Model Part C Explanation of Benefits
PPO, Quarterly Summary 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 per claim EOBs:

- Organizations may choose to send EOBs to non-dual 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 per claim EOBs can use their own templates for the per claim EOB as long as the claim information in the EOB includes the American Medical Association (AMA)'s HCPCS code descriptors and CPT consumer descriptors, followed by the HCPCS or CPT billing code shown in parentheses. Organizations that choose to send per claim EOBs must also send this model quarterly summary document to non-dual eligible members each quarter, *even in quarters when there were no claims processed during the reporting period*.
    - Organizations that choose to send monthly EOBs should use the "Monthly EOB" model developed by CMS. Refer to the "Monthly EOB" template for instructions and model language.

2. Instructions within the template:

- Italicized blue text in square brackets is information for the plans. Do not include in the summary document.
- Non-italicized blue text in square brackets is text that can be inserted or used as replacement text in the summary document. 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."

3. 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]*."

4. Instructions for formatting:

- With the exception of charts, which should generally be in landscape formation, either landscape or portrait may be used.
- The document is 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.

5. Instructions for HPMS submission:

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

[*Insert start month for reporting period*]
through [*Insert end month for reporting period*]
[insert year]

Summary of Your Out-of-Pocket Spending for Medical and Hospital Claims

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 <u>not</u> a bill:

- This report shows the totals for claims we have processed. It tells what the plan has paid and how much you have paid (or can expect to be billed). Use this document to keep track of how much you have spent "out-of-pocket" for your *[remove terms that are not applicable to your plan:* deductible, copayments, and coinsurance].
- 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.

[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 quarter (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 quarter.)]	$*[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:

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 plan deductible]

YEARLY LIMITS – these limits give you financial protection

These limits tell the <u>most</u> 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].

These yearly limits are called your "out-of-pocket maximums." They put a limit on how much you have to pay, but they do <u>not</u> put a limit on how much care you can get. This means:

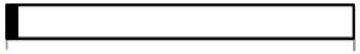
- Once you have reached a limit in out-of-pocket costs, **<u>you stop paying</u>.**
- You keep getting your covered services as usual, and **the <u>plan will pay the full cost</u> for the rest of the year**.

<u>In-network limit</u>

In *[insert year]*, $*[insert in-network MOOP amount]* is the most you will have to pay for covered services you get from in-network providers.

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



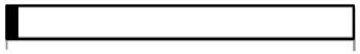
$ 0 $3,400]

<u>Combined (in-network + out-of-network) limit</u>

In *[insert year]*, $*[insert combined MOOP amount]* is the most you will have to pay for covered services you get from all providers (in-network providers + out-of network providers combined).

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