

# How to read Medicare Summary Notices and Explanation of Benefits

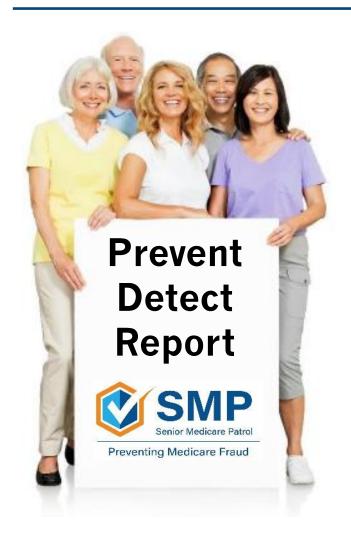


### SHIBA mission

SHIBA provides free, unbiased information about health care coverage and access to help improve the lives of all Washington state residents. We cultivate community commitment through partnership, service and volunteering.



### The Senior Medicare Patrol (SMP) mission



### The SMP mission:

**Empower and assist** Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling and education.



# Today's overview

- Make sense of your Medicare Summary Notices (MSNs) from Medicare.
- Make sense of your Explanation of Benefits (EOBs) from your Medicare Advantage (MA) or drug plan.
- Helpful information about Medicare coverage.
- Find out about volunteer opportunities.
- We'll wrap up.



### Important terms

**Appeal:** a formal request to Medicare, an MA or RX plan, to review a service or item coverage decision.

**Coinsurance/Copayment:** The amount you must pay for each service or item. Coinsurance is a percentage of the total cost. A copayment or copay is a fixed amount.

**Deductible:** The amount you must spend on health care or drugs before your insurance begins to pay.



# Medicare Summary Notice (MSN)



### What is an MSN?

- It's not a bill.
- It's a notice that people with Original Medicare get in the mail every 3 months for their Medicare Part A- and B-covered services.
- The MSN shows:
  - All your services or supplies that providers and suppliers bill to Medicare during the 3-month period.
  - What Medicare paid.
  - The maximum amount you may owe the provider.
- If Original Medicare will not pay for care you received, you will find this out when you receive your Medicare Summary Notice (MSN).



### Tips for understanding your MSN

- You can also view your MSNs online at medicare.gov when you open an account.
- Read the definitions and descriptions of services carefully.
- Review the Notes section where Medicare explains its payment decision or gives other important information.
- If Medicare rejects a covered service you received, you should appeal.
- See the "Where to go for Help" section on the last page.



# Sample MSN

#### 1 Type of Claim

Claims can either be assigned or unassigned.

#### O Definitions

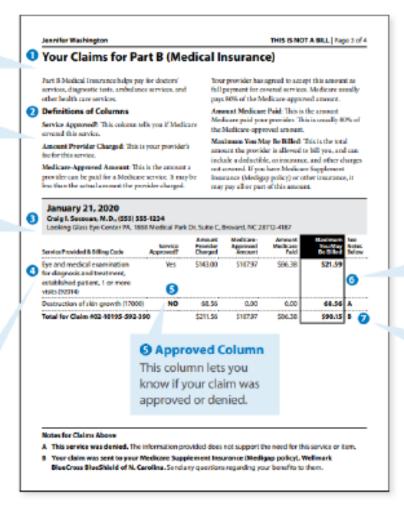
Don't know what some of the words on your MSN mean? Read the definitions to find out more.

#### Your Visit

This is the date you went to your doctor. Keep your bills and compare them to your notice to be sure you got all the services listed.

#### Service Descriptions

User-friendly service descriptions will make it easier for you to know what you were treated for.



#### Max You May Be Billed

This is the total amount the provider is able to bill you. It's highlighted and in bold for easy reading.

#### Notes

Refer to the bottom of the page for explanations of the services you got.



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Before starting, check to make sure the denial is not an error:

- Sometimes, the bill the provider sends to Medicare is incorrectly filed, which results in a denial of service.
- The provider's office can correct the error by contacting the company that processed the Medicare claim.



Start the appeal by filling out the shaded area on the last page of the MSN.

- Ask your provider to write a letter of support that explains why you need the care and addresses the plan's denial reason.
- Send copies of letters do NOT send originals.
- Mail copies to the address by the date indicated on the last page.



#### O Get More Details

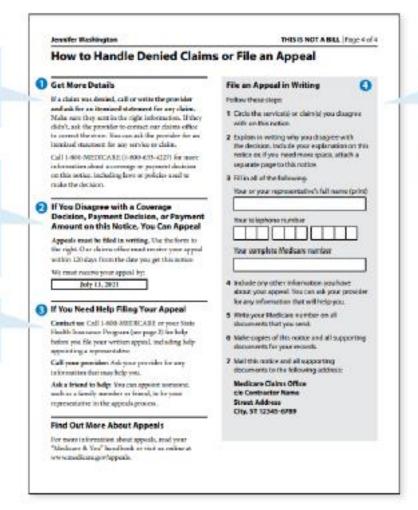
Find out your options on what to do about denied claims.

#### 1 If You Decide to Appeal

You have 120 days to appeal your claims. The date listed in the box is when your appeal must be received by us.

#### O If You Need Help

Helpful tips to guide you through filing an appeal.



#### O Appeals Form

You must file an appeal in writing. Follow the step-bystep directions when filling out the form.



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You can appeal Medicare's decision to deny coverage.

- There are multiple levels to the appeal process.
- If an appeal is denied, you can appeal to the next level.
- You can request a good cause extension if you miss the appeal deadline (file as normal with an explanation).



# Explanation of Benefits (EOBs)



### What is an EOB?

- You only receive an EOB if you have an MA plan or a Medicare Part D drug plan.
- It's not a bill.
- It's a summary of the services or items you have received and how much you may owe for them.
- It tells you:
  - How much your provider billed.
  - The approved amount your plan will pay.
  - How much you have to pay.



# Tips for understanding your EOB

- If you have an MA plan or Medicare Part D drug plan, your plan will send you your EOBs monthly.
- You'll only receive an EOB if you received service.
- Each insurance plan has its own format, but should include information such as claim number, date of service, amount the provider billed the plan, etc.



# Tips for understanding your EOB

- Read the definitions and descriptions of services carefully.
- Review the Notes section, including any footnotes where the plan explains its payment decision.
- If an MA or Medicare Part D plan rejects a covered service or prescription drug you received, you should appeal.
- See the "Where to go for Help" section on the last page of your EOB.



# Sample EOBs

This claim was for services received at an out-of-network doctor, which can cause higher out-of-pocket costs or denials. This column lists the total amount your provider is able to bill you. This also describes the coinsurance for in-network providers for this Medicare Advantage plan.

Susan	Was	hing	ton, I	M. D.
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Claim Number: 12345678 (Out of Network Provider)	Date of service	Amount the provider billed the plan	the plan approved)	Plan's share	Your share
Introductory visit, endocrinologist	7/2/2015	\$375.00	\$0.00 DENIED (Look below for information about your appeal rights)	\$0.00	Maximum potential liability

John Smith, M.D.								
Claim Number: 12345678 (In Network Provider)	Date of service	Amount the provider billed the plan	Total cost (amount the plan approved)	Plan's share	Your share			
Physical therapy services to strengthen leg functioning, 45 minutes	8/1/2015	\$250.00	\$75.00	\$63.75	\$11.25 (You pay 15% of the total amount at an in-network			
			This column tells you whether or not your claim was approved or denied.		provider)			



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Before starting, check to make sure the denial is not an error:

- Sometimes, the bill the provider sends to your MA plan is filed incorrectly, resulting in a denial of service.
- The provider's office can correct the error by contacting the company that processed the claim.



Start an appeal by sending a letter to the plan's grievances and appeals department that explains why you need the service or item.

- Ask the doctor to write a letter of support that explains why you need the care and addresses the plan's denial reason.
- Send copies of letters do NOT send originals.



You can appeal the MA or drug plan's decision to deny coverage.

- There are multiple levels to the appeal process.
- If an appeal is denied, you can appeal to the next level.
- You can request a good cause extension if you miss the appeal deadline (file as normal with an explanation).



# What else you need to know



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# Learn about Medicare's coverage rules

To learn more about Original Medicare's coverage of a service:

- Call 1-800-MEDICARE (1-800-633-4227).
- Visit Medicare.gov.
- Read the relevant sections in the Medicare & You handbook.
- Contact your local SHIBA office at 1-800-562-6900.



# Where to go for help

- For questions about your MSN, call: 1-800-MEDICARE (1-800-633-4227).
- For questions about your EOB, call:
   Your insurance plan the phone number is located on the back of your plan's insurance card.
- If you do not think you received the service, item or medication outlined on your MSN or EOB, contact your provider to inquire about a possible error.



### Volunteer for SHIBA!

Do you want to help explain health care benefits or options to:

- Friends?
- Neighbors?
- You community?
- Help people become better informed consumers?



Become a volunteer! Call: 1-800-562-6900



# Need help with other insurance questions?

The Office of the Insurance Commissioner can also help you with questions, information and complaints about all types of insurance, such as:

- Homeowner Annuities

Auto

Health

Life

And more!

Call our Insurance Consumer Hotline:

1-800-562-6900

On the web at: www.insurance.wa.gov

