# Help Guide to Your Medicare Medical and Hospital Claims MONTHLY REPORT

## Medicare Medical and Hospital Claims Monthly Report is a Communication Between MVP Health Care® and You

Medicare requires us to send you this Monthly Report. It will replace the individual Explanation of Benefits (EOB) you previously received. As a reminder, Medicare covers hospitalizations, doctor visits, outpatient surgery and physical therapy visits.

Your Medicare Medical and Hospital Claims Monthly Report is a summary of your medical or hospital claims. You will receive it monthly for the months you received care and a claim was processed under your MVP Medicare Advantage plan. The Monthly Report includes details about the medical care you received, what was paid by MVP and how much you paid out-of-pocket or can expect to be billed by the provider if you did not pay at the time of service.

On the following pages you will see an example of a Medicare Medical and Hospital Claims Monthly Report. Because health care expenses can be confusing, we've added some helpful notes in the red boxes through-out the document to better explain what you are reading.

The Monthly Report is written in standardized language that we are not allowed to change. We're here if you need help understanding any of the information we send to you. Call MVP's Medicare Customer Care Center at **1-800-665-7924**, Monday–Friday, 8 am–8 pm Eastern Time. TTY users may call **1-800-662-1220**. From October 1–February 14, call seven days a week from 8 am–8 pm.

If you have prescription drug coverage, you will continue to receive your Monthly Prescription Drug Summary from CVS/caremark.

## FREQUENTLY ASKED QUESTIONS About Your Medicare Medical and Hospital Claims Monthly Report

**Q: Is this a bill?**

**A:** No, this document is NOT A BILL. If you owe anything, you will receive a bill separately from your doctor or other health care provider. If you get a bill from a provider for services shown within your Monthly Report, please make sure that the amount that is billed to you matches the Your Share amount. If it is different, please contact the provider's office.

**Q: I already paid my doctor for care I received this month. Why am I receiving this document?**

**A:** Medicare requires that MVP send your Monthly Report for the months in which you receive care and a claim is processed. It is important to note that the Monthly Report may not yet reflect payments you have already made to a doctor or health care provider during that month.

**Q: Do I have to do anything?**

**A:** Not at this time. Keep your Monthly Report for your records.

**Q: Does the Monthly Report include claims that I may have filed? Or does it just include provider submitted claims?**

**A:** The Monthly Report will include both claims that your doctor has filed, and claims that you may have filed.

**Q: Why don't I see a recent service or visit on this Monthly Report?**

**A:** This is a Monthly Report based on claims received and processed. Some services may not appear until the following month.

**KEEP THIS GUIDE FOR FUTURE REFERENCE**

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YOUR MEDICARE MEDICAL AND
HOSPITAL CLAIMS MONTHLY REPORT

# Medical and Hospital Claims Processed in June 2015

For John Q. Sample,
Member ID-1234567890

**This is not a bill:**

- This Monthly Report of claims we have processed tells what care you have received, what the plan has paid, and how much you have paid out of pocket (or can expect to be billed).
- If you owe anything, your doctors and other health care providers will send you a bill.
- This report covers medical and hospital care only. We send a separate report on Part D prescription drugs.
- If you notice something suspicious that might be dishonest billing, you can report it by calling MVP at **1-877-TELL-MVP** or **1-877-835-5687**. TTY users should call **1-800-662-1220**.

SAMPLE

MVP Health Plan, Inc. is an HMO-POS/PPO organization with a Medicare contract. Enrollment in MVP Health Plan, Inc. depends on contract renewal.

**MVP Medicare Customer Care Center**

If you have questions, call us: **1-800-665-7924**

We are here Monday–Friday, 8 am–8 pm. From October 1–February 14, call 7 days a week from 8 am–8 pm.

TTY: **1-800-662-1220**

**www.mvphealthcare.com**

The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan. Benefits, formulary, pharmacy network, provider network, premium, copayments, and coinsurance may change each year.

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It is important to remember that this document is **not** your Monthly Prescription Drug Summary, which may look similar. You will continue to receive your drug summaries from CVS/caremark.

The Totals section gives you an overview of your claims for the month. You will see what was billed, and what MVP and you are responsible for paying. Individual claims are detailed in the pages below.

This is the amount MVP pays.

This is the amount you pay your provider. The amount shown here may not reflect payments you have already made to your provider.

## TOTALS
**for medical and hospital claims**

| | Amount providers have billed the plan | Total cost (amount the plan has approved) | **Plan's Share** | **Your Share** |
|---|---|---|---|---|
| **Totals for this month** (for claims processed from June 1, 2015 to June 30, 2015) | $115.00 | $70.00 | $55.00 | $15.00 |
| **Totals for 2015** (all claims processed through June 30, 2015) | $115.00 | $70.00 | $55.00 | $15.00 |

How much you have paid toward your out-of-pocket maximum as of the date shown. This total is the most up-to-date and may include claims processed after the last day of the month of this report.

## YEARLY LIMIT – this limit gives you financial protection

This limit tells the most you will have to pay in "out-of-pocket" costs (copays, coinsurance) for medical and hospital services covered by the plan.

This yearly limit is called your "out-of-pocket maximum." It puts a limit on how much you have to pay, but it does not put a limit on how much care you can get.

Your out-of-pocket spending for Part D prescription drugs, eye wear, dental and acupuncture services will not count toward your yearly out-of-pocket maximum.

Not all plans include all of these benefits.

This means:

- Once you have reached your limit in out-of-pocket costs, **you stop paying out of pocket for all services except for out-of-network services, non-covered services, your plan premium and your Part B premium**.
- You keep getting your **covered medical and hospital services** as usual, and **the plan will pay the full cost for the rest of the year**. Your out-of-pocket spending for services that are not covered by Medicare does not count toward your out-of-pocket maximum.

As of June 17, 2015, **you have had *$15* in out-of-pocket costs** that count toward your $4,500 out-of-pocket maximum for covered services in **2015**.

As of June 17, 2015, you have had $450 in out-of-pocket costs that count toward your $4,500 out-of-pocket maximum for covered services in **2014**.

If we receive a claim for the previous year during the month of this report, you will see this information.

Here's how to file an appeal if you do not agree with part or all of a claim being denied.

## Details for claims processed in June, 2015

### Look over the information about your claims – does it seem correct?

- If you have questions or think there might be a mistake, start by calling the doctor's office or other service provider. Ask them to explain the claim.
- If you still have questions, call MVP's Medicare Customer Care Center (phone numbers are in a box on page 1).

### You have the right to make an appeal or complaint.

- 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. 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. For information about making an appeal, call MVP's Medicare Customer Care Center (phone numbers are in a box on page 1).

### Remember, this report is NOT A BILL:

- If you have not already paid the amount shown for "your share," *wait until you get a bill* from the provider.
- If you get a bill that is *higher* than the amount shown for "your share," call MVP's Medicare Customer Care Center (phone numbers are in a box on page 1).

The provider name and date of service for each claim are listed for easy reference.

The Total Cost is the reduced rate MVP providers agree to accept.

The Plan's Share is the amount MVP pays.

Your Share is the amount you pay.

| Dr. James C. White<br>Claim Number: 111111111100<br>In-network provider | Date of Service | Amount the provider billed the plan | Total cost (amount the plan approved) | **Plan's Share** | **Your Share** |
|---|---|---|---|---|---|
| Evaluation and management of an established patient where the provider of service meets two of the following three criteria: expanded problem, focused history expanded problem, focused exam low (billing code 99213) | 6/2/14 | $100.00 | $70.00 | $55.00 | $15.00<br>You pay $15.00 for services from an in-network provider. |
| Venipuncture/specimen collection (billing code 36415) | 6/2/14 | $15.00 | $0 | $0 | $0<br>You pay $0 for service. |
| | **TOTALS:** | **$115.00** | **$70.00** | **$55.00** | **$15.00** |

This is where you will find the definition of the billing code that your provider used.

If the **Total Cost** (the amount the plan approves) is listed as $0, this service has been denied. Any amount for which you are responsible to pay is shown under **Your Share**. If the amount is $0, you are not responsible for any payment.

**Things to know about your denied claim:**

- **NOTE: We have denied all or part of this claim.** However, you are not responsible for paying the billed amount.
- If you have questions, you can contact:
  -MVP's Medicare Customer Care Center (phone numbers are in a box on page 1)
  -**1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week.
  (TTY users should call **1-877-486-2048**.)