CMS Approved Part C Explanation of Benefits Template
PPO, Quarterly Summary Version

General Instructions

This is a Centers for Medicare and Medicaid Services (CMS) approved Part C Explanation of Benefits (EOB) template. CMS views Part C EOBs as ad-hoc information materials; therefore, they are not subject to CMS review and approval. However, CMS reserves the right, as with other ad-hoc communication, to request and review a sample of the materials to ensure compliance with our requirements.

- Organizations that choose to send per claim EOBs must also send this quarterly summary document to non-dual eligible members.
- Plans are not required to send an EOB to dual eligible members.
- Plans are responsible for ensuring that members receive 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.
- The quarterly EOB must be sent to members each quarter there is claims activity, whether or not there is member liability.

HPMS submission:

- All plans may be required to submit a Part C EOB to HPMS. CMS will provide more information when available.

Format Instructions

- Organizations that choose to send per claim EOBs may use their own format for those.
- Minor grammar or punctuation changes, as well as changes in font type or color, are permissible.
- Text and numbers must be in font size 12 or larger.
- 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.
- The document may be printed double-sided and, in lieu of a paper mailing, may be sent electronically to members who elect the paperless format.
- 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 template language in this document, rows sometimes break across a page because of the instructions and substitution text.

Content Instructions

- CMS encourages MAOs to use the HCPCS code descriptors and American Medical Association's CPT code descriptors, followed by the HCPCS or CPT billing code shown in parentheses. Other appropriate billing codes, such as ADA approved dental codes, Medicare revenue codes for in-patient facility claims, and other widely recognized code descriptors may also be used.
- When providing claim information, plans may use date ranges to combine multiple occurrences of a service or item into a single row.
- All claim information provided in the EOB must be HIPAA compliant to protect member health information.

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. If applicable, claims for optional supplemental benefits are to be displayed separate from medical and hospital claims. Information for all claims includes: billing codes and descriptors, amount providers have billed the plan, total cost (amount the plan has approved), plan's share, and member's share (your share). Any benefit information that cannot be included timely must be accounted for in a subsequent reporting period.

Instructions within the template:

- All black text is required information that must be included as shown in the attached EOB template.
- Italicized blue text in square brackets is instruction and guidance specifically for MA plans. This information is not to be included in the beneficiary's EOB.
- Non-italicized blue text in square brackets is text to be inserted 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."
- Plans should make every effort to use a reporting period that aligns with a complete calendar month, however, 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]*."

[*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 may 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 out of pocket (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, provider network, premium, copayments, and coinsurance may change each year.

[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]*	$*[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]*	$*[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 both deductibles.]

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

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].

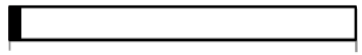
This yearly limit is called your "out-of-pocket maximum." It puts a limit on how much you have to pay, but it does not put a limit on how much care you can get.

Your out-of-pocket spending for [*insert service]* will not count toward your yearly out-of-pocket maximum. This means:

- Once you have reached your limit in out-of-pocket costs, **you stop paying out of pocket for all services *[insert, if applicable:* except *[insert service]*.**
- 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**. *[Insert if applicable:* Your out-of-pocket spending for services that are not covered by Medicare does not count toward your out-of-pocket maximum.]

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:



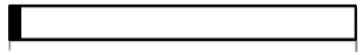
$ 0 $3,400]

Combined (in-network + out-of-network) limit

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]

= your yearly plan deductible]

[Plans with service category deductibles, include the text below 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*]]