Model Part C Explanation of Benefits
PFFS, Monthly EOB Version

General Instructions

This is a model Part C Explanation of Benefits (EOB). The text in this document is considered model; therefore any modifications, beyond those allowed or stated below, or as specified by CMS, will render this EOB a non-model document. As such, the document would be subject to a 45-day review period.

1. Instructions for organizations that send monthly EOBs:

- Organizations may choose to send EOBs to non-dual eligible members on either a per claim basis or a monthly basis. Plans are not required to send an EOB to dual eligible members.
    - Organizations that choose to send monthly EOBs should use this "Monthly EOB" model developed by CMS. Organizations that choose to send monthly EOBs must send this document to non-dual eligible members each month, *even in months when there was no claim processed during the reporting period*.
    - The claim information in the EOB must include the American Medical Association's HCPCS code descriptors and CPT consumer descriptors, followed by the HCPCS or CPT billing code shown in parentheses.

2. Claims that must be included within the EOB:

- Plans must include all Part C claims processed during the reporting period, including all claims for Part A and Part B covered services, mandatory supplemental benefits, and optional supplemental benefits. Any benefit information that cannot be included timely must be accounted for in a following reporting period.

3. Instructions within the template:

- Italicized blue text in square brackets is information for the plans. Do not include in the EOB.
- Non-italicized blue text in square brackets is text that can be inserted or used as replacement text in the EOB. Use it as applicable.
- The first time the plan name is mentioned the plan type designation (i.e., HMO, PPO, etc.) must be included.

- When instructions say "*[insert month]*", use a format that spells out the full name of the month, e.g., "January."

4. Permissible document alternations:

- Minor grammar or punctuation changes, as well as changes in font type or color, are permissible.
- References to a specific plan name in brackets may be replaced with generic language such as "our plan."
- References to Member Services can be changed to the appropriate name your plan uses.
- References to the plan's Optional Supplemental Benefits can be changed to the appropriate name your plan uses. If desired, you may add a brief description of these services, e.g., "dental services."
- References to "year" may be changed to "plan year."
- If your plan uses a reporting period that does not correspond exactly to a calendar month, you may substitute the date range for your reporting period (e.g., "1/1/12 to 2/3/12" OR "January 1 – February 3, 2013") whenever instructions say to "*[insert month] [insert year]*."

5. Instructions for formatting:

- With the exception of charts, which should generally be in landscape formation, either landscape or portrait may be used.
- With the exception of the chart that gives the details on claims, the remaining sections of the document are to be formatted as two-column or three-column text (the main title of a section may extend beyond the first column) to keep line lengths easy to read. Plans may adjust the width of the columns in the template.
- To help conserve paper, the document can be printed double-sided.
- The document must have a header or footer that includes the page number. In addition, if desired, plans may also include any of the following information in the header or footer: member identifiers, month and year, title of the document.
- Charts that continue from one page to the next should be marked with "continue" at the bottom on the page that continues. In an actual EOB, rows of a chart should not break across the page. Note: in the model language in this document, rows sometimes break across a page because of the instructions and substitution text.

6. Instructions related to member appeals:

- Plans are responsible for ensuring that members receive the notification of appeal rights within the timeframes specified by CMS. If notification with an EOB would hinder the plan's ability to provide timely notification, it must be delivered separately, within the required timeframes specified in the MA program regulations.

7. Instructions for HPMS submission:

- All plans should submit a Part C EOB through File & Use Certification using the HPMS code 2083.

MONTHLY REPORT

Medical and Hospital Claims Processed in *[Insert month] [Insert Year]*

For *[insert member name]*
[If desired, plans name also insert a member ID number and/or other member numbers typically used in member communications.]

This is not a bill:

- This monthly report of claims we have processed tells what care you have received, what the plan has paid, and how much you have paid (or can expect to be billed).
- If you owe anything, your doctors and other health care providers will send you a bill.
- This report covers medical and hospital care only. *[MA-only plans omit the next sentence.]* We send a separate report on Part D prescription drugs.
- If you notice something suspicious that might be dishonest billing, you can report it by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.)

[Plans may include the member's mailing address on this cover page.]

[Insert plan name and/or logo]

[Insert Federal contracting statement]

[Plans may insert their Web site URL]

[Insert plan name] Member Services

If you have questions, call us: *[Insert phone number]*

We are here *[insert days and hours of operation]*.
TTY / TDD only: [Insert TTY/TDD number]
[Plans may insert other Member Services numbers, e.g., a Spanish customer service number]

[*Plans that meet the 5% threshold, insert:* This information is available for free in other languages. Please contact Member Services at the number above.] Member Services [*plans that meet the 5% threshold, insert:* also] has free language interpreter services available for non-English speakers.

[Plans that meet the 5% threshold, insert the disclaimer about the availability of non-English translations in all applicable languages.]

The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan. [Omit terms in the following sentence that are not applicable to the plan:] Benefits, formulary, pharmacy network, premium, copayments, and coinsurance may change on January 1 of each year. [Plans that do not renew on January 1, revise date as needed in previous sentence.]

[Insert material ID] Accepted

[In the "totals" section, plans must insert the total amounts for all claims for Part A and Part B services and mandatory supplemental benefits. Amounts for claims for optional supplemental benefits should be excluded from the totals section.]

TOTALS for medical and hospital claims	Amount providers have billed the plan	Total cost (amount the plan has approved)	**Plan's share**	**Your share**
Totals for this month (for claims processed from *[insert reporting period start date]* to *[insert reporting period end date]*)	$*[insert total billed amount for the reporting period]* *[If no claims were processed, insert:* (No claims were processed this month.)]	$*[insert total approved amount for the reporting period]*	$*[insert total plan share amount for the reporting period]*	$*[insert total member liability amount for the reporting period]*
Totals for *[insert year]* (all claims processed through *insert reporting period end date]*)	$*[insert total billed amount for the year]* *[If no claims to date, insert:* (No claims have been processed this year.)]	$*[insert total approved amount for the year]*	$*[insert total plan share amount for the year]*	$*[insert total member liability amount for the year]*

[Plans with no deductibles, omit this section.]

DEDUCTIBLE:

[Plans with an overall deductible insert the text below. If the plan has both an overall deductible and service category deductible(s), insert information about the overall deductible only.]

For most covered services, the plan pays its share of the cost only after you have paid your yearly plan deductible.

As of *[insert reporting period end date]*, you have paid *[insert as applicable: [insert amount member has paid toward deductible if less than the full deductible amount]* toward *OR* the full amount of*]* your *[insert deductible amount]* yearly plan deductible.

[Plans are permitted, but not required, to include a graphic, such as the one shown below, to illustrate the member's progress toward the deductible:

$ 0 $250

= your yearly

YEARLY LIMIT – this limit gives you financial protection

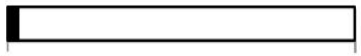
This limit tells the most you will have to pay in *[insert year]* in "out-of-pocket" costs (*[Delete references to deductibles, copayments, or coinsurance if not applicable for the plan:]* copays, coinsurance, and your deductible) for [*insert as applicable:* medical and hospital services covered by the plan *OR* covered Part A and Part B services].

This yearly limit is called your "out-of-pocket maximum." It puts a limit on how much you have to pay, but it does not put a limit on how much care you can get. This means:

- Once you have reached your limit in out-of-pocket costs, **you stop paying**.
- You keep getting your *[insert as applicable:* covered medical and hospital services *OR* covered Part A and Part B services] as usual, and **the plan will pay the full cost for the rest of the year**.

As of *[insert reporting period end date]*, **you have had *[insert amount paid toward MOOP as of reporting period end date]* in out-of-pocket costs** that count toward your *[insert MOOP amount]* out-of-pocket maximum for covered services.

[Plans are permitted, but not required, to include a graphic, such as the one shown below to illustrate the member's progress toward the MOOP:



$ 0 $3,400]

plan deductible]

[Plans with no overall deductible, but with service category deductibles, replace the text above with the text below. If the plan has more than one service category deductible, Include information about each.

The plan pays its share of the cost for *[insert service category]* only after you have paid a deductible.

As of *[insert reporting period end date]*, you have paid *[insert as applicable: [insert amount member has paid toward deductible if less than the full deductible amount]* toward *OR* the full amount of*]* your *[insert deductible amount]* deductible for *[insert service category]*.

[Plans are permitted, but not required, to include a graphic, such as the one shown below, to illustrate the member's progress toward the deductible:

$ 0 $250 = your deductible for

[insert service category]]		

NOTE: To describe the services you received, this report uses billing codes and descriptions that were developed and copyrighted by the American Medical Association (all rights reserved).

[If there are no claims processed during the reporting period, omit the remainder of the document.]

Details for claims processed in *[insert month] [insert year]*

Look over the information about your claims – does it seem correct?

- If you have questions or think there might be a mistake, start by calling the doctor's office or other service provider. Ask them to explain the claim.
- If you still have questions, call us at Member Services (phone numbers are in a box on page 1).

You have the right to make an appeal or complaint

- Making an appeal is a formal way of asking us to *change our decision* about your coverage. You can make an appeal if we deny a claim. You can also make an appeal if we approve a claim but you disagree with how much you are paying for the item or services. For information about making an appeal, call us at Member Services (phone numbers are in a box on page 1).

Remember, this report is NOT A BILL:

- If you have not already paid the amount shown for "your share," *wait until you get a bill* from the provider.
- If you get a bill that is *higher* than the amount shown for "your share," call us at Member Services (phone numbers are in a box on page 1).

[Plans may insert the first claim (or part of the claim) on this page or begin claims on the following page. Claims that continue from one page to the next should be marked with "continue" at the bottom of the page that continues. However, an individual row of a claim should not break across the page. Note: in the model language in this document, rows sometimes break across a page because of the instructions and substitution text.]

[Plans must insert information for all Part C claims processed during the reporting period, including all claims for Part A and Part B covered services, mandatory supplemental benefits, and optional supplemental benefits.]

[Insert name of provider] Claim Number: *[Insert claim number]* (*[Partial and full network plans, insert as applicable:* In-network *OR* Out-of-network*]* provider)	Date of service	Amount the provider billed the plan	Total cost (amount the plan approved)	**Plan's share**	**Your share**
[Show each service or item on a claim in a separate row.] *[Insert description of the service or item that was provided, using the American Medical Association (AMA)'s HCPCS code descriptors and CPT consumer descriptors, followed by the HCPCS or CPT billing code shown in parentheses. For example: "Air and bone conduction assessment of hearing loss and speech recognition (billing code 92557)"]* *[As needed, insert explanatory notes, preceded by "NOTE"]* *[If the service or item on the row is shown only to describe what was provided and is not billed separately, insert an explanatory note:* NOTE: The amounts are $0.00 because the cost for this service or item is covered under another part of this claim.]	*[Insert date of service, using x/x/xx format]*	$*[Insert billed amount for this service or item]*	$*[Insert approved amount for this service or item]* *[Note: if service or item is approved, use amount approved by the plan for the total cost. If service or item is denied use the contracted amount.]* *[Insert if applicable below amount:* **DENIED** (See below.)**]**	$*[Insert plan share amount for this service or item]*	$*[insert member liability amount for this service or item]* *[Note: if service or item has been denied, use either the maximum potential liability or "$0.00" for the member liability amount, whichever is applicable.]* *[If cost sharing is a coinsurance, insert:* You pay [*insert percentage]*% of the total amount for *[insert brief description of service, (e.g., "specialty care")] [insert if applicable:* from an [*insert as applicable:* in-network *OR* out-of-network*]* provider] *[If cost sharing is a copayment, insert:* You pay a $[*insert copayment amount]* copayment for *[insert brief description of service (e.g., "specialty care")] [insert if applicable:* from an *[insert as applicable:* in-network *OR* out-of-network] provider]

[Insert name of provider] Claim Number: *[Insert claim number]* (*[Partial and full network plans, insert as applicable:* In-network *OR* Out-of-network*]* provider)	Date of service	Amount the provider billed the plan	Total cost (amount the plan approved)	**Plan's share**	**Your share**
					[If the service is a preventive service that is covered at no cost under Original Medicare, add the following: (This is one of the preventive services that is covered at no cost under Original Medicare, and the plan covers this service at no cost to you.)*]* *[If balance billing is explicitly included in your contract with providers or in your terms and conditions of payment, add:* In addition to collecting your [*insert as applicable:* copayment *OR* coinsurance amount], this health care provider is allowed to bill you up to an additional [*insert balance billing amount of 15 or less*]% of the total plan payment amount for the services you received.] *[If the service or item shown on this row has been denied, and the amount in this column for "your share" is not zero, insert:* Because the claim was denied, you may be responsible for

[Insert name of provider] Claim Number: *[Insert claim number]* (*[Partial and full network plans, insert as applicable:* In-network *OR* Out-of-network*]* provider)	Date of service	Amount the provider billed the plan	Total cost (amount the plan approved)	**Plan's share**	**Your share**
					paying this amount. Look below for information about your appeal rights.]
[Insert next item or service for the claim, using language described above]					
[Insert next item or service for the claim, using language described above]					
	TOTALS:	**$[*Insert total billed amount for this claim]***	**$[*Insert total approved amount for this claim]*** *[Insert if applicable below amount:* **DENIED** (See below.)*]*	**$[*Insert total plan share amount for this claim]***	**$[*Insert total member liability amount for this claim]*** *[Note: if service or item has been denied, use either the maximum potential liability or "$0.00" for the member liability amount, whichever is applicable.]* *[If all items in the claim are subject to the same coinsurance percentage or copayment amount, plans may insert the coinsurance/copayment text in this total row rather than repeating the identical text in the rows for each item or service.]* *[If more than one service or item is denied, plans may omit the*

[Insert name of provider] Claim Number: *[Insert claim number]* (*[Partial and full network plans, insert as applicable:* In-network *OR* Out-of-network*]* provider)	Date of service	Amount the provider billed the plan	Total cost (amount the plan approved)	**Plan's share**	**Your share**
					denial language in this column from the claim item rows and insert it in this total row instead.]

[If a service or item has been denied and there is member liability, include approved NDP language with the EOB or insert the following text below the denied claim:

Things to know about your denied claim:

- *[Plans may insert a denial reason.]*
- We have denied all or part of this claim and **you have the right to appeal.** Making an appeal is a formal way of asking us to *change the decision* we made to deny your claim. If we agree to change our decision, it means we will approve the claim rather than deny it, and we will pay our share.
- **The provider can also make an appeal, and if this happens, you may not have to pay.** You may wish to contact the provider to find out if they will ask us for an appeal. If the provider properly asks for an appeal, you will not be responsible for payment, except for the normal cost-sharing amount, and you don't need to make an appeal yourself.
- **When we deny part or all of a claim, we send you a letter** ("Notice of Denial of Payment") explaining why the service or item is not covered. This letter also tells what to do if you want to appeal our decision and have us reconsider.
- **IMPORTANT**: If you do not have this letter, call us at Member Services (phone numbers are in a box on page 1).
- **If you have questions or need help with your appeal, you can contact:**
  - Our Member Services (phone numbers are in a box on page 1)
  - 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.)]

[Network plans: If a service or item has been denied and there is no member liability, insert the following text below the denied claim:

Things to know about your denied claim:

- **NOTE: We have denied all or part of this claim.** However, you are not responsible for paying the billed amount because you received this service *[insert as applicable:* from a *[insert plan name]* provider OR based on a referral from a *[insert plan name]* provider*].]*

- **If you have questions, you can contact:**
  - Our Member Services (phone numbers are in a box on page 1)
  - 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.)]

[If the service or item in this row was previously denied and has now been approved on appeal, insert the following text below the claim:

Things to know about your claim:

- NOTE: We initially denied this [*insert as applicable:* item *OR* service] and received a request to appeal our denial. [*Insert as applicable:* After reviewing the appeal request, we overturned our denial and approved the [*insert as applicable:* item *OR* service]. *OR* Our denial was overturned and this [*insert as applicable:* item *OR* service] is now approved.] This means that the [*insert as applicable:* item *OR* service] is covered and the plan [*Insert as applicable:* has paid OR will pay] its share of the cost.

- **If you have questions, you can contact:**
  - Our Member Services (phone numbers are in a box on page 1)
  - 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.)]

[If there are no claims for optional supplemental benefits processed during the reporting period, delete the remainder of this document.]

[If a claim for optional supplemental benefits was processed during the reporting period, it must be included in the EOB. Claims for optional supplemental benefits should appear after the claims for Part A and Part B services and mandatory supplemental benefits. Plans should include the section header provided below before the first claim for optional supplemental benefits. The format for the claims chart is provided below. Please note that the format is the same as for other Part C benefits, except for the additional text describing optional supplemental benefits which appears in the first column header.]

Optional Supplemental Services: Details for claims processed in *[insert month] [insert year]*

(Amounts for optional supplemental services are **not** included in the totals shown on page 2)

[Insert name of provider] Claim Number: *[Insert claim number]* (*[If applicable, insert: [Insert as applicable:* In-network *OR* Out-of-network*]* provider *[plans may add the type of optional supplemental benefits, e.g., "of dental services."]*) *[Insert type of optional supplemental benefits]* are "optional supplemental services." These are extra services for which you pay a separate premium.	Date of service	Amount the provider billed the plan	Total cost (amount the plan approved)	**Plan's share**	**Your share**
[Show each service or item on a claim in a separate row.] *[Insert description of the service or item that was provided, using the American Medical Association (AMA)'s HCPCS code descriptors and CPT consumer descriptors, followed by the HCPCS or CPT billing code shown in parentheses. For example: "Air and bone conduction assessment of hearing loss and speech*	*[Insert date of service, using x/x/xx format]*	$*[Insert billed amount for this service or item]*	$*[Insert approved amount for this service or item]* *[Note: if service or item is approved, use amount approved by*	$*[Insert plan share amount for this service or item]*	$*[insert member liability amount for this service or item]* *[Note: if service or item has been denied, use either the maximum potential liability or "$0.00" for the member liability amount, whichever is applicable.]* *[If cost sharing is a coinsurance,*

[Insert name of provider] Claim Number: *[Insert claim number]* (*[If applicable, insert: [Insert as applicable:* In-network *OR* Out-of-network*]* provider *[plans may add the type of optional supplemental benefits, e.g., "of dental services."]*) *[Insert type of optional supplemental benefits]* are "optional supplemental services." These are extra services for which you pay a separate premium.	Date of service	Amount the provider billed the plan	Total cost (amount the plan approved)	**Plan's share**	**Your share**
recognition (billing code 92557)"] *[As needed, insert explanatory notes, preceded by "NOTE"]* *[If the service or item on the row is shown only to describe what was provided and is not billed separately, insert an explanatory note:* NOTE: The amounts are $0.00 because the cost for this service or item is covered under another part of this claim.]			*the plan for the total amount. If service or item is denied use the contracted amount.]* *[Insert if applicable below amount:* **DENIED** (See below.)***]***		*insert:* You pay [*insert percentage]*% of the total amount for *[insert brief description of service, (e.g., "dental services")] [insert if applicable:* from an [*insert as applicable:* in-network *OR* out-of-network*]* provider] *[If cost sharing is a copayment, insert:* You pay a $[*insert copayment amount]* copayment for *[insert brief description of service (e.g., "dental services")] [insert if applicable:* from an *[insert as applicable:* in-network *OR* out-of-network] provider] *[If the service or item shown on this row has been denied, and the amount in this column for "your share" is not zero, insert:* Because the claim was denied, you may be responsible for

[Insert name of provider] Claim Number: *[Insert claim number]* (*[If applicable, insert: [Insert as applicable:* In-network *OR* Out-of-network*]* provider *[plans may add the type of optional supplemental benefits, e.g., "of dental services."]*) *[Insert type of optional supplemental benefits]* are "optional supplemental services." These are extra services for which you pay a separate premium.	Date of service	Amount the provider billed the plan	Total cost (amount the plan approved)	**Plan's share**	**Your share**
					paying this amount. Look below for information about your appeal rights.]
[Insert next item or service for the claim, using language described above]					
[Insert next item or service for the claim, using language described above]					
	TOTALS:	**$[*Insert total billed amount for this claim]***	**$[*Insert total approved amount for this claim]*** *[Insert if applicable below amount:* **DENIED** (See below.)*]*	**$[*Insert total plan share amount for this claim]***	**$[*Insert total member liability amount for this claim]*** *[Note: if service or item has been denied, use either the maximum potential liability or "$0.00" for the member liability amount, whichever is applicable.]* *[If all items in the claim are subject to the same coinsurance percentage or copayment amount, plans may insert the coinsurance/copayment text in this total row rather than repeating the identical text in*

[Insert name of provider] Claim Number: *[Insert claim number]* (*[If applicable, insert: [Insert as applicable:* In-network *OR* Out-of-network*]* provider *[plans may add the type of optional supplemental benefits, e.g., "of dental services."]*) *[Insert type of optional supplemental benefits]* are "optional supplemental services." These are extra services for which you pay a separate premium.	Date of service	Amount the provider billed the plan	Total cost (amount the plan approved)	**Plan's share**	**Your share**
					the rows for each item or service.] *[If more than one service or item is denied, plans may omit the denial language in this column from the claim item rows and insert it in this total row instead.]*

[If a service or item has been denied and there is member liability, include approved NDP language with the EOB or insert the following text below the denied claim:

Things to know about your denied claim:

- *[Plans may insert a denial reason.]*
- We have denied all or part of this claim and **you have the right to appeal.** Making an appeal is a formal way of asking us to *change the decision* we made to deny your claim. If we agree to change our decision, it means we will approve the claim rather than deny it, and we will pay our share.
- **The provider can also make an appeal, and if this happens, you may not have to pay.** You may wish to contact the provider to find out if they will ask us for an appeal. If the provider properly asks for an appeal, you will not be
- **When we deny part or all of a claim, we send you a letter** ("Notice of Denial of Payment") explaining why the service or item is not covered. This letter also tells what to do if you want to appeal our decision and have us reconsider.
- **IMPORTANT**: If you do not have this letter, call us at Member Services
- **If you have questions or need help with your appeal, you can contact:**
  - Our Member Services (phone numbers are in a box on page 1)
  - 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.)]

responsible for payment, except for the normal cost-sharing amount, and you don't need to make an appeal yourself.

(phone numbers are in a box on page 1).

[If a service or item has been denied and there is no member liability, insert the following text below the denied claim:

Things to know about your denied claim:

- **NOTE: We have denied all or part of this claim.** However, you are not responsible for paying the billed amount because you received this service *[insert as applicable:* from a *[insert plan name]* provider OR based on a referral from a *[insert plan name]* provider*].]*
- **If you have questions, you can contact:**
  - Our Member Services (phone numbers are in a box on page 1)
  - 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.)]

[If the service or item in this row was previously denied and has now been approved on appeal, insert the following text below the claim:

Things to know about your claim:

- NOTE: We initially denied this [*insert as applicable:* item *OR* service] and received a request to appeal our denial. [*Insert as applicable:* After reviewing the appeal request, we overturned our denial and approved the [*insert as applicable:* item *OR* service]. *OR* Our denial was overturned and this [*insert as applicable:* item *OR* service] is now approved.] This means that the [*insert as applicable:* item *OR* service] is covered and the plan [*Insert as applicable:* has paid OR will pay] its share of the cost.
- **If you have questions, you can contact:**
  - Our Member Services (phone numbers are in a box on page 1)
  - 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.)]