EXPLANATION OF BENEFITS (EOBS)

1.0. BENEFICIARY, PARENT/GUARDIAN

The contractor shall issue and mail an appropriate and easily understood EOB to the beneficiary (parent/guardian for minors or incompetents) for each claim processed to a final determination. In those circumstances where the beneficiary has no "out of pocket" expenses, including deductibles or cost-shares, and there are no denied charges included on the claim for which he/she is, or may be, responsible, issuance of an EOB may be waived. (For the purpose of issuing EOBs, Prime beneficiary copayments are not considered out-of-pocket expenses.) When an EOB is required, it must be issued to the beneficiary regardless of whether or not the provider is a participating provider and whether or not an actual payment is involved; e.g., allowed amount is applied to the deductible or payment is $.99 or less and no check is mailed.

2.0. NON-PARTICIPATING PROVIDER

The EOB shall be provided to the non-participating provider with the amount allowed so that he/she can determine what amount may be billed to the beneficiary under the balance billing provision (115% of the TRICARE allowable charge). When a claim for service from a non-participating provider is allowed at the billed charge, the EOB, at the contractor's discretion, need not be sent to the non-participating provider since the balance billing provision does not apply. Only the charges of the non-participating provider would normally appear on the EOB; however, the non-participating provider should only be provided with information where there is a "need to know." This means that if other information appears on the EOB that does not pertain to the non-participating provider, the TRICARE contractor is to suppress printing or remove it before sending the EOB to the non-participating provider. The non-participating provider will receive only the EOB and the beneficiary will receive the TRICARE payment.

3.0. PARTICIPATING PROVIDERS

The contractor shall also issue EOBs to participating providers or issue summary vouchers covering multiple claims and beneficiaries in lieu of issuing multiple EOBs. Sufficient information must be included on the vouchers to identify each beneficiary and explain the payment for each line item on each claim. Use of a summary voucher does not change the requirement for a separate EOB to be sent to each beneficiary for each claim. Each contractor shall include adequate identification of the fiscal year involved applicable to the various charges listed on the EOB to help keep the deductible information clear to the beneficiary.

4.0. STATE MEDICAID AGENCY

If the claim is from a state Medicaid agency, the EOB copy usually sent to a participating provider shall be sent to the state agency. The contractor shall include the same information on the copy sent to the state as it normally sends to participating providers. If the state has a need which cannot be accommodated except at extra expense, the contractor may negotiate with the state, if it chooses, and if the state is willing to pay for the accommodation.

5.0. EOB ISSUANCE EXCEPTIONS

5.1. Contractors shall not issue EOBs to beneficiaries (parents/guardians of minors or incompetents) when claims involve services related to any of the following diagnoses:

- Abortion
- AIDS/*HIV*
- Alcoholism
- *Pregnancy*
- Substance Abuse
- *Sexually Transmitted Diseases*

5.2. EOBs must be issued to participating providers, except as noted above. The contractor shall provide an EOB to a beneficiary upon request. When a request is made for a normally suppressed EOB, the copy provided may be a facsimile or a hand-produced copy. It must, however, include the required data and be certified by the contractor.

5.3. When a service(s) is denied due to an abortion, a letter of explanation shall be sent, but only when the denial is questioned by the beneficiary. Chapter 8, Addendum A, Figure 8-A-4 provides suggested wording for abortion claims that are denied. **The explanation shall be provided only to the beneficiary and participating provider.** The special denial letter shall be sent in an envelope marked "personal". **It is EMPHASIZED that using an Explanation of Benefits is NOT acceptable for denial of abortion services.** Only an approved letter may be used.

6.0. PROCEDURES FOR INFORMING THE BENEFICIARY OF CLAIM ACTION

The processing of claims for the diagnoses listed above, requires sensitivity to the beneficiary's right to privacy. Because of the need for contractors to apply reasonable judgment on a case-by-case basis, *TRICARE Management Activity (*TMA*)* has not prescribed specific procedures except in the case of abortion claims. For claims involving services and supplies for the other diagnoses, a phone call to the beneficiary may serve to obtain information on how the beneficiary wishes to have the EOB handled in some instances. In other cases, a request that the provider serve as an intermediary, or a personal letter to the beneficiary, using a plain envelope, may be appropriate. Whatever approach is chosen, contractors must observe the intent, as well as the letter, of the Privacy Act.

7.0. PAYMENT TO THE PROVIDER OR BENEFICIARY IS 99 CENTS OR LESS

Summary voucher payments or individual claims payment checks for $.99 or less, shall be written by the contractor, but NOT mailed to the beneficiary or provider, using an

appropriate EOB message. The checks shall be voided and processed as outlined in Chapter 3, Section 8. At the end of the year when the contractor issues the provider's Form 1099, the withheld amounts shall NOT be shown on the Form 1099.

8.0. EOB FORMAT

The form design of the EOB is not specifically prescribed. Contractors shall design the form to fit their individual equipment and system needs. The contractor shall provide their toll-free inquiry number on the EOB. Only the last four digits of the Social Security Number shall appear on the EOB.

9.0. REVERSE OF THE EOB FORM

The following information shall be on the reverse of the EOB:

Right To Appeal

If you disagree with the determination on your claim, you have the right to request a reconsideration. Your signed written request must state the specific matter with which you disagree and **MUST** be sent to the following address no later than 90 days from the date of this notice. If the postmark on the envelope is not legible, then the date of receipt is deemed the date of filing. Include a copy of this notice. On receiving your request, all TRICARE claims for the entire course of treatment will be reviewed.

(Contractor's Address)