CMS Approved Part C Explanation of Benefits Template
MSA, 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 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 (or can expect to be billed). Use this document to keep track of how much you have spent "out-of-pocket" for your deductible.
- 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.

[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 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]*

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.)

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

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.

[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.]

[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]