POLICY AND PROCEDURE

Policy No: 2019CLM0011
Page Number: 1 of 4
Effective Date: February 2017
Last Reviewed: June 2019

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TITLE: ENROLLEE'S EXPLANATION OF BENEFITS STATEMENT

Department:	Operations - Claims	**Department Head:** (Name and Signature)	Mychelle Scott Mychelle Scott
Approval Date:	8/14/19	**Next Review Date:** (12 months from approval date)	August 2020
Compliance/Executive Approval:			
Name : Deloria J. Williams		**Date:** 8/14/19	

APPLIES TO: ☐ **MEDICAID** ☐ **CHIP/ CHIP P** ☒ **HEALTH INS MARKETPLACE** ☒ **OTHER**

☒ **BH** ☐ **STAR+PLUS** ☐ **D SNP** ☐ **MMP** ☐ **ALL**

PURPOSE:
To outline and define the process of issuing Explanation of Benefit (EOB) statements to members.

POLICY:

After a claim is received and processed by Community Health Choice (Community), an EOB is mailed to the member. .

An EOB includes the date of service, the type of service rendered, the amount billed, discount amount, the amount covered, copay / coinsurance / deductible amount, the amount paid by the health insurance company and any balance the member is responsible for paying the provider. The EOB also include the member's year to date out of pocket maximum amount. An EOB is not a bill for services.

DEFINITIONS:
Explanation of Benefits (EOB) - a detailed statement explaining what medical treatments and/or services were paid or denied based on the enrollee's benefit plan.

PROCEDURE: N/A

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MONITORING: N/A

ATTACHMENTS:
Below is an example of a member's EOB statement.

2. **Dates of Service -** The date(s) the member received service.

3. **Type of Service -** The type of services or products the member received from their provider.

4. **Amount Billed -** The full amount billed by the member's provider to their health plan.

5. **Discount -** This section details the amounts that the member does not need to pay.

6. **Amount Not Covered -** The portion of the amount billed that was not covered or eligible for payment under the member's plan. Examples include charges for services or products that are not covered by the member's plan, duplicate claims that are not the member's responsibility, amount related to not getting a pre-approval for service, and any charges submitted that are above the maximum amount the member's plan pays for out-of-network care.

7. **Covered Amount –** The portion of the amount billed that is covered minus discounts and amount not covered.

8. **Copay -** A set amount the member pays for certain covered services such as office visits or prescriptions. Copays are usually paid at the time of service. **Deductible -** The deductible is the amount the member needs to pay each year for covered services before their plan starts paying benefits.

9. **COB** – Amount paid by the member's primary carrier

10. **Plan Paid -** The portion of the charges eligible for benefits minus the member's copay, deductible, coinsurance, network discount and amount paid by another source up to the billed amount.

11. **Member Responsibility -** This section details the portion of the bill that is the member's responsibility to pay. This amount might include the member's copay, deductible, coinsurance, any amount over the maximum reimbursable charge, or products/services not covered by the member's plan.

12. **Reason Code -** When present, these codes provide general information about the claim and may also provide specific explanation of activity that occurred in the Amount Not Covered, Amount Paid by Another Source, and What Your Plan Paid fields

Attachments: Attachment A – Sample Explanation of Benefits

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Attachment A

Community Health Choice
P.O. Box 301424
Houston, TX 77230-1424

201410100121

Electronic Service Requested

Page: 1 of 1
Statement Date: 09/26/2015

Health Insurance Marketplace

27444 0.3584 SP 0.500

Member Name
Address
State, TX Zip

Subscriber:
Subscriber ID: 0000XXXXXX
Plan Name: Community Care Gold Limited Cost
Claim Activity For:
Member ID: 0000XXXXXXX

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EXPLANATION OF BENEFITS THIS IS NOT A BILL

Please Retain for Future Reference

Provider Name: North Houston Clinic **Date of Service:** 9/24/15 – 9/24/15 **Claim Number:** 1111111222222

Date of Service	Type of Service 3	Amount Billed 4	Discount 5	Amount Not Covered 6	Covered Amount	Copay / Deductible	COB 9	Plan Paid 10	Member Responsibility 11	Reason Code 12
09/24/15	Professional Services	$182.00	$79.08	$0.00	$102.92 7	$60.00 8	$0.00	$42.92	$60.00	

Payment Sent To: **Amount**
North Houston Clinic $42.92

Reason Code Explanations

Out of Pocket Expense for this Plan Year	Limit	YTD
Individual Deductible	$0.00	$0.00
Family Deductible	$0.00	$0.00
Individual Out of Pocket	$0.00	$0.00
Family Out of Pocket	$0.00	$0.00

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mulation limits shown are as of the statement date above. Login to www.chchealth.org for the most current information.

Please submit your written appeal along with a copy of the entire EOB to the address below:

Community Health Choice, Inc.
Appeals Department
PO Box 301412
Houston, TX 77230-1412

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You are entitled to a review (appeal) of this benefit determination, if you have questions or do not agree.

To obtain a review, you or your authorized representative should call our Member Services Department using the telephone number displayed on the member ID card or submit a request in writing to the Appeals Department address shown above. Your request should include the group name, your name, member ID, address and your date of birth and other identifying information shown on this EOB, and any comments, documented records and other information you would like to have considered, whether or not submitted in connection with the initial claim. You may also review documents relevant to your claim. Verbal or written requests for review of the adverse determination must be communicated, mailed, or delivered, within 180 days from the date of this explanation of benefits or such longer period as may be specified in your plan document or Summary Plan Description.

If you have any questions, Contact us at **713.295.6704** OR **1.855.316.5386**