

AETNA MEDICARE OPENSM PLAN
PROVIDER TERMS AND CONDITIONS OF PARTICIPATION
DEEMED PROVIDERS

The Aetna Medicare Open Plan is a Medicare Advantage Private Fee-for-Service plan offered by Aetna Life Insurance Company (Aetna). Aetna does not contract with Providers for the Aetna Medicare Open Plan (Plan). Instead, Providers may choose to become “deemed” to participate in the Plan. Providers are considered “deemed” when,

- before rendering services, they have knowledge that a Medicare beneficiary is enrolled in the Plan;
- were informed of, or have a reasonable opportunity to obtain, Aetna’s Terms and Conditions of Participation in the Plan (see below); and
- they render items and services that are covered under the Plan (Covered Services).

Once these conditions are met, the Provider is considered a “deemed” provider that is participating in the Plan and will be subject to these Terms and Conditions of Participation when providing Covered Services.

A Provider that does not agree to accept these Terms and Conditions of Participation may **not** render services to a member and may not bill the member unless services are provided on an urgent or emergency basis.

Providers who are not eligible to provide services and/or receive payment under Original Medicare cannot be a deemed Provider and participate in the Plan. Federal health care providers, including Veterans Administration facilities, are not eligible for reimbursement under the Plan, except when providing emergency care.

PROVIDER TERMS & CONDITIONS OF PARTICIPATION

If you have any questions or require further information regarding these Terms and Conditions of Participation, please visit Aetna online at www.aetna.com or call us at 1-800-624-0756.

Generally, the Aetna Medicare Open Plan Terms and Conditions of Participation include the following provisions:

A. PROVIDERS:

- Must be eligible to participate in Medicare and be licensed or certified by the state in their specialty and be acting within the scope of that license or certification, and must not be sanctioned or excluded from participation in a federal health care program or have opted out of Medicare.
- Must abide by Medicare and all other laws, rules and regulations applicable to the Medicare Advantage program and/or Covered Services, including laws, rules and regulations pertaining to inspectors and audits, patient privacy and confidentiality and HIPAA.
- Must issue written notices to patients in advance of services ending. Skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities agree to comply with timely issuance of the Notice of Medicare Non-Coverage (NOMNC) and work with the plan to complete the Detailed Explanation of Non-Coverage (DENC). Hospitals must provide inpatients with the Important Message

from Medicare (IM) and work with the plan to complete the Detailed Notice of Discharge (DND). Providers can access these notices and instructions via the CMS website at <http://www.cms.hhs.gov/BNI/>

- Must abide by Aetna's Medicare Advantage member Grievance and Appeal policies and procedures. For more information regarding these policies and procedures contact Aetna.
- Must agree to cooperate with requests for medical records made by Aetna in support of the following types of reviews: Medicare risk adjustment data validation; advance determinations of coverage; medical necessity; fraud, waste and abuse; and appropriate billing practices.
- If a Provider disagrees with Aetna's claims review or organization determination on the Evidence of Provider Payment (EPP), the Provider has the right to file a request for review. This request for review can be oral or in writing and must be filed within 180 calendar days after the date of the EPP. Providers may access details on the Aetna Provider Appeal process by visiting us at www.aetna.com/provider/medical_providers.html or call us at 1-800-624-0756.
- Providers that agree to these Terms and Conditions of Participation must agree not to balance bill members above any applicable cost-sharing amounts, except that Providers that do not accept assignment may balance bill members up to the Medicare limiting charge for Medicare covered services (i.e., 15% over the Medicare allowable amount, unless the state has established a different amount). If a Provider collects more from a member than the amounts permitted under these Terms and Conditions of Participation, the Provider must refund the difference to the member.
- Details on member cost-sharing amounts are included on the Aetna Medicare Open Plan ID Card. If a member or provider is not sure whether a service will be covered under the Plan, they have the right to call Aetna and request an advance determination of coverage. Providers may obtain detailed Plan benefit and cost-sharing information by contacting Aetna at 1-800-624-0756, or by enrolling in Aetna's secure provider website at www.aetna.com. Copies of our individual Aetna Medicare Open Plan summary of benefits are available at www.aetnamedicare.com.
- Providers that do not accept the Terms and Conditions of Participation and do not accept Medicare assignment may balance bill members up to the Medicare limiting charge when rendering urgent or emergency services.
- Must follow the standards for patient's rights as outlined in the Aetna Member's Rights and Responsibilities. Providers may access details on Aetna Member's Rights and Responsibilities by contacting Aetna.
- Must agree that in no event, including but not limited to non-payment by Aetna, insolvency of Aetna or breach of these Terms and Conditions of Participation, shall the Provider or the Provider's assignees and/or subcontractors bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a member or persons having authority to act on behalf of the member, for Covered Services. This provision does not prohibit a Provider from collecting charges for non-covered services agreed to in advance in writing by the member or member cost-sharing amounts applicable under the Plan.

B. PAYMENT/BILLING INFORMATION

- Aetna will process all claims for services rendered to Aetna Medicare Open Plan members from Hospitals, physicians and other health care professionals within 30 days of receipt of a “clean” claim. A “clean” claim is one with no defect, impropriety, or lack of any required substantiating documentation as defined on the Aetna Medicare Open Plan Reimbursement Grid. Providers will receive as payment in full, the current Medicare allowable charge less any applicable member cost-sharing amounts. Aetna will make payment for all Covered Services under the Plan, as described in the Aetna Medicare Open Plan Reimbursement Grid.
- Where no Original Medicare allowable charge exists or is readily available, the Provider will be paid an estimated Medicare payment amount, and may collect only applicable cost-sharing amounts from the PFFS member and may not otherwise charge or bill the member. For additional details please refer to the Aetna Medicare Open Plan Reimbursement Grid.
- The Aetna Medicare Open Plan requires that all claims be submitted in accordance with Original Medicare’s timely filing limits. Original Medicare requires claims to be filed on or before December 31 of the calendar year following the year in which the services were furnished, unless the claim is incurred in the last 3 months of a year. The time limit on filing claims for services furnished in the last 3 months of a year is the same as if the services were furnished in the subsequent year. Thus, the time limit on filing claims for services furnished in the last 3 months of the year is December 31 of the second year following the year in which the services were rendered. A clean claim, one with no defect, impropriety, or lack of any required substantiating documentation as defined on the Aetna Medicare Open Plan Reimbursement Grid, must be received by Aetna prior to the expiration of the timely filing period.
- Aetna will process claims in accordance with Original Medicare billing rules, Medicare prompt payment provisions, the Medicare allowable fee schedule, and all prospective payment system requirements and Local Coverage Determinations (LCDs).
- In accordance with Medicare Secondary Payer rules, Aetna is precluded from paying for any member’s medical expenses where payment has been made or can reasonably be expected to be paid by another liable party which includes, but is not limited to: Employer group health plan, Worker’s compensation, No-fault or liability insurer and Federal Black Lung program. A Provider must include the primary payer’s Explanation of Payment when submitting a claim to Aetna for secondary payment.
- For Covered Services, Providers must submit claims using the same coding rules as Original Medicare, and use HCPCS, CPT codes and defined modifiers. Providers must follow all Medicare billing guidelines for claims submission. Providers must include all claims information required by Original Medicare, and certify that, to the best of the Provider’s knowledge, information, and belief, that the information provided to Aetna with respect to each such claim is accurate, complete and truthful.

Please refer to the Aetna Medicare Open Plan Reimbursement Grid, which is made a part of these Terms and Conditions of Participation by reference, for full details regarding claim billing and payment amounts.

C. CLAIMS SUBMISSIONS FORMAT

Providers must agree to submit claims for Covered Services to Aetna 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 must 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 ID card or may be obtained by contacting Aetna at 1-800-624-0756 or by enrolling in Aetna's secure provider website at www.aetna.com.

- Electronic Claims Submission: Providers must submit electronic claims using Aetna'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 claim form or by using the standard CMS-1500 or UB-92 form.

Benefits coverage is provided by Aetna Life Insurance Company, a Medicare Advantage organization, with a Medicare contract.

**POLICY ON MODIFICATIONS TO THE AETNA MEDICARE OPENSM PLAN
PROVIDER TERMS AND CONDITIONS OF PARTICIPATION AND THE AETNA
MEDICARE OPENSM PLAN REIMBURSEMENT GRID**

Generally, Aetna will only make changes to the Aetna Terms and Conditions of Participation and/or the Aetna Medicare Open Plan Reimbursement Grid on a quarterly basis, unless we determine that we must immediately change the Terms and Conditions to ensure compliance with Medicare laws, rules or regulations or CMS instructions, or to ensure the clarity and accuracy of requirements described in the Terms and Conditions. Content changes made by Aetna to the Terms and Conditions and the Reimbursement Grid will be submitted to CMS for review prior to posting on Aetna's website at www.aetna.com.

Providers may also obtain copies of the Terms and Conditions and information regarding the Terms and Conditions by calling our Provider Service Center telephone number at 1-800-624-0756. Aetna will provide copies of the Terms and Conditions and provide information regarding the Terms and Conditions by phone, mail or by fax, as requested by the provider. Providers are responsible for understanding Aetna's Terms and Conditions.

For additional information and details on the Aetna Medicare Open Plan, please visit the Health Care Professionals section of www.aetna.com or call Aetna Provider Services at 1-800-624-0756, Monday through Friday, 8 a.m.-5 p.m.

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