Model Monthly EOB

Instructions to Health Plans

? **If you have questions**, please call <plan name> at <toll-free number>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

❖ *The first time the plan name is mentioned, the plan type designation "(Medicare-Medicaid Plan)" must be included after the plan name, as detailed in the Medicare-Medicaid marketing guidance.*

❖ *When instructions say "[insert month] [insert year]," spell out the full name of the month (for example: January 2014).*

Permissible document alterations

❖ *Plans should add Medicaid-specific language where appropriate.*

❖ *Minor grammar or punctuation changes 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 "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 (for example: 1/1/14 to 2/3/14 __or__ January 1 – February 3, 2014) whenever instructions say to "[insert month] [insert year]."*

❖ *References to "calendar year" may be changed to "plan year".*

Formatting

❖ *Changes to the font type and/or font color are only permissible if such changes comply with Section 508 requirements.*

❖ *With the exception of charts, which should generally be in landscape formation, either landscape or portrait page format 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 to keep line lengths easy to read. (The main title of a section may extend beyond the first column.) Plans may adjust the width of the columns in the template.*

❖ *To help conserve paper, the document can be printed double-sided.*

? **If you have questions**, please call <plan name> at <toll-free number>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

❖ *The document must have a header or footer that includes the page number. 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. The marketing material ID must appear in the header or footer on the first page only.*

❖ *Charts that continue from one page to the next should be marked with "continue" at the bottom on the page. An individual row of a chart should not break across pages. (In the model language in this document, rows sometimes break across pages because of instructions and substitution text.)*

❖ *Unless specific formatting instructions for dates have been given, plans may use their preferred method of formatting the date (for example, "mm/dd/yy").*

Drug-coverage section

❖ *Prior-year fills that do not apply to the current EOB do not need to be included in this EOB and do not require a separate EOB.*

Member disenrollment

❖ *When a beneficiary disenrolls from the plan during the plan year, the sponsor must send an EOB to the beneficiary after disenrollment if any claims are processed prior to the beneficiary disenrolling. For example, if a beneficiary disenrolls at the end of August and the plan processes claims in months prior to disenrollment, the disenrolling plan must send the beneficiary a final EOB.*

Member appeals

❖ *Plans are responsible for ensuring that members receive the notification of appeal rights within the timeframe specified by CMS and the State. If notification with an EOB would hinder the plan's ability to provide timely notification, it must be delivered separately within the timeframe required by CMS and the State.*

HPMS submission

❖ *Prior to use, all plans must upload an EOB in HPMS under the material code and review process outlined for that specific State.*

If you have questions, please call <plan name> at <toll-free number>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

<Plan name>

Explanation of Benefits for Health Care and Drug Claims

For <Member name>

[*Insert mailing date.*]

[*Plans may also insert a member's mailing address, ID number and/or other information typically used in member communications.*]

[*Insert plan's legal or marketing name*] is a health plan that contracts with both Medicare and [*insert name of <State> Medicaid program*] to provide benefits of both programs to enrollees.

[*Plans that charge $0 copays for all Part D drugs may delete this paragraph.*] Copays for prescription drugs may vary based on the level of Extra Help you receive. Please contact the plan for more details.

Limitations [, copays,] and restrictions may apply. For more information, call <plan name> <Member Services> or read the <plan name> Member Handbook.

Benefits, the *List of Covered Drugs,* [and] pharmacies and provider networks [, and/or co-payments] may change from time to time throughout the year and on January 1 of each year. [*Plans that do not renew on January 1, revise date as needed.*]

This is <u>not</u> a bill.

This Explanation of Benefits (EOB) 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.

If you get a bill that is *higher* than the amount shown for "your share", call us at <toll-free number>.

? **If you have questions**, please call <plan name> at <toll-free number>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Languages other than English

You can get this information for free in other languages. Call <toll-free number>. The call is free. [*The preceding sentence must be in English and in all non-English languages that meet the Medicare or state thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.*]

Other formats

You can ask for this handbook in other formats, such as Braille or large print. Call Member Services at <toll-free number>, <days and hours of operation>.

Need help?

If you have questions, call us at <toll-free number>. We are here <days and hours of operation>. TTY/TDD only: <TTY/TDD number>.

[*Plans that delegate enrollment functions to an enrollment broker must include this paragraph.*] You can call <enrollment broker> at <phone number> <days and hours of operation>. The call is free.

You can also find information in your Member Handbook or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.)

How to use this Explanation of Benefits

Please check it over carefully.

- **Do you recognize the name of each doctor or provider?** Check the dates. Did you have an appointment that day?

- **Did you get the health care services or drugs listed?** Do they match those listed on your receipts and bills? Do the drugs match what your doctor prescribed? For example, did your doctor order generic or brand name drugs?

- **If you already paid the bill, did you pay the right amount?** Check the maximum you may be billed.

For more information, you can call <plan name> Member Services or read the <plan name> Member Handbook.

What if you see mistakes on this summary?

If something is confusing or doesn't look right on this Explanation of Benefits, please call us at <plan name> Member Services. [*If applicable:* You can also find answers to many questions at our website: <web address>.]

If you have questions, please call <plan name> at <toll-free number>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

What about possible fraud?

If this monthly summary shows services you did not receive, drugs you're not taking, or anything else that looks suspicious to you, please contact us.

- Call us at <plan name> Member Services.

- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

- [*Plans may also insert additional State-based resources for reporting fraud.*]

If you have questions, please call <plan name> at <toll-free number>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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A. Health Care Claims [*plans may add the following phrase, if preferred:* **and Long Term Services and Supports**]

[*Insert information for all claims processed during the reporting period.*]

[*If the EOB is being sent to a member who did not have any health care claims during the reporting period, (1) insert the following note in the first column:* No health care claims for the month of <insert month>. *and (2) insert amounts of "$0.00" for the columns labeled "Plan's share" and "Your share."*]

<Provider name> **Claim Number:** <Claim number> ([*Insert as applicable:* In-network **or** Out-of-network] provider)	**Date of service**	**Plan's share**	**Your share**
[*Show each service or item 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*	[*Insert date of service, using mm/dd/yy format.*]	$[*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 copayment, insert:* You pay a $[*insert copayment amount*] copayment for [*insert brief description of service (for example:* specialty care*)*] [*insert if applicable:* from an [*insert as applicable:* in-network **or** out-of-network] provider].] [*If the service or item shown in this row*

If you have questions, please call <plan name> at <toll-free number>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

<Provider name> **Claim Number:** <Claim number> ([*Insert as applicable:* In-network _**or**_ Out-of-network] provider)	Date of service	Plan's share	Your share
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.]			*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 paying this amount. See Section C 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.*]			

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).

[*Plans should include the following paragraph, if applicable*] <Provider name> is an out-of-network provider. You can keep seeing <provider name> for the first [*insert appropriate number of days*] you are with our plan at no cost to you. During this time, [*insert care coordinator or term used by plan*] will help you find a network provider who can treat your health care needs.

 [*If a service or item has been denied and there is member liability, include approved "Notice of Denial of Medical Coverage" language with the EOB or insert the following text below the denied claim:*

- [*Plans may insert a denial reason*]

If you have questions, please call <plan name> at <toll-free number>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **NOTE: We have denied all or part of this claim and you have the right to appeal.**

- **The provider can also make an appeal, and if this happens, you may not have to pay.** You may contact the provider to find out if they will ask us for an appeal. If the provider asks for an appeal, you won't be responsible for payment [*plans with any non-drug cost sharing insert*: except for the normal cost sharing amount]. You don't need to make an appeal yourself.

- **We sent you a letter** ([*insert the name of the denial notice, such as "*Notice of Denial of Medical Coverage*"*]) explaining the reason why this service or item is not covered and how you can appeal our decision. If you do not have this letter, or if you have questions, call Member Services.]

[*If a service or item has been denied and there is no member liability, insert the following text below the 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 <plan name> provider **or** based on a referral from a <plan name> provider].]

[***If a service or item was previously denied and has now been approved on appeal,*** *insert the following text below the denied 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 [*insert if applicable:* and the plan has paid its share of the cost].]

[?] **If you have questions**, please call <plan name> at <toll-free number>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

B. Drug Claims

[*If the EOB is being sent to a member who did not have any drug claims during the reporting period, (1) insert the following note in the first column:* No drug claims for this month. **and** *(2) insert amounts of "$0.00" for the columns labeled "Plan's share" and "Your share."*]

[*Plans should include the name of the pharmacy. Plans may add the location of the pharmacy and other additional pharmacy information (for example:* Non-network pharmacy*), if desired.*]	Date filled	Plan's share	Your share
[**Insert name of drug (other than compound) followed by quantity, strength, and form (for example: 25 mg tabs***). Identify compound drugs as such and provide quantity.*] [*Insert prescription number*], [*insert amount dispensed as quantity filled and/or days supply (for example:* 15 tablets **or** 30 days supply*).*] [*Plans may add additional information about the prescription, if desired.*] [*If Section D contains a change that applies to a drug listed in the drug claims chart, plans must insert a note here to alert the member that this change has taken place (for example:* **Note:** Beginning on January 1,	[*Insert date filled, using mm/dd/yy format.*]	$[*Insert plan share amount for this drug. Include any payments (e.g., Extra Help) made by other programs or organizations. Use $0.00 if applicable.*]	$[*Insert member liability amount for this drug. Use $0.00 if applicable.*]

If you have questions, please call <plan name> at <toll-free number>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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[*Plans should include the name of the pharmacy. Plans may add the location of the pharmacy and other additional pharmacy information (for example:* Non-network pharmacy*), if desired.*]	**Date filled**	**Plan's share**	**Your share**
2015, step therapy will be required for this drug. See Section D for details.*).*] [*The plan may also suggest lower-cost alternatives that a member and his or her doctor might want to consider in this section.*]			
[*Insert next drug for the claim, using language described above.*]			
[*Insert next drug for the claim, using language described above.*]			

[*Plans with one coverage stage, delete the following paragraph:*]

You met <$year-to-date TrOOP> towards your out-of-pocket limit of <$TrOOP amount*>.* [*The <year-to-date TrOOP> is the cumulative YTD total. Update the <year-to-date TrOOP> to include claims from the reporting period, any payments (e.g., the Low Income Subsidy) made by other programs or organizations, any claim reversals, and any TROOP balance transfers from the prior plan.*] Once you reach this limit, the plan will pay all the costs of your Medicare drugs for the rest of the year. The <$year-to-date TrOOP> amount includes <$0.00> in co-pays you paid and <$0.00> in payments made for you by the [*name(s) of program(s) or organization(s)*]. [*The <$0.00> in co-pays and <$0.00> in payments are the cumulative YTD totals that were applied to the TrOOP. Update these amounts to include claims from the reporting period. Update the <$0.00> in payments to include any payments (e.g., the Low Income Subsidy) made by other programs or organizations and include the name(s) of program(s) or organization(s)*].

? **If you have questions**, please call <plan name> at <toll-free number>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

C. You have the right to make an appeal or complaint about your health care or drug claims

[*Include plan-specific information about Medicaid appeals.*]

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 in whole or in part. [*Plans with cost sharing insert*: 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.]

There are rules for how coverage decisions and appeals are handled. These are legal procedures, and the deadlines are important. You can get a fast appeal, however, if your doctor tells us that your health requires a quick decision.

If you have questions, or if you need help making an appeal, you can call:

- <Plan name> Member Services at <phone number>.

- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

- Medicaid at <phone number>.

- Your State Health Insurance Assistance Program (SHIP). The name and phone numbers for this organization are in your Member Handbook.

For more information about making an appeal, please see the Member Handbook.

If you have questions, please call <plan name> at <toll-free number>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

D. Updates to the plan's Drug List that will affect drugs you take

- *[Use this section to give formulary updates that affect drugs the member is taking—that is, any plan-covered drugs the member received during the current calendar year while a member of the plan. Include updates only if they affect drugs the member is taking. (Changes to the formulary from one year to the next are announced in the Annual Notice of Change and do not need to be included in the EOB.)*

- ***If there are no updates, delete this section.***

- *If an update is for a negative formulary change that is not a formulary maintenance change, insert:* If you are currently taking this drug, this change will not affect your coverage for this drug for the rest of the plan year.]

About the Drug List

<Plan name> sent you a "List of Covered Drugs," or "Drug List" for short. The Drug List tells which drugs are covered by the plan. It also tells which [*Plans without cost-sharing, delete:* cost-sharing] tier each drug is in and whether there are any restrictions on coverage for a drug.

Our website (<website>) always has the most current version of the Drug List. You can also call Member Services and ask for a copy.

During the year, we may make changes to our Drug List.

- We may add new drugs, remove drugs, and add or remove restrictions on coverage for drugs. We are also allowed to change drugs from one [*Plans without cost-sharing, delete*: cost-sharing] tier to another.

- Unless noted otherwise, you will have at least 60 days notice before any changes take effect unless a serious safety issue is involved (for example, a drug is taken off the market).

If you have questions, please call <plan name> at <toll-free number>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Updates that affect drugs you take

The list that follows tells *only* about updates to the Drug List that will change the coverage or cost of **drugs you take**.

 "Drugs you take" means any plan-covered drugs that you received in [*insert year*] as a member of our plan.)

[*Below we show model language for reporting several common types of changes to the Drug List. Do not include sections that are not applicable. Plans may adapt this language as needed for grammatical consistency, accuracy, and relevant detail (for example, describing a drug as "brand name" or "generic"). Plans may also provide additional explanation of changes, if desired, and suggest specific drugs that might be suitable alternatives. To report changes for which model language is not supplied, use the model language shown below as a guide.*]

- **<Drug name>** [*Insert name of step therapy drug. Plans may also insert information about the strength or form in which the drug is dispensed (for example:* tablets **or** injectable).]

- **Date and type of change:** Beginning [*insert effective date of the change*], step therapy will be required for this drug. This means you will be required to try [*insert either:* a different drug first **or** one or more other drugs first] before we will cover [*name of step therapy drug*]. This requirement encourages you to try another drug that is less costly yet just as safe and effective as [*insert name of step therapy drug*]. If [*insert either:* this other drug does not **or** the other drugs do not] work for you, the plan will then cover [*insert name of step therapy drug*].

- **Note:** See the information later in this section that tells "What you and your doctor can do." [*If applicable, plans may insert information that identifies possible alternate drugs, for example:* (You and your doctor may want to consider trying <alternate-drug-1> or <alternate drug-2>. Both are on our Drug List and have no restrictions on coverage. They are used in similar ways as [*insert name of step therapy drug*], and they are on a lower cost-sharing tier.)]

- **<Drug name>** [*Insert name of drug for which the quantity is limited. Plans may also insert information about the strength or form in which the drug is dispensed (for example:* tablets **or** injectable*).]

- **Date and type of change:** Beginning [*insert effective date of the change*], there will be a new limit on the amount of the drug you can have. [*Insert description of how the quantity will be limited.*]

- **Note:** See the information below that tells "What you and your doctor can do."

- **<Drug name>** [*Insert name of drug for which prior authorization is required. Plans may also insert information about the strength or form in which the drug is dispensed (for example:* tablets **or** injectable).]

If you have questions, please call <plan name> at <toll-free number>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **Date and type of change:** Beginning [*insert effective date of the change*], prior authorization will be required for this drug. This means you or your doctor need to get approval from the plan before we will agree to cover the drug for you.

- **Note:** See the information later in this section that tells "What you and your doctor can do." [*Plans may insert more explanation if desired (for example:* Your choices include asking for prior authorization in order to continue having this drug covered or changing to a different drug.*).*]

- **<Drug name>** [*Insert name of brand-name drug to be replaced with generic. Plans may also insert information about the strength or form in which the drug is dispensed (for example:* tablets **or** injectable*).*]

- **Date and type of change:** Effective [*insert effective date of the change*]*,* the brand-name drug [*insert name of brand-name drug to be replaced with generic*] will be removed from our Drug List. We will add a new generic version of [*insert name of brand-name drug to be replaced with generic*] to the Drug List (it is called [*insert name of replacement generic drug*]).

- **Note:** [*Plans may insert further information if applicable, for example:* Beginning [*insert effective date of the change*]*,* any prescription written for [*insert name of brand-name drug to be replaced with generic*] will automatically be filled with [*insert name of replacement generic drug*]. This change can save you money, because [*insert name of replacement generic drug*] is in a lower cost-sharing tier than [*insert name of brand-name drug to be replaced with generic*]. If you want to keep using [*insert name of brand-name drug to be replaced with generic*], see the information later in this section that tells "What you and your doctor can do."]

- **<Drug name>** [*Insert name of drug for which cost-sharing will increase. Plans may also insert information about the strength or form in which the drug is dispensed (for example:* tablets **or** injectable*).*]

- **Date and type of change:** Effective [*insert effective date of the change*], [*insert description of the change, for example:* the brand-name drug [*insert name of drug for which cost-sharing will increase*] will move from tier 2 to tier 3.*] The amount you will pay for this drug depends on which drug payment stage you are in when you fill the prescription. To find out how much you will pay, please call Member Services.

- **Note:** See the information later in this section that tells "What you and your doctor can do." [*Plans may add more information if desired, for example:* (You and your doctor may want to consider trying a lower cost generic drug, [*insert name of lower-cost generic drug*]*,* which is in cost-sharing tier [*insert number or name of cost-sharing tier*].)]

If you have questions, please call <plan name> at <toll-free number>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

What you and your doctor can do

We are telling you about these changes now so that you and your doctor will have time (at least 60 days) to decide what to do.

Depending on the type of change, there may be different options to consider. For example:

- **You can call Member Services** at <phone number> to ask for a List of Covered Drugs that treat the same medical condition.

- **Your doctor might be able to find a different drug** covered by the plan. The drug might work just as well for you and have fewer restrictions or a lower cost.

  You and your doctor can ask the plan to make an exception for you. Your doctor will need to tell us why making an exception is medically necessary for you. For more information about requesting an exception, call Member Services at <phone number>.

If you have questions, please call <plan name> at <toll-free number>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.