CMS Approved Part C Explanation of Benefits Template
MSA, Monthly EOB 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.

- This template is for organizations that choose to send monthly EOBs 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 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.

- The monthly EOB must be sent to members each month 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

- 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, plans may 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 continuing page. 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 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]*."

MONTHLY REPORT

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

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 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.

- 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.

*[Insert material ID]*Accepted

[In the "totals" section, plans must insert the total amounts for all claims for Part A and Part B services. 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]*	$*[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]*

DEPOSIT:

In *[insert year]*, Medicare deposited $*[insert deposit amount]* into your medical savings account. You can use the money in your account to pay your health care costs, including health care costs that aren't covered by Medicare. (But only funds used to pay for Medicare Part A and Part B services will count toward your yearly deductible.)

DEDUCTIBLE:

In *[insert year]*, your plan deductible is $*[insert yearly deductible amount]*. Once you have paid this much for your Medicare-covered services, the plan will pay 100% of the costs for your Medicare-covered services for the rest of the year.
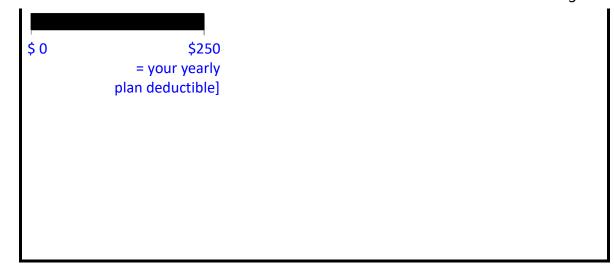
As of *[insert reporting period end date]*, you have paid *[insert as applicable: [insert amount member has paid toward deductible if less than the full deductible amount] [toward OR the full amount of]* your *[insert deductible amount]* yearly plan deductible.

[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:

As of *[insert reporting period end date]*, you have *[insert MSA balance]* available in your medical savings account to pay your health care costs.

[If the member has moved their account from the MSA trustee, replace the paragraph above with:

Because you are no longer using [insert MSA trustee name] for your medical savings account, we do not have information about your account balance. To find out your account balance, contact the bank or financial institution you have chosen.]

$ 0 $250

= your yearly
plan deductible]

[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 and optional supplemental benefits.]

[Insert name of provider] Claim Number: [Insert claim number] ([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. Although, date ranges may be used to combine multiple occurrences of a service or item into a single row, e.g., for claims related to inpatient services. [Insert description of the service or item that was provided and its billing code. 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, insert applicable denied amount and/or insert: **DENIED** (Look below for information about your appeal rights.)]	$[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] [insert if applicable: for services from an [insert as applicable: in-network OR out-of-network] provider] [If cost sharing is a copayment, insert: You pay [insert copayment amount] for services from an [insert as applicable: in-network OR out-of-network] provider] [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

[Insert name of provider] Claim Number: *[Insert claim number]* (*[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**
					under Original Medicare, and the plan covers this service in-network at no cost to you.)] *[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:* This service was denied, but you may be responsible for 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]* *[If service or item is denied, insert applicable denied amount and/or insert:* **DENIED**	$*[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* <u>all</u> *items in the claim are subject to the same coinsurance percentage or copayment*

[Insert name of provider] Claim Number: *[Insert claim number]* (*[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**
			(Look below for information about your appeal rights.)]		*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 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 <u>there is member liability</u>, 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.)]

[If a service or item has been denied and there is <u>no member liability</u>, 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. 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. In this section, deductible amounts may be included in the "Your share" column. 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 and its billing code. For example: "Air and bone conduction assessment of hearing loss and speech recognition (billing code 92557)"]* *[As needed, insert explanatory notes, preceded by "NOTE"]*	*[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,*	$*[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.]*

[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**
[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.]			*use amount approved by the plan for the total amount]* *[If service or item is denied, insert applicable denied amount and/or insert:* **DENIED** (Look below for information about your appeal rights.)]		*[If cost sharing is a coinsurance, insert:* You pay *[insert percentage]*% of the total amount *[insert if applicable:* for services 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 *[insert if applicable:* for services from an *[insert as applicable:* in-network *OR* out-of-network] provider]* *[If there is a deductible charged for the service or item, insert:* You pay a $ *[insert copayment amount]* deductible for this service or item]* *[If the service or item shown on this row has been denied, and the amount in this column for "your*

[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**
					share" is not zero, insert: This service was denied, but you may be responsible for 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 period claim]*	$*[Insert total approved amount for this claim]* [If service or item is denied, insert applicable denied amount and/or insert: **DENIED**	$*[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

[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**
			(Look below for information about your appeal rights.)]		*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 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 <u>there is member liability</u>, 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.

- **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

- **If you have questions or need help with your appeal, you can contact:**
  - o Our Member Services (phone numbers are in a box on page 1)

- **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.

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).

  - o 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.)]

[If a service or item has been denied and there is <u>no member liability</u>, 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:**
  - o Our Member Services (phone numbers are in a box on page 1)
  - o 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:**
  - o Our Member Services (phone numbers are in a box on page 1)
  - o 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.)]