AETNA MEDICARE OPEN℠ PLAN
PROVIDER TERMS AND CONDITIONS OF PAYMENT

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1. Introduction

Aetna Medicare Open Plan is a Medicare Advantage private fee-for-service (PFFS) plan offered by Aetna Life Insurance Company (Aetna). Aetna Medicare Open Plan allows members to use any provider, such as a physician, health professional, hospital, or other Medicare provider in the United States that agrees to treat the member after having the opportunity to review these terms and conditions of payment, as long as the provider is eligible to provide health care services under Medicare Part A and Part B (also known as 'Original Medicare') or eligible to be paid by Aetna Medicare Open Plan for benefits that are not covered under Original Medicare.

The law provides that if you have an opportunity to review these terms and conditions of payment and you treat an Aetna Medicare Open Plan member, you will be "deemed" to have a contract with us. Section 2 explains how the deeming process works. The rest of this document contains the contract that the law allows us to deem to hold between you, the provider, and Aetna Medicare Open Plan. Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with Aetna Medicare Open Plan for the services furnished to the member when the deeming conditions are met. **No prior authorization, prior notification, or referral is required as a condition of coverage when medically necessary, plan-covered services are furnished to a member.** However, a member or provider may request an advance coverage determination before a service is provided in order to confirm that the service is medically necessary and will be covered by the plan. Note that the terms prior authorization, prior notification, and advance coverage determination have different meanings. Prior authorization and prior notification rules are described in Section 4, and advance coverage determination is described in Section 7.

2. When a provider is deemed to accept Aetna Medicare Open Plan terms and conditions of payment

A provider is considered by law to be ***deemed*** to have a contract with Aetna Medicare Open Plan when all of the following three criteria are met:

1) The provider is aware, in advance of furnishing health care services, that the patient is a member of Aetna Medicare Open Plan. All of our members receive a member ID card that includes the Aetna Medicare Open Plan logo that clearly identifies them as PFFS members. The provider may further validate eligibility by calling our Provider Service Center at 1-800-624-0756, or by enrolling in Aetna Medicare Open Plan's secure provider website via www.aetna.com.
2) The provider either has a copy of, or has reasonable access to, our terms and conditions of payment (this document). The terms and conditions are available on our website at www.aetna.com/pffs. The terms and conditions may also be obtained by calling our Provider Service Center at 1-800-624-0756.
3) The provider furnishes covered services to an Aetna Medicare Open Plan member.

If all of these conditions are met, the provider is deemed to have agreed to Aetna Medicare Open Plan terms and conditions of payment for that member specific to that visit. **Note**: You, the provider, can decide whether or not to accept Aetna Medicare Open Plan terms and conditions of payment each time you see an Aetna Medicare Open Plan member. A decision to treat one plan member does not obligate you to treat other Aetna Medicare Open Plan members, nor does it obligate you to accept the same member for treatment at a subsequent visit.

For example: If an Aetna Medicare Open Plan member shows you an enrollment card identifying him/her as a member of Aetna Medicare Open Plan and you provide services to that member, you will be considered a deemed provider. Therefore, it is your responsibility to obtain and review the terms and conditions of payment prior to providing services, except in the case of emergency services (see below).

If you DO NOT wish to accept Aetna Medicare Open Plan's terms and conditions of payment, then you should not furnish services to an Aetna Medicare Open Plan member, except for emergency services. If you nonetheless do furnish non-emergency services, you will be subject to these terms and conditions whether you wish to agree to them or not. Providers furnishing emergency services will be treated as non-contract providers and paid at the payment amounts they would have received under Original Medicare.

3. Provider qualifications and requirements

In order to be paid by Aetna Medicare Open Plan for services provided to one of our members, you must:

- Have a National Provider Identifier in order to submit electronic transactions to Aetna Medicare Open Plan, in accordance with HIPAA requirements.
- Providers must agree to submit claims for covered services to Aetna Medicare Open Plan for reimbursement rather than a Medicare carrier or fiscal intermediary, with the exception of providers rendering covered services under a Medicare-certified Hospice Program.

  All member cost-sharing should be collected by the provider at the time that covered services are provided to the member. Details on member cost-sharing amounts are included on the Aetna Medicare Open Plan member ID card, or can be found by checking "Eligibility and Benefits Inquiry" on our secure provider website via www.aetna.com. You may also obtain this information by contacting our Provider Service Center at 1-800-624-0756.

  Electronic Claims Submission: Providers must submit electronic claims using Aetna Medicare Open Plan's electronic Payer ID #60054.

  Paper Claims Submission: Providers must send paper claims to:
  Aetna Life Insurance Company

PO Box 981107
El Paso, TX 79998-1107

Providers must submit all paper claims for covered services as soon as possible using an Aetna Medicare Open Plan claim form or by using the standard CMS-1500 or UB-04 form.

- Furnish services to an Aetna Medicare Open Plan member within the scope of your licensure or certification.
- Provide only services that are covered by our plan and that are medically necessary by Medicare definitions.
- Meet applicable Medicare certification requirements (e.g., if you are an institutional provider such as a hospital or skilled nursing facility).
- Not have opted out of participation in the Medicare program under §1802(b) of the Social Security Act, unless providing emergency or urgently needed services.
- Not be on the HHS Office of Inspectors General excluded and sanctioned provider lists.
- Not be a Federal health care provider, such as a Veterans' Administration provider, except when providing emergency care.
- Comply with all applicable Medicare and other applicable Federal health care program laws, regulations, and program instructions, including laws protecting patient privacy rights and HIPAA that apply to covered services furnished to members.
- Agree to cooperate with Aetna Medicare Open Plan to resolve any member grievance involving the provider within the time frame required under Federal law.
- For providers who are hospitals, home health agencies, skilled nursing facilities, or comprehensive outpatient rehabilitation facilities, provide applicable beneficiary appeals notices (See Section 10 for specific requirements).
- Not charge the member in excess of cost sharing and permitted balance billing under any condition, including in the event of plan bankruptcy.

4. Payment to providers

Plan payment

Aetna Medicare Open Plan reimburses deemed providers at the current Medicare allowable charge, as described in the Aetna Medicare Open Plan Reimbursement Grid, minus any member required cost sharing, for all medically necessary services covered by Medicare. We will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, then we will pay interest on the claim according to Medicare guidelines. Section 5 has more information on prompt payment rules. Payment to providers for which Medicare does not have a publicly published rate

will be based on the estimated Medicare amount. For more detailed information about our payment methodology for all provider types, go to www.aetna.com.

Services covered under the Aetna Medicare Open Plan that are not covered under Original Medicare are reimbursed using the Aetna Market Fee Schedule Please call us at 1-800-624-0756 to receive information on our fee schedule.

Deemed providers furnishing such services must accept the payment amount described in the Aetna Medicare Open Plan Reimbursement Grid, minus applicable member cost sharing as payment in full.

Member benefits and cost sharing

Payment of cost sharing amounts is the responsibility of the member. Providers should collect the applicable cost sharing from the member at the time of the service when possible. **You can only collect from the member the appropriate Aetna Medicare Open Plan co-payments or coinsurance amounts described in these terms and conditions.** After collecting cost sharing from the member, the provider should bill Aetna Medicare Open Plan for covered services. Section 5 provides instructions on how to submit claims to us. If a member is a dual-eligible Medicare beneficiary (that is, the member is enrolled in our PFFS plan and a state Medicaid program) that the state holds harmless for Medicare cost sharing, then the provider cannot collect any cost sharing from the member at the time of service. Instead, the provider may only look to the State Medicaid agency to collect the Medicaid allowable cost sharing amount(s).

You may call us at 1-800-624-0756 to obtain more information about covered benefits, plan payment rates, and member cost sharing amounts under Aetna Medicare Open Plan. Be sure to have the member's ID number when you call.

Aetna Medicare Open Plan follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by Aetna Medicare Open Plan, unless specified by the plan. Information on obtaining an advance coverage determination can be found in Section 7. Aetna Medicare Open Plan does not require members or providers to obtain prior authorization, prior notification, or referrals from the plan as a condition of coverage. Under prior authorization, a plan requires beneficiaries or providers to seek authorization from the plan prior to obtaining services. There is no such requirement for Aetna Medicare Open Plan members.

Note: Medicare supplemental policies, commonly referred to as Medigap plans, cannot cover cost sharing amounts for Medicare Advantage plans, including PFFS plans. All cost sharing is the member's responsibility.

Balance billing of members

In addition to collecting applicable plan cost sharing amounts from Aetna Medicare Open Plan members, providers that do not accept assignment with Original Medicare may balance bill the member up to 15% of the total plan payment amount for the service(s) furnished. Note that Aetna Medicare Open Plan does not permit a provider to balance bill a member who is also enrolled in a state Medicaid program and as a result the beneficiary is held harmless from Medicare cost sharing.

Hold harmless requirements

In no event, including, but not limited to, nonpayment by Aetna Medicare Open Plan, insolvency of Aetna Medicare Open Plan, and/or breach of these terms and conditions, shall a deemed provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a member or persons acting on their behalf for plan-covered services provided under these terms and conditions. This provision shall not prohibit the collection of any applicable coinsurance, co-payments, or deductibles in addition to allowed balance billing amounts billed in accordance with the terms of the member's benefit plan.

If any payment amount is mistakenly or erroneously collected from a member, you must make a refund of that amount to the member.

5. Filing a claim for payment

- You must submit a claim to Aetna Medicare Open Plan for an Original Medicare covered service within the same time frame you would have to submit under Original Medicare, which is within 15-27 months from the date of service. Failure to be timely with claim submissions may result in non-payment. The criteria for Original Medicare submission of claims can be found in section 70 of Chapter 1 of the Medicare Claims Processing Manual located at http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf.

- **Prompt Payment** Aetna Medicare Open Plan will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, Aetna Medicare Open Plan will pay interest on the claim according to Medicare guidelines. A clean claim includes the minimum information necessary to adjudicate a claim, not to exceed the information required by Original Medicare. Aetna Medicare Open Plan will process all non-clean claims and notify providers of the determination within 60 days of receiving such claims.

- Submit claims using the standard CMS-1500, CMS-1450 (UB-04), or the appropriate electronic filing format.

- Use the same coding rules and billing guidelines as Original Medicare, including Medicare CPT Codes, HCPCS codes and defined modifiers. Bill diagnosis codes to the highest level of specificity.

- Include the following on your claims:

    - National Provider Identifier.
    - The member's ID number.
    - Date(s) of service.

- For providers that are paid based upon interim rates, include with your claim a copy of your current interim rate letter if the interim rate has changed since your previous claim submission.

- Coordination of Benefits: All Medicare secondary payer rules apply. These rules can be found in the Medicare Secondary Payer Manual located at:

  http://www.cms.hhs.gov/Manuals/IOM/list.asp

Providers should identify primary coverage and provide information to Aetna Medicare Open Plan at the time of billing.

- Where to submit a claim:

    - For electronic claim submission, providers must submit electronic claims using Aetna Medicare Open Plan's electronic Payer ID #60054.
      .
    - For paper claim submission, providers must send paper claims to:

      Aetna Life Insurance Company
      PO Box 981107
      El Paso, TX 79998-1107

      Providers must submit all paper claims for covered services as soon as possible by using the standard CMS-1500, CMS-1450 (UB-04).

- If you have problems submitting claims to us or have any billing questions, contact our technical billing resource at 1-800-624-0756

6. Maintaining medical records and allowing audits

Deemed providers shall maintain timely and accurate medical, financial and administrative records related to services they render to Aetna Medicare Open Plan members. Unless a longer time period is required by applicable statutes or regulations, the provider shall maintain such records for at least 10 years from the date of service. Deemed providers must provide Aetna Medicare Open Plan, the Department of Health and Human Services, the Comptroller General, or their designees access to any books, contracts, medical records, patient care documentation, and other records maintained by

the provider pertaining to services rendered to Medicare beneficiaries enrolled in a Medicare Advantage plan, consistent with Federal and state privacy laws. Such records may be used for activities in the following situations: Centers for Medicare & Medicaid Services and Aetna Medicare Open Plan audits of risk adjustment data; Aetna Medicare Open Plan determinations of whether services are covered under the plan, are reasonable and medically necessary, and whether the plan was billed correctly for the service; and in order to make advance coverage determinations. Aetna Medicare Open Plan will not use medical record reviews to create artificial barriers that would delay payments to providers. Both voluntary and mandatory provision of medical records must be consistent with HIPAA privacy law requirements.

7. Getting an advance coverage determination

Providers may choose to obtain a written advance coverage determination (also known as an organization determination) from us before furnishing a service in order to confirm whether the service is medically necessary and will be covered by Aetna Medicare Open Plan. To obtain an advance coverage determination, call us at 1-800-624-0756. Aetna Medicare Open Plan will make a decision and notify you within 14 days of receiving the request, with a possible 14-day extension either due to the member's request or Aetna Medicare Open Plan justification that the delay is in the member's best interest. In cases where you believe that waiting for a decision under this time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy, you can request an expedited determination. To obtain an expedited determination, call us at 1-800-624-0756. We will notify you of our decision within 72 hours.

In the absence of an advance coverage determination, Aetna Medicare Open Plan can retroactively deny payment for a service furnished to a member if we determine that the service was not covered by our plan or was not medically necessary. However, providers have the right to dispute our decision by exercising member appeals rights.

8. Provider payment dispute resolution process

If you believe that the payment amount you received for a service is less than the amount indicated in our terms and conditions of payment, you have the right to dispute the payment amount by following our dispute resolution process.

To file a payment dispute with Aetna send a written dispute to:

Aetna
P.O. Box 14020
Lexington, KY 40512

or call us at 1-800-624-0756.

Additionally, please provide appropriate documentation to support your payment dispute: (e.g., a remittance advice from a Medicare carrier, other supporting documents, as needed, such as medical records, office notes, etc.). Claims must be disputed within 180 days from the date of the initial decision.

We will review your dispute and respond to you within 30 days of receipt of the dispute unless we need additional information. If we need additional information, we will respond within 30 days of receipt of the requested additional information. If we agree with your payment dispute, then we will pay you the additional amount with any interest that is due. We will inform you in writing if your payment dispute is denied.

After completing Aetna's dispute resolution process, if you believe that we have reached an incorrect decision regarding your payment dispute, you may file a request for review of this determination with an independent entity contracted by CMS. To file a request for review of a payment dispute with the independent entity, you may contact the entity directly at:

First Coast Service Options, Inc.
PFFS Payment Disputes
P.O. Box 44017
Jacksonville, Florida 32231-4017
Phone: (904) 791- 6430
Fax: (904) 361- 0551
Email: IREPFFS@FCSO.com

9. Member and provider appeals and grievances

Aetna Medicare Open Plan members have the right to file appeals and grievances when they have concerns or problems related to coverage or care. Members may appeal a decision made by Aetna Medicare Open Plan to deny coverage or payment for a service or benefit that they believe should be covered or paid for. Members should file a **grievance** for all other types of complaints.

A provider may appeal decisions on behalf of a member as an appointed representative, or appeal on his or her own right using the member's appeal process by signing a waiver of liability (promising to hold the member harmless regardless of the outcome). There must be existing potential member liability (e.g., a claim, as opposed to an advance coverage determination, is denied as not a medically necessary or a covered service) in order for a provider to appeal utilizing the member's appeal process. If you appeal on your own right, you agree to abide by the statutes, regulations, standards, and guidelines applicable to the Medicare PFFS Member appeals and grievance process.

The Aetna Medicare Open Plan Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance process. You can call our Member Services Department at 866-785-7337 for more information on our member appeals and grievance policies and procedures.

10. Providing members with notice of their appeals rights – Requirements for Hospitals, SNFs, CORFs, and HHAs

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their discharge appeal rights by complying with the requirements for providing the Important Message from Medicare (IM), including the time frames for delivery. For copies of the notice and additional information regarding this requirement, go to: http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp

Skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities must notify Medicare beneficiaries about their right to appeal a termination of services decision by complying with the requirements for providing Notice of Medicare Non-Coverage (NOMNC), including the time frames for delivery. For copies of the notice and the notice instructions, go to: http://www.cms.hhs.gov/MMCAG/Downloads/NOMNCForm.pdf and http://www.cms.hhs.gov/MMCAG/Downloads/NOMNCInstructions.pdf. In addition, the provider should send a copy of any NOMNC issued to:

Aetna Service Center
3 Independence Way
Mailstop F075
Princeton, NJ 08540

Aetna Medicare Open Plan will provide members with a detailed explanation if a member notifies the Quality Improvement Organization (QIO) that the member wishes to appeal a decision regarding a hospital discharge or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility services within the time frames specified by law.

11. If you need additional information or have questions

If you have general questions about Aetna's Medicare Open Plan terms and conditions of payment, contact us at:
Aetna Provider Service Center
1-800-624-0756
Monday – Friday, 8:00 a.m. to 8:00 p.m. ET
Fax 859-455-8650

Aetna Life Insurance Company
PO Box 981107
El Paso, TX 79998-1107

- If you have questions about submitting claims, call us at 1-800-624-0756.
- If you have questions about plan payments, call us at 1-800-624-0756.

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