		ANY AUTO					
		ALL OWNED AUTOS				BODILY INJURY (Per person)	$
		SCHEDULED AUTOS					
		HIRED AUTOS				BODILY INJURY (Per accident)	$
		NON-OWNED AUTOS					
						PROPERTY DAMAGE (Per accident)	$
		GARAGE LIABILITY				AUTO ONLY - EA ACCIDENT	$
		ANY AUTO				OTHER THAN AUTO ONLY: EA ACC	$
						AGG	$
		EXCESS/UMBRELLA LIABILITY				EACH OCCURRENCE	$
		OCCUR / CLAIMS MADE				AGGREGATE	$
		DEDUCTIBLE					$
		RETENTION $					$
							$
		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY				WC STATU-TORY LIMITS / OTH-ER	
		ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED?				E.L. EACH ACCIDENT	$
		If yes, describe under SPECIAL PROVISIONS below				E.L. DISEASE - EA EMPLOYEE	$
						E.L. DISEASE - POLICY LIMIT	$
A		OTHER Errors & Omissions	MPP-0016092-04	03/14/08	03/14/09	1,000,000 1,000,000	Each Claim Occurrence

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

Proof of Insurance.

CERTIFICATE HOLDER

TOWHOMI

To Whom It May Concern

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL _____ DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

Mark Shupp

ACORD CERTIFICATE OF LIABILITY INSURANCE

OP ID SA
MEDIV-1

DATE (MM/DD/YYYY)
06/03/08

PRODUCER

Ogilvy-Hill Insurance
P. O. Box 929
Santa Barbara CA 93102
Phone: 805-966-4101 Fax: 805-966-7810

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURED

Medivest Benefit Advisors, Inc
Medivest Allocation
Services Inc.
Jim Johnson
351 Paseo Nuevo
Santa Barbara CA 93101

INSURERS AFFORDING COVERAGE	NAIC #
INSURER A: Travelers Casualty & Surety	
INSURER B: Great American Assurance Co	
INSURER C:	
INSURER D:	
INSURER E:	

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
		GENERAL LIABILITY				EACH OCCURRENCE	$
		COMMERCIAL GENERAL LIABILITY				DAMAGE TO RENTED PREMISES (Ea occurence)	$
		CLAIMS MADE / OCCUR				MED EXP (Any one person)	$
						PERSONAL & ADV INJURY	$
		GEN'L AGGREGATE LIMIT APPLIES PER:				GENERAL AGGREGATE	$
		POLICY / PRO-JECT / LOC				PRODUCTS - COMP/OP AGG	$
		AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT (Ea accident)	$
		ANY AUTO					
		ALL OWNED AUTOS				BODILY INJURY (Per person)	$
		SCHEDULED AUTOS					
		HIRED AUTOS				BODILY INJURY (Per accident)	$
		NON-OWNED AUTOS					
						PROPERTY DAMAGE (Per accident)	$
		GARAGE LIABILITY				AUTO ONLY - EA ACCIDENT	$
		ANY AUTO				OTHER THAN AUTO ONLY: EA ACC	$
						AGG	$
		EXCESS/UMBRELLA LIABILITY				EACH OCCURRENCE	$
		OCCUR / CLAIMS MADE				AGGREGATE	$
							$
		DEDUCTIBLE					$
		RETENTION $					$
		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY				WC STATU-TORY LIMITS / OTH-ER	
		ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED?				E.L. EACH ACCIDENT	$
		If yes, describe under SPECIAL PROVISIONS below				E.L. DISEASE - EA EMPLOYEE	$
						E.L. DISEASE - POLICY LIMIT	$
		OTHER					
A		Crime	103061105	05/16/08	05/16/11	Limit	$1,000,000
B		Crime/Excess	CRP524-47-79-07	05/16/08	05/16/09	Ded	$10,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

Proof of Insurance

CERTIFICATE HOLDER

TOWHOMI

To Whom It May Concern

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL _____ DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

Mark Stupp

CERTIFICATE OF INSURANCE

This certifies that

- [x] STATE FARM FIRE AND CASUALTY COMPANY, Bloomington, Illinois
- [ ] STATE FARM GENERAL INSURANCE COMPANY, Bloomington, Illinois
- [ ] STATE FARM FIRE AND CASUALTY COMPANY, Aurora, Ontario
- [ ] STATE FARM FLORIDA INSURANCE COMPANY, Winter Haven, Florida
- [ ] STATE FARM LLOYDS, Dallas, Texas

insures the following policyholder for the coverages indicated below:

Policyholder: MEDIVEST BENEFIT ADVISORS INC & MEDIVEST ALLOCATION SERVICES, INC

Address of policyholder: 2100 ALAFAYA TRAIL SUITE 201 OVIEDO, FL 32765

Location of operations: SAME

Description of operations: OFFICE POLICY

The policies listed below have been issued to the policyholder for the policy periods shown. The insurance described in these policies is subject to all the terms, exclusions, and conditions of those policies. The limits of liability shown may have been reduced by any paid claims.

POLICY NUMBER	TYPE OF INSURANCE	POLICY PERIOD Effective Date	POLICY PERIOD Expiration Date	LIMITS OF LIABILITY (at beginning of policy period)
98-PG-2033-2 B	Comprehensive Business Liability	12/18/07	12/18/08	BODILY INJURY AND PROPERTY DAMAGE
This insurance includes:	[x] Products - Completed Operations [x] Contractual Liability [x] Personal Injury [x] Advertising Injury [ ] [ ] [ ]			Each Occurrence $1,000,000 General Aggregate $2,000,000 Products – Completed Operations Aggregate $
	EXCESS LIABILITY [ ] Umbrella [ ] Other	POLICY PERIOD Effective Date	POLICY PERIOD Expiration Date	BODILY INJURY AND PROPERTY DAMAGE (Combined Single Limit) Each Occurrence $ Aggregate $
	Workers' Compensation and Employers Liability	POLICY PERIOD Effective Date	POLICY PERIOD Expiration Date	Part I - Workers Compensation - Statutory Part II - Employers Liability Each Accident $ Disease - Each Employee $ Disease - Policy Limit $
POLICY NUMBER	TYPE OF INSURANCE	POLICY PERIOD Effective Date	POLICY PERIOD Expiration Date	LIMITS OF LIABILITY (at beginning of policy period)

THE CERTIFICATE OF INSURANCE IS NOT A CONTRACT OF INSURANCE AND NEITHER AFFIRMATIVELY NOR NEGATIVELY AMENDS, EXTENDS OR ALTERS THE COVERAGE APPROVED BY ANY POLICY DESCRIBED HEREIN.

Name and Address of Certificate Holder

If any of the described policies are canceled before their expiration date, State Farm will try to mail a written notice to the certificate holder 30 days before cancellation. If however, we fail to mail such notice, no obligation or liability will be imposed on State Farm or its agents or representatives.

Signature of Authorized Representative

AGENT — Title

03/03/2008 — Date

ROCCO ENGLISH — Agent Name

Telephone Number 407-657-7800

Agent's Code Stamp
Agent Code 59-2521
AFO Code P352

telephone: 877.725.2467 facsimile: 407.971.4742 www.medivest.com

MEDIVEST®
THE CARE COST ADVOCATE

2100 Alafaya Trail, Suite 201
Oviedo, Florida
32765

Addressing Bankruptcy Concerns

In the interest of protecting client monies in the unlikely event of bankruptcy, we want to address any concerns regarding this matter. It is our duty and privilege to safeguard our client's interests as well as ensure that Medivest's stability is never in question.

We maintain a sophisticated accounting system that tracks every financial transaction for every Medical Fund it handles. This software has been built from the ground up and customized to specifically meet the needs of Medivest's clients and the medical funds we administer on their behalf. We have spent two years refining the system to ensure it meets the needs for all main aspects of the business.

Medivest is fully insured in the sense that we have in place policies that cover professional liability for $1,000,000 for each occurrence, primary and excess crime coverage for $1,000,000 each for $2,000,000 in total, and general liability coverage.

We understand that in the unlikely event of a bankruptcy filing by Medivest, if a Beneficiary were to claim that he or she did not receive the full amount of his or her Medical Fund, the Bankruptcy Court would make a determination of how to regard the rights of such individual Beneficiary for any balance due. The judge apparently would apply a "facts and circumstances" type analysis in balancing the rights of the individual Beneficiary and those of the general creditors. We believe that an individual Beneficiary should and would prevail as we've discussed with our legal council. However, given the unique nature of our business, we have not been able to locate any legal precedent that deals with facts identical to ours.

Should you have any further questions, please don't hesitate to confer with us.

Medivest Benefit Advisors, Inc.

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To Whom It May Concern:

Enclosed you will find our Medivest Benefit Advisors Due Diligence Kit. The purpose of this kit is to provide all parties involved the information they need to appreciate the importance we put on keeping our client's money safe.

From our beginnings in 1996, the security of the funds and information we keep for our injured clients is our top priority. We review every part of our business to ensure that the funds and information we manage continues to be completely safe. We strive to achieve piece of mind for every customer and every client whom we serve.

You will find all of our insurances that protect the money we handle for our injured clients as well as our processes for ensuring the security of their data. This includes redundancy in our servers as well as offsite backups of our data in the event of an emergency.

We list references from our banking and legal teams as well as the credentials for those that oversee the operations of the company. Should you have any further questions or need more detail, please don't hesitate to give us a call at 877.725.2467.

Sincerely,

Doug Shaw
COO

Protections

References:

Legal: Mr. Joe Howell, Attorney at Law
Howell Moore & Gough
812 Presidio Ave.
Santa Barbara, CA 93101
805-962-0524

Banking: Brian Sullivan, UBS Paine Webber
999 Monterey St, Suite 360
San Luis Obispo, CA 93401
805-782-6456
*Safeguards available upon request.

Insurance: Professional Liability Errors & Omissions coverage through
XL Insurance
Contact Ogilvy-Hill Insurance 805-966-4101
For $1M per claim and $1M aggregate.

Fidelity, Employee Forgery, & Computer Fraud through
Travelers Casualty and Surety Company of America
Contact Ogilvy-Hill Insurance 805-966-4101
$1,000,000 each occurrence
$2,000,000 aggregate
Great American, Excess Fidelity Coverage
$1,000,000 each occurrence
$2,000,000 aggregate

Accounting: Staff accounting includes Beverly Brown, Ed Menders certified bookkeepers and Doug Shaw, CPA.
Harold Winett, CPA
310-207-2595

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Disaster Recovery Plan

We take our business, our data and our systems very seriously here at Medivest. It is our utmost concern to ensure that everything we do allows for a smooth running operation and for quick recovery should the unforeseen occur.

In the event of a disaster, Medivest is fully prepared to recover quickly with no loss of data and very little company downtime. We define disaster as any occurrence that would result in the loss or corruption of data that is essential for Medivest to do business. This could be caused by a natural disaster (i.e. hurricane, earthquake, fire) or theft of computers and/or files.

Redundancy & Backups

Our server has mirrored hard drives. In the event of a hard drive failure, we continue to operate with no downtime. All data is backed up daily, which includes weekly backups on a four-week rotation. These backups are taken offsite daily so in the event of a fire or theft, we could restore all data and be back up within 1-2 days.

For all bills we receive for paying our client's medical claims, we have each one scanned into our system. Because these are stored on our server, these get backed up daily.

All users store critical data on our server and not on their local hard drives, which ensures that in the event of a local computer crashing, there will be no loss of data or employee time getting back up on another computer.

Custom Software

Medivest employs custom software that incorporates all the main facets of our business for our clients. Because this is proprietary software that we have developed to handle not only our client contact and history information, but also bill processing and client accounting, it is important that this is protected properly.

The source code is located offsite at our developer's location. The executable files on our server are backed up daily. In the event of corruption of this data or computer crash, all data and software is easily recovered.

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Financial Data

The financial data that we keep on each case for our clients is stored at our Oviedo, FL location. All of our company financial information is stored at our Santa Barbara, CA location. Our staff that handles our client financial data does not take part in any processing of Medivest's corporate financial information.

Our accounting department is also audited monthly by an outside consultant who ensures that our books balance, both on the client side and the corporate side. In addition, we employ a CPA to provide another external check.

As with our FL location, our backup strategy is the same to ensure no loss of data and a quick recovery in the event of a disaster.

Printed Materials

Digital art and print-ready files are housed at the individual print vendors' facilities. In the event of a disaster, we could reprint our forms and marketing materials inventory within 10-15 business days. A small supply of our printed material is also kept at the Santa Barbara, CA office and would be available in the event of an emergency.

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Joe Sample Medical Custodial Account Agreement

***** NOTICE *****

This Medical Custodial Account Agreement (the "Agreement") shall not become activated until:

(1) (1) the Custodian has received a copy of the completed Agreement, with all required attachments, approved and signed by duly authorized representatives of the designated Payor, Beneficiary and Beneficiary's counsel;

(2) the Custodian has received an initial payment in accordance with the Agreement; and

(3) a duly authorized representative of the Custodian has approved and signed the Agreement.

Medivest Benefit Advisors, Inc.
2100 Alafaya Trail
Suite 201
Oviedo, FL 32765-9488
877-725-2467 407-971-4742 fax

THIS Joe Sample MEDICAL CUSTODIAL ACCOUNT AGREEMENT (the "Agreement") is made and entered into by and between Payor and Custodian as hereafter defined, pursuant to Settlement Arrangement between Beneficiary and Payor dated _____, attached to and incorporated herein and subject to acknowledgement by Beneficiary and Beneficiary's counsel at the end of this Agreement.

RECITALS:

A. In connection with a separate settlement, compromise and release, or similar arrangement ("Settlement Arrangement"), between Beneficiary and Payor, Payor has agreed to transfer a designated amount, as set forth in Section A-4, to be administered by Medivest Benefit Advisors, Inc. ("Custodian") in the manner set forth in this Agreement, for future medical expenses of the Beneficiary.

B. All parties desire to set forth the amount which shall constitute the Medical Fund, the terms upon which Custodian shall handle the Medical Fund and shall pay Allowable Benefits incurred by the Beneficiary, and certain other terms and conditions of the relationship between the parties.

C. This Agreement shall not create any independent liability for the Payor, as the Payor and the Beneficiary acknowledge and agree that the liability of the Payor to the Beneficiary is governed solely by the Settlement Arrangement, and this Agreement is intended solely to implement the payment and other arrangements described in such Settlement Arrangement.

AGREEMENT:

NOW, THEREFORE, in light of the foregoing and in consideration of the mutual covenants set forth in this Agreement, the parties to this Agreement, intending to be legally bound, agree as follows:

BASIC PROVISIONS:

These Basic Provisions set forth certain information concerning the terms of this Agreement, are included as part of the Agreement, and are subject to the Terms and Conditions of the Agreement.

A-1 Name of Payor: **Sample Company**
Street Address: **Street Address**
City: **City** State: **State** Zip: **Zip**
Contact Person: **Contact Person** Telephone Number: **Telephone Number**
File or Claim #: **File or Claim #** Taxpayer ID #: **Taxpayer ID#**

A-2 Beneficiary's Name: **Joe Sample**
Street Address: **Street Address**
City: **City** State: **State** Zip: **Zip**
Telephone Number: **Telephone Number**
Social Security Number: **Social Security Number** Date of Birth: **DOB**

A-3 Guardian for Beneficiary (applies only if beneficiary has a court appointed legal guardian):

Name: **Sample Guardian**

Street Address: **Street Address**

City: **City** State: **State** Zip: **Zip**

Telephone Number: **Telephone Number**

Note: The minimum funding for a Custodial Account is the greater of: (1) Twenty-Five Thousand Dollars ($25,000), or (2) an amount equal to six (6) months medical expenses. When submitted with a Medicare Set-Aside Account, minimum funding for a Custodial Account is the greater of: (1) Ten Thousand Dollars ($10,000), or (2) an amount equal to six (6) months medical expenses. (Proposed accounts are evaluated on a case by case basis.)

A-4 Amount of Medical Fund: **$10,500,000.00**

Initial Payment and Date Payable: **$253,503.00 (For Medical Expenses Only) Within 30 days of approval by a Judge or Elected Official.**

Annuity Payments and Dates Payable: **$72,235.00 (For Medical Expenses Only) Payable annually for life, guaranteed 25 years, compounding annually at 3%, with the first payment commencing on 01/01/2009.**

$[illegible]6,000.00 (For Educational Expenses Only) Payable quarterly for 4 years, commencing 01/01/2009. If Joe Sample does not attend school by the age of 40, the balance remaining shall be transferred to the Medical Expense portion of Joe Sample's account.

$25,000.00 (Graduation Gift upon completion of Bachelors Degree) Lump sum payment due on 01/01/2010.

$28,000.00 (Graduation Gift upon completion of Masters Degree) Lump sum payment due on 01/01/2015.

Name of Company Issuing Annuity: **Sample Life Company**

Make Checks Payable to: **Medivest Benefit Advisors, Inc., FBO Joe Sample**

A-5 Please attach the most recent medical summary and include Date Of Injury

Date of Injury: **Date of Injury**

Brief Injury Description: **Injury Description**

A-6 Type of Case: Liability ___ Workers' Compensation _____ Which state? ___

A-7 *Specific future medical expenses covered under this agreement include the following:*
(Please itemize in detail; add extra sheet if necessary.):
What is to be paid out of the MCA account?

The following are exclusions/restrictions (Please list with detail; add extra sheet if necessary.):
What is not to be paid out of the MCA account?

A-8 The specific term of this Agreement shall be: **See Basic Provisions, Section A-4**
(If no date is provided, the Agreement shall be terminated in accordance with Section 5 of the Terms and Conditions.)

A-9 Terminating Distributions:

Payor: **0 %**
Beneficiary: **0 %**
***Other:** **0 %**

* If other, please specify:
Name: _____
Address: _____
Social Security: _____
Date of birth: _____

A-10 Will there be periodic distributions to the Beneficiary? Yes (No)

If yes, please indicate the amount and when payable:

Amount: $ _____ When Payable: _____

A-11

Settlement Consultant's Name: **Broker's Name** Phone: **Phone Number**

Applicant / Plaintiff Attorney's Name: **Plaintiff Attorney's Name** Phone: **Phone Number**

Defense Attorney's Name: **Defense Attorney's Name** Phone: **Phone Number**

TERMS AND CONDITIONS

These Terms and Conditions constitute an integral part of this Agreement. Each reference to these Terms and Conditions contained in the Basic Provisions shall be construed to incorporate all of the information to which reference is made.

1. DEFINITIONS

1.1 "Allowable Benefits" shall mean the necessary and reasonable medical and care expenses of the Beneficiary incurred on or after the settlement date for the following purposes: (a) any and all expenses described in Section A-7 of the Basic Provisions; and/or (b) any other necessary and reasonable medical and care expense ordered by the treating physician or health care provider for the care of the Beneficiary for injuries described in Section A-5 of the Basic Provisions.

1.2 "Approved Investments" shall mean the investments that the Custodian shall make for the Medical Fund, which shall be as follows: (a) certificates of deposit issued by any financial institution organized under laws of the United States or any State thereof; and/or (b) interest-bearing checking and savings accounts with financial institutions. **"Investment Supervision"** shall mean those duties and obligations typically performed by an investment counselor employed by an investment company or financial institution. (See Section 3.5 for disclaimer of Investment Supervision by Custodian.)

1.3 "Medical Expenses" shall mean those expenses that the Custodian determines are necessary and reasonable medical and care expenses. The Custodian to be guided by its determination of expenses that would be allowable as medical expenses under applicable state or federal statutes, regulations and case law. Custodian may also consider any recognized "standard of practice" in its determination and the usual and customary reimbursement schedules (including but not limited to any applicable state workers' compensation fee schedules) for the applicable geographic area.

1.4 "Medical Fund" shall consist of and be limited to: (1) the initial amount and any additional amounts per Section A-4 of the Basic Provisions; plus (2) interest on such amount(s) at an interest rate equal to the prevailing rate for money market funds of like amount (Custodian currently uses Barron's weekly money market rate data); minus (3) any disbursements made pursuant to the terms of this Agreement.

2. DUTIES AND OBLIGATIONS OF PAYOR

2.1 Payments to Custodian. The Payor shall transfer to Custodian all payments on the dates specified in Section A-4 of the Basic Provisions.

2.2 Timing for Payments. Payor must make all payments required under Section A-4 no later than three (3) business days after the date specified. Failure to pay specified amounts within such time frame may subject this Agreement to an increase to the fee schedule in effect at the time of such delinquent payment.

3. DUTIES AND OBLIGATIONS OF CUSTODIAN

3.1 Medical Fund. Custodian accepts and agrees to hold, administer, and disburse the Medical Fund according to the terms of this Agreement.

3.2 Payment of Allowable Benefits. Custodian shall pay from the Medical Fund all Allowable Benefits. Such payments shall be made to the provider of the service or, as applicable, to the Beneficiary for reimbursement. The receipt of payment by such provider shall constitute full and complete discharge of the obligations of the Custodian with respect to any such payment.

3.3 No Discretion. Custodian shall have no discretion with respect to the distribution of funds under this Agreement and is directed to disburse funds solely in payment of Allowable Benefits. If an expense is determined to not be an Allowable Benefit, Custodian shall notify Beneficiary in writing.

3.4 Reliance Upon Presentation. Custodian shall have the right to rely upon presentation of bills and statements from providers of medical and care services and items that are provided to Beneficiary and/or to his/her legal guardian. Custodian may approve an expense as an Allowable Benefit and pay such item without obtaining any order or approval of any court and without prior approval of Payor or Beneficiary, subject to the conditions set forth in this Agreement.

3.5 No Investment Supervision. The Custodian may, for purposes of maintaining the principal amount of the Medical Fund in funds available for disbursement under this Agreement, deposit the Medical Fund in Approved Investments. Custodian may pool the Medical Fund with the medical funds of other agreements for purposes of making deposits or for Custodian's administrative convenience. Custodian is not providing, is not being retained to provide and shall neither provide nor be responsible for providing investment management or investment management type services to the Beneficiary or the Payor or with respect to the Medical Fund.

3.6 No Obligation for Disbursements in Excess of Medical Fund. As long as Custodian has otherwise satisfied its obligations under this Agreement, the Custodian shall have no obligation nor responsibility to Payor, Beneficiary or any other party should the amounts required to discharge all Allowable Benefits exceed the Medical Fund.

3.7 Reporting. Custodian shall provide to Beneficiary, on at least a semi-annual basis, within thirty (30) days after the close of each reporting period, a report indicating the current balance and all debits and deposits to the Medical Fund for the prior period. In addition, on or before April 1 each year, Custodian shall provide to Beneficiary a summary of all such activity for the prior calendar year. If Payor has a reversionary interest per Section A-9 of the Basic Provisions, Custodian shall provide Payor with a copy of the report.

3.8 Periodic Distributions. If set forth in Section A-10 of the Basic Provisions, Custodian shall pay the specified periodic distributions of the Medical Fund to the Beneficiary on the specified dates.

4. COMPENSATION OF CUSTODIAN

Custodian shall receive reasonable compensation in accordance with its Schedule of Fees attached as Schedule 1, as may be amended from time to time by Custodian after at least thirty (30) days advance written notice of any amendments, and shall make disbursements from the Medical Fund for said compensation. Should the actual income generated from Approved Investments exceed the minimum rate prescribed in Section 1.4, Custodian shall be entitled to retain such excess, if any, as additional compensation.

5. TERMINATION OF MEDICAL FUND AND AGREEMENT

5.1 Specified Term or Exhaustion of Funds. If a specified term is set forth in Section A-8 of the Basic Provisions, this Agreement shall terminate on the earlier of such date (the "Termination Date"), the death of the Beneficiary or the exhaustion of funds. For purposes of this Agreement, "exhaustion of funds" shall not refer to a circumstance when the entire balance of the Medical Fund is temporarily exhausted by the Custodian to pay Allowable Benefits and there is in place an annuity or similar recurring source of funds to be deposited in the Medical Fund within the twelve (12) months following such temporary exhaustion. At the time of termination, Custodian shall liquidate the Medical Fund and distribute any remaining balance as follows: (a) first, to Custodian for payment of any accrued but unpaid fees per the Schedule of Fees; (b) next, to appropriate service providers for payment of unpaid Allowable Benefits; and (c) finally, in accordance with Section A-9. In order to assure that Custodian has received and processed all outstanding claims for Allowable Benefits, Custodian has the discretion to defer the final distribution per this Section 5.1 until sixty (60) days after the Termination Date. For purposes of computing the annual fee payable at the time of termination, the entire annual fee is due and payable in full upon termination regardless of the actual termination date. Within thirty (30) days after Custodian's distribution of funds per this Section 5.1, Custodian shall provide to Beneficiary and Payor a closing statement setting forth all activity since its last account statement. Should the Medical Fund at the time of termination not be sufficient to pay amounts described in this Section 5.1, the Beneficiary shall be obligated to pay any deficiency.

5.2 Death of Beneficiary. Upon the death of the Beneficiary, Custodian shall pay any unpaid Allowable Benefits for services provided prior to the death of Beneficiary and for which payment by the Custodian has been requested; provided, however, such expenses must be submitted for review and payment within sixty (60) days after the date of Beneficiary's death. Within sixty (60) days of the date of Beneficiary's death, Custodian shall liquidate the Medical Fund and distribute any remaining balance as set forth in Section 5.1 above.

5.3 Termination by Notice. This Agreement may be terminated by either Payor or Custodian by providing at least thirty (30) days prior written notice to all interested parties. (In those cases where Payor has a reversionary interest per Section A-9 of the Basic Provisions, Payor must also agree in writing to such termination.) Within sixty (60) days after the noticed Termination Date, Custodian shall deliver the Medical Fund and distribute any remaining balance as set forth in Section 5.1 above. Custodian shall deduct from such sum compensation to which Custodian is entitled through the noticed Termination Date. For purposes of computing the annual fee at the time of termination, the entire annual fee is due and payable in full upon termination regardless of the actual termination date. Within thirty (30) days after Custodian's distribution of funds per Section 5.1 above, Custodian shall provide all interested parties with a closing statement setting forth all activity since its last account statement.

5.4 Termination of Custodian's Obligations. Upon Custodian's delivery of amounts per Section 5.1 above, all of Custodian's financial obligations under this Agreement shall terminate, Custodian's sole remaining obligation shall be preparation and delivery of a closing statement within the applicable time frames specified in this Section 5.

6. EXPENSES PAID BY OTHER SOURCES

Custodian shall make no payments for medical care where the payment for such care (or any portion thereof) is covered by another insurance policy, governmental agency, medical insurance or by any other government programs. This provision shall include but not be limited to payments made by Medicare, Medicaid, or any other medical insurance policy for the benefit of the Beneficiary. Custodian will determine payments based on coordination of benefits standards and the Medicare Secondary Payer guidelines. Custodian shall make no payment for medical expenses when Beneficiary has been previously reimbursed for such expenses or Custodian reasonably expects Beneficiary to be reimbursed by such other sources. If Beneficiary receives reimbursement for any such expense and payment has previously been made by the Custodian from the Medical Fund, the full amount of such reimbursement shall be refunded to Custodian and shall be returned to the Medical Fund for administration by the Custodian in accordance with this Agreement. Custodian shall not be liable for payments it makes in good faith reliance upon requests or information provided to Custodian.

7. GENERAL PROVISIONS

7.1 Mutual Indemnification. Each party agrees to indemnify the other and hold it, and its respective officers, directors, employees or agents, free and harmless from and against any and all liabilities, damages, losses, claims, costs or expenses, including reasonable attorneys' fees (collectively "Claims"), which the indemnified party may incur, suffer, or be required to pay as a result of claims or demands brought by any person , entity , or organization arising from any act of negligence or other wrongful act or omission by the indemnifying party.

7.2 Notices. Any notices permitted or required hereunder shall be in writing and shall be deemed to have been given (a) on the date of delivery, if delivery of a legible copy was made personally or by facsimile transmission; or (b) on the second business day after the date on which mailed by registered or certified mail, return receipt requested, addressed to the party for whom intended at the address set forth on the signature page of this Agreement or such other address, notice of which is given as provided herein.

7.3 Facsimile Signatures. Signatures of the parties on this Agreement or on any document or instrument delivered pursuant to this Agreement and exchanged by facsimile transmission shall be deemed to be original signatures and shall be sufficient to bind the parties.

7.4 Binding Effect. This Agreement shall be binding upon and shall inure to the benefit of each of the parties and their respective heirs, successors, assigns and legal representatives.

7.5 Waiver. No waiver of any right under this Agreement shall be effective for any purpose unless in writing and signed by the party possessing said right. Any such written waiver shall not be construed to waive any subsequent right or other term or provision of this Agreement.

7.6 Counterparts and Execution. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original and all of which taken together shall constitute one and the same instrument binding on all the parties hereto, notwithstanding that all of the parties are not signatories to the original or the same counterpart. This Agreement shall not become effective/activated until the Effective/Activation Dates specified in Section 8 below.

7.7 Construction. The parties agree that each party and its counsel has reviewed and approved this Agreement and any rule of construction to the effect that ambiguities are to be resolved against the drafting party shall not apply in the interpretation of this Agreement or any amendments of exhibits thereto.

7.8 Governing Law. This Agreement, the construction and enforcement of its terms, and the interpretation of the rights and duties of the parties hereunder shall be governed by the laws of the State of California. The rights of Beneficiary to the payment of covered medical expenses shall be construed in accordance with the Settlement Arrangement and shall be governed by the applicable laws governing said Settlement Arrangement.

7.9 Partial Invalidity. Each term and provision of this Agreement shall be valid and enforceable to the fullest extent permitted by law. If any term or provision of this Agreement or the application thereof to any person or circumstance shall, to any extent, be invalid or unenforceable, then the remainder of this Agreement or the application of such term or provision to persons or circumstances other than those to which it is held invalid or unenforceable shall not be affected thereby.

7.10 Arbitration. Unless the relief sought requires the exercise of the equity powers of a court of competent jurisdiction, any dispute arising in connection with the interpretation or endorsement of the provisions of this Agreement, or the application or validity thereof, shall be submitted to arbitration. Such arbitration proceedings shall be held in Santa Barbara, California in accordance with the rules of the American Arbitration Association. This Agreement to arbitrate shall be specifically enforceable. Any award rendered in any such arbitration proceedings shall be final and binding on each of the parties hereto, and judgment may be entered thereon in any court of competent jurisdiction.

7.11 Attorneys Fees. Should either party to this Agreement bring an action to enforce such party's rights herein, the prevailing party in such action shall be entitled to recover its reasonable attorneys' fees and costs incurred with such action.

7.12 Amendments. Other than Custodian's unilateral right to modify its fees by advance written notice per Section 4 above, this Agreement may be amended or modified only by a written instrument signed by the parties to this Agreement.

7.12.1 Alterations to Original Agreement. The original contract may be amended or entirely rewritten if agreed upon by all parties, incorporated into a document bearing Medivest's letterhead and then sent by Medivest Benefit Advisors, Inc. to all parties for their signature. Any other alterations to this agreement will not be considered valid until they have gone through the steps outlined previously.

7.13 Assignment. No party may assign without prior written approval of the other party; provided however, the Custodian may assign its interests herein in connection with a merger or a sale of all or substantially all of its stock or assets. This agreement shall be binding upon and shall inure to the benefit of all assignees, transferees and successors in the interest of the parties hereto.

7.14 Complete Agreement. This written instrument, together with any exhibits or appendices referred to herein, constitutes the entire understanding of the parties with respect to the matters that are the subject of this Agreement, and no representations, warranties or covenants not included in this Agreement may be relied upon by any party hereto.

8. EFFECTIVE DATE OF AGREEMENT

The Effective Date of this Agreement will become the date of the final settlement approval. The Activation Date of this Agreement is the date on which all requirements specified in the "Notice" on the facing page are satisfied. This Agreement shall be considered executory until the Activation Date. No rights, obligations or duties shall be created hereunder unless the Beneficiary is alive on the Activation Date.

ACKNOWLEDGMENT AND ACCEPTANCE BY PARTIES:

Acceptance by Payor

The undersigned, a duly authorized representative of Payor, acknowledges that the undersigned has reviewed and accepted the Basic Provisions, the Terms and Conditions, and all attachments and Exhibits comprising this Agreement and agrees that as of the Effective Date, Payor shall be legally bound.

"PAYOR"
Sample Company

Date

(Signature)

Print name of Representative

Address and Telephone Numbers

Acceptance by Custodian

The undersigned, a duly authorized representative of Custodian, acknowledges that the undersigned has reviewed and accepted the Basic Provisions, the Terms and Conditions, and all Exhibits comprising this Agreement and agrees that as of the Activation Date, Custodian shall be legally bound.

"CUSTODIAN"
MEDIVEST BENEFIT ADVISORS, INC.

Date

(Signature)

Name Title

2100 Alafaya Trail
Suite 201
Oviedo, FL 32765-9488
877-725-2467 Fax 407-971-4742

ACKNOWLEDGMENT BY BENEFICIARY

The undersigned represents that he or she is the Beneficiary or has full authority to act on behalf of the Beneficiary as a legal representative. The undersigned acknowledges that, although he or she is not a party to this agreement, the undersigned has reviewed the Basic Provisions and the Terms and Conditions of this Agreement.

1. **Submission of Claims.** Beneficiary agrees to submit to Custodian claims for payment or reimbursement of Allowable Benefits in a timely manner. Beneficiary shall provide proof of incurred expenses and shall assist Custodian if additional information is needed for the evaluation and review of a claim.

2. **Payment of Claims if Medical Fund is Exhausted.** The Beneficiary understands and agrees, if the amount of incurred Allowable Benefits exceeds the amount of funds in the Medical Fund, the Beneficiary will be monetarily responsible for the payment of the incurred expense. Thereafter, if and when the balance of the Medical Fund, through receipt of future payments, exceeds the cost of the Allowable Benefit paid by the Beneficiary, the Beneficiary may re-submit a claim for reimbursement of those expenses if such claim includes satisfactory proof of payment.

3. **Full Cooperation.** Further, the undersigned understands and agrees that Medivest shall administer this allocation for the remainder of the Beneficiary's lifetime, until the funds are exhausted or the term of this Agreement expires, whichever occurs first. The undersigned understands and agrees that he or she must cooperate fully with the Custodian and provide the Custodian with any and all information, documentation, etc., as well as any additional requests for any other information that may be made during the term of this Agreement.

4. **Indemnification.** The undersigned shall indemnify, defend, and hold the Custodian and Payor, and their respective officers, directors, employees, or agents, free and harmless from and against any and all liabilities, damages, losses, claims, costs, or expense, including reasonable attorney fees (collectively "claims"), that are hereafter made or brought against either the Payor and/or the Custodian arising from or attributable to the undersigned's failure to cooperate with the Custodian and/or failure to abide by the terms, provisions and obligations of this Agreement, amendments/addenda, as well as future requests for information and documentations as deemed necessary by the Custodian for the proper administration of this Agreement.

The undersigned must write the following words in his/her own handwriting:

"I acknowledge that under this Custodial Agreement only Allowable Benefits, as defined in this Agreement, may be paid by the Custodian under the Agreement."

_____

_____

_____

_____
Initials

"Beneficiary"
Joe Sample by his Guardian ad Litem

_____
Date

_____
(Signature)

_____
Print Name of Beneficiary or name of legal representative if signing for Beneficiary

_____
Relationship to Beneficiary (if Guardian)

Approved in Form and Content by Counsel for Beneficiary (only if Beneficiary is represented by counsel).

_____
Date

_____
(Signature)

_____
Print Name of Counsel

MEDIVEST®

THE CARE COST ADVOCATE

Joe Sample
ADDENDUM TO
MEDICAL CUSTODIAL
ACCOUNT AGREEMENT

THIS ADDENDUM TO MEDICAL CUSTODIAL ACCOUNT AGREEMENT (the "Addendum") is made and entered into on the date set forth below, between **"Custodian", "Payor" and "Beneficiary"**, each of whom is identified below.

WHEREAS:

A. Custodian, Payor and Beneficiary are entering into a Medical Custodial Account Agreement (the "MCA Agreement") but desire to amend certain provisions of the MCA Agreement. The Medical Custodial Account Agreement makes reference to "Payor" (Sample Company) throughout its entirety. The role of the Payor is to fund this Medical Custodial Account by having the initial funding paid into the account as well as by purchasing the appropriate annuities to maintain the account. The Payor has no other rights to the Medical Custodial Account Agreement and/or Medical Custodial Account. As referenced in the Medical Custodial Account Agreement, this would include but not be limited to changing or modifying the Medical Custodial Account Agreement, request or receive any statements on this account, request account to be terminated, request any portion of the funds on deposit, etc.

B. Other than as modified by this Addendum, the parties ratify, confirm and approve the MCA Agreement.

NOW, THEREFORE, Custodian, Payor and Beneficiary agree as follows:

1. AMENDMENT TO MCA AGREEMENT

1.1 Revisions. The following provisions of the MCA Agreement are revised in the manner set forth below:

Paragraph 1.1 is amended by adding the following unnumbered paragraph:
"Allowable Benefits" shall also mean the necessary and reasonable educational expenses of the Beneficiary incurred on or after the settlement date as defined in Paragraph 1.5 below.

1.2 Additions. The following are new provisions to be added to the MCA Agreement:

A new Paragraph 1.5 is added as follows:
1.5 "Educational Expenses" shall mean those expenses that the Custodian and/or College determine are necessary and reasonable educational expenses incurred by the Beneficiary during such periods of time as the Beneficiary is a full-time student as that term is defined by the college attended by the Beneficiary. **'College'** shall include any college, university, community college, vocational school, or any other accredited institution awarding Associates, Bachelors, Masters or Doctorate degrees or other professional certifications.

"Educational Expenses" shall include tuition, books, room and board, student fees and incidentals that are required for the Beneficiary to attend college.

In addition, the Custodian is authorized to make the following distributions to or for the benefit of the Beneficiary for formal and informal instruction, training and education, including, but not limited to the following:

a. Tutoring;
b. Advanced classes or training if the Custodian and/or College determines that the Beneficiary has special abilities which will be enhanced by such advanced classes or training;
c. Educational materials and tools such as laboratory supplies;
d. Conferences and seminars;
e. Payment for costs and fees related to internships or similar programs; and
f. Reasonable food, reasonable transportation, reasonable accommodations and reasonable incidental expenses related to the provision of any educational benefit under this paragraph.

A new Paragraph 3.9 is added as follows:
3.9 "Payment of Educational Benefits". Custodian shall pay from the Educational Fund all allowable education benefits. Such payments shall be made to the provider of the service or, as applicable, to the Beneficiary's parents or parent for reimbursement or to the Beneficiary for reimbursement, as the case may be. If the Beneficiary is requesting reimbursement, the appropriate documentation must be received. The receipt of payment by such provider shall constitute full and complete discharge of the obligations of the Custodian with respect to any such payment.

A new Paragraph 3.10 is added as follows:
3.10 "Allocation of Educational Funds". As set forth under Basic Provisions, Section A-4, of the Medical Custodial Account Agreement, the Custodian will be receiving $64,000.00 per year for the Educational Expense Fund, at the rate of $16,000.00 per quarter for 16 quarters, or 4 years. To the extent these funds are not utilized for the educational needs of the Beneficiary (as defined herein), within any given calendar year, the balance remaining from the $64,000 per year of the Educational Expense Fund shall be distributed to Joe Sample, upon receipt of school enrollment and completion documentation. If Joe Sample does not attend school by age 40, all funds in the educational expense portion of his account will be transferred to the Medical fund to be held, administered and distributed pursuant to the terms of the Agreement.

A new Paragraph 3.11 is added as follows:
3.11 "Allocation of Graduation Gift Upon Completion of Bachelors Degree". As set forth under Basic Provisions, Section A-4, of the Medical Custodial Account Agreement, the Beneficiary will be receiving a $25,000.00 lump sum payment upon proof of graduation.

A new Paragraph 3.12 is added as follows:
3.12 "Allocation of Graduation Gift Upon Completion of Masters Degree". As set forth under Basic Provisions, Section A-4, of the Medical Custodial Account Agreement, the Beneficiary will be receiving a $28,000.00 lump sum payment upon proof of graduation.

5.3 Termination by Notice. This Agreement may be terminated by Custodian by providing at least thirty (30) days prior written notice to all interested parties. Within sixty (60) days after the noticed Termination Date, Custodian shall deliver the Medical Fund and distribute any remaining balance as set forth in Section 5.1 above. Custodian shall deduct from such sum

compensation to which Custodian is entitled through the noticed Termination Date. For purposes of computing the annual fee at the time of termination, the entire annual fee is due and payable in full upon termination regardless of the actual termination date. Within thirty (30) days after Custodian's distribution of funds per Section 5.1 above, Custodian shall provide all interested parties with a closing statement setting forth all activity since its last account statement.

At no time shall Joe Sample have the right to terminate this agreement prior to attaining the age of 40, or 01/01/2030. Upon attaining the age of 40, Joe Sample shall have the right to terminate all or a portion of this agreement upon written notice to Custodian. If Joe Sample chooses not to terminate this agreement upon attaining the age of 40, the Medical Expense provisions of this agreement will remain in effect.

2. RATIFICATION OF MCA AGREEMENT

Other than those revisions or additions set forth in Section 1 above, the MCA Agreement is ratified, confirmed and approved.

(Intentionally left blank)

ACKNOWLEDGMENT AND ACCEPTANCE BY PARTIES:

The undersigned, a duly authorized representative of Payor, acknowledges that the undersigned has reviewed and now accepts this Addendum.

"PAYOR"
Sample Company

_____ Date

_____ (Signature)

The undersigned, a duly authorized representative of Custodian, acknowledges that the undersigned has reviewed and now accepts this Addendum.

"CUSTODIAN"
MEDIVEST BENEFIT ADVISORS, INC.

_____ Date

_____ (Signature)

_____ Name Title

2100 Alafaya Trail
Suite 201
Oviedo, FL 32765-9488
877-725-2467 Fax 407-971-4742

The undersigned: (1) represents that he or she is the Beneficiary or has full authority to act on behalf of the Beneficiary as a legal representative; and (2) acknowledges that he/she has reviewed and now accepts this Addendum.

"BENEFICIARY"
Joe Sample by his Guardian ad Litem

_____ Date

_____ (Signature)

_____ Print Name

_____ Relationship to Beneficiary (if Guardian)

Approved in Form and Content by Counsel for Beneficiary

_____ Date

_____ (Signature)

_____ Print Name of Counsel

EXHIBIT 3

Date/Time of Request:	Tuesday, March 24, 2009 07:15 Central
Client Identifier:	
Database:	USCA
Citation Text:	42 USCA s 1395y
Lines:	5019
Documents:	1
Images:	0

Westlaw.

42 U.S.C.A. § 1395y

Effective: July 15, 2008

United States Code Annotated Currentness
Title 42. The Public Health and Welfare
Chapter 7. Social Security (Refs & Annos)
Subchapter XVIII. Health Insurance for Aged and Disabled (Refs & Annos)
Part E. Miscellaneous Provisions (Refs & Annos)
§ 1395y. Exclusions from coverage and medicare as secondary payer

(a) Items or services specifically excluded

Notwithstanding any other provision of this subchapter, no payment may be made under part A or part B of this subchapter for any expenses incurred for items or services--

(1)(A) which, except for items and services described in a succeeding subparagraph or additional preventive services (as described in section 1395x(ddd)(1) of this title), are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,

(B) in the case of items and services described in section 1395x(s)(10) of this title, which are not reasonable and necessary for the prevention of illness,

(C) in the case of hospice care, which are not reasonable and necessary for the palliation or management of terminal illness,

(D) in the case of clinical care items and services provided with the concurrence of the Secretary and with respect to research and experimentation conducted by, or under contract with, the Medicare Payment Advisory Commission or the Secretary, which are not reasonable and necessary to carry out the purposes of section 1395ww(e)(6) of this title,

(E) in the case of research conducted pursuant to section 1320b-12 of this title, which is not reasonable and necessary to carry out the purposes of that section,

(F) in the case of screening mammography, which is performed more frequently than is covered under section 1395m(c)(2) of this title or which is not conducted by a facility described in section 1395m(c)(1)(B) of this title, in the case of screening pap smear and screening pelvic exam, which is performed more frequently than is provided under section 1395x(nn) of this title, and, in the case of screening for glaucoma, which is performed more frequently than is provided under section 1395x(uu) of this title,

(G) in the case of prostate cancer screening tests (as defined in section 1395x(oo) of this title), which are performed more frequently than is covered under such section,

(H) in the case of colorectal cancer screening tests, which are performed more frequently than is covered under section 1395m(d) of this title,

(I) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation,

(J) in the case of a drug or biological specified in section 1395w-3a(c)(6)(C) of this title for which payment is made under part B that is furnished in a competitive area under section 1395w-3b of this title, that is not furnished by an entity under a contract under such section,

(K) in the case of an initial preventive physical examination, which is performed more than 1 year after the date the individual's first coverage period begins under part B of this subchapter,

(L) in the case of cardiovascular screening blood tests (as defined in section 1395x(xx)(1) of this title), which are performed more frequently than is covered under section 1395x(xx)(2) of this title,

(M) in the case of a diabetes screening test (as defined in section 1395x(yy)(1) of this title), which is performed more frequently than is covered under section 1395x(yy)(3) of this title,

(N) in the case of ultrasound screening for abdominal aortic aneurysm which is performed more frequently than is provided for under section 1395x(s)(2)(AA) of this title, and

(O) in the case of kidney disease education services (as defined in paragraph (1) of section 1395x(ggg) of this title), which are furnished in excess of the number of sessions covered under paragraph (4) of such section;

(2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for, except in the case of Federally qualified health center services;

(3) which are paid for directly or indirectly by a governmental entity (other than under this chapter and other than under a health benefits or insurance plan established for employees of such an entity), except in the case of rural health clinic services, as defined in section 1395x(aa)(1) of this title, in the case of Federally qualified health center services, as defined in section 1395x(aa)(3) of this title, in the case of services for which payment may be made under section 1395qq(e) of this title, and in such other cases as the Secretary may specify;

(4) which are not provided within the United States (except for inpatient hospital services furnished outside the United States under the conditions described in section 1395f(f) of this title and, subject to such conditions, limitations, and requirements as are provided under or pursuant to this subchapter, physicians' services and ambulance services furnished an individual in conjunction with such inpatient hospital services but only for the period during which such inpatient hospital services were furnished);

(5) which are required as a result of war, or of an act of war, occurring after the effective date of such individual's current coverage under such part;

(6) which constitute personal comfort items (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C));

(7) where such expenses are for routine physical checkups, eyeglasses (other than eyewear described in section 1395x(s)(8) of this title) or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations (except as otherwise allowed under section 1395x(s)(10) of this title and subparagraph (B), (F), (G), (H), or (K) of paragraph (1);

(8) where such expenses are for orthopedic shoes or other supportive devices for the feet, other than shoes furnished pursuant to section 1395x(s)(12) of this title;

(9) where such expenses are for custodial care (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C));

(10) where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;

(11) where such expenses constitute charges imposed by immediate relatives of such individual or members of his household;

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or

structures directly supporting teeth, except that payment may be made under part A of this subchapter in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services;

(13) where such expenses are for--

(A) the treatment of flat foot conditions and the prescription of supportive devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care);

(14) which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph), services described by section 1395x(s)(2)(K) of this title, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist, and which are furnished to an individual who is a patient of a hospital or critical access hospital by an entity other than the hospital or critical access hospital, unless the services are furnished under arrangements (as defined in section 1395x(w)(1) of this title) with the entity made by the hospital or critical access hospital;

(15)(A) which are for services of an assistant at surgery in a cataract operation (including subsequent insertion of an intraocular lens) unless, before the surgery is performed, the appropriate utilization and quality control peer review organization (under part B of subchapter XI of this chapter) or a carrier under section 1395u of this title has approved of the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition, or

(B) which are for services of an assistant at surgery to which section 1395w-4(i)(2)(B) of this title applies;

(16) in the case in which funds may not be used for such items and services under the Assisted Suicide Funding Restriction Act of 1997;

(17) where the expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1395w-3(a) of this title) by an entity other than an entity with which the Secretary has entered into a contract under section 1395w-3(b) of this title for the furnishing of such an item or service in that area, unless the Secretary finds that the expenses were incurred in a case of urgent need, or in other circumstances specified by the Secretary;

(18) which are covered skilled nursing facility services described in section 1395yy(e)(2)(A)(i) of this title and which are furnished to an individual who is a resident of a skilled nursing facility during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1395x(s)(2)(D) of this title, which are furnished to such an individual without regard to such period), by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1395x(w)(1) of this title) with the entity made by the skilled

nursing facility;

(19) which are for items or services which are furnished pursuant to a private contract described in section 1395a(b) of this title;

(20) in the case of outpatient physical therapy services, outpatient speech-language pathology services, or outpatient occupational therapy services furnished as an incident to a physician's professional services (as described in section 1395x(s)(2)(A) of this title), that do not meet the standards and conditions (other than any licensing requirement specified by the Secretary) under the second sentence of section 1395x(p) of this title (or under such sentence through the operation of subsection (g) or (ll)(2) of section 1395x of this title) as such standards and conditions would apply to such therapy services if furnished by a therapist;

(21) where such expenses are for home health services (including medical supplies described in section 1395x(m)(5) of this title, but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency;

(22) subject to subsection (h), for which a claim is submitted other than in an electronic form specified by the Secretary;

(23) which are the technical component of advanced diagnostic imaging services described in section 1395m(e)(1)(B) of this title for which payment is made under the fee schedule established under section 1395w-4(b) of this title and that are furnished by a supplier (as defined in section 1395x(d) of this title), if such supplier is not accredited by an accreditation organization designated by the Secretary under section 1395m(e)(2)(B) of this title; or

(24) where such expenses are for renal dialysis services (as defined in subparagraph (B) of section 1395rr(b)(14) of this title) for which payment is made under such section unless such payment is made under such section to a provider of services or a renal dialysis facility for such services.

Paragraph (7) shall not apply to Federally qualified health center services described in section 1395x(aa)(3)(B) of this title.

In making a national coverage determination (as defined in paragraph (1)(B) of section 1395ff(f) of this title) the Secretary shall ensure consistent with subsection (l) of this section that the public is afforded notice and opportunity to comment prior to implementation by the Secretary of the determination; meetings of advisory committees with respect to the determination are made on the record; in making the determination, the Secretary has considered applicable information (including clinical experience and medical, technical, and scientific evidence) with respect to the subject matter of the determination; and in the determination, provide a clear statement of the basis for the determination (including responses to comments received from the public), the assumptions underlying that basis, and make available to the public the data (other than proprietary data) considered in making the determination.

(b) Medicare as secondary payer

(1) Requirements of group health plans

(A) Working aged under group health plans

(i) In general

A group health plan--

(I) may not take into account that an individual (or the individual's spouse) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(a) of this title, and

(II) shall provide that any individual age 65 or older (and the spouse age 65 or older of any individual) who has current employment status with an employer shall be entitled to the same benefits under the plan under the same conditions as any such individual (or spouse) under age 65.

(ii) Exclusion of group health plan of a small employer

Clause (i) shall not apply to a group health plan unless the plan is a plan of, or contributed to by, an employer that has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

(iii) Exception for small employers in multiemployer or multiple employer group health plans

Clause (i) also shall not apply with respect to individuals enrolled in a multiemployer or multiple employer group health plan if the coverage of the individuals under the plan is by virtue of current employment status with an employer that does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current calendar year and the preceding calendar year; except that the exception provided in this clause shall only apply if the plan elects treatment under this clause.

(iv) Exception for individuals with end stage renal disease

Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 426 of this title) would upon application be, entitled to benefits under section 426-1 of this title.

(v) "Group health plan" defined

In this subparagraph, and subparagraph (C), the term "group health plan" has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, without regard to section 5000(d) of Title 26.

(B) Disabled individuals in large group health plans

(i) In general

A large group health plan (as defined in clause (iii)) may not take into account that an individual (or a member of the individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(b) of this title.

(ii) Exception for individuals with end stage renal disease

Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 426 of this title) would upon application be, entitled to benefits under section 426-1 of this title.

(iii) "Large group health plan" defined

In this subparagraph, the term "large group health plan" has the meaning given such term in section 5000(b)(2) of Title 26, without regard to section 5000(d) of Title 26.

(C) Individuals with end stage renal disease

A group health plan (as defined in subparagraph (A)(v))--

(i) may not take into account that an individual is entitled to or eligible for benefits under this subchapter under section 426-1 of this title during the 12-month period which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section 426-1 of this title, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 426-1 of this title if the individual had filed an application for such benefits; and

(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from paying benefits secondary to this subchapter when an individual is entitled to or eligible for benefits under this subchapter under section 426-1 of this title after the end of the 12-month period described in clause (i). Effective for items and services furnished on or after February 1, 1991, and before August 5, 1997, [FN1] (with respect to periods beginning on or after February 1, 1990), this subparagraph shall be applied by substituting "18-month" for "12-month" each place it appears. Effective for items and services furnished on or after August 5, 1997, (with respect to periods beginning on or after the date that is 18 months prior to such date), clauses (i) and (ii) shall be applied by substituting "30-month" for "12-month" each place it appears.

(D) Treatment of certain members of religious orders

In this subsection, an individual shall not be considered to be employed, or an employee, with respect to the performance of services as a member of a religious order which are considered employment only by virtue of an election made by the religious order under section 3121(r) of the Internal Revenue Code of 1986.

(E) General provisions

For purposes of this subsection:

(i) Aggregation rules

(I) All employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer.

(II) All employees of the members of an affiliated service group (as defined in section 414(m) of Title 26) shall be treated as employed by a single employer.

(III) Leased employees (as defined in section 414(n)(2) of Title 26) shall be treated as employees of the person for whom they perform services to the extent they are so treated under section 414(n) of Title 26.

In applying sections of the Internal Revenue Code of 1986 under this clause, the Secretary shall rely upon regulations and decisions of the Secretary of the Treasury respecting such sections.

(ii) Current employment status defined

An individual has "current employment status" with an employer if the individual is an employee, is the employer, or is associated with the employer in a business relationship.

(iii) Treatment of self-employed persons as employers

The term "employer" includes a self-employed person.

(F) Limitation on beneficiary liability

An individual who is entitled to benefits under this title and is furnished an item or service for which such benefits are incorrectly paid is not liable for repayment of such benefits under this paragraph unless payment of such benefits was made to the individual.

(2) Medicare secondary payer

(A) In general

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that--

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

(B) Repayment required

(i) Authority to make conditional payment

The Secretary may make payment under this subchapter with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

(ii) Primary plans

A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is

received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(iii) Action by United States

In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

(iv) Subrogation rights

The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(v) Waiver of rights

The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this subchapter.

(vi) Claims-filing period

Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.

(C) Treatment of questionnaires

The Secretary may not fail to make payment under subparagraph (A) solely on the ground that an individual failed to complete a questionnaire concerning the existence of a primary plan.

(3) Enforcement

(A) Private cause of action

There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A).

(B) Reference to excise tax with respect to nonconforming group health plans

For provision imposing an excise tax with respect to nonconforming group health plans, see section 5000 of Title 26.

(C) Prohibition of financial incentives not to enroll in a group health plan or a large group health plan

It is unlawful for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits under this subchapter not to enroll (or to terminate enrollment) under a group health plan or a large group health plan which would (in the case of such enrollment) be a primary plan (as defined in paragraph (2)(A)). Any entity that violates the previous sentence is subject to a civil money penalty of not to exceed $5,000 for each such violation. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(4) Coordination of benefits

Where payment for an item or service by a primary plan is less than the amount of the charge for such item or service and is not payment in full, payment may be made under this subchapter (without regard to deductibles and coinsurance under this subchapter) for the remainder of such charge, but--

(A) payment under this subchapter may not exceed an amount which would be payable under this subchapter for such item or service if paragraph (2)(A) did not apply; and

(B) payment under this subchapter, when combined with the amount payable under the primary plan, may not exceed--

(i) in the case of an item or service payment for which is determined under this subchapter on the basis of reasonable cost (or other cost-related basis) or under section 1395ww of this title, the amount which would be payable under this subchapter on such basis, and

(ii) in the case of an item or service for which payment is authorized under this subchapter on another basis--

(I) the amount which would be payable under the primary plan (without regard to deductibles and coinsurance under such plan), or

(II) the reasonable charge or other amount which would be payable under this subchapter (without regard to deductibles and coinsurance under this subchapter),

whichever is greater.

(5) Identification of secondary payer situations

(A) Requesting matching information

(i) Commissioner of Social Security

The Commissioner of Social Security shall, not less often than annually, transmit to the Secretary of the Treasury a list of the names and TINs of medicare beneficiaries (as defined in section 6103(l)(12) of the Internal Revenue Code of 1986) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.

(ii) Administrator

The Administrator of the Centers for Medicare & Medicaid Services shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the Administrator the information described in subparagraph (B) of section 6103(l)(12) of the Internal Revenue Code of 1986.

(B) Disclosure to fiscal intermediaries and carriers

In addition to any other information provided under this subchapter to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under subparagraph (A) for purposes of carrying out this subsection.

(C) Contacting employers

(i) In general

With respect to each individual (in this subparagraph referred to as an "employee") who was furnished a written statement under section 6051 of the Internal Revenue Code of 1986 by a qualified employer (as defined in section 6103(l)(12)(E)(iii) of such title), as disclosed under subparagraph (B), the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse may be (or have

been) covered under a group health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

(ii) Employer response

Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed $1,000 for each individual with respect to which such an inquiry is made. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(D) Obtaining information from beneficiaries

Before an individual applies for benefits under part A of this subchapter or enrolls under part B of this subchapter, the Administrator shall mail the individual a questionnaire to obtain information on whether the individual is covered under a primary plan and the nature of the coverage provided under the plan, including the name, address, and identifying number of the plan.

(6) Screening requirements for providers and suppliers

(A) In general

Notwithstanding any other provision of this subchapter, no payment may be made for any item or service furnished under part B of this subchapter unless the entity furnishing such item or service completes (to the best of its knowledge and on the basis of information obtained from the individual to whom the item or service is furnished) the portion of the claim form relating to the availability of other health benefit plans.

(B) Penalties

An entity that knowingly, willfully, and repeatedly fails to complete a claim form in accordance with subparagraph (A) or provides inaccurate information relating to the availability of other health benefit plans on a claim form under such subparagraph shall be subject to a civil money penalty of not to exceed $2,000 for each such incident. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(7) Required submission of information by group health plans

(A) Requirement

On and after the first day of the first calendar quarter beginning after the date that is 1 year after December 29, 2007, an entity serving as an insurer or third party administrator for a group health plan, as defined in paragraph (1)(A)(v), and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary, shall--

(i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been a primary plan to the program under this subchapter; and

(ii) submit such information to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) Enforcement

(i) In general

An entity, a plan administrator, or a fiduciary described in subparagraph (A) that fails to comply with the requirements under such subparagraph shall be subject to a civil money penalty of $1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted. The provisions of subsections (e) and (k) of section 1320a-7a of this title shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title. A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this subchapter with respect to an individual.

(ii) Deposit of amounts collected

Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund under section 1395i of this title.

(C) Sharing of information

Notwithstanding any other provision of law, under terms and conditions established by the Secretary, the Secretary--

(i) shall share information on entitlement under Part A and enrollment under Part B under this subchapter with entities, plan administrators, and fiduciaries described in subparagraph (A);

(ii) may share the entitlement and enrollment information described in clause (i) with entities and persons not described in such clause; and

(iii) may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(D) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(8) Required submission of information by or on behalf of liability insurance (including self-insurance), no fault insurance, and workers' compensation laws and plans

(A) Requirement

On and after the first day of the first calendar quarter beginning after the date that is 18 months after December 29, 2007, an applicable plan shall--

(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this subchapter on any basis; and

(ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) Required information

The information described in this subparagraph is--

(i) the identity of the claimant for which the determination under subparagraph (A) was made; and

(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

(C) Timing

Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

(D) Claimant

For purposes of subparagraph (A), the term "claimant" includes--

(i) an individual filing a claim directly against the applicable plan; and

(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

(E) Enforcement

(i) In general

An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant shall be subject to a civil money penalty of $1,000 for each day of noncompliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1320a-7a of this title shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title. A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this subchapter with respect to an individual.

(ii) Deposit of amounts collected

Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

(F) Applicable plan

In this paragraph, the term "applicable plan" means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:

(i) Liability insurance (including self-insurance).

(ii) No fault insurance.

(iii) Workers' compensation laws or plans.

(G) Sharing of information

The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(H) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(c) Drug products

No payment may be made under part B of this subchapter for any expenses incurred for--

(1) a drug product--

(A) which is described in section 107(c)(3) of the Drug Amendments of 1962,

(B) which may be dispensed only upon prescription,

(C) for which the Secretary has issued a notice of an opportunity for a hearing under subsection (e) of section 355 of Title 21 on a proposed order of the Secretary to withdraw approval of an application for such drug product under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling, and

(D) for which the Secretary has not determined there is a compelling justification for its medical need; and

(2) any other drug product--

(A) which is identical, related, or similar (as determined in accordance with section 310.6 of title 21 of the Code of Federal Regulations) to a drug product described in paragraph (1), and

(B) for which the Secretary has not determined there is a compelling justification for its medical need,

until such time as the Secretary withdraws such proposed order.

(d) For purposes of subsection (a)(1)(A) of this section, in the case of any item or service that is required to be provided pursuant to section 1395dd of this title to an individual who is entitled to benefits under this subchapter, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.

(e) Item or service by excluded individual or entity or at direction of excluded physician; limitation of liability of beneficiaries with respect to services furnished by excluded individuals and entities

(1) No payment may be made under this subchapter with respect to any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished--

(A) by an individual or entity during the period when such individual or entity is excluded pursuant to section 1320a-7, 1320a-7a, 1320c-5, or 1395u(j)(2) of this title from participation in the program under this subchapter; or

(B) at the medical direction or on the prescription of a physician during the period when he is excluded pursuant to section 1320a-7, 1320a-7a, 1320c-5, or 1395u(j)(2) of this title from participation in the program under this subchapter and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

(2) Where an individual eligible for benefits under this subchapter submits a claim for payment for items or services furnished by an individual or entity excluded from participation in the programs under this subchapter, pursuant to section 1320a-7, 1320a-7a, 1320c-5, 1320c-9 (as in effect on September 2, 1982), 1395u(j)(2), 1395y(d) (as in effect on August 18, 1987), or 1395cc of this title, and such beneficiary did not know or have reason to know that such individual or entity was so excluded, then, to the extent permitted by this subchapter, and notwithstanding such exclusion, payment shall be made for such items or services. In each such case the Secretary shall notify the beneficiary of the exclusion of the individual or entity furnishing the items or services. Payment shall not be made for items or services furnished by an excluded individual or entity to a beneficiary after a reasonable time (as determined by the Secretary in regulations) after the Secretary has notified the beneficiary of the exclusion of that individual or entity.

(f) Utilization guidelines for provision of home health services

The Secretary shall establish utilization guidelines for the determination of whether or not payment may be made, consistent with paragraph (1)(A) of subsection (a) of this section, under part A or part B of this subchapter for expenses incurred with respect to the provision of home health services, and shall provide for the implementation of such guidelines through a process of selective postpayment coverage review by intermediaries or otherwise.

(g) Contracts with utilization and quality control peer review organizations

The Secretary shall, in making the determinations under paragraphs (1) and (9) of subsection (a) of this section, and for the purposes of promoting the effective, efficient, and economical delivery of health care services, and of promoting the quality of services of the type for which payment may be made under this subchapter, enter into contracts with utilization and quality control peer review organizations pursuant to part B of subchapter XI of this chapter.

(h) Waiver of electronic form requirement

(1) The Secretary--

(A) shall waive the application of subsection (a)(22) in cases in which--

(i) there is no method available for the submission of claims in an electronic form; or

(ii) the entity submitting the claim is a small provider of services or supplier; and

(B) may waive the application of such subsection in such unusual cases as the Secretary finds appropriate.

(2) For purposes of this subsection, the term "small provider of services or supplier" means--

(A) a provider of services with fewer than 25 full-time equivalent employees; or

(B) a physician, practitioner, facility, or supplier (other than provider of services) with fewer than 10 full-time equivalent employees.

(i) Awards and contracts for original research and experimentation of new and existing medical procedures; conditions

In order to supplement the activities of the Medicare Payment Advisory Commission under section 1395ww(e) of this title in assessing the safety, efficacy, and cost-effectiveness of new and existing medical procedures, the Secretary may carry out, or award grants or contracts for, original research and experimentation of the type described in clause (ii) of section 1395ww(e)(6)(E) of this title with respect to such a procedure if the Secretary finds that--

(1) such procedure is not of sufficient commercial value to justify research and experimentation by a commercial organization;

(2) research and experimentation with respect to such procedure is not of a type that may appropriately be carried out by an institute, division, or bureau of the National Institutes of Health; and

(3) such procedure has the potential to be more cost-effective in the treatment of a condition than procedures currently in use with respect to such condition.

(j) Nonvoting members and experts

(1) Any advisory committee appointed to advise the Secretary on matters relating to the interpretation, application, or implementation of subsection (a)(1) of this section shall assure the full participation of a nonvoting member in the deliberations of the advisory committee, and shall provide such nonvoting member access to all information and data made available to voting members of the advisory committee, other than information that--

(A) is exempt from disclosure pursuant to subsection (a) of section 552 of Title 5 by reason of subsection (b)(4) of such section (relating to trade secrets); or

(B) the Secretary determines would present a conflict of interest relating to such nonvoting member.

(2) If an advisory committee described in paragraph (1) organizes into panels of experts according to types of items or services considered by the advisory committee, any such panel of experts may report any recommendation with respect to such items or services directly to the Secretary without the prior approval of the advisory committee or an executive committee thereof.

(k)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v) [FN2] of this section) providing supplemental or secondary coverage to individuals also entitled to services under this subchapter shall not require a medicare claims determination under this subchapter for dental benefits specifically excluded under subsection (a)(12) of this section as a condition of making a claims determination for such benefits under the group health plan.

(2) A group health plan may require a claims determination under this subchapter in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this subchapter pursuant to actions taken by the Secretary.

(l) National and local coverage determination process

(1) Factors and evidence used in making national coverage determinations

The Secretary shall make available to the public the factors considered in making national coverage determinations of whether an item or service is reasonable and necessary. The Secretary shall develop guidance documents to carry out this paragraph in a manner similar to the development of guidance documents under section 371(h) of Title 21.

(2) Timeframe for decisions on requests for national coverage determinations

In the case of a request for a national coverage determination that--

(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 9 months after the date of the request.

(3) Process for public comment in national coverage determinations

(A) Period for proposed decision

Not later than the end of the 6-month period (or 9-month period for requests described in paragraph (2)(B)) that begins on the date a request for a national coverage determination is made, the Secretary shall make a draft of proposed decision on the request available to the public through the Internet website of the Centers for Medicare & Medicaid Services or other appropriate means.

(B) 30-day period for public comment

Beginning on the date the Secretary makes a draft of the proposed decision available under subparagraph (A), the Secretary shall provide a 30-day period for public comment on such draft.

(C) 60-day period for final decision

Not later than 60 days after the conclusion of the 30-day period referred to under subparagraph (B), the Secretary shall--

(i) make a final decision on the request;

(ii) include in such final decision summaries of the public comments received and responses to such comments;

(iii) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and

(iv) in the case of a final decision under clause (i) to grant the request for the national coverage determination, the Secretary shall assign a temporary or permanent code (whether existing or unclassified) and implement the coding change.

(4) Consultation with outside experts in certain national coverage determinations

With respect to a request for a national coverage determination for which there is not a review by the Medicare Coverage Advisory Committee, the Secretary shall consult with appropriate outside clinical experts.

(5) Local coverage determination process

(A) Plan to promote consistency of coverage determinations

The Secretary shall develop a plan to evaluate new local coverage determinations to determine which determinations should be adopted nationally and to what extent greater consistency can be achieved among local coverage determinations.

(B) Consultation

The Secretary shall require the fiscal intermediaries or carriers providing services within the same area to consult on all new local coverage determinations within the area.

(C) Dissemination of information

The Secretary should serve as a center to disseminate information on local coverage determinations among fiscal intermediaries and carriers to reduce duplication of effort.

(6) National and local coverage determination defined

For purposes of this subsection--

(A) National coverage determination

The term "national coverage determination" means a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under this subchapter.

(B) Local coverage determination

The term "local coverage determination" has the meaning given that in section 1395ff(f)(2)(B) of this title.

(m) Coverage of routine costs associated with certain clinical trials of category A devices

(1) In general

In the case of an individual entitled to benefits under part A of this subchapter, or enrolled under part B of this subchapter, or both who participates in a category A clinical trial, the Secretary shall not exclude under subsection (a)(1) of this section payment for coverage of routine costs of care (as defined by the Secretary) furnished to such individual in the trial.

(2) Category A clinical trial

For purposes of paragraph (1), a "category A clinical trial" means a trial of a medical device if--

(A) the trial is of an experimental/investigational (category A) medical device (as defined in regulations under section 405.201(b) of title 42, Code of Federal Regulations (as in effect as of September 1, 2003));

(B) the trial meets criteria established by the Secretary to ensure that the trial conforms to appropriate scientific and ethical standards; and

(C) in the case of a trial initiated before January 1, 2010, the device involved in the trial has been determined by the Secretary to be intended for use in the diagnosis, monitoring, or treatment of an immediately life-threatening disease or condition.

EXHIBIT 4

42 C.F.R. § 411.20

Code of Federal Regulations Currentness
Title 42. Public Health
Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services (Refs & Annos)
Subchapter B. Medicare Program
Part 411. Exclusions from Medicare and Limitations on Medicare Payment (Refs & Annos)
Subpart B. Insurance Coverage That Limits Medicare Payment: General Provisions

411.20 Basis and scope.

(a) Statutory basis.

(1) Section 1862(b)(2)(A)(i) of the Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made under a group health plan with respect to—

(i) A beneficiary entitled to Medicare on the basis of ESRD during the first 18 months of that entitlement;

(ii) A beneficiary who is age 65 or over, entitled to Medicare on the basis of age, and covered under the plan by virtue of his or her current employment status or the current employment status of a spouse of any age; or

(iii) A beneficiary who is under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of his or her current employment status or the current employment status of a family member.

(2) Section 1862(b)(2)(A)(ii) of the Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made under any of the following:

(i) Workers' compensation.

(ii) Liability insurance.

(iii) No-fault insurance.

(b) Scope. This subpart sets forth general rules that apply to the types of insurance specified in paragraph (a) of this section. Other general rules that apply to group health plans are set forth in subpart E of this part.

42 C.F.R. § 411.21

Code of Federal Regulations Currentness
Title 42. Public Health
Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services (Refs & Annos)
Subchapter B. Medicare Program
Part 411. Exclusions from Medicare and Limitations on Medicare Payment (Refs & Annos)
Subpart B. Insurance Coverage That Limits Medicare Payment: General Provisions
§ 411.21 Definitions.

In this subpart B and in subparts C through H of this part, unless the context indicates otherwise-
Conditional payment means a Medicare payment for services for which another payer is responsible, made either on the bases set forth in Subparts C through H of this part, or because the intermediary or carrier did not know that the other coverage existed.

Coverage or covered services, when used in connection with primary payments, means services for which a primary payer would pay if a proper claim were filed.

Monthly capitation payment means a comprehensive monthly payment that covers all physician services associated with the continuing medical management of a maintenance dialysis patient who dialyses at home or as an outpatient in an approved ESRD facility.

Plan means any arrangement, oral or written, by one or more entities, to provide health benefits or medical care or assume legal liability for injury or illness.

Primary payer means, when used in the context in which Medicare is the secondary payer, any entity that is or was required or responsible to make payment with respect to an item or service (or any portion thereof) under a primary plan. These entities include, but are not limited to, insurers or self-insurers, third party administrators, and all employers that sponsor or contribute to group health plans or large group health plans.

Primary payment means, when used in the context in which Medicare is the secondary payer, payment by a primary payer for services that are also covered under Medicare.

Primary plan means, when used in the context in which Medicare is the secondary payer, a group health plan or large group health plan, a workers' compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan), or no-fault insurance.

Prompt or promptly, when used in connection with primary payments, except as provided in § 411.50, for payments by liability insurers, means payment within 120 days after receipt of the claim.

Proper claim means a claim that is filed timely and meets all other claim filing requirements specified by the plan, program, or insurer.

Secondary, when used to characterize Medicare benefits, means that those benefits are payable only to the extent that payment has not been made and cannot reasonably be expected to be made under other coverage that is primary to Medicare.

Secondary payments means payments made for Medicare covered services or portions of services that are not payable under other coverage that is primary to Medicare.

42 C.F.R. § 411.22

Code of Federal Regulations Currentness
Title 42. Public Health
Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services (Refs & Annos)
Subchapter B. Medicare Program
Part 411. Exclusions from Medicare and Limitations on Medicare Payment (Refs & Annos)
Subpart B. Insurance Coverage That Limits Medicare Payment: General Provisions

411.22 Reimbursement obligations of primary payers and entities that received payment from primary payers.

(a) A primary payer, and an entity that receives payment from a primary payer, must reimburse CMS for any payment if it is demonstrated that the primary payer has or had a responsibility to make payment.

(b) A primary payer's responsibility for payment may be demonstrated by—

(1) A judgment;

(2) A payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary payer or the primary payer's insured; or

(3) By other means, including but not limited to a settlement, award, or contractual obligation.

(c) The primary payer must make payment to either of the following:

(1) To the entity designated to receive repayments if the demonstration of primary payer responsibilities is other than receipt of a recovery demand letter from CMS or designated contractor.

(2) As directed in a recovery demand letter.

42 C.F.R. § 411.23

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Title 42. Public Health
Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services (Refs & Annos)
Subchapter B. Medicare Program
Part 411. Exclusions from Medicare and Limitations on Medicare Payment (Refs & Annos)
Subpart B. Insurance Coverage That Limits Medicare Payment: General Provisions
§ 411.23 Beneficiary's cooperation.

(a) If CMS takes action to recover conditional payments, the beneficiary must cooperate in the action.

(b) If CMS's recovery action is unsuccessful because the beneficiary does not cooperate, CMS may recover from the beneficiary.

42 C.F.R. § 411.24

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Title 42. Public Health
Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services (Refs & Annos)
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§ 411.24 Recovery of conditional payments.

If a Medicare conditional payment is made, the following rules apply:

(a) Release of information. The filing of a Medicare claim by on or behalf of the beneficiary constitutes an express authorization for any entity, including State Medicaid and workers' compensation agencies, and data depositories, that possesses information pertinent to the Medicare claim to release that information to CMS. This information will be used only for Medicare claims processing and for coordination of benefits purposes.

(b) Right to initiate recovery. CMS may initiate recovery as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan.

(c) Amount of recovery.

(1) If it is not necessary for CMS to take legal action to recover, CMS recovers the lesser of the following:

(i) The amount of the Medicare primary payment.

(ii) The full primary payment amount that the primary payer is obligated to pay under this part without regard to any payment, other than a full primary payment that the primary payer has paid or will make, or, in the case of a primary payment recipient, the amount of the primary payment.

(2) If it is necessary for CMS to take legal action to recover from the primary payer, CMS may recover twice the amount specified in paragraph (c)(1)(i) of this section.

(d) Methods of recovery. CMS may recover by direct collection or by offset against any monies CMS owes the entity responsible for refunding the conditional payment.

(e) Recovery from primary payers. CMS has a direct right of action to recover from any primary payer.

(f) Claims filing requirements.

(1) CMS may recover without regard to any claims filing requirements that the insurance program or plan imposes on the beneficiary or other claimant such as a time limit for filing a claim or a time limit for notifying the plan or program about the need for or receipt of services.

(2) However, CMS will not recover its payment for particular services in the face of a claims filing requirement unless it has filed a claim for recovery by the end of the year following the year in which the Medicare intermediary or carrier that paid the claim has notice that the third party is a primary plan to Medicare for those particular services. (A notice received during the last three months of a year is considered received during the following year.)

(g) Recovery from parties that receive primary payment. CMS has a right of action to recover its

payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment.

(h) Reimbursement to Medicare. If the beneficiary or other party receives a primary payment, the beneficiary or other party must reimburse Medicare within 60 days.

(i) Special rules.

(1) In the case of liability insurance settlements and disputed claims under employer group health plans, workers' compensation insurance or plan, and no-fault insurance, the following rule applies: If Medicare is not reimbursed as required by paragraph (h) of this section, the primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.

(2) The provisions of paragraph (i)(I) of this section also apply if a primary payer makes its payment to an entity other than Medicare when it is, or should be, aware that Medicare has made a conditional primary payment.

(3) In situations that involve procurement costs, the rule of § 411.37(b) applies.

(j) Recovery against Medicaid agency. If a primary payment is made to a State Medicaid agency and that agency does not reimburse Medicare, CMS may reduce any Federal funds due the Medicaid agency (under title XIX of the Act) by an amount equal to the Medicare payment or the primary payment, whichever is less.

(k) Recovery against Medicare contractor. If a Medicare contractor, including an intermediary or carrier, also insures, underwrites, or administers as a third party administrator, a program or plan that is primary to Medicare, and does not reimburse Medicare, CMS may offset the amount owed against any funds due the intermediary or carrier under title XVIII of the Act or due the contractor under the contract.

(l) Recovery when there is failure to file a proper claim—

(1) Basic rule. If Medicare makes a conditional payment with respect to services for which the beneficiary or provider or supplier has not filed a proper claim with a primary payer, and Medicare is unable to recover from the primary payer, Medicare may recover from the beneficiary or provider or supplier that was responsible for the failure to file a proper claim.

(2) Exceptions:

(i) This rule does not apply in the case of liability insurance nor when failure to file a proper claim is due to mental or physical incapacity of the beneficiary.

(ii) CMS will not recover from providers or suppliers that are in compliance with the requirements of § 489.20 of this chapter and can show that the reason they failed to file a proper claim is that the beneficiary, or someone acting on his or her behalf, failed to give, or gave erroneous, information regarding coverage that is primary to Medicare.

(m) Interest charges.

(1) With respect to recovery of payments for items and services furnished before October 31, 1994, CMS charges interest, exercising common law authority in accordance with 45 CFR 30.13, consistent with the Federal Claims Collection Act (31 U.S.C. 3711).

(2) In addition to its common law authority with respect to recovery of payments for items and services furnished on or after October 31, 1994, CMS charges interest in accordance with section 1862(b)(2)(B)(i) of the Act. Under that provision-

(i) CMS may charge interest if reimbursement is not made to the appropriate trust fund before the

expiration of the 60-day period that begins on the date on which notice or other information is received by CMS that payment has been or could be made under a primary plan;

(ii) Interest may accrue from the date when that notice or other information is received by CMS, is charged until reimbursement is made, and is applied for full 30-day periods; and

(iii) The rate of interest is that provided at § 405.378(d) of this chapter.

42 C.F.R. § 411.25

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§ 411.25 Primary payer's notice of primary payment responsibility.

(a) If it is demonstrated to a primary payer that CMS has made a Medicare primary payment for services for which the primary payer has made or should have made primary payment, it must provide notice about primary payment responsibility and information about the underlying MSP situation to the entity or entities designated by CMS to receive and process that information.

(b) The notice must describe the specific situation and the circumstances (including the particular type of insurance coverage as specified in 5 411.20(a)) and, if appropriate, the time period during which the insurer is primary to Medicare.

(c) The primary payer must provide additional information to the designated entity or entities as the designated entity or entities may require this information to update CMS' system of records.

42 C.F.R. § 411.26

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§ 411.26 Subrogation and right to intervene.

(a) Subrogation. With respect to services for which Medicare paid, CMS is subrogated to any individual, provider, supplier, physician, private insurer, State agency, attorney, or any other entity entitled to payment by a primary payer.

(b) Right to intervene. CMS may join or intervene in any action related to the events that gave rise to the need for services for which Medicare paid.

42 C.F.R. § 411.28

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Title 42. Public Health
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§ 411.28 Waiver of recovery and compromise of claims.

(a) CMS may waive recovery, in whole or in part, if the probability of recovery, or the amount involved, does not warrant pursuit of the claim.

(b) General rules applicable to compromise of claims are set forth in Subpart F of Part 401 and § 405.376 of this chapter.

(c) Other rules pertinent to recovery are contained in Subpart C of Part 405 of this chapter.

42 C.F.R. § 411.30

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Title 42. Public Health
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Subchapter B. Medicare Program
Part 411. Exclusions from Medicare and Limitations on Medicare Payment (Refs & Annos)
Subpart B. Insurance Coverage That Limits Medicare Payment: General Provisions
§ 411.30 Effect of primary payment on benefit utilization and deductibles.

(a) Benefit utilization. Inpatient psychiatric hospital and SNF care that is paid for by a primary payer is not counted against the number of inpatient care days available to the beneficiary under Medicare Part A.

(b) Deductibles. Expenses for Medicare covered services that are paid for by primary payers are credited toward the Medicare Part A and Part B deductibles.

42 C.F.R. § 411.31

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Title 42. Public Health
Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services (Refs & Annos)
Subchapter B. Medicare Program
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Subpart B. Insurance Coverage That Limits Medicare Payment: General Provisions
§ 411.31 Authority to bill primary payers for full charges.

(a) The fact that Medicare payments are limited to the DRG amount, or the reasonable charge, reasonable cost, capitation or fee schedule rate, does not affect the amount that a primary payer may pay.

(b) With respect to workers' compensation plans, no-fault insurers, and employer group health plans, a provider or supplier may bill its full charges and expect those charges to be paid unless there are limits imposed by laws other than title XVIII of the Act or by agreements with the primary payer.

42 C.F.R. § 411.32

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411.32 Basis for Medicare secondary payments.

(a) Basic rules.

(1) Medicare benefits are secondary to benefits payable by a primary payer even if State law or the primary payer states that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries.

(2) Except as provided in paragraph (b) of this section, Medicare makes secondary payments, within the limits specified in paragraph (c) of this section and in § 411.33, to supplement the primary payment if that payment is less than the charges for the services and, in the case of services paid on other than a reasonable charge basis, less than the gross amount payable by Medicare under § 411.33(e).

(b) Exception. Medicare does not make a secondary payment if the provider or supplier is either obligated to accept, or voluntarily accepts, as full payment, a primary payment that is less than its charges.

(c) General limitation: Failure to file a proper claim. When a provider or supplier, or a beneficiary who is not physically or mentally incapacitated, receives a reduced primary payment because of failure to file a proper claim, the Medicare secondary payment may not exceed the amount that would have been payable under § 411.33 if the primary payer had paid on the basis of a proper claim.

The provider, supplier, or beneficiary must inform CMS that a reduced payment was made, and the amount that would have been paid if a proper claim had been filed.

42 C.F.R. § 411.33

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§ 411.33 Amount of Medicare secondary payment.

(a) Services for which CMS pays on a Medicare fee schedule or reasonable charge basis. The Medicare secondary payment is the lowest of the following:

(1) The actual charge by the supplier (or the amount the supplier is obligated to accept as payment in full if that is less than the charges) minus the amount paid by the primary payer.

(2) The amount that Medicare would pay if the services were not covered by a primary payer.

(3) The higher of the Medicare fee schedule, Medicare reasonable charge, or other amount which would be payable under Medicare (without regard to any applicable Medicare deductible or coinsurance amounts) or the primary payer's allowable charge (without regard to any deductible or co-insurance imposed by the policy or plan) minus the amount actually paid by the primary payer.

(b) Example: An individual received treatment from a physician for which the physician charged $175. The primary payer allowed $150 of the charge and paid 80 percent of this amount or $120. The Medicare fee schedule for this treatment is $125. The individual's Part B deductible had been met. As secondary payer, Medicare pays the lowest of the following amounts:

(1) Excess of actual charge minus the primary payment: $175-120=$55.

(2) Amount Medicare would pay if the services were not covered by a primary payer: .80x$125=$100.

(3) Primary payer's allowable charge without regard to its coinsurance (since that amount is higher than the Medicare fee schedule in this case) minus amount paid by the primary payer: $150-120=$30.

The Medicare payment is $30.

(c), (d) [Reserved]

(e) Services reimbursed on a basis other than fee schedule, reasonable charge, or monthly capitation rate. The Medicare secondary payment is the lowest of the following:

(1) The gross amount payable by Medicare (that is, the amount payable without considering the effect of the Medicare deductible and coinsurance or the payment by the primary payer), minus the applicable Medicare deductible and coinsurance amounts.

(2) The gross amount payable by Medicare, minus the amount paid by the primary payer.

(3) The provider's charges (or the amount the provider is obligated to accept as payment in full, if that is less than the charges), minus the amount payable by the primary payer.

(4) The provider's charges (or the amount the provider is obligated to accept as payment in full if that is less than the charges), minus the applicable Medicare deductible and coinsurance amounts.

(f) Examples:

(1) A hospital furnished 7 days of inpatient hospital care in 1987 to a Medicare beneficiary. The provider's charges for Medicare-covered services totaled $2,800. The primary payer paid $2,360. No part of the Medicare inpatient hospital deductible of $520 had been met. If the gross amount payable by Medicare in this case is $2,700, then as secondary payer, Medicare pays the lowest of the following amounts:

(i) The gross amount payable by Medicare minus the Medicare inpatient hospital deductible: $2,700-$520=$2,180.

(ii) The gross amount payable by Medicare minus the primary payment: $2,700-$2,360=$340.

(iii) The provider's charges minus the primary payment: $2,800-$2,360=$440.

(iv) The provider's charges minus the Medicare deductible: $2,800-$520=$2,280. Medicare's secondary payment is $340 and the combined payment made by the primary payer and Medicare on behalf of the beneficiary is $2,700. The $520 deductible was satisfied by the primary payment so that the beneficiary incurred no out-of-pocket expenses.

(2) A hospital furnished 1 day of inpatient hospital care in 1987 to a Medicare beneficiary. The provider's charges for Medicare-covered services totalled $750. The primary payer paid $450. No part of the Medicare inpatient hospital deductible had been met previously. The primary payment is credited toward that deductible. If the gross amount payable by Medicare in this case is $850, then as secondary payer, Medicare pays the lowest of the following amounts:

(i) The gross amount payable by Medicare minus the Medicare deductible: $850-$520=$330.

(ii) The gross amount payable by Medicare minus the primary payment: $850-$450=$400.

(iii) The provider's charges minus the primary payment: $750-$450=$300.

(iv) The provider's charges minus the Medicare deductible: $750-$520=$230. Medicare's secondary payment is $230, and the combined payment made by the primary payer and Medicare on behalf of the beneficiary is $680. The hospital may bill the beneficiary $70 (the $520 deductible minus the $450 primary payment). This fully discharges the beneficiary's deductible obligation.

(3) An ESRD beneficiary received 8 dialysis treatments for which a facility charged $160 per treatment for a total of $1,280. No part of the beneficiary's $75 Part B deductible had been met. The primary payer paid $1,024 for Medicare-covered services. The composite rate per dialysis treatment at this facility is $131 or $1,048 for 8 treatments. As secondary payer, Medicare pays the lowest of the following:

(i) The gross amount payable by Medicare minus the applicable Medicare deductible and coinsurance: $l,048-$75-$194.60=$778.40. (The coinsurance is calculated as follows: $1,048 composite rate-$75 deductible=$973x20=$194.60).

(ii) The gross amount payable by Medicare minus the primary payment: $1,048-$1,024=$24.

(iii) The provider's charges minus the primary payment: $1,280-$1,024=$256.

(iv) The provider's charge minus the Medicare deductible and coinsurance: $l,280-$75-$194.60=1010.40. Medicare pays $24. The beneficiary's Medicare deductible and coinsurance were met by the third party payment.

(4) A hospital furnished 5 days of inpatient care in 1987 to a Medicare beneficiary. The provider's

charges for Medicare-covered services were $4,000 and the gross amount payable was $3,500. The provider agreed to accept $3,000 from the primary payer as payment in full. The primary payer paid $2,900 due to a deductible requirement under the primary plan. Medicare considers the amount the provider is obligated to accept as full payment ($3,000) to be the provider charges. The Medicare secondary payment is the lowest of the following:

(i) The gross amount payable by Medicare minus the Medicare inpatient deductible: $3,500-$520=$2,980.

(ii) The gross amount payable by Medicare minus the primary payment: $3,500-$2,900=$600.

(iii) The provider's charge minus the primary payment: $3,000-$2,900=$100.

(iv) The provider's charges minus the Medicare inpatient deductible: $3,000-$520=$2,480. The Medicare secondary payment is $100. When Medicare is the secondary payer, the combined payment made by the third party payer and Medicare on behalf of the beneficiary is $3,000. The beneficiary has no liability for Medicare-covered services since the third party payment satisfied the $520 deductible.

42 C.F.R. § 411.35

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411.35 Limitations on charges to a beneficiary or other party when a workers' compensation plan, a no-fault insurer, or an employer group health plan is primary payer.

(a) Definition. As used in this section Medicare-covered services means services for which Medicare benefits are payable or would be payable except for the Medicare deductible and coinsurance provisions and the amounts payable by the primary payer.

(b) Applicability. This section applies when a workers' compensation plan, a no-fault insurer or an employer group health plan is primary to Medicare.

(c) Basic rule. Except as provided in paragraph (d) of this section, the amounts the provider or supplier may collect or seek to collect, for the Medicare-covered services from the beneficiary or any entity other than the workers' compensation plan, the no-fault insurer, or the employer plan and Medicare, are limited to the following:

(1) The amount paid or payable by the primary payer to the beneficiary. If this amount exceeds the amount payable by Medicare (without regard to deductible or coinsurance), the provider or supplier may retain the primary payment in full without violating the terms of the provider agreement or the conditions of assignment.

(2) The amount, if any, by which the applicable Medicare deductible and coinsurance amounts exceed any primary payment made or due to the beneficiary or to the provider or supplier for the medical services.

(3) The amount of any charges that may be made to a beneficiary under 5 413.35 of this chapter when cost limits are applied to the services, or under § 489.32 of this chapter when the services are partially covered, but only to the extent that the primary payer is not responsible for those charges.

(d) Exception. The limitations of paragraph (c) of this section do not apply if the services were furnished by a supplier that is not a participating supplier and has not accepted assignment for the services or claimed payment under 5 424.64 of this chapter.

42 C.F.R. § 411.37

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§ 411.37 Amount of Medicare recovery when a primary payment is made as a result of a judgment or settlement.

(a) Recovery against the party that received payment--

(1) General rule. Medicare reduces its recovery to take account of the cost of procuring the judgment or settlement, as provided in this section, if--

(i) Procurement costs are incurred because the claim is disputed; and

(ii) Those costs are borne by the party against which CMS seeks to recover.

(2) Special rule. If CMS must file suit because the party that received payment opposes CMS's recovery, the recovery amount is as set forth in paragraph (e) of this section.

(b) Recovery against the primary payer. If CMS seeks recovery from the primary payer, in accordance with § 411.24(i), the recovery amount will be no greater than the amount determined under paragraph (c) or (d) or (e) of this section.

(c) Medicare payments are less than the judgment or settlement amount. If Medicare payments are less than the judgment or settlement amount, the recovery is computed as follows:

(1) Determine the ratio of the procurement costs to the total judgment or settlement payment.

(2) Apply the ratio to the Medicare payment. The product is the Medicare share of procurement costs.

(3) Subtract the Medicare share of procurement costs from the Medicare payments. The remainder is the Medicare recovery amount.

(d) Medicare payments equal or exceed the judgment or settlement amount. If Medicare payments equal or exceed the judgment or settlement amount, the recovery amount is the total judgment or settlement payment minus the total procurement costs.

(e) CMS incurs procurement costs because of opposition to its recovery. If CMS must bring suit against the party that received payment because that party opposes CMS's recovery, the recovery amount is the lower of the following:

(1) Medicare payment.

(2) The total judgment or settlement amount, minus the party's total procurement cost.

42 C.F.R. § 411.40

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Subpart C. Limitations on Medicare Payment for Services Covered Under Workers' Compensation

§ 411.40 General provisions.

(a) Definition. "Workers' compensation plan of the United States" includes the workers' compensation plans of the 50 States, the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands, as well as the systems provided under the Federal Employees' Compensation Act and the Longshoremen's and Harbor Workers' Compensation Act.

(b) Limitations on Medicare payment.

(1) Medicare does not pay for any services for which—

(i) Payment has been made, or can reasonably be expected to be made under a workers' compensation law or plan of the United States or a state; or

(ii) Payment could be made under the Federal Black Lung Program, but is precluded solely because the provider of the services has failed to secure, from the Department of Labor, a provider number to include in the claim.

(2) If the payment for a service may not be made under workers' compensation because the service is furnished by a source not authorized to provide that service under the particular workers' compensation program. Medicare pays for the service if it is a covered service.

(3) Medicare makes secondary payments in accordance with § 411.32 and § 411.33.

42 C.F.R. § 411.43

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411.43 Beneficiary's responsibility with respect to workers' compensation.

(a) The beneficiary is responsible for taking whatever action is necessary to obtain any payment that can reasonably be expected under workers' compensation.

(b) Except as specified in § 411.45(a). Medicare does not pay until the beneficiary has exhausted his or her remedies under workers' compensation.

(c) Except as specified in § 411.45(b), Medicare does not pay for services that would have been covered under workers' compensation if the beneficiary had filed a proper claim.

(d) However, if a claim is denied for reasons other than not being a proper claim, Medicare pays for the services if they are covered under Medicare.

42 C.F.R. § 411.45

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411.45 Basis for conditional Medicare payment in workers' compensation cases.

(a) A conditional Medicare payment may be made under either of the following circumstances:

(1) The beneficiary has filed a proper claim for workers' compensation benefits, but the intermediary or carrier determines that the workers' compensation carrier will not pay promptly. This includes cases in which a workers' compensation carrier has denied a claim.

(2) The beneficiary, because of physical or mental incapacity, failed to file a proper claim.

(b) Any conditional payment that CMS makes is conditioned on reimbursement to CMS in accordance with subpart B of this part.

42 C.F.R. § 411.46

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411.46 Lump-sum payments.

(a) Lump-sum commutation of future benefits. If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment.

(b) Lump-sum compromise settlement.

(1) A lump-sum compromise settlement is deemed to be a workers' compensation payment for Medicare purposes, even if the settlement agreement stipulates that there is no liability under the workers' compensation law or plan.

(2) If a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition, the settlement will not be recognized. For example, if the parties to a settlement attempt to maximize the amount of disability benefits paid under workers' compensation by releasing the workers' compensation carrier from liability for medical expenses for a particular condition even though the facts show that the condition is work-related, Medicare will not pay for treatment of that condition.

(c) Lump-sum compromise settlement: Effect on services furnished before the date of settlement. Medicare pays for medical expenses incurred before the lump-sum compromise settlement only to the extent specified in § 411.47.

(d) Lump-sum compromise settlement: Effect on payment for services furnished after the date of settlement—

(1) Basic rule. Except as specified in paragraph (d)(2) of this section, if a lump-sum compromise settlement forecloses the possibility of future payment of workers' compensation benefits, medical expenses incurred after the date of the settlement are payable under Medicare.

(2) Exception. If the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump-sum settlement allocated to future medical expenses.

42 C.F.R. § 411.47

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Subpart C. Limitations on Medicare Payment for Services Covered Under Workers' Compensation

§ 411.47 Apportionment of a lump-sum compromise settlement of a workers' compensation claim.

(a) Determining amount of compromise settlement considered as a payment for medical expenses.

(1) If a compromise settlement allocates a portion of the payment for medical expenses and also gives reasonable recognition to the income replacement element, that apportionment may be accepted as a basis for determining Medicare payments.

(2) If the settlement does not give reasonable recognition to both elements of a workers' compensation award or does not apportion the sum granted, the portion to be considered as payment for medical expenses is computed as follows:

(i) Determine the ratio of the amount awarded (less the reasonable and necessary costs incurred in procuring the settlement) to the total amount that would have been payable under workers' compensation if the claim had not been compromised.

(ii) Multiply that ratio by the total medical expenses incurred as a result of the injury or disease up to the date of the settlement. The product is the amount of the workers' compensation settlement to be considered as payment for medical expenses.

Example: As the result of a work injury, an individual suffered loss of income and incurred medical expenses for which the total workers' compensation payment would have been $24,000 if the case had not been compromised. The medical expenses amounted to $18,000. The workers' compensation carrier made a settlement with the beneficiary under which it paid $8,000 in total. A separate award was made for legal fees. Since the workers' compensation compromise settlement was for one-third of the amount which would have been payable under workers' compensation had the case not been compromised ($8,000/$24,000= 1/3), the workers' compensation compromise settlement is considered to have paid for one-third of the total medical expenses (1/3 x$18,000=$6,000).

(b) Determining the amount of the Medicare overpayment. When conditional Medicare payments have been made, and the beneficiary receives a compromise settlement payment, the Medicare overpayment is determined as set forth in this paragraph (b). The amount of the workers' compensation payment that is considered to be for medical expenses (as determined under paragraph (a) of this section) is applied, at the workers' compensation rate of payment prevailing in the particular jurisdiction, in the following order:

(1) First to any beneficiary payments for services payable under workers' compensation but not covered under Medicare.

(2) Then to any beneficiary payments for services payable under workers' compensation and also covered under Medicare Part B. (These include deductible and coinsurance amounts and, in unassigned cases, the charge in excess of the reasonable charge.)

(3) Last to any beneficiary payments for services payable under workers' compensation and also covered under Medicare Part A. (These include Part A deductible and coinsurance amounts and charges for services furnished after benefits are exhausted.)

The difference between the amount of the workers' compensation payment for medical expenses and any beneficiary payments constitutes the Medicare overpayment. The beneficiary is liable for that amount.

Example: In the example in paragraph (a) of this section, it was determined that the workers' compensation settlement paid for $6,000 of the total medical expenses. The $18,000 in medical expenses included $1,500 in charges for services not covered under Medicare, $7,500 in charges for services covered under Medicare Part B, and $9,000 in hospital charges for services covered under Medicare Part A. All charges were at the workers' compensation payment rate, that is, in amounts the provider or supplier must accept as payment in full.

The Medicare reasonable charge for physicians' services was $7,000 and Medicare paid $5,600 (80 percent of the reasonable charge). The Part B deductible had been met. The Medicare payment rate for the hospital services was $8,000. Medicare paid the hospital $7,480 ($8,000—the Part A deductible of $520).

In this situation, the beneficiary's payments totalled $3,920:

Services not covered under Medicare	$1,5(
Excess of physicians' charges over reasonable charges	5(
Medicare Part B coinsurance	1,4(
Part A deductible	52
Total	3,9;

The Medicare overpayment, for which the beneficiary is liable, would be $2,080 ($6,000-$3,920).

EXHIBIT 5

JUL 23 2001

To: All Associate Regional Administrators
Attention: Division of Medicare

From: Deputy Director
Purchasing Policy Group
Center for Medicare Management

SUBJECT: Workers' Compensation: Commutation of Future Benefits

Medicare's regulations (42 CFR 411.46) and manuals (MIM 3407.7&3407.8 and MCM 2370.7 & 2370.8) make a distinction between lump sum settlements that are commutations of future benefits and those that are due to a compromise between the Workers' Compensation (WC) carrier and the injured individual. This Regional Office letter clarifies the Centers for Medicare & Medicaid Services (CMS) policy regarding a number of questions raised recently by several Regional Offices (RO) concerning how the RO should evaluate and approve WC lump sum settlements to help ensure that Medicare's interests are properly considered.

Regional Office staff may choose to consult with the Regional Office's Office of the General Counsel (OGC) on WC cases because these cases may entail many legal questions. OGC should become involved in WC cases if there are legal issues which need to be evaluated or if there is a request to compromise Medicare's recovery claim or if the Federal Claims Collection Act (FCCA) delegations require such consultation. Because most WC carriers typically dispute liability in WC compromise cases, it is very common that Medicare later finds that it has already made conditional payments. (A conditional payment means a Medicare payment for which another payer is responsible.) If Medicare's conditional payments are more than $100,000 and the beneficiary also wishes Medicare to compromise its recovery under FCCA (31U.S.C.3711), the case must be referred to Central Office and then forwarded to the Department of Justice. It is important to note in all WC compromise cases that all pre-settlement and post-settlement requests to compromise **any** Medicare recovery claim amounts must be submitted to the RO for appropriate action. Regional Offices must comply with general CMS rules regarding collection of debts (please reference the Administrator's March 27, 2000 memo re: New instructions detailing your responsibilities for monies owed to the government).

Medicare is secondary payer to WC, therefore, it is in Medicare's best interests to learn the existence of WC situations as soon as possible in order to avoid making mistaken payments. The use of administrative mechanisms[1] sometimes referred to by attorneys as Medicare Set-

[1] Although 42 CFR 411.46 requires that all WC settlements must adequately consider Medicare's interests, 42 CFR 411.46 does not mandate what particular type of administrative mechanism should be used to set-aside monies for Medicare including a self-administered arrangement (State law permitting). Of course, if an arrangement is self-administered, then the injured individual/beneficiary **must** adhere to

aside Trusts (hereafter referred to as "set-aside arrangements") in WC commutation cases enables Medicare to identify WC situations that would otherwise go unnoticed, which in turn prevents Medicare from making mistaken payments.

Set-aside arrangements are used in WC commutation cases, where an injured individual is disabled by the event for which WC is making payment, but the individual will not become entitled to Medicare until some time after the WC settlement is made. Medicare learns of the existence of a primary payer (WC) as soon as possible when Medicare reviews a proposed set-aside arrangement at or about the time of WC settlement. In such cases, Medicare greatly increases the likelihood that no Medicare payment is made until the set-aside arrangement's funds are depleted. These set-aside arrangements provide both Medicare and its beneficiaries security with regard to the amount that is to be used to pay for an individual's disability related expenses. It is important to note that set-aside arrangements are **only** used in WC cases that possess a commutation aspect; they are not used in WC cases that are strictly or solely compromise cases.

Lump sum compromise settlements represent an agreement between the WC carrier and the injured individual to accept less than the injured individual would have received if he or she had received full reimbursement for lost wages and life long medical treatment for the injury or illness. In a typical lump sum compromise case between a WC carrier and an injured individual, the WC carrier strongly disputes liability and usually will not have voluntarily paid for all the medical bills relating to the accident. Generally, settlement offers in these cases are relatively low and allocations for income replacement and medical costs may not be disaggregated. Such agreements, rather than being based on a purely mathematical computation, are based on other factors. These may include whether there was a preexisting condition, whether the accident was really work related, or whether the individual was acting as an employee, or performing work-related duties at the time the accident occurred.

One of the distinctions that Medicare's regulations and manuals make between compromise and commutation cases is the absence of controversy over whether a WC carrier is liable to make payments. A significant number of WC lump-sum cases are commutations of future WC benefits where typically there is no controversy between the injured individual and the WC carrier over whether the WC carrier is actually liable to make payments. An absence of controversy over whether a WC carrier is liable to make payments is not the only distinction that Medicare's manuals and regulations make between compromise and commutation cases. Thus, lump-sum settlements should not automatically be considered as compromise cases simply because a WC carrier does not admit to being liable in the settlement agreement. Conversely, lump-sum settlements should not automatically be considered as commutation

the same rules/requirements as any other administrator of a set-aside arrangement.

cases simply because a WC carrier does admit to being liable in a settlement agreement. Therefore, an admission of liability by the WC carrier is not the sole determining factor of whether or not a case is considered a compromise or commutation.

WC commutation cases are settlement awards intended to compensate individuals for **future** medical expenses required because of a work-related injury or disease. In contrast, WC compromise cases are settlement awards for an individual's current or past medical expenses that were incurred because of a work-related injury or disease. Therefore, settlement awards or agreements that intend to compensate an individual for any medical expenses after the date of settlement (i.e., future medical expenses) are commutation cases.

It is important to note that a single WC lump-sum settlement agreement can possess both WC compromise and commutation aspects. That is, some single lump-sum settlement agreements can designate part of a settlement for an injured individual's future medical expenses and simultaneously designate another part of the settlement for all of the injured individual's medical expenses up to the date of settlement. This means that a commutation case may possess a compromise aspect to it when a settlement agreement also stipulates to pay for all medical expenses up to the date of settlement. Conversely, a compromise case may possess a commutation aspect to it when a settlement agreement also stipulates to pay for future medical expenses. Therefore, it is possible for a single WC lump-sum settlement agreement to be both a WC compromise case and a WC commutation case.

Generally, parties to WC commutation cases agree on a lump sum amount in exchange for giving up the usual continuing payments by WC for lost wages and for lifetime medical care related to the injuries. Such lump sum amounts are usually requested because the beneficiary wishes to use the funds for some specific purpose. For example, the individual's home may need to be remodeled to accommodate a wheelchair or, more typically, he or she is so disabled that lifetime attendant care is needed. In these latter cases, the injured individual seeks a lump sum payment so that such care can be arranged with certainty in the future. The amount of the lump sum is typically established by using a life care plan[2] and actuarial methods to determine the individual's life expectancy. When WC has accepted full liability in a case prior to the creation of a set-aside arrangement, the likelihood of any Medicare conditional payments being made is reduced.

Set-aside arrangements are most often used in those cases in which the beneficiary is comparatively young and has an impairment that seriously restricts his or her daily living

2
If a life care plan is not used to justify the injured individual's future medical expenses, then the injured individual or his/her representative **must** present other alternative evidence that sufficiently justifies the amounts set-aside for Medicare.
expenses may be.

activity. These set-aside arrangements are typically not created until the individual's

condition has stabilized so that it can be determined, based on past experience, what the future medical expenses may be.

Medicare regulations at 42 CFR 411.46 state that:

> If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment.

In addition the Medicare manuals (3407.8 of the MIM, 2370.8 of the MCM) state:

> When a beneficiary accepts a lump-sum payment that represents a commutation of all future medical expenses and disability benefits, and the lump-sum amount is reasonable considering the future medical services that can be anticipated for the condition, Medicare does not pay for any items or services directly related to the injury or illness for which the commutation lump-sum is made, until the beneficiary presents medical bills related to the injury equal to the total amount of the lump-sum settlement allocated to medical treatment.

Questions that have been raised are paraphrased below.

Question 1:

(a) Does the Medicare program have a claim against a lump sum WC payment before an individual's Medicare entitlement?
(b) If not, can the Medicare program give a written opinion on the sufficiency of a set-aside arrangement even if the individual is not as yet entitled to Medicare?
(c) In WC cases involving injured individuals who are not yet Medicare beneficiaries, when must Medicare's interests be considered before the parties can settle the case?

Answer:

These questions have been raised by attorneys who wish to devise set-aside arrangements, which represent amounts for medical items, and services that would ordinarily be covered by Medicare and are specified for future medical treatment for work-related illness or injuries. The attorneys are concerned that Medicare will not pay once the individual becomes entitled to Medicare, because the lump-sum included payment for future medical treatment.

The answer to Question 1(a) is no, Medicare cannot make a formal determination until the individual actually becomes entitled to Medicare. However, the attorneys are correct that once the individual becomes entitled, Medicare payment may not be made to the extent of Medicare's interests in the lump sum payment per 42 CFR 411.46 or a set-aside arrangement that adequately considers Medicare's interests in the lump sum payment.

The answer to Question 1(b) is that the RO (with consultation from the Regional OGC, if necessary) can review a proposed settlement including a set-aside arrangement and can give a written opinion on which the potential beneficiary and the attorney can rely, regarding whether the WC settlement has adequately considered Medicare's interests per 42 CFR 411.46. These settlements should all be handled on a case-by-case basis, as each situation is different. If there are several years prior to Medicare entitlement, the RO should use its best judgment regarding what Medicare utilization might be once there is Medicare entitlement. This decision should be based on the documentation obtained as stated in the answer to Question 10. Once the RO has given written assurance that the set-aside arrangement is sufficient to satisfy the requirements at 42 CFR 411.46, when the set-aside arrangement is established and the settlement is approved, the RO, should then set up a procedure to follow the case.

The answer to question 1(c) is, it is not in Medicare's best interests to review every WC settlement nationwide in order to protect Medicare's interests per 42 CFR 411.46. Injured individuals (who are not yet Medicare beneficiaries) should only consider Medicare's interests when the injured individual has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date, **and** the anticipated **total** settlement amount for future medical expenses **and** disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.[3]

For example, if the injured individual is designated by WC as a Permanent Total disabled individual, has filed for Social Security disability, and the settlement apportions $25,000 per year (combined for both future medical expenses **and** disability/lost wages) for the next 20 years, then the RO should review that WC settlement because the total settlement amount over the life of the settlement agreement is greater than $250,000 ($25,000 x 20 years = $500,000) and the injured individual has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date. If the injured individual in this example fails to consider Medicare's interests, then Medicare may preclude its payments pursuant to 42 CFR 411.46 once the injured individual actually becomes entitled to Medicare.

3 Please note that the review thresholds (i.e., 30 months and $250,000) will be subject to adjustment once CMS has experience reviewing these matters under these instructions.

NOTE: Injured individuals who are already Medicare beneficiaries **must** always consider
Medicare's interests prior to settling their WC claim regardless of whether or not the total settlement amount exceeds $250,000. That is, **ALL WC PAYMENTS** regardless of amount **must** be considered for current Medicare beneficiaries.

Question 2:

Should a system of records be established for the documentation that the RO and contractors receive/collect concerning these set-aside arrangements?

Answer:

Yes. CMS' Division of Benefit Coordination is in the process of establishing a system of records via the Federal Register process, which will provide legal authority to maintain records on individuals that are not enrolled in Medicare. The RO will be responsible for maintaining or housing the records for every arrangement on which the RO provides a written opinion. Please note that these records are not subject to Freedom of Information Act requests and may not be disseminated to the public.

Question 3:

Once the set-aside arrangement has been approved by the RO (with consultation from the Regional OGC, if necessary), what is the subsequent role of the ROs and contractors?

Answer:

When the RO approves a set-aside arrangement (with consultation from the regional OGC, if necessary), the RO will check on a monthly basis the National Medicare Enrollment database in order to determine when an injured individual actually becomes enrolled in Medicare. Once the RO verifies that the injured individual has actually been enrolled in Medicare, the RO will assign a contractor responsible for monitoring the individual's case. The RO will assign the contractor based on the injured individual's State of residence.

When the injured individual has actually been enrolled in Medicare, the RO **must** provide the Coordination of Benefits Contractor (COBC) with identifying information to add a WC record to Common Working File. The RO must exercise one of the following

options: 1) Fax the information to the COBC; or 2) Submit through an Electronic

Correspondence Referral System (ECRS) inquiry. At a minimum, the RO must indicate that this is a WC set-aside arrangement case, and include the following information:

Beneficiary Name Beneficiary HIC Date of Incident DX code(s): If you do not have dx codes readily available, you must include a description of the illness/injury. **Note:** Do not forward to COB without a dx or description.

Administrator of Trust

Claimant Attorney Information

The administrator of the set-aside arrangement must forward annual accounting summaries concerning the expenditures of the arrangement to the contractor responsible for monitoring the individual's case. The contractor responsible for monitoring the individual's case is then responsible for insuring/verifying that the funds allocated to the set-aside arrangement were expended on medical services for Medicare covered services only. Additionally, the contractor responsible for monitoring the individual's case will be responsible for ensuring that Medicare makes no payments related to the illness or accident until the set-aside arrangement has been exhausted.

Question 4:

What types of measures should the RO and the contractors take to ensure that Medicare makes no payments related to the illness or accident until the set-aside arrangement has been depleted?

Answer:

Generally, set-aside arrangements that are designed as lump sums (i.e., the arrangement is funded by the WC settlement all at once) present less of a problem to monitor than structured arrangements. Medicare would not make any payments for individuals that possess lump sum arrangements until all of the funds within the arrangement have been depleted. For example, if a set-aside arrangement were established for $90,000, Medicare would not make any payments until the entire $90,000 (plus interest, if applicable) were exhausted on the individual's medical care (for Medicare covered services only).

Structured set-aside arrangements generally apportion settlement monies over fixed or defined periods of time. For example, a structured arrangement may be designed to disburse $20,000 per year over the next ten years for an individual's medical care (for Medicare-covered services only). If the $20,000 allocated on January 1 for Year One were fully exhausted on August 31, Medicare may make payments for the services performed after August 31 once the contractor responsible for monitoring the individual's case can verify that the entire $20,000 (plus interest, if applicable) is exhausted. However, when the structured arrangement allocates money for the start of

Year Two (i.e., on January 1) Medicare would not make any payments for services performed until Year Two's allocation was completely exhausted.

In every set-aside arrangement case the contractor responsible for monitoring the individual's case (with assistance from the RO, if necessary) should ensure that Medicare does not make any payments until the contractor responsible for monitoring the individual's case can verify that the funds apportioned to the arrangement have truly been exhausted.

NOTE:
Until the individual actually becomes entitled to Medicare, the set-aside arrangement fund must **not** be used to pay the individual's expenses. That is, an individual's medical expenses must be paid from some other source besides the set-aside arrangement when the individual is not a Medicare beneficiary. Once the individual actually becomes entitled to Medicare, then the administrator of the arrangement is permitted to make payments for the individual's medical care (for Medicare-covered services only) from the arrangement.

ADDITIONAL NOTE: THE ABOVE PARAGRAPH OF THIS NOTE HAS BEEN REPLACED BY QUESTION 3 OF THE JULY 11. 2005 ARA MEMORANDUM

If the contractor monitoring the individual's case discovers that payments from the set-aside arrangement have been used to pay for services that are not covered by Medicare or for administrative expenses that exceed those approved by the RO (see Question 11), then the contractor will not pay the Medicare claims. The contractor must provide the evidence of the unauthorized expenditures to the RO for investigation. If the RO determines that the expenditures were contrary to the RO's written opinion on the sufficiency of the arrangement, then the RO will notify the administrator of the arrangement that the RO's informal approval of the arrangement is withdrawn until such time as the funds used for non-Medicare expenses and/or unapproved administrative expenses are restored to the set-aside arrangement.

Question 5:

What are the criteria that Medicare uses to determine whether the amount of a lump sum or structured settlement has sufficiently taken its interests into account?

Answer:

The following criteria should be used in evaluating the amount of a proposed settlement to determine whether there has been an attempt to shift liability for the

cost of a work-related injury or illness to Medicare. Specifically, is the amount allocated for future medical expenses reasonable? If Medicare has already made conditional payments their repayment also has to be taken into account.

1. Date of entitlement to Medicare.

2. Basis for Medicare entitlement (disability, ESRD or age)-- If the beneficiary has entitlement based on disability and would also be eligible on the basis of ESRD, this should be noted since the medical expenses would be higher. This would also be true for beneficiaries who are over 65 but had been entitled prior to attaining that age.

3. Type and severity of injury or illness— Obtain diagnosis codes so injury or illness related expenses can be identified. Is full or partial recovery expected? What is the projected time frame if partial or full recovery is anticipated? As a result of the accident is the individual an amputee, paraplegic or quadriplegic? Is the beneficiary's condition stable or is there a possibility of medical deterioration?

4. Age of beneficiary- Acquire an evaluation of whether his/her condition would shorten the life span.

5. WC classification of beneficiary (e.g., permanent partial, permanent total disability, or a combination of both).

6. Prior medical expenses paid by WC due to the injury or illness in the 1 or 2 year period after the condition has stabilized— If Medicare has paid any amounts, they must be recovered. Also, this would indicate that the case may not purely be a commutation case, but may also entail some compromise aspects, e.g., the WC carrier or agency may have taken the position that the services were not covered by WC.

7. Amount of lump sum or amount of structured settlement— Obtain as much information as possible regarding the allocation between income replacement, loss of limb or function, and medical benefits.

8. Is the commutation for the beneficiary's lifetime or for a specific time period? If not for lifetime, what is the basis?-- Medicare must insist that there is a reasonable relationship between the respective allocation for services covered by Medicare and services not covered by Medicare. For example, is it reasonable for the settlement agreement's allocation for services not covered by Medicare to be based on the beneficiary's life time while the agreement's allocation for services covered by Medicare is based on a lesser time period? What is the State law regarding how long WC is obligated to cover the items or services

related to the accident or illness?

9. Is the beneficiary living at home, in a nursing home, or receiving assisted living care, etc.?-- If the beneficiary is living in a nursing home, or receiving assisted living care, it should be determined who is expected to pay for such care, e.g., WC (for life time or a specified period) from the medical benefits allocation of lump sum settlement, Medicaid, etc.

10. Are the expected expenses for Medicare covered items and services appropriate in light of the beneficiary's condition?-- Estimated medical expenses should include an amount for hospital and/or SNF care during the time period for the commutation of the WC benefit. (Just one hospital stay that is related to the accident could cost $20,000.) For example, a quadriplegic may develop decubitus ulcers requiring possible surgery, urinary tract infections, kidney stones, pneumonia and/or thrombophlebitis. Although each case must be evaluated on its own merits, it may be helpful to ascertain for comparison purposes the average annual amounts of Part A and Part B spending for a disabled person in the appropriate State of residence. Keep in mind that these Fee-for-Service amounts are for all Medicare covered services, while our focus here only deals with services related to the WC accident or illness. Therefore, the RO should use appropriate judgment and seek input from a medical consultant when determining whether the amount of the lump sum or structured settlement has sufficiently taken Medicare's interests into account.

The attorney for the individual for whom the arrangement is set-up should be advised that Medicare applies a set of criteria to any WC settlement on a case-by-case basis in order to determine whether Medicare has an obligation for services provided after the settlement that originally were the responsibility of WC.

NOTE:
Before evaluating whether an arrangement reasonably covers/considers Medicare's interests, **the RO must know** whether the arrangement is based upon WC fee schedule amounts or full actual charge amounts.

Question 6:

Some attorneys have indicated that a set-aside arrangement should only contemplate three to five years of estimated Medicare covered items or services. Would this be reasonable?

Answer:

No. To protect the Medicare Trust Fund, a set-aside arrangement should be funded based on the expected life expectancy of the individual unless the State law specifically limits the length of time that WC covers work related conditions. If an estimate of the beneficiary's estimated longevity was not submitted, one must be obtained.

Question 7:

What other issues should be considered ?

Answer:

The lump sum amount should be interest bearing and indexed to account for inflation consistent with how Medicare calculates its growth in spending. Provision should also be made in the settlement agreement to provide for a mechanism so that items or services that were not covered by Medicare at the time, but later become covered, are transferred from the commutation specified for non-Medicare covered items and services to the set-aside arrangement. (For example if outpatient prescription drugs become more widely covered.) If the beneficiary belongs to a Health Maintenance Organization that may not be coordinating benefits based on WC entitlement, the settlement should still set-aside funds for Medicare covered services in case the beneficiary converts to a fee for service plan.

NOTE: THIS ANSWER WAS REPLACED BY QUESTION 4 OF THE OCTOBER 15, 2004 ARA MEMORANDUM AND LATER REPLACED BY QUESTION 15 OF THE JULY 11. 2005 ARA MEMORANDUM.

Question 8:

Is it permissible for Medicare to accept an up-front cash settlement instead of a set-aside arrangement?

Answer:

An up-front cash settlement is only appropriate in certain instances when Medicare agrees to a compromise in order to recover conditional payments made when WC did not pay promptly. Thus, when future benefits are included in a WC settlement agreement, Medicare cannot pay until the medical expenses related to the injury or disease equal the amount of the settlement allocated to future medical expenses or the amount included for medical expenses in the set-aside arrangement has been exhausted.

Question 9:

How do providers and suppliers obtain payment for the services covered by the set-aside arrangement?

Answer:

There are two distinct methods for providers, physicians and other suppliers to obtain payment for WC covered services when funds are held in a set-aside arrangement. Determining which distinct payment method applies depends on two factors: 1.) How the set-aside arrangement is constructed and 2.) Whether the arrangement was constructed by contemplating full actual charges or WC fee schedule amounts (i.e., were the injured individual's medical expenses determined based on full actual charge estimates or WC fee schedule estimates).

When a set-aside arrangement's settlement agreement contains specific provisions establishing that the WC carrier will ensure that the arrangement cannot be charged more than what would normally be payable under the WC plan, and when the RO reviews and approves the sufficiency of the arrangement based on the WC plan's WC fee schedules, then, providers, physicians and other suppliers will be paid based on what would normally be payable under the WC plan (i.e., under the WC fee schedule). Therefore, providers, physicians and other suppliers would not be permitted to bill the arrangement more than the WC fee schedule rate. For example, if a provider's full charge for a particular service is $100 and the WC carrier normally pays $65 for that particular service, then the arrangement should only pay $65. However, when an arrangement's settlement agreement does **not** contain specific provisions ensuring that the arrangement cannot be charged more than what would normally be payable under the WC plan, then providers, physicians and other suppliers are permitted to bill the arrangement their full charges. It is important to note that when an arrangement's settlement agreement does not contain specific provisions ensuring that providers, physicians and other suppliers cannot bill the arrangement more than the WC fee schedule amounts, then the RO must review the sufficiency of that particular arrangement based upon full actual charge estimates.

Before evaluating whether an arrangement reasonably covers/considers Medicare's interests, **the RO must know** whether the arrangement is based upon WC fee schedule amounts or full actual charge amounts. If the arrangement is based upon WC fee schedule amounts, then, the RO cannot provide a written opinion on the sufficiency of an arrangement until the arrangement's settlement agreement contains specific provisions that establish that the WC carrier can and will ensure that the arrangement cannot be charged more than what would normally be payable under the WC plan. The WC carrier must require all entities and individuals that accept WC payments to agree not to charge

the arrangement more than what the **WC** plan would normally pay.

If a **WC** carrier is unable to enforce the requirement that the arrangement can only be charged the **WC** fee schedule rates, then the RO will evaluate whether an arrangement reasonably covers/considers Medicare's interest based on whether the future medical expenses billed to the arrangement are enough to cover the actual expenses for the services at issue. If State **WC** laws do not provide a particular **WC** carrier with the legal authority to enforce that requirement, then the RO can still provide a written opinion on the sufficiency of the arrangement so long as future medical expenses are evaluated by the RO using full actual charge estimates, not **WC** fee schedule amounts.
If the arrangement is constructed based upon full actual charge estimates, then the RO must determine whether the proposed amount to be placed in the arrangement for future medical expenses and administrative costs (see Question 11) is sufficient to cover the actual charges for the services at issue (rather than an amount equal to what would have been the Medicare approved amount for a particular service).

Once the arrangement has been depleted because of payments for otherwise Medicare covered services, a complete accounting must be provided to the contractor responsible for monitoring the individual's case and if the payments have been properly made Medicare can then be billed.

NOTE: THIS ANSWER HAS BEEN REPLACED BY QUESTION 1 OF THE OCTOBER 15, 2004 ARA MEMORANDUM

Question 10:

Are there documentation requirements that must be satisfied before the RO can provide a written opinion on the sufficiency of a set-aside arrangement?

Answer:

Yes. At a minimum, the following documentation must be obtained by the RO prior to the approval of any arrangement:

A copy of the settlement agreement, or proposed settlement agreement, a copy of the life care plan (if there is one), and, if the life care plan does not contain an estimate of the injured individual's estimated life span, then a rated age may be obtainable from life insurance companies for injuries/illnesses sustained by other similarly situated individuals. Also, documentation which gives the basis for the amounts of projected expenses for Medicare covered services and services not covered by Medicare (this could be a copy of letters from doctors/providers documenting the necessity of continued care).

The RO may require additional documentation, if necessary and approved by CO.

NOTE: THE ABOVE ANSWER WAS CLARIFIED BY QUESTION 5 OF THE OCTOBER 15, 2004 ARA MEMORANDUM

Question 11:

How does the RO determine whether or not the administrative fees and expenses charged to the arrangement are reasonable?

Answer:

Before a proposed arrangement can be approved, the RO must determine whether the administrative fees and expenses to be charged to the arrangement are reasonable. The RO must be notified (in writing) of all proposed administrative fees prior to the RO providing its written assurance that the set-aside arrangement is sufficient to satisfy the requirements of 42 CFR 411.46. If the administrative fees are determined to be unreasonable, the RO must withhold its approval of the set-aside arrangement. The amount of the approved arrangement must include both the estimated medical expenses plus the amount of administrative fees found to be reasonable.

NOTE: THE ABOVE ANSWER HAS BEEN REPLACED BY THE MAY 7. 2004 ARA MEMORANDUM

Question 12:

What impact will arrangements have on Medicare payment systems and procedures?

Answer:

Because an arrangement's purpose is to pay for all services related to the individual's work-related injury or disease, Medicare will not make any payments (as a primary, secondary or tertiary payer) for any services related to the work-related injury or disease until nothing remains in the set-aside arrangement. Arrangements are established in order to pay for **all** medical expenses resulting from work- related injuries or diseases; arrangements are not designed to simply pay portions of medical expenses for work-related injuries or diseases.

When arrangements are designed as lump sum commutations (i.e., the arrangement is designed in a manner that the WC settlement is paid into the arrangement all at once, see Question #4 above), Medicare would not make any payments for that individual's

medical expenses (for work-related injuries or diseases) until all the funds (including interest) within the arrangement have been completely exhausted. These same basic principles also apply to structured commutations (see Question #4 above).

When providers, physicians and other suppliers submit claims to Medicare related to the individual's work-related injury or disease, claims processing contractors should deny those claims and instruct the entity or individual to seek payment from the administrator of the arrangement. Since the injured individual will be a Medicare beneficiary at the time when the provider, physician, or other supplier submits the claim to Medicare, the contractor responsible for monitoring the individual's case will have already updated the Common Working File to indicate that the injured individual's claims should be denied. However, when a provider, physician or other supplier submits any claims that are for injuries or diseases that **are not** work-related, then contractors should process those claims like they would any other claim for Medicare payment.

When the administrator of an arrangement refuses to make payment on a provider's, physician's or other supplier's claim because the administrator of the arrangement asserts the services are for injuries or diseases that are not work-related (or when the administrator of the arrangement denies the claim for any other reason), and the provider, physician or other supplier, subsequent to the administrator's denial, submits the claim to Medicare, then the contractor should consult the RO in order to determine whether Medicare should pay the claim. If a determination to deny the claim is made, then Medicare's regular administrative appeals process for claim denials would apply to the claim.

Please note that Central Office is planning to have a contractor assist ROs in monitoring and processing (however, not evaluating) these set-aside arrangement cases as early as possible in Fiscal Year 2002. Further instructions will be issued at that time.

Regional Office staff's questions on these issues should be directed to Fred Grabau at (410) 7860206. We will issue additional guidance as necessary.

/s/

Parashar B. Patel

cc: Regional Administrators Gerry Nicholson, Benefits Operations Group
Liz Richter, Financial Services Group

FARD3/F.Grabau/60206/final 7/11/01 Document: /g:/ppg/dids/araWC2.doc Typist: T. Cox x60750

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850

Center for Medicare Management

DATE: APRIL 22, 2003

TO: All Regional Administrators

FROM: Director
Center for Medicare Management

SUBJECT: Medicare Secondary Payer ~ Workers' Compensation (WC) Frequently Asked Questions

Questions raised are paraphrased below. This memorandum will be posted on the Centers for Medicare & Medicaid Services' (CMS) website.

1) What statutory law, regulations, or Federal case law supports/allows CMS to review proposed settlements of injured workers who are not Medicare beneficiaries?

Answer: Section 1862(b)(2) of the Social Security Act (the Act) (42 USC 1395y(b)(2)) requires that Medicare payment may not be made for any item or service to the extent that payment has been made under a workers' compensation (WC) law or plan. Medicare does not pay for an individual's WC related medical services when that individual received a WC settlement, judgment, or award that includes funds for future medical expenses, until all such funds are properly expended.

Because Medicare does not pay for an individual's WC related medical services when the individual receives a WC settlement that includes funds for future medical expenses, it is in that individual's interests to consider Medicare at the time of settlement. Once CMS agrees to a Medicare set-aside amount, the individual can be certain that Medicare's interests have been appropriately considered.

2) When dealing with a WC case, what is "a reasonable expectation" of Medicare enrollment within 30 months?

Answer: Situations where an individual has a "reasonable expectation" of Medicare enrollment for any reason include but are not limited to:

a) The individual has applied for Social Security Disability Benefits;
b) The individual has been denied Social Security Disability Benefits but anticipates appealing that decision;
c) The individual is in the process of appealing and/or re-filing for Social Security Disability Benefits;
d) The individual is 62 years and 6 months old (i.e., may be eligible for Medicare based upon his/her age within 30 months); or
e) The individual has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.

3) How does Medicare determine its interests in WC cases when the parties to the settlement do not explicitly state how much of the settlement is for past medical expenses and how much is for future medical expenses?

Answer: A settlement that does not specifically account for past versus future medical expenses will be considered to be entirely for future medical expenses once Medicare has recovered any conditional payments it made. This means that Medicare will not pay for medical expenses that are otherwise reimbursable under Medicare and are related to the WC case, until the entire settlement is exhausted.

Example: A beneficiary is paid $50,000 by a WC carrier, and the parties to the settlement do not specify what the $50,000 is intended to pay for. If there is no CMS approved Medicare set-aside arrangement, Medicare will consider any amount remaining after recovery of its conditional payments as compensation for future medical expenses.

Additionally, please note that any allocations made for lost wages, pre-settlement medical expenses, future medical expenses, or any other settlement designations that do not consider Medicare's interests, will not be approved by Medicare.

4) What's the difference between commutation and compromise cases? And can a single WC case possess both?

Answer: When a settlement includes compensation for future medical expenses, it is referred to as a "WC commutation case." When a settlement includes compensation for medical expenses incurred prior to the settlement date, it is referred to as a "WC compromise case." A WC settlement can have both a compromise aspect as well as a commutation aspect.

Additionally, a settlement possesses a commutation aspect if it does not provide for future medical expenses when the facts of the case indicate the need for continued medical care related to the WC illness or injury.

Example: The parties to a settlement may attempt to maximize the amount of disability/lost wages paid under WC by releasing the WC carrier from liability for medical expenses. If the facts show that this particular condition is work-related and requires continued treatment, Medicare will not pay for medical services related to the WC injury/illness until the entire settlement has been used to pay for those services.

5) When a state WC judge approves a WC settlement, will Medicare accept the terms of that settlement?

Answer: Medicare will generally honor judicial decisions issued after a hearing on the merits of a WC case by a court of competent jurisdiction. If a court or other adjudicator of the merits specifically designates funds to a portion of a settlement that is not related to medical services (e.g., lost wages), then Medicare will accept that designation.

However, a distinction must be made where a court or other adjudicator is only approving a settlement that incorporates the parties' settlement agreements. Medicare cannot accept the terms of the settlement as to an allocation of funds of any type if the settlement does not adequately address Medicare's interests. If Medicare's interests are not reasonably considered, Medicare will refuse to pay for services related to the WC injury (and otherwise reimbursable by Medicare) until such expenses have exhausted the amount of the entire WC settlement. Medicare will also assert a recovery claim, if appropriate.

6) What is the expected time frame for the regional offices (ROs) to review and make their decisions regarding proposed WC settlements?

Answer: ROs seek to review and make a decision regarding proposed WC settlements within 45 to 60 days, from the time that all necessary/required documentation has been submitted.

7) May administrative fees/expenses for administration of the Medicare set-aside arrangement and/or attorney costs specifically associated with establishing the Medicare set-aside arrangement be charged to the set-aside arrangement?

Answer: Yes, such fees and costs may be charged to the arrangement if all the following are true:

a) They are related to the Medicare set-aside itself;
b) They are reasonable in amount; and
c) They are included in the proposed Medicare set-aside arrangement submitted to CMS and incorporated into the Medicare set-aside approved by CMS.

It is important to note that all administrative fees and other costs and expenses associated with the disability/lost wages portion of the settlement and/or the portion of the settlement that provides for medical services that are not covered by Medicare cannot be charged to the Medicare set-aside arrangement.

NOTE: THE ABOVE ANSWER WAS REPLACED BY THE MAY 7, 2004 ARA MEMORANDUM

Note: This question and answer does not address attorney fees and costs in connection with procurement of the WC settlement from the WC carrier.

8) May a beneficiary self-administer his or her own Medicare set-aside arrangement?

Answer: Yes, if this is permitted under state law. It should be noted though, that a self-administered arrangement is subject to the same rules/requirements as any other set-aside arrangement.

9) In WC cases that use structured Medicare set-aside arrangements (i.e., settlement monies are apportioned over fixed or defined periods of time), will Medicare agree to cover the beneficiary when it has not been verified whether the funds as apportioned in the arrangement have been exhausted?

Answer: No, Medicare does not make any payments until the contractor responsible for monitoring the individual's case can verify that the funds apportioned to the period, including any carry-forward amount, have been completely exhausted as set forth in the Medicare set-aside arrangement.

Additionally, please note that any structured set-aside arrangement agreed to by the parties will not be approved by Medicare if the settlement has not adequately considered Medicare's interests.

10) In a structured Medicare set-aside arrangement where payments are made at regular intervals to cover expenses incurred during those periods, how should an administrator account for unspent funds during a given period?

Answer: If funds are not exhausted during a given period then the excess funds must be carried forward to the next period. The threshold after which Medicare would begin to pay claims related to the injury would then be increased in any subsequent period by the amount of the carry-forward.

Example: A structured set-aside is designed to pay $20,000 per year over the next 10 years for an individual's Medicare covered services. Medicare would begin paying covered expenses in any given year after this $20,000 is exhausted. However, in 2003 the injured individual needs only $15,000 to cover all related expenses. The administrator would need to carry-forward the excess $5,000 into 2004. Therefore, in 2004 a total of $25,000 of Medicare covered expenses would need to be spent for services otherwise reimbursable by Medicare before Medicare would begin to cover WC related expenses, but only for the balance of 2004. This carry-forward process continues until the accumulated carry-forward plus the payment for a given year is exhausted.

NOTE: THE ABOVE ANSWER WAS CLARIFIED BY QUESTION 5 OF THE OCTOBER 15, 2004 ARA MEMORANDUM

11) If a beneficiary or injured individual's physical condition substantially improves, may the administrator of the Medicare set-aside arrangement release or reduce the amounts of the set-aside?

Answer: The administrator of the CMS approved Medicare set-aside arrangement cannot release or reduce the set-aside amounts without approval from CMS. If the treating physician concludes that the beneficiary's medical condition has substantially improved, then the beneficiary (or his/her representative) may submit a written request to the appropriate CMS RO asking for a reduction of the Medicare set-aside arrangement. This request must include supporting documentation from the treating physician(s). Once the RO receives all pertinent documentation, the RO will then evaluate the request and make a decision. The RO decision is final and not subject to administrative appeal.

NOTE: THE ABOVE ANSWER WAS REPLACED BY QUESTION 10 OF THE JULY 11, 2005 ARA MEMORANDUM

12) What are an attorney's ethical and legal obligations when his or her client effectively ignores Medicare's interests in a WC case?

Answer: Attorneys should consult their national, state, and local bar associations for information regarding their ethical and legal obligations. Additionally, attorneys should review applicable statutes and regulations, including, but not limited to, 42 CFR 411.24(e) and 411.26.

13) From where can CMS recover funds if Medicare's interests are ignored in a WC case?

Answer: The CMS has a direct priority right of recovery against any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received any portion of a third party payment directly or indirectly. The CMS also has a subrogation right with respect to any such third party payment. See, for example, 42 CFR 411.24(b), (e), and (g) and 42 CFR 411.26.

14) If Medicare rejects a proposed Medicare set-aside arrangement, how can the parties to a WC settlement appeal this rejection?

Answer: The CMS has no formal appeals process for rejection of a Medicare set-aside arrangement. However, when CMS does not believe that a proposed set-aside adequately protects Medicare's interests, the parties may provide the RO with additional information/documentation in order to justify their proposal. If the additional information does not convince the RO to approve the set-aside arrangement, and the parties proceed to settle the case despite the ROs objections, then Medicare will not recognize the settlement. Medicare will exclude its payments for the medical expenses related to the injury or illness until such time as WC settlement funds expended for services otherwise reimbursable by Medicare exhaust the entire settlement. At this point, when Medicare denies a particular beneficiary's claim, the beneficiary may appeal that particular claim denial through Medicare's regular administrative appeals process. Information on applicable appeal rights is provided at the time of each claim denial.

15) When the parties to a WC settlement present CMS with documentation that is intended to support and justify their proposed Medicare set-aside amounts, will Medicare accept a "life care plan" or similar evaluation prepared by a non-treating physician?

Answer: Yes, Medicare will consider accepting a life care plan or similar evaluation from a non-treating physician, if the physician does all of the following:

a) Examines the WC claimant;
b) Reviews the claimant's medical records;
c) Contacts any of the claimant's treating physicians (if applicable);
d) Is available to answer CMS' questions;
e) Prepares a report that summarizes the above; and
f) Offers a written medical opinion as to all of the reasonably anticipated future medical needs of the claimant related to the claimant's work injury.

Please note that such a life care plan or evaluation is not automatically conclusive. The CMS may not credit the report if there is information that calls the evaluation or plan into question for some reason, such as contrary evidence, internal conflicts, or if the plan is not credible on its face.

16) If a current Medicare beneficiary has outstanding WC related claims that were not paid prior to the settlement and are not covered in that settlement, will Medicare or the Medicare set-aside arrangement pay those claims?

Answer: No, Medicare cannot pay because it is secondary to the WC settlement and the Medicare set-aside arrangement cannot pay because it is created solely for future medical expenses related to the WC case. Medical expenses incurred prior to the settlement need to be accounted for in the compromise portion of the settlement. These services should be known to the parties. The provider/supplier will typically have billed Medicare and/or the WC carrier for these services and the beneficiary's representative will have made inquiries about outstanding related claims.

In addition, to the extent Medicare has made any conditional payments, Medicare will recover those payments pursuant to 42 CFR 411.47.

17) When an annuity is included in a settlement for an injured individual (who is not yet a Medicare beneficiary), how does Medicare determine whether the value of the annuity meets the $250,000 monetary threshold?

Answer: Medicare determines the value of an annuity based on how much the annuity is expected to pay over the life of the settlement, not on the Present Day Value (PDV) or cost of funding that annuity.

Example: A settlement is to pay $15,000 per year for the next 20 years to an individual who has a "reasonable expectation" of Medicare enrollment within 30 months. This settlement is to be funded with an annuity that will cost $175,000. The RO will review this settlement because the total settlement to be paid is greater than $250,000 ($15,000 per year x 20 years = $300,000). It is immaterial for Medicare's purposes that the PDV or cost ($175,000) to fund this settlement is less than $250,000.

18) Is there a means by which an injured individual can permanently waive his or her right to certain specific services related to a WC case, and thereby reduce the amount of a Medicare set-aside arrangement?

Answer: No, the ROs cannot approve settlements that promise not to bill Medicare for certain services in lieu of including those services in a Medicare set-aside arrangement. This is true even if the claimant/beneficiary offers to execute an affidavit or other legal document promising that Medicare will not be billed for certain services if those services are not included in the Medicare set-aside arrangement.

19) Does CMS require that a Medicare set-aside arrangement be established in situations that involve both a WC claim and a third party liability claim?

Answer: Third party liability insurance proceeds are also primary to Medicare. To the extent that a liability settlement is made that relieves a WC carrier from any future medical expenses, a CMS approved Medicare set-aside arrangement is appropriate. This set-aside would need sufficient funds to cover future medical expenses incurred once the total third party liability settlement is exhausted. The only exception to establishing a Medicare set-aside arrangement would be if it can be documented that the beneficiary does not require any further WC claim related medical services. A Medicare set-aside arrangement is also unnecessary if the medical portion of the WC claim remains open, and WC continues to be responsible for related services once the liability settlement is exhausted.

20) If the settling parties of a WC case contend that a WC settlement is not intended to compensate an injured individual for future medical expenses, does CMS still require that a Medicare set-aside arrangement be established?

Answer: It is <u>unnecessary</u> for the individual to establish a set-aside arrangement for Medicare if all of the following are true:

a) The facts of the case demonstrate that the injured individual is only being compensated for past medical expenses (i.e., for services furnished prior to the settlement);

b) There is no evidence that the individual is attempting to maximize the other aspects of the settlement (e.g., the lost wages and disability portions of the settlement) to Medicare's detriment; and

c) The individual's treating physicians conclude (in writing) that to a reasonable degree of medical certainty the individual will no longer require any Medicare-covered treatments related to the WC injury.

However, if Medicare made any conditional payments for work-related services furnished prior to settlement, then Medicare would require recovery of those payments. In addition, Medicare will not pay for any services furnished prior to the date of the settlement for which it has not already paid.

21) If a beneficiary or injured individual dies before the Medicare set-aside arrangement is completely exhausted, what happens to the remaining money?

Answer: Once the RO and the contractor responsible for monitoring the beneficiary's case ensure that all of the beneficiary's claims have been paid, then any amount left over in the beneficiary's Medicare set-aside arrangement may be disbursed pursuant to state law, once Medicare's interests have been protected. This may involve holding the Medicare set-aside arrangement open for some period after the date of death, as providers, physicians, and other suppliers are permitted to submit their initial bill to Medicare for a period ranging from 15-27 months after the date of service.

22) What happens if one of the parties settling a WC case refuses to involve CMS, even though Medicare has an interest in the case?

Answer: In these situations, the "cooperative" settling party should notify the appropriate CMS RO. Where the RO believes it is appropriate, the RO will then send the "uncooperative" party a letter (via certified mail) conveying that Medicare's interests must be considered in the WC settlement.

The ROs should inform the "uncooperative" settling party that: "Pursuant to 42 CFR 411.24(g), CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received a third party payment. Moreover, pursuant to 42 CFR 411.26, CMS is subrogated to any individual, provider, supplier, physician, private insurer, state agency, attorney, or any other entity entitled to payment by a third party payer. Therefore, pursuant to 42 CFR 411.24(b), CMS may initiate recovery against the parties listed under 42 CFR 411.26 as soon as it learns that payment has been made or could be made under workers' compensation."

Additionally, if Medicare's interests are not adequately considered in any settlement, then Medicare may refuse to pay for services related to the WC injury until such time as expenses for such services have exhausted the amount of the <u>entire</u> WC settlement.

23) Who should the parties settling a WC case contact in the RO?

Answer: The first report of attorney representation of a Medicare beneficiary for a WC claim should be made to the CMS Coordination of Benefits (COB) Contractor. Attorneys can call the COB Contractor from 8am-8pm, Monday - Friday, Eastern Time; the toll-free number is 1-800-999-1118.

Settling parties should also contact the CMS RO responsible for a particular state (contact information is provided in an attachment to these questions and answers) for approval of a Medicare set-aside arrangement. The inquiry should be directed to the attention of the Regional Office Medicare Secondary Payer Coordinator, who will forward the inquiry to the appropriate RO if a transfer is necessary. (WC set-aside responsibilities are generally, but not always, assigned based upon RO responsibility for contractor oversight over the lead fiscal intermediary for WC recoveries for a particular state. This may or may not be the same RO as the one with general responsibilities for a particular state.)

All RO questions on the issues addressed in these "questions and answers" should be directed to Fred Grabau at (410) 786-0206.

Thomas L. Grissom

Attachment

cc: All ARA's for Financial Management
ARA for DHPP RO VII
All RO MSP Coordinators

bcc: Paul Olenick
Martha Kuespert
Fred Grabau
Eve Fisher
Tina Merritt
Barbara Wright
Betty Noble
Hugh Hill
Joan Fowler
Harry Gamble
Donna Kettish

NOTE: THIS REGIONAL OFFICE CONTACT LIST HAS BEEN UPDATED AND IS AVAILABLE AS A DOWNLOAD UNDER THE WCMSA REVIEW PROCESS WEB PAGE

MEDICARE SECONDARY PAYER REGIONAL OFFICE COORDINATORS
(WORKERS' COMPENSATION CONTACTS')

NAME	REGIONAL OFFICE	PHONE
James Bryant	I--Boston	617-565-1331
Thomas Hatchfield		617-565-1254
Sedric Goutier		617-565-1228
Jerry Kerr	II--New York	212-264-3760
	III--Philadelphia	
Catherine McCoy		215-861-4250
Maria Kuehn		215-861-4306
Juanita Dixon	IV--Atlanta	404-562-7313
Geraldine Taylor		404-562-7311
	V--Chicago	
Janice Edwards		312-886-3256
Barry Thomas	VI--Dallas	214-767-6455
Doug Rundle	VII--Kansas City	816-426-5783
Cindy Christensen	VIII--Denver	303-844-7095
Rosie Sagum	IX--San Francisco	415-744-3655
Tom Bosserman		415-744-4907
Jean Tsutakawa	X--Seattle	206-615-2382
Jonella Windell		206-615-2385

Note: If the caller is simply contacting Medicare for the first time in order to report workers' compensation coverage (as opposed to seeking out RO approval of a proposed Medicare set-aside arrangement), then the calle should contact the Coordination of Benefits Contractor at
1-800-999-1118.

NOTE: THIS LIST HAS BEEN UPDATED

STATES IN EACH REGION

REGION I - BOSTON	Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont
REGION II - NEW YORK	New York Puerto Rico Virgin Islands
REGION III - PHILADELPHIA	Delaware District of Columbia Maryland Pennsylvania Virginia West Virginia
REGION IV - ATLANTA	Alabama North Carolina South Carolina Florida Georgia Kentucky Mississippi Tennessee New Jersey Louisiana
REGION V - CHICAGO	Illinois Indiana Michigan Minnesota Ohio Wisconsin
REGION VI - DALLAS	Arkansas New Mexico Oklahoma Texas
REGION VII - KANSAS CITY	Iowa Kansas Missouri Nebraska

REGION VIII- DENVER	Colorado Montana North Dakota South Dakota Wyoming
REGION IX - SAN FRANCISCO	America Samoa Arizona California Guam Hawaii Nevada
REGION X - SEATTLE	Alaska Idaho Oregon Washington Utah

DATE: MAY 23, 2003

TO: All Regional Administrators

FROM: Director
Center for Medicare Management

SUBJECT: Medicare Secondary Payer — Workers' Compensation (WC) Additional Frequently Asked Questions

Questions raised are paraphrased below. This memorandum will be posted on the Centers for Medicare & Medicaid Services' (CMS) website.

1.) What are the review thresholds set by the July 23, 2001 All Associate Regional Administrators (ARA) letter concerning WC Commutation of Future Benefits?

Answer: They state that to the extent a WC settlement meets both of the criteria (i.e., the settlement is greater than $250,000 AND the claimant is reasonably expected to become a Medicare beneficiary within 30 months of the settlement date), then a CMS-approved Medicare set-aside arrangement is appropriate. However, if a WC settlement is $250,000 or less OR where the claimant of that settlement is not reasonably expected to become a Medicare beneficiary within 30 months of the settlement date, then a CMS-approved Medicare set-aside arrangement is unnecessary.

Additional Information: Please note that the current review thresholds are subject to adjustment. The CMS reserves the right to modify or eliminate its review criteria if it determines that Medicare's interests are not being protected.

2.) When an injured individual's WC settlement does not meet the current review thresholds, will the Regional Offices (RO) provide the settling parties with "verification" letters confirming that approval of a Medicare set-aside arrangement is unnecessary?

Answer: No, the ROs will not provide "verification" letters. However, the CMS will honor threshold levels that are in effect as of the date of a WC settlement. (See the July 23, 2001 ARA letter concerning WC Commutation of Future Benefits.)

3.) An injured individual, who does not have a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date, settles his/her WC case for less than $250,000. Once this individual becomes a Medicare beneficiary, will CMS pay for services that are otherwise reimbursable under Medicare, that are related to the WC injury, even though funds still remain in the individual's settlement?

Answer: Yes. When an individual's settlement does not meet both thresholds Medicare will make payment for WC related services that are otherwise reimbursable under Medicare once the individual enrolls in Medicare.

NOTE: THE ABOVE ANSWER WAS REPLACED BY QUESTION 3 OF THE JULY 11, 2005 ARA MEMORANDUM

Additional Information: The CMS assumes that when a non-Medicare eligible claimant's WC settlement does not meet the 30-month and $250,000 thresholds, typically that individual will completely exhaust his/her settlement by the time Medicare eligibility is reached. Also, according to various members of the WC community, most settlements for these individuals are in the range of $10,000 to $50,000. Therefore, the amount of money in the settlement that is actually being provided for an individual's medical care normally will be appropriately exhausted before the individual becomes a Medicare beneficiary.

Please note that the current review thresholds (see the July 23, 2001 ARA letter concerning WC Commutation of Future Benefits) are subject to adjustment. The CMS reserves the right to modify or eliminate its review criteria if it determines that Medicare's interests are not being protected.

4.) Will CMS treat WC cases that were settled prior to the issuance of the July 23, 2001 ARA letter concerning WC Commutation of Future Benefits in the same manner as those settled after the review threshold guidelines were established?

Answer: Yes. For WC settlements that do not meet the review thresholds, Medicare will make payment for WC related services that are otherwise reimbursable under Medicare, once the individual becomes enrolled in Medicare. This will be done regardless of when the settlement actually occurred. However, a reopening of claims (see 42 C.F.R. 405.750 and 405.841) that Medicare previously denied for these individuals will not be granted, nor will the CMS change any decisions already made with respect to settlements which pre-date July 23, 2001.

Additional Information: When the CMS issued the July 23, 2001 ARA letter, it established review thresholds for WC cases settled by injured individuals who are not yet Medicare beneficiaries. This was done in order to organize and prioritize workloads for its ROs and to convey to its ROs that it is not in Medicare's best interests to review WC settlements that do not meet the review thresholds.

All RO questions on the issues addressed in these "questions and answers" should be directed to Fred Grabau at (410) 786-0206.

Thomas L. Grissom

cc: All ARA's for Financial Management

ARA for DHPP RO VII
All RO MSP Coordinators

bcc: Paul Olenick
Martha Kuespert
Fred Grabau
Eve Fisher
Tina Merritt
Barbara Wright
Betty Noble
Hugh Hill
Joan Fowler
Harry Gamble
Donna Kettish

DATE: May 7, 2004

TO: All Regional Administrators

FROM: Director
Center for Medicare Management

SUBJECT: Medicare Secondary Payer - Workers' Compensation (WC)- INFORMATION

THE PURPOSE OF THIS ALL REGIONAL ADMINISTRATORS MEMORANDUM IS TO REPLACE THE POLICY THAT WAS OUTLINED IN THE ANSWERS TO QUESTIONS IN THE ALL ASSOCIATE REGIONAL ADMINISTRATORS (ARA) MEMORANDUM CONCERNING WORKERS' COMPENSATION COMMUTATION OF FUTURE BENEFITS (ISSUED ON JULY 23, 2001, ATTACHED) AND IN THE ANSWER TO QUESTION SEVEN FROM THE APRIL 21, 2003 FREQUENTLY ASKED QUESTIONS (FAQ). The CMS replaces the policies regarding administrative fee and attorney costs specifically associated with establishing Medicare set-aside arrangements in question eleven of the July 23, 2001 ARA memorandum and question seven of the April 21, 2003 FAQ's with the following policy—

> Administrative fees/expenses for administration of the Medicare set-aside arrangement and/or attorney costs specifically associated with establishing the Medicare set-aside arrangement cannot be charged to the set-aside arrangement. The CMS will no longer be evaluating the reasonableness of any of these costs because the payment of these costs must come from some other payment source that is completely separate from the Medicare set-aside arrangement funds.
>
> For example, if the settling parties submit a Medicare set-aside proposal to CMS that claims that the injured individual will need $50,000 worth of work-related medical expenses that would otherwise be reimbursable under Medicare and the settling parties claim that it will cost $10,000 in administrative and attorney fees in order to both administer and establish the Medicare set-aside arrangement proposal of $50,000, then CMS will only evaluate/judge the reasonableness of the $50,000 figure.
>
> The CMS will not evaluate whether or not the $10,000 in administrative and attorney fees are reasonable nor will CMS permit the settling parties to add that $10,000 amount to the $50,000 Medicare set-aside arrangement amount. Therefore, if CMS approves that proposal for a $50,000 Medicare set-aside arrangement, the settling parties $10,000 in administrative and attorney fees cannot be charged to/against the Medicare set-aside arrangement of $50,000 because CMS considers those costs to be a separate issue for the settling parties to negotiate.
>
> NOTE: This policy will be implemented on a prospective basis.

If you have any questions or concerns contact Fred Grabau at (410) 786-0206.

Herb Kuhn

Attachments

CENTERS for MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services 7500 Security Boulevard, Mail Stop Baltimore, Maryland 21244-1850

OFM/FSG/DMSPPO

DATE: October 15, 2004

TO: All Regional Administrators

FROM: Director
Financial Services Group Office of Financial Management

SUBJECT:

Medicare Secondary Payer (MSP)--Workers' Compensation (WC) Additional Frequently Asked Questions: 1) Use of WC Fee Schedule vs. Full Actual Charges for WC Medicare Set-aside Arrangement (WCMSA); 2) Self-administration of a WCMSA; 3) Up-front Settlement of Future Medicals vs. WCMSA; 4) Inflation Adjustment/Discount to Present Value; 5) Structured WCMSAs; 6) WC Claim Resolution Where Medicals Remain Open.

The above-referenced issues are addressed below. This memorandum will be posted on the Centers for Medicare & Medicaid Services (CMS) Coordination of Benefits website.

Q1. Use of WC Fee Schedule vs. Actual Charges for WC Medicare Set-aside Arrangement - What is CMS's policy with respect to reviewing WC Medicare Set-aside Arrangement proposals using either WC fee schedule amounts or full actual charges as the basis for the proposal?

A1. Effective with the issuance of this memorandum, CMS will use either the WC fee schedule (for states that have such schedules) or frill actual charges for its review of a proposed WC Medicare Set-aside Arrangement based upon whichever methodology was used by the individual/entity submitting the proposal. The administrator of the WC Medicare Set-aside Arrangement (both professional administrators and self-administrators) should make payments

from the WC Medicare Set-aside Arrangement on the same basis. That is, if the proposal was submitted and approved based upon full actual charges, the administrator should make payment from the WC Medicare Set-aside Arrangement based upon full actual charges; if the proposal was submitted and approved Page 2 - Medicare Secondary - Workers' Compensation Additional Frequently Asked Questions

based upon WC fee schedule amounts, the administrator should make payment from the WC Medicare Set-aside Arrangement based upon WC fee schedule amounts.

NOTE: THE ABOVE ANSWER REPLACES QUESTION 9 ON THE JULY 23, 2001 ARA MEMORANDUM

Q2. Self-administration of a WC Medicare Set-aside Arrangement ~ If an individual has a designated representative payee for Social Security purposes pursuant to 20 C.F.R. 404.2010 and 404.2015 (e.g., because the individual is legally incompetent, mentally incapable of managing benefit payments, etc.), has an appointed guardian/conservator, or has otherwise been declared incompetent by a court, may that individual self-administer his/her Medicare set-aside arrangement?

A2. WC Medicare Set-aside Arrangements must be administered by a competent administrator (the representative payee, a professional administrator, etc.). Moreover, when an individual does (in fact) have a designated representative payee, appointed guardian/conservator, or has otherwise been declared incompetent by a court; the settling parties must include that information in their Medicare set-aside arrangement proposal to CMS.

Q3. Up-front Settlement of Future Medicals vs. WC Medicare Set-aside Arrangement - May Medicare accept an up-front cash settlement for future medicals directly from the settling parties instead of a WC Medicare Set-aside Arrangement?

A3. CMS currently has no process to accept up-front cash payments in lieu of a CMS-approved WC Medicare Set-aside Arrangement.

Q4. Inflation Adjustment/Discount for Present Value/Change in Policy - Must the WC Medicare Set-aside Arrangement include an upward adjustment for inflation? May the WC Medicare Set-aside Arrangement include a downward adjustment as a discount for the present-day value of the total WC Medicare Set-aside Arrangement?

A4. Effective with the issuance of this memorandum, CMS's position is that the WC Medicare Set-aside Arrangement does not need to be indexed for inflation and may not be discounted to present-day value.

NOTE: THIS ANSWER REPLACES QUESTION 7 IN THE JULY 23, 2001 ARA MEMORANDUM

Q5. Can a WC Medicare Set-aside Arrangement be established as a structured arrangement, where payments are made to the arrangement on a defined schedule to cover expenses

projected for future years?

A5. Yes. However, CMS will approve a payout amount for services that would otherwise be reimbursable by Medicare from the WC Medicare Set-aside Arrangement in the following manner:

The seed money for the WC Medicare Set-aside Arrangement must include an amount equal to the amount of monies calculated to cover the first surgery procedure and/or replacement and two years of annual payments.

The remainder of the approved amount should be divided by the remainder of the claimant's life expectancy (or a shorter defined period of time if CMS has agreed to a shorter time period).

Subsequent annual deposits into the WC Medicare Set-aside Arrangement are to be based upon a set "anniversary date" which cannot be more than one year after the settlement date.

NOTE: THIS ANSWER IS INTENDED TO PROVIDE CLARIFICATION OF QUESTION **10** IN THE APRIL **21, 2003** ARA MEMORANDUM AND FAQ **#1903**

Q6. WC Claim Resolution Where Medicals Remain Open - Is a WC Medicare Set-aside Arrangement appropriate when resolution of the WC claim leaves the medical aspects of the claim open?

A6. No. However, a WC Medicare Set-aside Arrangement is appropriate where the resolution of the WC claim permanently closes the medical aspects of the claim, and the claimant will require future medical services related to the WC claim that Medicare would otherwise reimburse.

Please direct questions or concerns to Eve Fisher at (410) 786-5641.

/s/ Gerald Walters

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEMORANDUM

DATE: **December 30, 2005**

FROM: **Director**
Financial Services Group
Office of Financial Management

SUBJECT: **Part D and Workers' Compensation Medicare Set-aside Arrangements (WCMSAs) Questions and Answers**

TO: **All Regional Administrators**

Beginning January 1, 2006, Medicare will begin its Part D prescription drug coverage as a result of the implementation of the Medicare Modernization Act of 2003 (MMA). This memorandum includes policy regarding the inclusion of prescription drugs that Medicare will cover as of January 1, 2006, in Workers' Compensation Medicare Set-aside Arrangements (WCMSAs).

NOTE: References to prescription drugs in this document are limited to those prescription drugs that are for the treatment of the Workers' Compensation (WC) related injury(ies) and/or illness(es)/disease(s), (hereinafter referred to as "WC injury") and those where Medicare provides coverage.

Question 1: What is the Centers for Medicare & Medicaid Services' (CMS) policy regarding the inclusion of prescription drugs in WCMSAs with the implementation of the MMA?

Answer 1: All WC settlements that occur on or after January 1, 2006, must consider and protect Medicare's interests when future treatment includes prescription drugs along with the future medical services that would otherwise be reimbursable by Medicare. The recommended method to protect Medicare's interests is to include a WCMSA as part of the WC settlement.

Question 2: Will the submission of WCMSA proposals change with the implementation of the MMA on January 1, 2006?

Answer 2: Yes, the submission of WCMSA proposals will change with the implementation of the MMA on January 1, 2006. For WCMSA proposals received by CMS' Coordination of Benefits Contractor (COBC) on or after January 1, 2006, the cover letter must include separate amounts for: (1) future medical treatment, and (2) future prescription drug treatment. In addition, the cover letter must include an explanation as to how the submitter calculated the future prescription drug treatment amount *(i.e.,* actual costs, average wholesale price, etc.).

Question 3: What happens if a WCMSA proposal received on or after January 1, 2006, does not include an amount for future prescription drug treatment?

Answer 3: If the cover letter does not include an amount for future prescription drug treatment, and the current treatment records indicate that the claimant has been prescribed drugs and/or may need prescription drugs related to the WC injury in the future, the submitter did not adequately consider Medicare's interests. In such a case, CMS will advise the submitter in its written opinion that the parties to the WC settlement may not have protected Medicare's interests.

If the cover letter does not include an amount for future prescription drug treatment, and there is no indication in the current treatment records that the claimant will need future treatment with prescription drugs related to the WC injury, then CMS will accept that Medicare's interests have been adequately protected. Medicare will then pay primary for future prescription drugs if the beneficiary has enrolled in a Medicare prescription drug plan and does not have any other coverage that is primary to Medicare.

Question 4: Will CMS' review of WCMSA proposals change with the implementation of the MMA on January 1, 2006?

Answer 4: The CMS' review of WCMSA proposals will not change until it begins to independently price for future prescription drug treatment for WCMSAs received by the COBC on or after January 1, 2007. Until the review of future prescription drug treatment begins on January 1, 2007, CMS will continue to review and independently price for future Medicare-covered medical expenses in WCMSAs in accordance with CMS' published policy memoranda dated: July 23, 2001; April 21, 2003; May 23, 2003; May 7, 2004; October 15, 2004; and July 11, 2005.

For a WCMSA proposal received by COBC on or after January 1, 2006, CMS will provide in its written opinion the total WCMSA amount that adequately protects Medicare's interests with regard to the claimant's future medical treatment. In addition, CMS' written opinion will note the submitted prescription drug amount. The CMS' written opinion will provide the total WCMSA amount, which is a combination of the future medical treatment reviewed by CMS and the future prescription drug costs noted in the submitter's cover letter. The parties to the WC settlement must note the total WCMSA amount in the final settlement agreement. Once the final settlement agreement is submitted to CMS' COBC, the claimant and all other parties to the WC settlement can rely on CMS' written opinion regarding whether the WC settlement adequately protects Medicare's interests.

The total WCMSA amount (future medical treatment and future prescription drug treatment) must be deposited in an interest bearing account. The administrator of the WCMSA must forward an annual accounting, separately identifying the expenditures for the medical treatment and prescription drug treatment to the Medicare contractor responsible for monitoring the claimant's case. For example, if the total WCMSA amount in CMS' written opinion is $10,000 ($7,000 identified for future prescription drug treatment and $3,000 identified for future medical expenses), then the administrator must forward an annual accounting that separately identifies how much of the $10,000 was spent for medical expenses and prescription drugs. Exhaustion of the total WCMSA amount is not limited to the separate amounts set-aside for future medical expenses and future prescription drug treatment. As long as the annual accounting shows bona fide payments were made from the total WCMSA account, CMS will consider the account appropriately exhausted. For example, final actual expenditures may be $6,000 for future prescription drug treatment and $4,000 for the future medical expenses that may appropriately exhaust the $10,000 WCMSA.

Question 5: Will the submission of WCMSA proposals change when CMS begins to review and independently price for future prescription drug treatment on January 1, 2007?

Answer 5: When CMS begins to review and independently price for future prescription drug treatment on January 1, 2007, the submitter must include in the cover letter separate amounts for: (1) future medical treatment, and (2) future prescription drug treatment. In addition, the cover letter must include an explanation as to how the submitter calculated the future prescription drug treatment amount *(i.e.,* actual costs, average wholesale price, etc.). Moreover, the submitter must include with the submission a payment history of the prescription drugs paid by the WC carrier, as follows:

- If the injury occurred less than 2 years from the date of the submission, a payment history should include those prescription drugs paid from the injury date through the date of submission.

- If the injury occurred more than 2 years from the date of the submission, a payment history should include the last 2 years of payments for prescription drugs.

The CMS will review WCMSAs that include an allocation for future treatment with prescription drugs based on the required payment history, anticipated future prescription drug treatment information, and Medicare Part D data. If the submitter fails to provide a payment history or the payment history reflects that the WC carrier did not previously pay for prescription drugs indicated for the claimant's future treatment, CMS will independently price the Medicare-covered prescription drugs using CMS information available from current Medicare Part D data.

Question 6: Should funds for future prescription drug treatment be included in the calculation of the total settlement amount to determine if the WCMSA proposal should be reviewed by CMS?

Answer 6: Yes, the total settlement amount calculation should include an amount for prescription drugs if the future treatment indicates that the claimant has been prescribed drugs and/or may need drugs in the future. As stated in the July 11, 2005 memorandum, the computation of the total settlement amount includes, but is not limited to, wages, attorney fees, ***all*** future medical expenses, and repayment of any Medicare conditional payments. Payout totals for all annuities to fund the above expenses should be used rather than cost or present values of any annuities. Also note that any previously *settled* portion of the WC claim must be included in computing the total settlement amount.

Current review thresholds for Medicare beneficiary and non-beneficiary WCMSA proposals will remain in effect as stated in the following policy memoranda: July 23, 2001; April 21, 2003; May 23, 2003; May 7, 2004; October 15, 2004; and July 11, 2005.

Note: Question/Answer #6 is not a change in CMS' policy for determining whether a WC settlement that includes a WCMSA meets CMS' review thresholds.

Question 7: Do claimants have to resubmit their WCMSA proposals if CMS already issued a written opinion as to the total WCMSA amount?

Answer 7: No, claimants do not have to resubmit their WCMSA proposals, if CMS has already issued a written opinion as to the total WCMSA amount for settlements occurring prior to January 1, 2006, or where the WCMSA review occurred prior to January 1, 2006, the MMA implementation date.

Note: If the WC settlement occurred prior to January 1, 2006, and the WC settlement included an allocation for future prescription drug treatment, then the claimant must exhaust those funds prior to billing Medicare for those future prescription drugs. For example, if the WC settlement allocates $5,000 for prescription drugs related to the WC injury, then the claimant must exhaust that amount from the settlement funds before billing Medicare for prescription drug costs incurred on or after January 1, 2006. However, the claimant does not have to transfer these funds to the existing WCMSA account or include them in the annual WCMSA accounting.

THE ABOVE NOTE CLARIFIES Q/A #15 OF THE JULY 11, 2005 MEMORANDUM.

/s/

Gerald Walters
Director, Financial Services Group
Office of Financial Management

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

DATE: July 11, 2005

FROM: Director
Financial Services Group
Office of Financial Management

SUBJECT: Medicare Secondary Payer (MSP) - Workers' Compensation (WC)
Additional Frequently Asked Questions

TO: **All Regional Administrators**

Additional Frequently Asked Questions:

1 Clarification of WCMSA Non-beneficiary Threshold;
2 Low Dollar Threshold for Medicare Beneficiaries;
3 Use of WC Settlement Funds Prior to Medicare Entitlement;
4 Avoiding the Continuation of Indemnity Payments While Waiting for CMS to Review a WC Medicare Set-aside Arrangement (WCMSA);
5 Settlement of WC Medical Expenses Prior to Submission to CMS;
6 Treatment of Taxable Interest Income Earned on a WCMSA;
7 Sample Submission of a WCMSA;
8 Group Health Plan (GHP) Insurance and Veteran's Administration (VA) Coverage;
9 Loss of Medicare Entitlement after CMS Approval of a WCMSA;
10 Beneficiaries that Request Termination of WCMSA Funds;
11 Compromising of Future Medical Expenses;
12 Additional Information Submission after WCMSA Case is Closed;
13 Effect of WCMSA on Medicaid Eligibility;
14 CMS Recognition of State Specific Statutes;
15 Transfer Mechanism for Items and Services Not Covered by Medicare.

The above-referenced issues are addressed below. This memorandum will be posted on the Centers for Medicare & Medicaid Services (CMS) Coordination of Benefits website @ www.cms.hhs.gov/medicare/cob/attorneys/att_wc.asp.

Q1. Clarification of WCMSA Review Thresholds - Should I establish a Workers' Compensation Medicare Set-aside Arrangement (WCMSA) even if I am not yet a Medicare beneficiary and/or even if I do not meet the CMS thresholds for review of a WCMSA proposal?

A1. The thresholds for review of a WCMSA proposal are only CMS workload review thresholds, not substantive dollar or "safe harbor" thresholds for complying with the Medicare Secondary Payer law. Under the Medicare Secondary Payer provisions, Medicare is always secondary to workers' compensation and other insurance such as no-fault and liability insurance. Accordingly, all beneficiaries and claimants must consider and protect Medicare's interest when settling any workers' compensation case; even if review thresholds are not met, Medicare's interest must always be considered.

Q2. Low Dollar Threshold for Medicare Beneficiaries - Has Medicare considered a low dollar threshold for review of WCMSA proposals for Medicare beneficiaries?

A2. Effective with the issuance of this memorandum, CMS will no longer review new WCMSA proposals for Medicare beneficiaries where the total settlement amount is less than $10,000. In order to increase efficiencies in our process, and based on available statistics, CMS is instituting this workload review threshold. However, CMS wishes to stress that this is a CMS workload review threshold and not a substantive dollar or "safe harbor" threshold. Medicare beneficiaries must still consider Medicare's interests in all WC cases and ensure that Medicare is secondary to WC in such cases.

Note that the computation of the total settlement amount includes, but is not limited to, wages, attorney fees, all future medical expenses, and repayment of any Medicare conditional payments, and that payout totals for all annuities to fund the above expenses should be used rather than cost or present values of any annuities. Also note that any previously settled portion of the WC claim must be included in computing the total settlement amount.

Also note that both the beneficiary and non-beneficiary review thresholds are subject to adjustment. Claimants, employers, carriers, and their representatives should regularly monitor the CMS website at www.cms.hhs.gov/medicare/cob/attoraeys/att_wc.asp for changes to these thresholds and for other changes in policies and procedures.

Q3. Use of WC Settlement Funds Prior to Medicare Entitlement - May workers' compensation settlement funds attributable to future medicals be used prior to Medicare entitlement?

A3. For claimants who are not yet Medicare beneficiaries and for whom CMS has approved a WCMSA, the WCMSA may be used prior to becoming a beneficiary because the amount was priced based on the date of the expected settlement. Use of the WCMSA is limited to services that are related to the workers' compensation claim or settlement and that would be covered by Medicare if the individual were a Medicare beneficiary. The same requirements that Medicare beneficiaries follow for reporting and administration are to be used in the

above cases. The CMS will not pay for any expenses related to the workers' compensation illness or injury until a self-attestation document or a full accounting of all monies expended from the WCMSA are sent to the lead contractor upon Medicare entitlement. At that time, the lead contractor will adjust the WCMSA record to reflect the expenses paid prior to entitlement.

Even if there is no CMS-approved WCMSA, any funds from a WC settlement attributable to future medicals that are remaining at the time a claimant becomes a Medicare beneficiary must be used for Medicare-covered services related to the workers' compensation claim or settlement until such funds are exhausted. Only then will CMS pay for Medicare-covered services related to the workers' compensation claim or settlement.

NOTE: THE ABOVE ANSWER REPLACES THE FIRST PARAGRAPH OF THE NOTE AT THE END OF ANSWER NUMBER FOUR IN THE JULY 23, 2001 ARA WC MEMORANDUM AND QUESTION NUMBER THREE IN THE MAY 23, 2003 ARA WC MEMORANDUM.

Q4. Avoiding the Continuation of Indemnity Payments While Waiting for CMS to Review a WCMSA - Is there a way to avoid the continuation of indemnity payments while awaiting a CMS determination on a proposed WCMSA?

A4. Yes. To avoid this situation, CMS recommends that the claimant (or the claimant's representative) close out the indemnity portion of the settlement and leave the settlement of medical expenses open pending a determination by CMS on the proposed WCMSA. In determining the review thresholds, the total settlement amount, including indemnity and medicals, shall be used.

Note that the computation of the total settlement amount includes, but is not limited to, wages, attorney fees, all future medical expenses, and repayment of any Medicare conditional payments, and that payout totals for all annuities to fund the above expenses should be used rather than cost or present values of any annuities. Also note that any previously settled portion of the WC claim must be included in computing the total settlement amount.

Q5. Settlement of WC Medical Expenses Prior to Submission to CMS - Can the parties proceed with the settlement of the medical expenses portion of a WC claim before CMS actually reviews the proposed WCMSA and determines an amount that adequately protects Medicare's interests?

A5. The parties may proceed with the settlement, but any statement in the settlement of the amount needed to fund the WCMSA is not binding upon CMS unless/until the parties provide CMS with documentation that the WCMSA has actually been funded for the full amount as specified by CMS that adequately protects Medicare's interests as a result of its review.

If CMS does not subsequently provide approval of the funded WCMSA amount as specified in the settlement and proof is not provided to CMS that the CMS-approved amount has been fully funded, CMS may deny payment for services related to the WC claim up to the full

amount of the settlement. Only the approval of the WCMSA by CMS and the submission of proof that the WCMSA was funded with the approved amount, would limit the denial of related claims to the amount in the WCMSA. This shall be demonstrated by submitting a copy of the final, signed settlement documents indicating the WCMSA is the same amount as that recommended by CMS.

As a reminder, the claimant may be at risk if the WCMSA is funded for less than the amount that CMS determines to be adequate to protect Medicare's interests.

Q6. **Treatment of Taxable Interest Income Earned on a WCMSA** - If I receive a Form 1099-LNT for the interest income earned on my WCMSA account, may I charge the income tax on that amount against the WCMSA?

A6. Assuming that there is adequate documentation for the amount of incremental tax that the claimant must pay for the interest earned on this set-aside account, the claimant or his/her administrator may withdraw an amount equal to the additional tax as a "cost that is directly related to the account" to cover the additional tax liability. Such documentation should be submitted along with the annual accounting.

Q7. **Sample Submission of a WCMSA** - Does CMS provide an example of what a proper WCMSA looks like?

A7. Yes, at http://www.cms.hhs.gov/medicare/cob/pdf/attwc_sample.pdf, CMS has posted a sample WCMSA proposal. Any comments or questions regarding this sample submission should be directed to mspcentral@cms.hhs.gov.

Q8. **Group Health Plan (GHP) Insurance, Managed Care Plan, and Veterans' Administration (VA) Coverage** - In a WC settlement, is a WCMSA recommended where the claimant is covered under a GHP or a managed care plan, or has coverage through the VA?

A8. Yes, a WCMSA is still appropriate because such other health insurance or health service could in the future be canceled or reduced, or the injured individual may elect not to take advantage of such services. It is important to remember that workers' compensation is always primary to Medicare and many other types of health insurance coverage for expenses related to the WC claim or settlement.

Q9. **Loss of Medicare Entitlement after CMS Approval of a WCMSA** - Am I entitled to a release of my WCMSA funds if I lose my Medicare entitlement?

A9. No. However, the funds in the WCMSA may be expended for medical expenses specified in the WCMSA until Medicare entitlement is re-established or the WCMSA is exhausted. Use of the WCMSA is limited to services that are related to the workers' compensation claim or settlement and that would be covered by Medicare if the individual were a Medicare beneficiary. The same requirements that Medicare beneficiaries follow for reporting and administration are to be used in the above cases. The CMS will not pay for any expenses related to the workers' compensation claim or settlement until a self-attestation document or a full accounting of all monies expended from the WCMSA are sent to the lead contractor

upon the re-establishment of Medicare entitlement. At that time, the lead contractor will adjust the WCMSA record to reflect the expenses paid prior to entitlement.

Q10. Beneficiaries that Request Termination of a WCMSA Account - May a claimant have any or all of a WCMSA released for personal purposes under any circumstances?

A10. The administrator of the CMS-approved WCMSA should not release set-aside funds for any purpose other than the purpose for which the WCMSA was established without approval from CMS. However, if the treating physician concludes that the beneficiary's medical condition has substantially improved, then the beneficiary (or the beneficiary's representative) may submit a new WCMSA proposal covering future expected medical expenses. Such proposals must justify at least a 25% reduction in the outstanding WCMSA funds. In addition, such proposal may not be submitted until at least five years after a previous CMS approval letter and should be accompanied by all supporting documentation not previously submitted with the original WCMSA proposal. The CMS decision on the new proposal is final and not subject to administrative appeal.

The above proposals shall be submitted to CMS c/o COBC. If CMS determines that a 25% or greater reduction is justified, CMS will issue a new approval letter. After CMS issues a new approval letter, any funds in the current WCMSA in excess of the newly calculated amount may be released to the claimant.

NOTE: THE ABOVE ANSWER REPLACES QUESTION NUMBER ELEVEN IN THE APRIL **21, 2003** ARA **WC** MEMORANDUM.

Q11. Compromising of Future Medical Expenses - Does CMS compromise or reduce future medical expenses related to a WC injury?

A11. No. Some submitters have argued that 42 C.F.R. §411.47 justifies reduction to the amount of a WCMSA. The compromise language in this regulation only addresses conditional (past) Medicare payments. The CMS does not allow the compromise of future medical expenses related to a WC injury.

Q12. Additional Information Submission after WCMSA Case Is Closed - If I disagree with the amount that CMS has determined for my WCMSA, do I have any recourse?

A12. There are no appeal rights stemming from a CMS determination of the appropriate amount of a WCMSA; however, claimants and submitters have several other options available to them. First, a claimant or submitter may always contact the Regional Office that issued the CMS determination for a clarification. Also, if the claimant or submitter believes that a CMS determination contains obvious mistakes, such as mathematical errors or failure to recognize that medical records already submitted show that a surgery that CMS priced has already occurred, then the claimant or submitter should contact the CMS Regional Office that issued the CMS determination for a correction of the errors.

Where the claimant or submitter believes that CMS has misinterpreted the evidence or disagrees with the CMS determination for some other reason, there are two choices available. If the claimant or submitter believes that there is additional evidence not previously

considered by CMS that would warrant a change in the CMS determination, the claimant or submitter may resubmit the case with the additional evidence and request a re-evaluation. The re-evaluation request should be clearly marked as such, submitted to the Coordination of Benefits Contractor (COBC), P.O. Box 660, New York, New York 10274-660, and must be accompanied by additional evidence not available at the time of the original submission. It will then be considered a new submission and shall be processed in order of receipt. Although a claimant has no formal appeal rights with respect to the WCMSA process, beneficiaries do have appeal rights with respect to specific denied claims. If CMS denies a submitted claim for a service on the basis that CMS determined the WCMSA amount has not been exhausted, the beneficiary may appeal that specific claim denial through the administrative appeal process.

Q13. Effect of WCMSA on Medicaid Eligibility - Does a WCMSA have an effect on Medicaid resources for purposes of eligibility to Medicaid?

A13. Medicare set-aside arrangements are not subject to any special treatment under Medicaid resource rules. These funds should be evaluated to determine if they meet the legal definition of a resource for Supplemental Security Income (SSI), and therefore Medicaid, purposes, i.e., "cash or other assets that an individual owns and could convert to cash to be used for his or her support and maintenance." The funds must be in interest-bearing accounts. These funds may meet the SSI/Medicaid resource definition.

There may be cases in which funds in a Medicare set-aside arrangement are placed into trusts, possibly trusts that would satisfy the definition of "special needs trusts" under Section 1917 of the Social Security Act. In those cases, the funds might not be a countable resource, but that result would be solely on the basis of Medicaid, not Medicare, rules.

Q14. State Specific Statutes - Does CMS recognize or honor any State-specific statutes that conflict with CMS policy?

A14. The CMS will recognize or honor any non-compensable medical services and CMS will separately evaluate any special situations regarding workers' compensation cases. This is subject to a copy of the applicable statute being forwarded to the COBC, P.O. Box 660, New York, New York 10274-660, as part of the case file.

Q15. Transfer Mechanism for Items and Services Not Covered by Medicare -Is a mechanism for items and services not covered by Medicare that may later become covered necessary?

A15. Should the settlement agreement provide for items and services that are not covered by Medicare but later become covered, those funds should then be considered part of the set-aside and treated accordingly, i.e., used to pay for any services as they were designated in the non-Medicare portion of the set-aside included in the WC settlement. These funds do not have to be transferred to a separate WCMSA bank account or be included in the annual WCMSA accounting.

NOTE: THE ABOVE ANSWER REPLACES THE ANSWER TO QUESTION 7 OF THE JULY **23. 2001** ARA MEMORANDUM.

Please direct questions or concerns to Eve Fisher at (410)-786-5641.

/s/
Gerald Walters

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEMORANDUM

DATE: **April 25, 2006**

FROM: Director
Financial Services Group
Office of Financial Management

SUBJECT: Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs) and Revision of the Low Dollar Threshold for Medicare Beneficiaries

TO: All Regional Administrators

The purpose of this memorandum is to replace Q/A #2 of the July 11, 2005 Memorandum with regard to the Centers for Medicare & Medicaid Services' (CMS') low dollar WCMSA threshold for Medicare beneficiaries. Effective with the issuance of this memorandum, CMS will only review new WCMSA proposals for Medicare beneficiaries where the total settlement amount is greater than $25,000.00. The CMS wishes to stress that this is a CMS **workload review** threshold and not a substantive dollar or "safe harbor" threshold. Medicare beneficiaries must still consider Medicare's interests in all WC cases and ensure that Medicare is secondary to WC in such cases.

Note that the computation of the total settlement amount includes, but is not limited to, wages, attorney fees, all future medical expenses (including prescription drugs) and repayment of any Medicare conditional payments. Payout totals for all annuities to fund the above expenses should be used rather than cost or present values of any annuities. Also note that any previously settled portion of the WC claim must be included in computing the total settlement amount.

Also note that both the beneficiary and non-beneficiary review thresholds are subject to adjustment. Claimants, employers, carriers and their representatives should regularly monitor the CMS website at www.cms.hhs.gov/WorkersCompAgencyServices for changes to these thresholds and for other changes in policies and procedures.

/s/

Gerald Walters

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEMORANDUM

DATE: **July 24, 2006**

FROM: **Director**
Financial Services Group
Office of Financial Management

SUBJECT: **Questions and Answers for Part D and Workers' Compensation Medicare Set-aside Arrangements**

TO: **All Regional Administrators**

This memorandum **supersedes** the Part D and Workers' Compensation Medicare Set-aside Arrangements (WCMSA) memorandum that was published on December 30, 2005. It includes policy regarding the inclusion of future prescription drug treatment costs/expenses in WCMSAs.

> **NOTE:** References to prescription drugs in this document are limited to those prescription drugs that are for the treatment of the Workers' Compensation (WC) related injury(ies) and/or illness(es)/disease(s), (hereinafter referred to as "WC injury") and those where Medicare provides coverage.

Question 1: What is the Centers for Medicare & Medicaid Services' (CMS) policy regarding the inclusion of prescription drugs in WCMSAs with the implementation of the MMA?

Answer 1: All WC settlements that occur on or after January 1, 2006 must consider and protect Medicare's interests when future treatment includes prescription drugs along with the future medical services that would otherwise be reimbursable by Medicare. The recommended method to protect Medicare's interests is to include a WCMSA as part of the WC settlement. However, if the WC claim settled prior to January 1, 2006, the WCMSA proposal does not need to include an amount for future prescription drug treatment.

Question 2: How does CMS define a WC "settlement"?

Answer 2: A WC "settlement" is an executed settlement agreement that is approved by the court of competent jurisdiction for the applicable state.

Question 3: What are CMS' submission requirements if the WC claim did not "settle" (as defined in Answer 2 above) prior to January 1, 2006?

Answer 3: If the WC case did not "settle" (as defined in Answer 2 above) prior to January 1, 2006 and the WCMSA proposal is received by CMS' Coordination of Benefits Contractor (COBC) on or after January 1, 2006, then the submitter must include separate amounts for future medical treatment and future prescription drug treatment in the cover letter. In addition, the cover letter must include an explanation as to how the submitter calculated the future prescription drug treatment amount *(i.e.,* actual costs, average wholesale price, etc.).

For structured WCMSA proposals, the submitter must also indicate whether any portion of the future prescription drug treatment amount has been included in the initial deposit (i.e., seed money). Per Question and Answer Number 5 of the October 15, 2004 memorandum, the seed money for a structured WCMSA must include a sum equal to the amount of monies calculated to cover the first surgery procedure and/or replacement and two years of annual payments (which must include prescription drug treatment). The remainder of the approved amount should be divided by the remainder of the claimant's life expectancy (or a shorter defined period of time if CMS has agreed to a shorter time period).

> **NOTE:** The amount for future prescription drug treatment should **not** be a separate annuity from the future medical portion of the WCMSA.

Question 4: What happens if CMS closes its case because the submitter failed to provide requested information in a timely manner?

Answer 4: If the WC case did not "settle" (as defined in Answer 2 above) prior to January 1, 2006, and the submitter provides additional documentation with regard to the closed case on or after January 1, 2006, the case is considered a new WCMSA submission and the requirements included in this memorandum related to: (1) future medical treatment; and, (2) future prescription drug treatment will be applied to the new WCMSA submission.

If the WC claim settled prior to January 1, 2006 and the submitter provides additional documentation with regard to a closed case, the case is considered a new WCMSA submission; however, the WCMSA proposal **does not** need to include an amount for future prescription drug treatment.

Question 5: Should submitters provide an explanation in the cover letter when the claimant has not been prescribed drugs for the work-related injury, illness/disease or if the drugs prescribed are excludable under the MMA?

Answer 5: Yes. Submitters should provide such an explanation in the cover letter when submitting their WCMSA proposals to CMS.

Question 6: Where a WC claim settled prior to January 1, 2006, can the claimant use the WCMSA funds to pay for prescription drug expenses related to the WC injury?

Answer 6: No, the claimant cannot use the WCMSA funds to pay for prescription drug expenses related to the WC injury. If the WC settlement included an allocation for non-Medicare covered medical and/or prescription drug expenses, the claimant must exhaust those funds prior to billing Medicare for prescription drugs. However, the claimant does not have to transfer these funds to the existing WCMSA account or include them in the annual WCMSA accounting. After exhausting these funds, if the claimant enrolls in a Part D plan, Medicare may be billed for prescription drug expenses related to the WC injury, assuming that the claimant does not have any other coverage primary to Medicare.

> **NOTE:** The above questions clarify Question and Answer Number 5 of the July 11, 2005 memorandum.

Question 7: Should submitters include an amount for future prescription drug expenses if the claimant has not enrolled in a Part D plan?

Answer 7: Yes. Claimants who have not enrolled in a Part D plan need to include future prescription drug expenses in their WCMSA proposals if the current treatment records indicate that the claimant has been prescribed drugs and/or may need future prescription drug treatment related to the WC injury.

Question 8: Has CMS' review of WCMSA proposals changed with the implementation of the MMA on January 1, 2006?

Answer 8: The CMS' review of WCMSA proposals has not changed with the implementation of the MMA. The CMS continues to review and independently price for future Medicare-covered medical expenses in WCMSAs in accordance with CMS' published policy memoranda dated: July 23, 2001; April 21, 2003; May 23, 2003; May 7, 2004; October 15, 2004; July 11, 2005; and April 25, 2006.

For a WCMSA proposal received by COBC on or after January 1, 2006, CMS will provide in its written opinion the total WCMSA amount that adequately protects Medicare's interests with regard to the claimant's future medical treatment. However, CMS' written opinion will also note the submitted prescription drug amount. The CMS' written opinion will provide the total WCMSA amount, which is a combination of the future medical treatment reviewed by CMS and the future prescription drug costs noted in the submitter's cover letter. The parties to the WC settlement must note the total WCMSA amount in the

final settlement agreement. Once the final settlement agreement is submitted to CMS' COBC, the claimant and all other parties to the WC settlement can rely on CMS' written opinion regarding whether the WC settlement adequately protects Medicare's interests.

The total WCMSA amount (future medical treatment and future prescription drug treatment) must be deposited in an interest-bearing account. The administrator of the WCMSA must forward an annual accounting, separately identifying the expenditures for the medical treatment and prescription drug treatment, to the Medicare contractor responsible for monitoring the claimant's case. For example, if the total WCMSA amount in CMS' written opinion is $10,000 ($7,000 identified for future prescription drug treatment and $3,000 identified for future medical expenses), then the administrator must forward an annual accounting that separately identifies how much of the $10,000 was spent for medical expenses and prescription drugs. Exhaustion of the total WCMSA amount is not limited to the separate amounts set-aside for future medical expenses and future prescription drug treatment. As long as the annual accounting shows bona fide payments were made from the total WCMSA account, CMS will consider the account appropriately exhausted. For example, final actual expenditures may be $6,000 for future prescription drug treatment and $4,000 for the future medical expenses that may appropriately exhaust the $10,000 WCMSA.

Question 9: What happens if a WCMSA proposal received by the COBC on or after January 1, 2006, does not include an amount for future prescription drug treatment?

Answer 9: If the cover letter does not include an amount for future prescription drug treatment, and the current treatment records indicate that the claimant has been prescribed drugs and/or may need prescription drugs related to the WC injury in the future, the submitter did not adequately consider Medicare's interests. In such a case, CMS, in its written opinion, will advise the submitter that the parties to the WC settlement have not protected Medicare's interests.

If the cover letter does not include an amount for future prescription drug treatment, and there is <u>no indication</u> in the current treatment records that the claimant will need future treatment with prescription drugs related to the WC injury, then CMS will accept that Medicare's interests have been adequately protected. Medicare will then pay primary for future prescription drags if the beneficiary has enrolled in a Medicare prescription drug plan and does not have any other coverage that is primary to Medicare.

Question 10: Has CMS published any guidelines about how to price for future prescription drug expenses in WCMSAs?

Answer 10: No. The CMS has not published any guidelines regarding the pricing for future prescription drug expenses in WCMSAs.

Question 11: Should funds for future prescription drug treatment be included in the calculation of the total settlement amount to determine if the WCMSA proposal should be reviewed by CMS?

Answer 11: Yes, the total settlement amount calculation should include an amount for prescription drugs if the future treatment indicates that the claimant has been prescribed drugs and/or may need drugs in the future. As stated in the July 11, 2005 memorandum, the computation of the total settlement amount includes, but is not limited to, wages, attorney fees, ***all*** future medical expenses, and repayment of any Medicare conditional payments. Payout totals for all annuities to fund the above expenses should be used rather than cost or present values of any annuities. Also note that any previously ***settled*** portion of the WC claim must be included in computing the total settlement amount.

Current review thresholds for Medicare beneficiary and non-beneficiary WCMSA proposals will remain in effect as stated in the following policy memoranda: July 23, 2001; April 21, 2003; May 23, 2003; May 7, 2004; October 15, 2004; July 11, 2005; and April 25, 2006.

> **NOTE:** Question and Answer Number 11 is not a change in CMS' policy for determining whether a WC settlement that includes a WCMSA meets CMS' review thresholds.

Question 12: Do claimants have to resubmit their WCMSA proposals if CMS already issued a written opinion as to the total WCMSA amount?

Answer 12: No, claimants do not have to resubmit their WCMSA proposals if CMS has already issued a written opinion as to the total WCMSA amount.

> **NOTE:** If the WC settlement occurred prior to January 1, 2006, and the WC settlement included an allocation for future prescription drug treatment, then the claimant must exhaust those funds before Medicare can be billed for those future prescription drugs. For example, if the WC settlement allocates $5,000 for prescription drugs related to the WC injury, then the claimant must exhaust that amount from the settlement funds before Medicare can be billed for prescription drug costs incurred on or after January 1, 2006. However, the claimant does not have to transfer these funds to the existing WCMSA account or include them in the annual WCMSA accounting.

> **NOTE:** The above note clarifies Question and Answer Number 15 of the July 11, 2005 memorandum.

Question 13: Will CMS begin to independently price for future prescription drug treatment in WCMSAs beginning on January 1, 2007?

Answer 13: No. Beginning January 1, 2007, CMS will not change its current procedures and will not independently price for future prescription drug treatment in WCMSA

proposals. The CMS will provide advanced notification when it plans to begin to independently price for future prescription drug treatment in WCMSAs. The CMS will continue to review and independently price for future Medicare-covered medical expenses in WCMSAs in accordance with CMS' published policy memoranda dated: July 23, 2001; April 21, 2003; May 23, 2003; May 7, 2004; October 15, 2004; July 11, 2005; and April 25, 2006.

/s/

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