Model Monthly Integrated EOB

Instructions to Health Plans

***NOTE: Do not include these instruction pages when you send EOBs to members.***

*This is a model Explanation of Benefits (EOB) for monthly reporting of health care, long-term services and supports, and drug claims.*

Plans are not required to send an EOB if the member has no claims of any kind (e.g., health care, long-term services and supports, and drug claims) in the reporting period. However, plans must send the EOB if the member has at least one claim in Section A or Section B.

**Claims that must be included within the EOB**

* Plans must include all claims processed during the reporting period, including all claims for covered services and drugs. Any benefit information that cannot be included timely must be accounted for in a following reporting period.

**Descriptors and billing codes**

* The health care claim information in the EOB must include the American Medical Association’s HCPCS code descriptors and CPT consumer descriptors, followed by the HCPCS or CPT billing code in parentheses. When HCPCS or CPT codes are not available, health care information in the EOB may include NOC codes and descriptors. Drug claim information must include the name of the drug, followed by quantity, strength and form (for example: 25 mg tabs) and the name of the pharmacy.

**Instructions within the template**

* Italicized blue text in square brackets is information for the plans. Do not include it in the EOB.
* Non-italicized blue text in square brackets is text that can be inserted or used as replacement text in the EOB. Use it as applicable.
* 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 State-specific Marketing Guidance for Medicare-Medicaid Plans.
* When instructions say to insert the month and year, spell out the full name of the month (for example: January 2025).
* Where the template instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.

**Permissible document alterations**

* Plans should modify the text in the introduction to be consistent with the required disclaimer language in the State-specific Marketing Guidance for Medicare-Medicaid Plans.
* Plans should add Medicaid-specific language where appropriate.
* Minor grammar or punctuation changes are permissible.
* References to “Member,” “Member Services,” and “Member Handbook” can be changed to the appropriate name used by the plan or required by the State.
* References to “year” or “calendar year” may be changed to “plan year.”
* 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 (for example: 1/1/25 to 2/3/25 **or** January 1 – February 3, 2025) whenever instructions say to insert the month and year.
* Consistent with the “Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses” final rule (CMS-4180-F), CMS required plans to include negotiated price increases and lower cost therapeutic alternatives in their members’ Part D EOBs beginning January 1, 2021.

**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 Sections A and B, 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.
* 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 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.
* Unless specific formatting instructions for dates have been given, plans may use their preferred method of formatting the date (for example, “mm/dd/yy”).
* *Wherever possible, plans are encouraged to adopt good formatting practices that make information easier for English-speaking and non-English-speaking enrollees to read and understand. The following are based on input from beneficiary interviews:*
* *Format a section, chart, table, or block of text to fit onto a single page. In instances where plan-customized information causes an item or text to continue on the following page, enter a blank return before right aligning with clear indication that the item continues (for example, similar to the Benefits Chart in Chapter 4 of the Member Handbook, insert:* **This section is continued on the next 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.)*.*
* *Ensure plan-customized text is in plain language and complies with reading level requirements established in the three-way contract.*
* *Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple of plan-specific examples as applicable.*
* *Spell out an acronym or abbreviation before its first use in a document or on a page (for example, Long-term services and supports (LTSS) or low income subsidy (LIS)).*
* *Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.*
* *Avoid separating a heading or subheading from the text that follows when paginating the model.*
* *Use universal symbols or commonly understood pictorials.*
* *Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.*
* *Consider using regionally appropriate terms or common dialects in translated models.*
* *Include instructions and navigational aids in translated models in the translated language rather than in English.*

**Drug-coverage section**

* Insert Part D drug claims and non-Part D (Medicaid) drug and non-Part D (Medicaid) over-the-counter product claims from all pharmacy settings (mail order, retail, LTC) in the Drug Claims section (Section B). Note that Part A and Part B drug claims should be included with Health Care Claims (Section A).
* 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 member disenrolls from the plan during the plan year, the plan must send an EOB to the former member after disenrollment if any claims are processed prior to the member disenrolling. For example, if a member disenrolls at the end of August and the plan processes claims in months prior to disenrollment, the disenrolling plan must send a final EOB.

**Member appeals**

* Plans are responsible for ensuring that members get 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 in accordance with the process for an Illinois EOB.

<Plan name>

*Explanation of Benefits*

A summary of your health care [plans may add the following phrase, if preferred:long-term services and supports,] and drug claims for [insert: <month year> or <date range>]

<mailing date>

For <member name>

[For the member’s easy reference, plans may also insert the member’s mailing address, member ID number, and/or other information typically used in member communications.]

This is a bill.

[Insert plan’s legal or marketing name] is a health plan that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to enrollees.

This *Explanation of Benefits* (EOB) is a summary of claims (bills) sent to <plan name> for services and drugs you got during [insert month and year **or** date range]. The EOB tells you what we paid providers, such as doctors and pharmacies. [Plans with no cost sharing for all services and drugs, delete the rest of this paragraph.] The EOB also shows how much you paid (or can expect to be billed). If you owe anything, your doctors and other health care providers will send you a bill.

Disclaimers

[*Plans must include all applicable disclaimers as required in the State-specific Marketing Guidance.*]

Other formats

You can get this *Explanation of Benefits* for free in other formats, such as large print, braille, or audio. Call <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free.

Need help?

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

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?
* [Plans with no cost sharing for all services and drugs, delete the following language.] **If you already paid the bill, did you pay the right amount?** Call us at <toll-free phone and TTY numbers>, <days and hours of operation> if you have questions about how much you must pay. The call is free.

For more information, you can call <plan name> Member Services or read the <plan name> *Member Handbook*.[*Plans must include information about how to access the Member Handbook on the plan’s website.*]

What if you find 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 on our website: <URL>.]

What about possible fraud?

If this summary shows services you did not get, 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.]

Your health care [plans may add the following phrase, if preferred: and long-term services and supports] claims for [insert: <month year> or <date range>]

[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 or long-term services and supports claims during the reporting period, (1) insert the following note in the first column: No health care claims or long-term services and supports claims for <month and year **or** date range>; **and** (2) insert amounts of “$0.00” for the columns labeled “Plan’s share” and “Your share.”]

**NOTE:** To describe the services you got, this summary uses billing codes and descriptions that were developed and copyrighted by the American Medical Association (all rights reserved). If you do not understand any of the services listed below, call us at <toll-free number> and we can explain the services.

| **<Provider name>**  [Insert as applicable: In-network or Out-of-network] provider  Claim Number: <Claim number> | Date(s) of service  The date(s) you got the services | Plan’s share  The amount <plan name> pays for the services | Your share  The amount you may need to pay for the services |
| --- | --- | --- | --- |
| [Show each service or item 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). When HCPCS or CPT codes are not available, health care information in the EOB may include NOC codes and descriptors.]  [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(s) 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 copay, insert: You pay a $[insert copay amount] copay 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 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. Refer to Section C for information about your appeal rights.] |
| [Insert next service or item for the claim, using language described above.] |  |  |  |
| [Insert next service or item for the claim, using language described above.] |  |  |  |

**THIS IS NOT A BILL**

[Plans with cost sharing include: If you get a bill that is higher than the amount shown in the “your share” column, call us at <toll-free number>.] [Plans without cost sharing include: You pay nothing for your covered services as long as you follow the plan’s rules. If you get a bill from a network provider for covered services, call us at <toll-free number>.]

[Plans should include the following paragraph, if applicable] <Provider name> is an out-of-network provider. You can keep using <provider name> for the first [insert appropriate number of days] you are with our plan at no cost to you. During this time, your [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 (and if the plan has not previously sent a "Notice of Denial of Medical Coverage" regarding that denial to the member), the plan must 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]
* **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 got 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 got 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].]]

# Your drug claims for [insert: <month year> or <date range>]

[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 [insert: <month year> **or** <date range>]; **and** (2) insert $0.00 for amounts in the columns labeled “Plan’s share” and “Your share.” Drug claims in this section should not include Part A or Part B drug claims.]

**NOTE:** The amount in the “Plan’s share” column includes payments made for you by Extra Help for Medicare Part D drugs. Extra Help is a Medicare program that helps you pay prescription drug costs. [Insert if applicable: The “Plan’s share” column also includes payments made for you by <names(s) of other programs or organizations>.]

The “Drug price and change in price” column includes the **total price of the drug** (including any amounts in the “Plan’s share” and “Your share” columns) and the **percentage change** (increase or decrease in the drug price since the first fill).

When lower cost therapeutic alternative drugs are available, they appear in the table below your current drugs. You can talk to your prescriber to find out more and know if they’re right for you.

| [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(s) of service  The date(s) you got the drugs | Plan’s share  The amount <plan name> pays for the drugs | Your share  The amount you may need to pay for the drugs | Drug price and change in price  Total drug price and percentage change since first fill |
| --- | --- | --- | --- | --- |
| [**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 preferred, plans may insert drug information here exactly as shown on the pharmacy claim.]  [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, 2025, step therapy will be required for this drug. Refer to Section D for details.] | [Insert date(s) 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.] | $[*Insert total drug price, including amounts in “Plan’s share” and “Your share” columns. Then insert percentage change (increase or decrease) in drug price since first fill.*] |
| [*The plan may also suggest lower-cost alternatives that a member and their doctor might want to consider in this section.*]  [Insert lower cost therapeutic alternative(s). Plans have flexibility to determine the number of alternatives to list. Plans must provide at least one drug for each filled prescription if there is an equivalent lower cost therapeutic alternative available. Plans should use their clinical expertise when deciding which alternative drugs to list. If no lower-cost therapeutically equivalent drug is available, plans should enter “No lower-cost alternative drug is available”.] |  |  |  |  |
| [Insert next drug for the pharmacy, using language described above.] |  |  |  |  |
| [Insert next drug for the pharmacy, using language described above.] |  |  |  |  |

**THIS IS NOT A BILL**

[Plans with one coverage stage (that is, with no member cost sharing for any Part D drugs), delete the following paragraph:]

You have 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., Extra Help) made by other programs or organizations, any claim reversals, and any TROOP balance transfers from the prior plan.] Once you reach this limit, you will have no more cost sharing for your Medicare Part D drugs for the rest of the year. The <$year-to-date TrOOP> amount includes <$0.00> in copays you paid and <$0.00> in payments made for you by Medicare’s Extra Help program [insert if applicable: and <names(s) of other programs or organizations>]. [The <$0.00> in copays 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., Extra Help) made by other programs or organizations and include the name(s) of program(s) or organization(s).]

# You have the right to make an appeal about your health care [plans may add the following phrase, if preferred:, long-term services and supports,] or drug claims

[Include plan-specific information about Medicaid appeals.]

When we decide whether a service or drug is covered [plans with cost sharing insert: and how much you pay], it’s called a “coverage decision.” Making an appeal is a formal way of asking us to change our coverage decision. 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 service or drug.]

There are rules for how appeals are handled. These are legal procedures, and the deadlines are important. You can get a fast appeal 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 <toll-free 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.
* The Illinois Department of Healthcare and Family Services Health Benefits Hotline at 1-800-226-0768 Monday through Friday from 8:00 a.m. to 4:30 p.m. TTY users should call 1-877-204-1012.
* Your local Ombudsman at 1-800-252-8966 Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 1-888-206-1327. The call and the help are free.
* The Senior Health Insurance Program (SHIP) at 1-800-252-8966 Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 1-888-206-1327. The call and the help are free.

For more information about making an appeal, please refer to Chapter 9 [*plans may insert reference, as applicable*] in your *Member Handbook*.

# Updates to our *Drug List* that will affect drugs you take

* [Use this section to provide negative formulary updates that affect drugs the member is taking—that is, any plan-covered drugs the member got during the current calendar year while a member of the plan. Include updates only if they affect drugs the member is taking and involve negative changes. (Changes to the formulary from one year to the next do not need to be included in the EOB.)
* Plans that use this chart in lieu of providing a separate written notice of formulary change must ensure this EOB includes the content of written notice required under § 423.120(f)(4), including a list of alternative drugs, and otherwise comply with applicable requirements under § 423.120(e) and (f), including providing notice within required timeframes. Plans can insert the relevant content of Sections A through C of the 2025 Part D Model Notice of Formulary Change in the chart, as instructed below.
* If there are no formulary updates, include the following: At this time, there are no new or upcoming changes to our Drug List that will affect the coverage [insert if applicable: or cost] of the drugs you take. (By drugs you take we mean any plan-covered drugs that you got in CY 2025 as a Participant of our plan.)]

About the *Drug List*

[*Plan must insert if it sends a hard copy List of Covered Drugs:* <Plan name> sent you a *List of Covered Drugs* or “*Drug List*” for short.] [*Plan must insert if it only sends a hard copy List of Covered Drugs upon request:* <Plan name> sent you a notice telling how to get a *List of Covered Drugs* or “*Drug List*” or how to access it online.] The *Drug List* tells which drugs are covered by our plan. It also tells which [plans with cost sharing insert: cost-sharing] tier each drug is in and whether there are any restrictions on coverage for a drug.

Our website (<URL>) 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 with cost sharing insert: cost-sharing] tier to another.

Updates that affect drugs you take

The list that follows tells **only**about updates to the *Drug List* that change the coverage [plans with cost sharing insert: or cost] of **drugs you take**.

“Drugs you take” means any plan-covered drugs that you got in [insert year] as a member of our plan.

[Repeat the following as necessary to include all relevant changes. Plans may use “us” where “the plan” is used on the Notice of Formulary Change.]

[Insert name of drug subject to change. Plans may also insert information about the strength or form in which the drug is dispensed (e.g., tablets, injectable, etc.).]

[Insert type of formulary change (e.g. Step therapy)]

* Beginning [insert effective date of the change], [insert <name of drug> subject to change] [insert relevant content of Section A of the 2025 Part D Model Notice of Formulary Change that describes the change].

Understanding these changes

If any of the above terms are new to you, for a discussion of drug types, please see our *Member Handbook* Chapter 5, [insert section letter].

[Insert relevant content of Sections B and C of the 2025 Part D Model Notice of Formulary Change.]

What you and your doctor can do

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

* **You can call Member Services** at <toll-free phone and TTY numbers>, <days and hours of operation> to ask for a list of covered drugs that treat the same medical condition. The call is free.
* **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 [plans with cost sharing for any tier of drugs insert: 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. To learn how to ask for an exception, refer to Chapter 9 [*plans to insert reference, as applicable*] in your *Member Handbook*. For more information about asking for an exception, call Member Services at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free.