



**A Medicare Advantage  
Private Fee-for-Service  
Group Plan**

**Terms and Conditions  
of Payment**

**January 1, 2010 -  
December 31, 2010**

**STERLING HEALTH PLANS**

Real People. Wise Choices.

Underwritten by Sterling Life Insurance Company®

**CONTRACT YEAR 2010 MEDICARE ADVANTAGE  
PRIVATE FEE-FOR-SERVICE PLAN  
TERMS AND CONDITIONS OF PAYMENT**

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## 1. Introduction

Sterling Retiree Options<sup>SM</sup> is a Medicare Advantage private fee-for-service (PFFS) plan offered by Sterling Life Insurance Company. Sterling allows enrollees to use any provider, such as a physician, health professional, hospital, or other Medicare provider in the United States that agrees to treat the enrollee 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 Sterling 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 a Sterling enrollee, 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 Sterling. Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with Sterling for the services furnished to the enrollee 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 an enrollee.** However, an enrollee or provider may request an advance organization 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 organization determination have different meanings. Prior authorization and prior notification rules are described in Section 4, and advance organization determination is described in Section 7.

## 2. When a provider is deemed to accept Sterling’s terms and conditions of payment

A provider is deemed by law to have a contract with Sterling 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 an enrollee of Sterling. All of our enrollees receive an enrollment ID card that includes the Sterling logo that clearly identifies them as PFFS enrollees. The provider may validate eligibility by calling our Customer Service Department at [1-888-858-8551].
- 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 [<https://secure.sterlingplans.com/providers/index.html>]. The terms and conditions may also be obtained by calling our Customer Service Department at [1-888-858-8551].
- 3) The provider furnishes covered services to a Sterling enrollee.

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

For example: If a Sterling enrollee shows you an enrollment card identifying him/her as an enrollee of Sterling and you provide services to that enrollee, 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 Sterling's terms and conditions of payment, then you should not furnish services to a Sterling enrollee, 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 Sterling for services provided to one of our enrollees, you must:

- Have a National Provider Identifier in order to submit electronic transactions to Sterling, in accordance with HIPAA requirements.
- Paper claims may be sent to: Sterling Life Insurance Company, [P.O. Box 69314, Harrisburg, PA 17106-9314].
- Furnish services to a Sterling enrollee 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 enrollees.
- Agree to cooperate with Sterling to resolve any enrollee 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 enrollee in excess of cost sharing under any condition, including in the event of plan bankruptcy.

### **4. Payment to providers**

#### **Plan payment**

Sterling reimburses deemed providers at the amount they would have received as participating providers under Original Medicare for Medicare-covered services, minus any

enrollee required cost sharing, for all medically necessary services covered by Medicare. Sterling will pay Physician Quality Reporting Initiative (PQRI) bonus and e-prescribing incentive payment amounts to physicians who would receive them in connection with treating Medicare beneficiaries who are not enrolled in a Medicare Advantage plan.

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 [<https://secure.sterlingplans.com/providers/providermanual.html>].

Services covered under Sterling that are not covered under Original Medicare are reimbursed using the following fee schedule located at [<https://secure.sterlingplans.com/providers/providermanual.html>].

Deemed providers furnishing such services must accept the fee schedule amount, minus applicable enrollee cost sharing, as payment in full.

### **Enrollee benefits and cost sharing**

Payment of cost sharing amounts is the responsibility of the enrollee. Providers should collect the applicable cost sharing from the enrollee at the time of the service when possible. **You can only collect from the enrollee the appropriate Sterling co-payments or coinsurance amounts described in these terms and conditions.** After collecting cost sharing from the enrollee, the provider should bill Sterling for covered services. Section 5 provides instructions on how to submit claims to us.

For your quick reference, please refer to Exhibit A of this document which lists some of the important services covered under Sterling and the associated enrollee cost sharing amounts.

To view a complete list of covered services and enrollee cost sharing amounts under Sterling, go to [<https://secure.sterlingplans.com/providers/providermanual.html>]. You may call us at [1-888-858-8551] to obtain more information about covered benefits, plan payment rates, and enrollee cost sharing amounts under Sterling. Be sure to have the enrollee's ID number when you call.

Sterling follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by Sterling, unless specified by the plan. Information on obtaining an advance coverage determination can be found in Section 7. Sterling does not require enrollees 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 Sterling enrollees. For information on Sterling's prior notification policies, see section on "Prior notification rules" below.

**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 enrollee's responsibility.**

### **Prior notification rules**

No prior authorization or referral is required as a condition of coverage when medically necessary, plan-covered services are furnished to enrollees. However, to assist us in better managing care for our enrollees, we request that you notify us *prior* to the enrollee receiving any of the following services: Prior notification is requested for planned inpatient hospital admissions. Prior notification is requested for Durable Medical Equipment (DME) and/or prosthetic devices purchases over [\$750].

Sterling does not require the enrollee or the provider to prior notify the plan as a condition for covering services. To provide prior notification or to obtain more information about our prior notification rules, call us at [1-888-858-8551].

### **Balance billing of enrollees**

A provider may collect only applicable plan cost sharing amounts from Sterling enrollees and may not otherwise charge or bill enrollees. Balance billing is prohibited by providers who furnish plan-covered services to Sterling enrollees.

### **Hold harmless requirements**

In no event, including, but not limited to, nonpayment by Sterling, insolvency of Sterling, 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 an enrollee 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 billed in accordance with the terms of the enrollee's benefit plan.

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

## **5. Filing a claim for payment**

- You must submit a claim to Sterling for an Original Medicare covered services 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** Sterling will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, Sterling 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. Sterling 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. Please refer to the General Billing Tips in Exhibit B.
- 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 enrollee's ID number.
  - Date(s) of service.
- 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 Sterling at the time of billing.
- Where to submit a claim:
  - For electronic claim submission, Sterling's electronic Payer number with Availity (formerly THIN), ClaimsNet and Emdeon is [#91151].
  - For paper claim submission, mail to Sterling Health Plans, [P.O. Box 69314, Harrisburg, PA 17106-9314].
  - For electronic Part B covered drugs claim submission, Sterling requires the following two items of information: [Bin# 004303] and [PCN# STERLING]. Pharmacies billing for Part B covered drugs who need to be activated in our billing system should call [1-877-264-1221].
- If you have problems submitting claims to us or have any billing questions, contact Customer Service at [1-888-858-8551].

## **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 Sterling enrollees. 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 Sterling, 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 will primarily be used for Centers for Medicare & Medicaid Services (CMS) audits of risk adjustment data upon which CMS capitation payments to Sterling are based. To encourage providers to submit

enrollee medical records to Sterling in this case, Sterling will reimburse the provider for the cost of copying and forwarding requested medical records and/or send plan staff on-site to obtain copies of the records it is requesting.

Sterling may also request records for activities in the following situations: Sterling audits of risk adjustment data, determinations of whether services are covered under the plan, are reasonable and medically necessary, and whether the plan was billed correctly for the service; to investigate fraud and abuse; and in order to make advance coverage determinations. Sterling will not use these records for any purpose other than the intended use. To encourage providers to submit enrollee medical records to Sterling in this case, Sterling will reimburse the provider for the cost of copying and forwarding requested medical records and/or send plan staff on-site to obtain copies of the records it is requesting.

Sterling will not use medical record reviews to create artificial barriers that would delay payments to providers. Both mandatory and voluntary provision of medical records must be consistent with HIPAA privacy law requirements.

## **7. Getting an advance organization determination**

Providers may choose to obtain a written advance coverage determination (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 Sterling. To obtain an advance organization determination, call us at [1-888-858-8551]. Sterling will make a decision and notify you and the enrollee within 14 days of receiving the request, with a possible 14-day extension either due to the enrollee's request or Sterling justification that the delay is in the enrollee's best interest. In cases where you believe that waiting for a decision under this time frame could place the enrollee'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 [1-888-858-8551]. We will notify you of our decision within 72 hours.

In the absence of an advance organization determination, Sterling can retroactively deny payment for a service furnished to an enrollee 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 enrollee 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 Sterling, send a written dispute to Sterling Life Insurance, [P.O. Box 1917, Bellingham, WA 98227-1917] or call us at [1-888-858-8551]. Additionally, please provide appropriate documentation to support your payment dispute (e.g., a remittance advice from a Medicare carrier would be considered such documentation). Claims must be disputed within 120 days from the date payment is initially received by the provider. Note that in cases where we re-adjudicate a claim, for instance, when we discover that we processed it incorrectly the first time, you have an

additional 120 days from the date you are notified of the re-adjudication in which to dispute the claim.

We will review your dispute and respond to you within 60 days. If we agree with the reason for your payment dispute, we will pay you the additional amount you are requesting, including any interest that is due. We will inform you in writing if our decision is unfavorable and no additional amount is owed.

After Sterling's payment dispute resolution process is completed, if you still believe that we have reached an incorrect decision regarding payment on your claim, you may file an additional request for review with an independent review organization contracted by CMS. To file this additional request for review of a payment dispute with the independent review organization, you may contact the organization directly at:

First Coast Service Options, Inc.  
Payment Dispute Resolution Contractor  
P.O. Box 44017  
Jacksonville, FL 32231-4017

FCSO may also be reached by email at [PDRC@fcs.com](mailto:PDRC@fcs.com) and by phone at 1-904-791-6430. Note that you must first complete Sterling's payment dispute resolution process before you can request a review by the independent review organization.

## **9. Enrollee and provider appeals and grievances**

Sterling enrollees have the right to file appeals and grievances with Sterling when they have concerns or problems related to coverage or care. Enrollees may appeal a decision made by Sterling to deny coverage or payment for a service or benefit that they believe should be covered or paid for. Enrollees should file a **grievance** for all other types of complaints not related to the provision or payment for health care.

A physician who is providing treatment may, upon notifying the enrollee, appeal pre-service organization determination denials to the plan on behalf of the enrollee. The physician may also appeal a post-service organization determination denial as a representative, or sign a waiver of liability (promising to hold the enrollee harmless regardless of the outcome) and appeal the denial using the enrollee appeal process. There must be potential enrollee liability (e.g., an actual claim for services already rendered, as opposed to an advance organization determination), in order for a provider to appeal utilizing the enrollee appeal process.

A non-physician provider may appeal organization determinations on behalf of the enrollee as a representative, or sign a waiver of liability (promising to hold the enrollee harmless regardless of the outcome) and appeal post-service organization determinations (e.g., claims) using the enrollee appeal process. As noted above, there must be potential enrollee liability in order for a provider to appeal utilizing the enrollee appeal process.

If a provider appeals using the enrollee appeal process, the provider agrees to abide by the statutes, regulations, standards, and guidelines applicable to the Medicare PFFS Enrollee appeals and grievance processes.

You can call our Customer Service Department at [1-888-858-8551] for more information on our enrollee appeals and grievance policies and procedures.

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

Hospitals must notify Medicare beneficiaries, including Medicare Advantage beneficiaries enrolled in PFFS plans, who are hospital inpatients about their discharge appeal rights by complying with the requirements for providing the Important Message from Medicare (IM), including complying with the normal 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](http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp)

Skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities must notify Medicare beneficiaries, including Medicare Advantage beneficiaries enrolled in PFFS plans, about their right to appeal a termination of services decision by complying with the requirements for providing the Notice of Medicare Non-Coverage (NOMNC), including complying with the normal 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>. As directed in the instructions, the NOMNC should contain (Plan Name)'s contact information somewhere on the form (such as in the *additional information* section on page 2 of the NOMNC).

Sterling will provide enrollees with a detailed explanation if an enrollee notifies the Quality Improvement Organization (QIO) that the enrollee wishes to appeal a decision regarding a hospital discharge (Detailed Notice of Discharge) or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility services (Detailed Explanation of Non-coverage) within the time frames specified by law.

## **11. If you need additional information or have questions**

If you have general questions about Sterling's terms and conditions of payment, contact us at Sterling Life Insurance Company, [P.O. Box 1917, Bellingham, WA 98227-1917] or telephone [1-888-858-8551] Monday through Friday, 5:00 a.m. to 8:00 pm. Pacific Time.

- If you have questions about submitting claims, call us at [1-888-858-8551].
- If you have questions about plan payments, call us at [1-888-858-8551].

## Exhibit A

### Sterling Retiree Options<sup>SM</sup> (PFFS) for retirees of ERAMET Marietta, Inc.

Services covered by Sterling Options <sup>SM</sup> (PFFS) ERAMET Marietta, Inc.	The amount(s) you may charge the plan enrollee
Inpatient hospital services	<ul style="list-style-type: none"> <li>• Days 1-5: [\$75] co-pay per day</li> <li>• Days 6-90: [\$0] co-pay per day</li> </ul>
Skilled nursing facility	<ul style="list-style-type: none"> <li>• Days 1-10: [\$0] co-pay per day</li> <li>• Days 11-100: [\$25] co-pay per day</li> </ul>
Office services (Physician, specialist, chiropractic and podiatry)	<ul style="list-style-type: none"> <li>• [\$5] primary care per visit</li> <li>• [\$15] chiropractic per visit</li> <li>• [\$20] specialist care per visit</li> </ul>
Immunizations	<ul style="list-style-type: none"> <li>• [\$0] co-pay (immunizations for travel not covered) <ul style="list-style-type: none"> <li>• \$5 or \$20 copayment for each Medicare-covered office visit, depending on provider type.</li> </ul> </li> </ul>
Mammography	<ul style="list-style-type: none"> <li>• [\$0] co-pay <ul style="list-style-type: none"> <li>• \$5 or \$20 copayment for each Medicare-covered office visit, depending on provider type.</li> </ul> </li> </ul>
Physical Exams	<ul style="list-style-type: none"> <li>• [\$0] co-pay <ul style="list-style-type: none"> <li>• [\$150] limit for one routine physical exam every twelve (12) months. Lab tests are not covered as a part of this benefit.</li> </ul> </li> </ul>
Emergency room visit	<ul style="list-style-type: none"> <li>• [\$25] co-pay</li> <li>• \$0 if admitted within 1 day for the same condition.</li> </ul>
Urgent care center visits	<ul style="list-style-type: none"> <li>• [\$5] primary care per visit</li> <li>• [\$20] specialist care per visit</li> </ul>
Hearing Services	<ul style="list-style-type: none"> <li>• [\$0] co-pay <ul style="list-style-type: none"> <li>• [\$100] limit for routine hearing tests every twelve (12) months.</li> </ul> </li> </ul>
Vision Services	<ul style="list-style-type: none"> <li>• [\$0] co-pay <ul style="list-style-type: none"> <li>• [\$100] limit for eye exams every twelve (12) months.</li> <li>• [\$200] limit for eye wear every twenty-four (24) months.</li> </ul> </li> </ul>
Dental Services (oral exams, cleaning, fluoride treatments and dental X-rays)	<ul style="list-style-type: none"> <li>• [\$0] co-pay <ul style="list-style-type: none"> <li>• [\$300] limit for preventive dental benefits every twelve (12) months.</li> </ul> </li> </ul>

## Exhibit A

### Sterling Retiree Options<sup>SM</sup> (PFFS) for retirees of Rockford Products Corporation

Services covered by Sterling Options <sup>SM</sup> (PFFS) Rockford Products Corporation	The amount(s) you may charge the plan enrollee
Inpatient hospital services	<ul style="list-style-type: none"> <li>• Days 1-5: [\$75] co-pay per day</li> <li>• Days 6-90: [\$0] co-pay per day</li> </ul>
Skilled nursing facility	<ul style="list-style-type: none"> <li>• Days 1-10: [\$0] co-pay per day</li> <li>• Days 11-100: [\$25] co-pay per day</li> </ul>
Office services (Physician, specialist, chiropractic and podiatry)	<ul style="list-style-type: none"> <li>• [\$5] primary care per visit</li> <li>• [\$15] chiropractic per visit</li> <li>• [\$20] specialist care per visit (including podiatry)</li> </ul>
Immunizations	<ul style="list-style-type: none"> <li>• [\$0] co-pay (immunizations for travel not covered) <ul style="list-style-type: none"> <li>• \$5 or \$20 copayment for each Medicare-covered office visit, depending on provider type.</li> </ul> </li> </ul>
Mammography	<ul style="list-style-type: none"> <li>• [\$0] co-pay <ul style="list-style-type: none"> <li>• \$5 or \$20 copayment for each Medicare-covered office visit, depending on provider type.</li> </ul> </li> </ul>
Physical Exams	<ul style="list-style-type: none"> <li>• [\$0] co-pay <ul style="list-style-type: none"> <li>• [\$150] limit for one routine physical exam every twelve (12) months. Lab tests are not covered as a part of this benefit.</li> </ul> </li> </ul>
Emergency room visit	<ul style="list-style-type: none"> <li>• [\$25] co-pay</li> <li>• \$0 if admitted within 1 day for the same condition.</li> </ul>
Urgent care center visits	<ul style="list-style-type: none"> <li>• [\$5] primary care per visit</li> <li>• [\$20] specialist care per visit</li> </ul>
Hearing Services	<ul style="list-style-type: none"> <li>• [\$0] co-pay <ul style="list-style-type: none"> <li>• [\$100] limit for routine hearing tests every twelve (12) months.</li> </ul> </li> </ul>
Vision Services	<ul style="list-style-type: none"> <li>• [\$0] co-pay <ul style="list-style-type: none"> <li>• [\$100] limit for eye exams every twelve (12) months.</li> <li>• [\$200] limit for eye wear every twenty-four (24) months.</li> </ul> </li> </ul>
Dental Services (oral exams, cleaning, fluoride treatments and dental X-rays)	<ul style="list-style-type: none"> <li>• [\$0] co-pay <ul style="list-style-type: none"> <li>• [\$300] limit for preventive dental benefits every twelve (12) months.</li> </ul> </li> </ul>

## Exhibit A

### Sterling Retiree Options<sup>SM</sup> (PFFS) for retirees of Inova Health Systems<sup>®</sup>

Services covered by Sterling Options <sup>SM</sup> (PFFS) Inova Health Systems <sup>®</sup>	The amount(s) you may charge the plan enrollee
Inpatient hospital services	<ul style="list-style-type: none"> <li>• Days 1-5: [\$75] co-pay per day</li> <li>• Days 6-90: [\$0] co-pay per day</li> </ul>
Skilled nursing facility	<ul style="list-style-type: none"> <li>• Days 1-10: [\$0] co-pay per day</li> <li>• Days 11-100: [\$25] co-pay per day</li> </ul>
Office services (Physician, specialist, chiropractic & podiatry)	<ul style="list-style-type: none"> <li>• [\$5] primary care per visit</li> <li>• [\$25] specialist care per visit (including chiropractic and podiatry)</li> </ul>
Immunizations	<ul style="list-style-type: none"> <li>• [\$0] co-pay (immunizations for travel not covered) <ul style="list-style-type: none"> <li>• \$5 or \$25 copayment for each Medicare-covered office visit, depending on provider type.</li> </ul> </li> </ul>
Mammography	<ul style="list-style-type: none"> <li>• [\$0] co-pay <ul style="list-style-type: none"> <li>• \$5 or \$25 copayment for each Medicare-covered office visit, depending on provider type.</li> </ul> </li> </ul>
Physical Exams	<ul style="list-style-type: none"> <li>• [\$0] co-pay <ul style="list-style-type: none"> <li>• [\$150] limit for one routine physical exam every twelve (12) months. Lab tests are not covered as a part of this benefit.</li> </ul> </li> </ul>
Emergency room visit	<ul style="list-style-type: none"> <li>• [\$50] co-pay</li> <li>• \$0 if admitted within 1 day for the same condition.</li> </ul>
Urgent care center visits	<ul style="list-style-type: none"> <li>• [\$5] primary care per visit</li> <li>• [\$25] specialist care per visit</li> </ul>
Hearing Services	<ul style="list-style-type: none"> <li>• [\$0] co-pay <ul style="list-style-type: none"> <li>• [\$100] limit for routine hearing tests every twelve (12) months.</li> </ul> </li> </ul>
Vision Services	<ul style="list-style-type: none"> <li>• [\$0] co-pay <ul style="list-style-type: none"> <li>• [\$100] limit for eye exams every twelve (12) months.</li> <li>• [\$200] limit for eye wear every twenty-four (24) months.</li> </ul> </li> </ul>
Dental Services (oral exams, cleaning, fluoride treatments and dental X-rays)	<ul style="list-style-type: none"> <li>• [\$0] co-pay <ul style="list-style-type: none"> <li>• [\$300] limit for preventive dental benefits every twelve (12) months.</li> </ul> </li> </ul>

## Exhibit B

### General Billing Tips

- To assist you in claims submission, we have put compiled the following list of billing tips. Please review and incorporate this guidance when submitting a claim to Sterling.
- For electronic claim submission, Sterling’s electronic Payor number with ClaimsNet, Emdeon and Availity (formerly THIN) is [#91151]. Pharmacies billing for Part B covered drugs who need to be activated in our billing system should call [1-877-264-1221]. Sterling requires the following two items of information to process Part B pharmacy claims electronically: [Bin# 004303] and [PCN# STERLING].
- For paper claim submission, mail to [Sterling Health Plans, P.O. Box 69314, Harrisburg, PA 17106].

		<b>Common Naming Convention</b>	<b>CMS-1500</b>	<b>837P</b>
<b>Professional</b>	Referring Provider Name		Box 17	Loop 2310A NM1
	Referring Provider Legacy ID		Box 17a	Loop 2310A REF Q=1G
	Referring Provider NPI		Box 17b	Loop 2310A NM1 Q=XX
	Rendering Certification (Rendering CLIA)		Box 23	Loop 2310D REF Q=X4
	Rendering Certification (Referred CLIA)		Box 32b	Loop 2400 REF Q=X4
	Rendering Certification (ASC, NSC/PTAN)		Box 23	Loop 2010AA REF Q=1C
	Rendering Provider Legacy ID (i.e. UPIN)		Box 24j	Loop 2310B REF Q=1G
	Rendering Provider NPI		Box 24j	Loop 2310B NM1 Q=XX
	Pay To Provider Tax ID		Box 25	Loop 2010AB REF Q=EI
	Rendering Provider Name and Credentials		Box 31	Loop 2310B NM1
	Service Facility Name Physical Address where Services were Rendered		Box 32	Loop 2310D NM1 Entity ID=77 or FA Loop 2310D N3, N4
	Pay-To Name Pay-To Address		Box 33	Loop 2010AB NM1 Loop 2010AB N3, N4
	Pay-To Provider NPI		Box 33a	Loop 2010AB NM1 Q=XX
	Misc. Provider Identifier (i.e. DME/NSC/PTAN)		Box 33b	Loop 2310B REF Q=1C
		<b>Common Naming Convention</b>	<b>UB-04</b>	<b>837I</b>
<b>Institutional</b>	Pay To Provider Tax ID		FL 5	Loop 2010AB REF Q=EI
	Rendering Facility Medicare Identifier (6-digit Legacy ID)		FL 57	Loop 2010AA REF Q=1C
	Rendering Provider Taxonomy		FL 81	Loop 2000A PRV Q=BI
	Rendering Facility Name		FL 1	<b>Loop 2310E</b> NM1
	Rendering Facility Physical Address		FL 1	<b>Loop 2310E</b> N3, N4
	Rendering Facility Provider NPI (or subunit NPI if applicable)		FL 56	Loop 2310AA NM1 Q=XX
	Pay-To Facility Name		FL 2	Loop 2010AB NM1
	Pay-To Address		FL 2	Loop 2010AB N3, N4
Pay-To Provider NPI		N/A	Loop 2010AB NM1 Q=XX	

For questions about Sterling’s Terms and Conditions, please contact Customer Service at [1-888-858-8551] or see our online Provider Manual at <https://secure.sterlingplans.com/providers/providermanual.html>. The Provider Manual also contains Provider specific billing tips, sample copies of a completed CMS-1500 and UB04 form, payment methodologies and specific plan benefit information.

### ONLINE CLAIMS AND ELIGIBILITY NOW AVAILABLE:

Sterling is proud to announce our new Medicare Advantage Provider Web Portal offering secure access to claims and eligibility lookup for our providers! Go to <https://sterling.healthtrioconnect.com> to sign up for access to Sterling Medicare Advantage information 24 hours per day, 365 days per year.

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