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## Best Practice Recommendation for

### *Requesting and Receiving Coverage Information for Eligibility and Benefits (270-271 4010A1v Batch Transaction & Web Access)*

For use with ANSI ASC X12N 270/271 (004010X092A1)  
Health Care Eligibility Benefits  
Inquiry and Response Implementation Guide

Version	
Issue Date	Explanation
02-01-10	Initial release
02-22-10	Amended: Removed EB05-EB05 table from Appendix. EB05 information will be made available by each health plan
03-02-10	Amended: Minor wording revisions and fixes for typographical errors

## Table of Contents

**Overview: ..... 2**

**Minimum Standard Set of Eligibility and Benefits Information: ..... 3**

    General Eligibility Coverage ..... 4

    Contract Level Benefits Information ..... 4

    Standard Services - Benefit Information ..... 5

    Benefits Information for Specified Services ..... 6

**Web Based Access to the Information ..... 6**

**270-271 Transaction Exchange of the Information ..... 7**

**271 Response Transaction: ..... 10**

    General Eligibility Coverage ..... 10

    Contract Level Benefits Information ..... 11

    Standard Services - Benefit Information ..... 14

    Benefits Information for Specified Services ..... 22

Best Practice Recommendation  
**Requesting and Receiving Coverage Information for Eligibility and Benefits**

- Topic:** Minimum standard set of eligibility and benefits coverage information
- Goals:**
- 1) Define an acceptable set of coverage information that will allow a provider to determine a patient's cost share for a service or treatment
  - 2) Reduce the need for telephone calls to get information about a patient
- Summary:** This document outlines the minimum standard set of eligibility and benefits information that should be available to providers whether they access health plan web sites directly or use the 4010A1v of the HIPAA 270-271 transaction set.
- Applicability:** The table located at <http://www.onehealthport.com/worksmart/wsadoptionmatrix.php> identifies participating health plans and provider organizations. i.e. those that have endorsed and implemented these best practices.

All providers and health plans are encouraged to follow these Recommended Best Practices. However, providers should be aware that information received from the following organizations may not be consistent with this best practice:

- Self-funded plans
- FEP
- Blue Card
- NASCO
- And there may be others

## Overview

This BPR outlines a set of information that should be communicated by the health plans to provider organizations about a patient's eligibility and benefits coverage. This information will be communicated via two different methods:

- a) on the health plan's web site, and
- b) in a HIPAA 271 transaction

The information may be also available from a Customer Service type department. The information must be consistent across all available sources.

*All of the information outlined in the BPR must be communicated via a health plan's transaction and web site, though the formatting/presentation of the information may vary depending upon the method. For a specific patient at a given point in time, the information presented in the transaction and on the web must match, though there doesn't need to be a specific field on the web site that exactly corresponds to every field in the transaction. As an example, the BPR calls for the health plan to communicate whether or not a patient has eligibility. In the transaction,*

that information will be communicated by placing a value in a particular field. On the web site, that same information may be communicated simply by presenting eligibility and benefits information, i.e. the web site may not have a single, specific display field that states that coverage is in place.

*Health plans may choose to implement their web site to be consistent with the 5010v of the transaction, rather than the 4010A1v.* The current version of the BPR addresses the 4010A1v of the transaction. The 5010v of the transaction appears to be more comprehensive than the 4010A1v of the transaction. However, health plans and providers cannot exchange the 5010v of the transaction until system testing starts on January 1, 2011. Prior to Jan 2011, health plans may choose to implement their web sites to match the 5010v even if situations are encountered where information on the 4010A1v is not included in the 5010v.

*The web site content is not limited to the information that can be contained in the transaction.* A health plan's web site and their transaction must convey the set of information outlined in this BPR. However, on their web sites, health plans may expand beyond the set of information that can fit in the transaction. All of a patient's eligibility and coverage information that is displayed on a health plan's web site should be clearly conveyed and easily accessible to a provider.

## **Minimum Standard Set of Eligibility and Benefits Information**

A patient's eligibility coverage and benefit information varies depending upon the specific plan in which they are enrolled. The capabilities and information listed in each of the following sections represent the *minimum* set of information to be provided by a health plan, *to the extent that it is appropriate for the specific patient's plan and the information is available to the health plan.* If a listed information element, e.g. deductible, PCP, etc., is not appropriate for the patient's plan or is not available to the health plan, the element may not be presented for that patient. Health plans may always provide more capabilities and information depending upon their policies and level of system sophistication.

Health plans will make this set of eligibility and benefits information available on their web site and via a 270-271 transaction set exchange.

This document outlines Best Practice Recommendations for Eligibility Coverage and Benefits information for each of the following categories:

- I. General Eligibility Coverage
- II. Contract Level Benefits Information
- III. Standard Services - Benefit Information
- IV. Benefits Information for Specified Services

I. General Eligibility Coverage

The following information will be provided for every patient, given the availability caveat highlighted above. The information highlighted in **bold** should always be available.

<b>Information Elements</b>
<b>Subscriber Name</b>
<b>Patient Name</b>
<b>Patient’s Relationship to Subscriber</b>
<b>Patient Date of Birth</b>
<b>Patient Gender</b>
<b>Patient Member Number</b>
Group Name
<b>Group Number</b>
Plan Type
<b>Coverage Date (aka Policy Effective Date)</b>
Other Coverage <sup>*1</sup>
Primary Care Physician (PCP) <sup>*1</sup>
<b>Eligibility Status</b>

<sup>\*1</sup> - This information should be sent if it is in the health plan's records and appropriate to the coverage. The health plans will send the information that they have. The accuracy of the information cannot be assured.

Note: As more fully described in the Overview section above, *All of the information outlined in the BPR must be communicated via a health plan's transaction and web site, though the formatting/presentation of the information may vary depending upon the method.*

II. Contract Level Benefits Information

The following table lists the Contract Level Limitations for which information will be available, given the availability caveat highlighted above.

	<b>In-Network Provider</b>				<b>Out-of--Network Provider</b>			
	<b>Individual Coverage</b>		<b>Family Coverage</b>		<b>Individual Coverage</b>		<b>Family Coverage</b>	
<b>Contract Level Limits</b>	<b>Benefit Limit Amount</b>	<b>Benefit Amount Remain</b>	<b>Benefit Limit Amount</b>	<b>Benefit Amount Remain</b>	<b>Benefit Limit Amount</b>	<b>Benefit Amount Remain</b>	<b>Benefit Limit Amount</b>	<b>Benefit Amount Remain</b>
Medical Deductibles								
Out of Pocket Maximums								
Lifetime Payment Maximum								

For each of the Contract Level Limitations, the Benefit Limit Amount and the Benefit Amount Remaining will be provided for Individual, In-Network coverage. These Amounts may be also available for the Family, In-Network coverage, depending upon the specific patient's plan. If and as appropriate to the patient's plan, these Amounts may also be separately described for Out of Network coverage.

### III. Standard Services - Benefit Information

If the service level benefit is provided by the health plan as part of the member's coverage, the following benefit information will be made available.

Service Type	In-Network Provider					
	Co-Pay	Co-Ins	Service Specific Deductible	Benefit Limit	Service Delivery Limits	Benefit Remain
Professional (Physician) Visit Office - Sick						
Hospital -Inpatient						
Hospital - Outpatient						
Hospital - Emergency Medicine						
Psychiatric - Inpatient						
Psychiatric - Outpatient						
Rehabilitation - Inpatient						
Rehabilitation - Outpatient						
Substance Abuse						
Vision (Optometry)						

Service Type	Out-of-Network Provider					
	Co-Pay	Co-Ins	Service Specific Deductible	Benefit Limit	Service Delivery Limits	Benefit Remain
Professional (Physician) Visit Office - Sick						
Hospital -Inpatient						
Hospital - Outpatient						
Hospital - Emergency Medicine						
Psychiatric - Inpatient						
Psychiatric - Outpatient						
Rehabilitation - Inpatient						
Rehabilitation - Outpatient						
Substance Abuse						
Vision (Optometry)						

The following describes the information that will be available for In-Network coverage, as appropriate, for each of the Service Types listed above. If and as appropriate to the patient's coverage, this information may also be separately described for Out of Network coverage.

- *Co-Pay*: The amount to be paid to the provider by the patient at the time of the visit.
- *Co-Insurance*: The %age of the allowed amount to be paid to the provider by the patient after the health plan has paid their portion.
- *Service-Specific Deductible*: A specific deductible amount, only if it is not included as part of the Contract Level Medical Deductible Amount.
- *Benefit Limit*: Information about any limits that apply to this Service Level Benefit for a patient, e.g. number of visit, number of days, etc.
- *Benefit Remaining*: If there is a benefit limit, this is information about how much of that limit remains. For the Psychiatric and Substance Abuse benefits, health plans may indicate that the provider should call customer service for this information.
- *Service Delivery Limitations*: If appropriate to the service, information pertaining to the frequency and timeframe in which the services must be delivered, e.g. 3 visits per week for 1 month, or Benefit Limit is 12 visits and Service Delivery Limits is no more than 2 visits per month

Service Type	Benefit Applies
Pharmacy - <i>Prescription</i>	

#### IV. Benefits Information for Specified Services

Benefit information may be available for services in addition to those listed in the table above. Over time, health plans will increase the number of services for which they provide benefit information on their web sites and in the transaction. When a health plan provides a service level benefit as part of the member's coverage, the benefit information described above should be available.

### **Web-Based Access to the Information**

The Minimum Standard Set of Eligibility and Benefits Information outlined above will be available on each health plan's web site. The specific design of how this information is presented on their web site is left to each health plan. However, to enhance usability by the provider, a Best Practice Recommended design should consider the following factors:

- *Single sign-on*: The provider should be able to use their OHP credential to access the health plan's site.
- *Number of 'clicks'*: The provider should be able to get to the eligibility & benefits information with as few 'clicks' as possible. Fewer clicks should be required to get to basic eligibility information than to detail benefits information.

- *Options for Patient Search.* The web site should offer providers multiple ways to "look-up" a patient. Each of the look-up options will be a different combination of data elements from the following list.
  - Firstname
  - Lastname, Firstname
  - Lastname
  - Member Date of Birth
  - Subscriber ID (Some health plans may refer to this as Member ID)

Each option should require the provider to enter only the minimum number of data elements (1-4) that is consistent with the health plan's patient privacy & security requirements per HIPAA regulations.

- *Time Period:* The health plan's system should respond to each query in no longer than 20 seconds from the point that their system receives the query. (A query is initiated when the provider enters "enter", "submit" or other similar command on their web browser.) Time periods may appear longer to the provider depending upon the type of computer they are using, type of browser, speed of the internet, etc.
- *Printer-Friendly Report.* The provider should be able to easily print out a readable, paper version of the information that is on the web site.

## **270-271 Transaction Exchange of the Information**

The Minimum Standard Set of Eligibility and Benefits Information outlined above will be available via the exchange of the 270-271 transaction set. Best Practice Recommendations for implementation of the transaction set follow:

### **Performance Best Practices**

This Best Practice talks about the Batch Mode exchange, between providers and health plans, of the HIPAA 270-271 Health Care Eligibility Benefits Inquiry and Response transaction. The provider organization will send the 270 Inquiry transaction and health plans will reply with the 271 Response transaction.

#### *Time Period*

Health plans will respond, with one or more 271 transactions, to every eligibility request contained in a 270 transaction, as soon as possible and not later than 24 hours after receiving the 270 transaction. The time period starts when the health plan receives the 270 transaction and ends when all eligibility requests pertaining to that health plan's members contained in the 270 transaction are answered, ie via the sending of one or more 271 transactions. The time period does not include any processing/wait time by clearinghouses or intermediary organizations between the provider and the health plan.

*Scope of Response*

The scope of response, within the time period, includes a reply to every request for information that is contained within the 270 transaction and that is not forwarded to another health plan. The scope includes, as appropriate, either a Member Not Found response or a response with eligibility/benefits information. The scope does not include responding to a request for information that is forwarded to another health plan, e.g. Blue Card or FEP.

**Formatting Best Practices**

Using the 270 transaction providers can make one of two types of requests, a basic request or an expanded request.

1. **Basic Request:** If a provider wants eligibility information, contract level benefit information and service level benefit information for the standard set of services listed above -- Office Visit, Hospital & ER, Mental Health, Rehabilitation, Chemical Dependency, Vision and Pharmacy

In the 270 Request Transaction . . .

Make sure the field *EQ01* = '30'. (EQ01 can be found in the EQ Segment of Loop 2110C/2110D).

The following fields do not need to be populated in the transaction. In many cases, the health plans will not even look at the field. In all cases, the health plan will send the exact same response regardless of the values that are in the fields.

<b>IG Page#</b>	<b>Element</b>
81-82 & 121-123	Provider Information (PRV01-PRV06)
106-107, 145-146	Date-Time Information (DTP01-DTP03)
95-96 & 137-138	Composite Medical Procedure Identifier (EQ02)
97 & 139	Coverage Level Code (EQ03)
97 & 139	Insurance Type Code (EQ04)
99-105 & 140-143	AMT01-02, III01-02, REF01-02

In the 271 Response Transaction . . .

Participating health plans have agreed to respond with General Eligibility Coverage and Standard Services Benefits information for the member's policy. See the sections I, II and III below.

2. **Expanded Request:** If a provider wants service level benefit information for a specified service(s) AS WELL AS eligibility information, contract level benefit information and service level benefit information for the standard set of services listed above

In the 270 Request Transaction . . .

Make sure the field *EQ01* = *the appropriate HIPAA code associated with the service type* that is of interest. (EQ01 is in the EQ Segment of Loop 2110C/2110D). If you want detail benefit information for more than one benefit type, a separate EQ segment will be required for each benefit type.

The following fields do not need to be populated in the transaction. In many cases, the health plans will not even look at the field. In all cases, the health plan will send the exact same response regardless of the values that are in the fields.

IG Page#	Element
81-82 & 121-123	Provider Information (PRV01-PRV06)
88, 106-107, 130 & 145-146	Date-Time Information (DTP01-DTP03)
95-96 & 137-138	Composite Medical Procedure Identifier (EQ02)
97 & 139	Coverage Level Code (EQ03)
97 & 139	Insurance Type Code (EQ04)
99-105 & 140-143	AMT01-02, III01-02, REF01-02

In the 271 Response Transaction . . .

Participating health plans will always respond with General Eligibility and Benefits Coverage information for the member's policy. See the sections I, II, & III below.

***If the member's policy does have*** a covered benefit for the service type that is specified in EQ01, then the health plan will also respond with detail benefit coverage data for that service type. See the section IV below.

***If the member's policy does not have*** a covered benefit for the service type that is specified in EQ01, then the health plan will not respond with detail benefit coverage information but will include the following EB segment in Loop 2110C/D.

	Non-Covered Benefit Values
EB01	'I'
EB02	Blank
EB03	HIPAA code that was in EQ01
EB04	Blank
EB05	Blank
EB06	Blank
EB07	Blank
EB08	Blank
EB09	Blank
EB10	Blank
EB11	Blank
EB12	Blank

Blank – No value is put between the field delimiters

**271 Response Transaction****I. General Eligibility Coverage**

Data Element	Location in 271 Transaction	
	For patient as subscriber	For patient as dependent
Subscriber Name	Loop 2100C, NM1 Segment	
Patient Name	Same as Subscriber Name above	Loop 2100D, NM1 Segment, NM101-NM105
Patient's Relationship to Subscriber	Loop 2100C, INS Segment, INS01-INS02 INS01='Y', INS02 = '18' - Self	Loop 2100D INS Segment, INS01= N, INS02 = '01' - Spouse, '19' - Child, '21' - Unknown, '34' - Other Adult
Patient Date of Birth	Loop 2100C, DMG Segment, DMG02	Loop 2100D, DMG Segment, DMG02
Patient Gender	Loop 2100C, DMG Segment, DMG03="F" – Female, "M" – Male, "U" - Unknown	Loop 2100D, DMG Segment, DMG03="F" – Female, "M" – Male, "U" - Unknown
Patient Member Number	Loop 2100C, NM1 Segment, NM109	Loop 2100D, NM1 Segment, NM109
Group Number	Loop 2100C, REF Segment, REF01-02, REF01 = '6P' - Group Number	Loop 2100D, REF Segment, REF01-02, REF01 = '6P' -Group Number
Coverage Date (aka Policy Effective Date)	Loop 2100C, DTP Segment, DTP01-DTP03	Loop 2100D, DTP Segment, DTP01-DTP03
Transaction Reference Number	TRN02 (that matches to the respective 270 transaction)	
Eligibility Status	EB Segment = EB*1**30*)	
Group Name	Loop 2100C, REF Segment, REF03	Loop 2100D, REF Segment, REF03
Plan Type	Loop 2110C, EB Segment, EB04-EB05	Loop 2110D, EB Segment, EB04-EB05
Other Coverage <sup>*1</sup>	Loop 2120C, Segments, NM101 = 'PRP' - Primary, 'SEP' – Secondary Payer' or 'TTP – Tertiary Payer'. Other fields as appropriate to the payer.	Loop 2120D, Segments, NM101 = 'PRP' - Primary, 'SEP – Secondary Payer' or 'TTP – Tertiary Payer'. Other fields as appropriate to the payer.
Primary Care Physician (PCP) <sup>*1</sup>	Loop 2120C, NM101 = 'P3' -Primary Care Provider. PCP Name (NM1) and phone number (PER Segment).	Loop 2120D, NM101 = 'P3' -Primary Care Provider. PCP Name (NM1) and phone number (PER Segment).

<sup>\*1</sup> - This information should be sent if it is in the health plan's records and appropriate to the coverage. The health plans will send the information that they have. The accuracy of the information cannot be assured.

Note: Unfortunately, per HIPAA mandated specifications, valid data values may vary between transactions. Make sure that values valid for one transaction are also valid for the other transaction before using them in the other transaction.

## II. Contract Level Benefits Information

### A. Deductibles and Accumulators Information

#### 1. Individual

Medical Deductible	Total Amount	Per Period	Amount Remaining
In Network	Y	Annual	Y
Out of Network	Y	Annual	Y

#### 2. Family

Medical Deductible	Total Amount	Per Period	Amount Remaining
In Network	Y	Annual	Y
Out of Network	Y	Annual	Y

For each type of deductible, e.g. Individual-Medical-In Network, Family-Medical-Out of Network, etc., there will be 2 related EB segments. One EB segment will contain information about the total amount of the deductible for the specified period – either calendar year (EB06=23) or contract year (EB06=25). The other EB segment will contain information about how much of the deductible is remaining at the time the transaction was generated (EB06=29).

The values listed in EB02 and EB06 are typical for the basic deductible information. There may be slight variations between health plans.

Standard Deductible & Accumulator Values	
EB01	'C'
EB02	<ul style="list-style-type: none"> <li>• 'IND' – Individual</li> <li>• 'FAM' – Family</li> </ul>
EB03	'30' – Medical or Blank
EB04	Blank or a Standard Value
EB05	Check with the health plan for values and meanings.
EB06	<ul style="list-style-type: none"> <li>➤ '22' – When EB07 contains the total deductible amount for the service year</li> <li>➤ '23' – When EB07 contains the total deductible amount for the calendar year</li> <li>➤ '25' – When EB07 contains the total deductible amount for the contract year</li> <li>➤ '29' – When EB07 contains the remaining deductible amount for the specified period</li> </ul>
EB07	Deductible Amount

<b>Standard Deductible &amp; Accumulator Values</b>	
EB08	Blank
EB09	Blank
EB10	Blank
EB11	Blank
EB12	<ul style="list-style-type: none"> <li>• 'Y' – if only for In-Network</li> <li>• 'N' – if only for Out of Network</li> <li>• Blank – if for both In-Network and Out of Network</li> </ul>

Blank – No value is put between the field delimiters

## B. Out of Pocket Maximums and Accumulators Information

### 1. Individual

<b>Out of Pocket Maximum</b>	<b>Total Amount</b>	<b>Per Period</b>	<b>Amount Remaining</b>
In Network	Y	Annual	Y
Out of Network	Y	Annual	Y

### 2. Family

<b>Out of Pocket Maximum</b>	<b>Total Amount</b>	<b>Per Period</b>	<b>Amount Remaining</b>
In Network	Y	Annual	Y
Out of Network	Y	Annual	Y

For each type of out of pocket maximum, e.g. Individual In Network, Family Out of Network, etc, there will be 2 related EB segments. One EB segment will contain information about the total amount of the out of pocket maximum for the specified period, e.g. calendar year (EB06=23). The other EB segment will contain information about how much of the out of pocket maximum is remaining at the time the transaction was generated, i.e. annual period (EB06=29).

The value listed in EB02 and EB06 are typical for the basic out of pocket maximum information. There may be slight variations between health plans.

<b>Standard Out of Pocket Max &amp; Accumulator Values</b>	
EB01	'G'
EB02	<ul style="list-style-type: none"> <li>• 'IND' – Individual</li> <li>• 'FAM' – Family</li> </ul>
EB03	'30' – Medical or Blank
EB04	Blank or a Standard Value

<b>Standard Out of Pocket Max &amp; Accumulator Values</b>	
EB05	Check with the health plan for values and meanings.
EB06	<ul style="list-style-type: none"> <li>➤ '22' – When EB07 contains the total deductible amount for the service year</li> <li>➤ '23' – When EB07 contains the total out of pocket maximum amount for the calendar year</li> <li>➤ '25' – When EB07 contains the total deductible amount for the contract year</li> <li>➤ '29' – When EB07 contains the remaining out of pocket maximum amount for the specified annual period</li> </ul>
EB07	Out of Pocket Maximum Amount
EB08	Blank
EB09	Blank
EB10	Blank
EB11	Blank
EB12	<ul style="list-style-type: none"> <li>• 'Y' – In-Network</li> <li>• 'N' – Out of Network</li> <li>• Blank – total for In-Network &amp; Out of Network</li> </ul>

Blank – No value is put between the field delimiters

### C. Lifetime Payment Maximum and Accumulators Information

#### Individual

<b>Lifetime Payment Maximum</b>	Total Amount	Per Period	Amount Remaining
	Y	Lifetime	Y

For the Lifetime Payment Maximum, there will be 2 related EB segments. One EB segment will contain information about the total amount of the lifetime payment maximum for the specified period. The other EB segment will contain information about how much of lifetime payment maximum is remaining at the time the transaction was generated.

The value listed in EB02 and EB06 are typical for the basic lifetime payment maximum information. There may be slight variations between health plans.

<b>Standard Lifetime Payment Max &amp; Accumulator Values</b>	
EB01	'F'
EB02	'IND' – Individual
EB03	'30' – Medical or Blank

<b>Standard Lifetime Payment Max &amp; Accumulator Values</b>	
EB04	Blank or a Standard Value
EB05	Check with the health plan for values and meanings.
EB06	<ul style="list-style-type: none"> <li>➤ '32' – When EB07 contains the total lifetime payment maximum amount for the patient</li> <li>➤ '29' or '33' – When EB07 contains the remaining lifetime payment maximum amount for the patient</li> </ul>
EB07	Lifetime Payment Maximum
EB08	Blank
EB09	Blank
EB10	Blank
EB11	Blank
EB12	<ul style="list-style-type: none"> <li>• 'Y' – In-Network</li> <li>• 'N' – Out of Network</li> </ul> Blank – total for In-Network & Out of Network

Blank – No value is put between the field delimiters

### **III. Standard Services - Benefit Information: CoPay, CoInsurance, Deductible & Limitations**

This section talks about Standard Services. Benefits information for the each service currently includes:

- A. CoPay, CoInsurance and Overriding Deductible Information
- B. Maximum Benefit Limit and Accumulator Information
  - Dollar Amount
  - Number of Days
  - Number of Visits
  - Limitation about the benefit period
- C. Service Delivery Limitations

The following set of Standard Services benefit information may be supplied by a health plan in a 271 transaction in response to a 270 request transaction.

- If a health plan does not offer a benefit for one of the standard services, the health plan will either:
  - Not include any information about that service in the 271 response, OR
  - Include an EB segment in Loop 2110C/D with EB03=service type and EB01="I".
- If the member's policy does not have a covered benefit for a service type that is typically part of a general medical benefit, then the health plan will include an EB segment in Loop 2110C/D with EB03=service type and EB01="I".

For each service listed below, health plans will provide benefit information as long as they offer than benefit. Each service may have a number of EB segments to describe the related benefits. Depending upon their policies and capabilities, health plans may supply more information about the services listed below, or about other services.

*Note:* The EB03 column of each table indicates how each specified type of service will be coded in the transaction.

***Information about the following Standard Services must provided in the 271 when EQ01=30 in the 270 transaction.***

1.

<b>Office Visit</b>	In- Network	Out of Network	EB03 =
Professional (Physician) Visit Office - <i>Sick</i>	Y	Y	'98'
Professional (Physician) Visit Office - <i>Well</i>	This is not currently supported in the 4010 version of the transaction. In the 5010 version, a 'BY' will indicate a sick visit and a 'BZ' will indicated a well visit, i.e. preventive care		

2.

<b>Hospital</b>	In- Network	Out of Network	EB03 =
Hospital - Inpatient	Y	Y	'48'
Hospital - Outpatient	Y	Y	'50'
Hospital - Emergency Medicine	Y	Y	'52'

3.

<b>Mental Health</b>	In- Network	Out of Network	EB03 =
Psychiatric - Inpatient	Y	Y	'A7'
Psychiatric - Outpatient	Y	Y	'A8'

***Providers must be able to get information about the following Standard Services via a 270-271 exchange. A number of providers have indicated their preference for getting this information in response to an EQ01=30 in the 270. Some health plans may require providers to request each of these services with a separate EQ01=x in the 270.***

4.

<b>Rehabilitation</b>	In- Network	Out of Network	EB03 =
Rehabilitation - Inpatient	Y	Y	'AB'
Rehabilitation - Outpatient	Y	Y	'AC'

There is typically no difference in copay amounts for the different type of rehabs, eg. Physical therapy, occupational therapy, speech therapy, etc.

5.

<b>Chemical Dependency</b>	<b>In-Network</b>	<b>Out of Network</b>	<b>EB03 =</b>
Substance Abuse	Y	Y	'AI'

There is typically no difference in copay amounts for the different type of chemical dependency, eg. alcohol, drugs, etc.

6.

<b>Vision</b>	<b>In-Network</b>	<b>Out of Network</b>	<b>EB03 =</b>
Vision (Optometry)	Y	Y	'AL'

7.

<b>Pharmacy</b>	<b>EB03=</b>
Pharmacy - Prescription	'88'

#### A. CoPay, CoInsurance and Overriding Deductible Information

The following table identifies how the EB segment of Loop 2110C (for Subscriber) and 2110D (for Dependent) will be coded.

NOTE: Co-pay information will not be available in the 271 for the following situations:

- The health plan provides tiered benefits for the service type, e.g Pharmacy.. (The 4010A1 version of this transaction cannot accommodate the tiered structure of tiered benefits.)
- The health plan would like the provider to call customer service for benefit specific information. This is designated when EB01 = 'U' for the service type specified in EB03.

Except in these two situations, there will **ALWAYS** be at least one EB segment for co-pay whenever one of the above services are offered as a benefit for the covered patient. If there is no co-pay for that service, or if the co-pay is waived, the co-pay value will be '0'. Other EB segments will be included as appropriate to the benefit.

	<b>Standard Co-Pay Values</b>	<b>Standard Co-Insurance Values</b>	<b>Standard Deductible Values</b>
EB01	'B'	'A' *3	'C'
EB02	V *3	V *3	V *3

	<b>Standard Co-Pay Values</b>	<b>Standard Co-Insurance Values</b>	<b>Standard Deductible Values</b>
EB03	See each service above	See each service above	See each service above
EB04	V <sup>*1a</sup>	V <sup>*1a</sup>	V <sup>*1a</sup>
EB05	V <sup>*1b</sup>	V <sup>*1b</sup>	V <sup>*1b</sup>
EB06	V <sup>*2</sup>	V <sup>*2</sup>	V <sup>*2</sup>
EB07	CoPay Amount due from the patient or '0' if no co-pay or co-pay waived.	Blank	V <sup>*4</sup>
EB08	Blank	CoInsurance Percent -due from the patient – from .0-1	Blank
EB09	Blank	Blank	Blank
EB10	Blank	Blank	Blank
EB11	V <sup>*3</sup>	V <sup>*3</sup>	V <sup>*3</sup>
EB12	<ul style="list-style-type: none"> <li>• 'Y' – In-Network</li> <li>• 'N' – Out of Network</li> <li>• Blank – both In-Network and Out of Network</li> </ul>	<ul style="list-style-type: none"> <li>• 'Y' – In-Network</li> <li>• 'N' – Out of Network</li> <li>• Blank – both In-Network and Out of Network</li> </ul>	<ul style="list-style-type: none"> <li>• 'Y' – In-Network</li> <li>• 'N' – Out of Network</li> <li>• Blank – both In-Network and Out of Network</li> </ul>

V<sup>\*1a</sup> - Will contain Blank or a standard value

V<sup>\*1b</sup> - Check with the health plan for values and meanings

V<sup>\*2</sup> - Will contain Blank or the time period appropriate to the benefit

V<sup>\*3</sup> - Will contain Blank or appropriate value from the Implementation Guide

V<sup>\*4</sup> - Only put a deductible amount if it is different than the amount specified in the contract level deductible information. In other words,

- If a deductible amount does not need to be met for the specific benefit to apply, the deductible amount, EB07, will be '0'.
- If a deductible amount does need to be met and the deductible amount is different than the general information, then EB07 will contain a value greater than '0'.

Blank – No value is put between the field delimiters

\*3 – WDS will use 'D' rather than 'A'

## B. Maximum Benefit Limit and Accumulator Information

For each service type,

### *If the service type has maximum benefit limitations*

NOTE: When a provider creates a 270 Request transaction with EQ01 = 30, some health plans interpret HIPAA Privacy regulations as preventing them from sending the level of benefit information described below for service types:

- A7 – Psychiatric-Inpatient
- A8 – Psychiatric-Outpatient
- AI – Substance Abuse

In these cases, the health plan will include an EB record with EB01 = ‘U’ in the transaction to indicate that customer service should be contacted for this information.

To get this level of benefit information, the provider can either contact customer service for the information or can send a 270 transaction with EQ01 = A7, A8 and/or AI.

In the 271, an EB segment pair will identify the benefit maximum limitations (benefit \$ amount, # of visits, # of days) and the remaining benefit for each of those limitations. There will be at least two EB segments, with EB01 = ‘F’ (Limitation).

- *The first EB segment of the pair* will identify the benefit maximum limitation for the service type. EB06 will indicate the benefit period -- a calendar year (EB06=‘23’) or a contract year (EB06=‘25’) or an episode of care (EB06 = ‘26’). The following fields will be used depending upon the type of benefit limitation for that period:
  - EB07 will contain any maximum benefit dollar amount. By convention this field will only be used for the benefit dollar amount, if one exists. It will not be used for any other limitation as EB06 doesn’t qualify that limitation. (EB06 defines the benefit period.)
  - EB09 will identify whether there is a benefit maximum limitation related to number of days or number of visits.
  - EB10 will contain the benefit maximum limitation related to EB09

For example, if the benefit maximum limitations for a contract year are \$5000 and 12 visits then EB06 = 25, EB07 = 5000, EB09 = VS, EB10 = 12

- *The second EB segment of the pair* will identify the benefit remaining for the service type (EB06 will = ‘29’). The following fields will be used depending upon the type of benefit limit
  - EB07 will contain any remaining benefit dollar amount. By convention this field will only be used for the benefit dollar amount, if one exists. It will not

be used for any other limitation as EB06 doesn't qualify that limitation. (EB06 defines the benefit period.)

- EB09 will identify whether there is a benefit remaining related to number of days or number of visits.
- EB10 will contain the benefit remaining related to EB09

For example, if the benefit maximum remaining for the contract year are \$2000 and 4 visits then EB06 = 29, EB07 = 2000, EB09 = VS, EB10 = 4

If a service type has more than two benefit limitations, e.g. benefit \$ amount and number of visits and number of days, then an additional pair(s) of EB segments will be required. The first EB segment of the second pair will specify the benefit maximum limitation(s) that can't fit in the first pair. The second EB segment of the second pair will specify benefit remaining that can't fit in the first pair.

<b>Benefit Description Values</b>	
EB01	<b>'F'</b>
EB02	Blank
EB03	See each service above
EB04	Blank
EB05	Blank
EB06	<ul style="list-style-type: none"> <li>➤ <b>'23'</b> – For benefit limitations for the calendar year</li> <li>➤ <b>'25'</b> - For benefit limitations for the contract year</li> <li>➤ <b>'26'</b> – For benefit limitations for an episode of care</li> <li>➤ <b>'29'</b> – For a benefit remaining</li> </ul>
EB07	Blank or Benefit \$ Amount
EB08	Blank
EB09	Blank or <ul style="list-style-type: none"> <li>• <b>'DY'</b> – Days</li> <li>• <b>'VS'</b> - Visits</li> </ul>
EB10	Blank or EB09-related quantity for benefit limitation or benefit remaining
EB11	<ul style="list-style-type: none"> <li>• <b>'Y'</b> – if pre-auth required</li> </ul>
EB12	<ul style="list-style-type: none"> <li>• <b>'Y'</b> – In-Network</li> <li>• <b>'N'</b> – Out of Network</li> <li>• Blank – both In-Network and Out of Network</li> </ul>

Blank – No value is put between the field delimiters

C. Service Delivery Limitations*If the service type has service delivery limitations,*

For some benefit plans, there may be limitations pertaining to the frequency and timeframe in which the services must be delivered, e.g. 12 visits, 3 visits per week for 1 month. In these cases, the HSD segment will be used to specify those limitations.

Service Delivery Values	
HSD01	<ul style="list-style-type: none"> <li>• <b>'DY'</b> – Days</li> <li>• <b>'VS'</b> - Visits</li> </ul>
HSD02	Quantity of HSD01 (same as EB09)
HSD03	<ul style="list-style-type: none"> <li>• <b>'DA'</b> – Days</li> <li>• <b>'MO'</b> – Months</li> <li>• <b>'VS'</b> – Visits</li> <li>• <b>'WK'</b> – Week</li> <li>• <b>'YR'</b> – Years</li> </ul>
HSD04	Quantity of HSD01 within the time period of HSD03
HSD05	<ul style="list-style-type: none"> <li>• <b>'21'</b> – Years</li> <li>• <b>'26'</b> – Episode</li> <li>• <b>'27'</b> – Visit</li> <li>• <b>'32'</b> – Lifetime</li> <li>• <b>'34'</b> – Month</li> <li>• <b>'35'</b> – Week</li> </ul>
HSD06	HSD05 Duration in which benefits need to be delivered
HSD07	Blank
HSD08	Blank

Blank – No value is put between the field delimiters

For the example of 12 visits, 3 visits per week for 1 month

Service Delivery Values	
HSD01	<b>'VS'</b> - Visits
HSD02	12
HSD03	<b>'WK'</b> – Week
HSD04	3
HSD05	<b>'34'</b> – Month
HSD06	1
HSD07	Blank
HSD08	Blank

Blank – No value is put between the field delimiter

#### IV. Benefits Information for Specified Services

This section talks about obtaining information about specific service types specified in EQ01 in the 270 request. Benefits information for each service currently includes:

- C. CoPay, CoInsurance and Overriding Deductible Information
- D. Maximum Benefit Limit and Accumulator Information
  - Dollar Amount
  - Number of Days
  - Number of Visits
  - Limitation about the benefit period
- C. Service Delivery Limitations

The table below identifies specific service types for which information may be requested in a 270 transaction. For each Service Type, the table identifies limitation information that may be provided by health plan in the 271 Response transaction. (This information is in addition to the General Eligibility and Coverage information and is in addition to benefit-specific copay, coinsurance and deductible information.)

'Y' indicates the maximum possible set of detail benefit information to be provided in the 271. Note, health plans may not always provide the maximum possible set of information. They will only provide the information that is relevant to their member's specific policy. For example, one patient's policy may have a maximum number of visits for acupuncture and another patient's policy would not. As another example, a patient's policy may have Date Limitations around the benefit period and those limitations are different than the patient's general eligibility period. In this case, the Date Limitations specific to the benefit will be included in the 271 transaction. If the benefit's Date Limitations are the same as the patient's general eligibility period, then Date Limitations specific to the benefit will not be included.

#### NOTES:

1. Over time, additional service types are likely to be added to this list.
2. If a patient has coverage for a service type and their system is not yet able to provide detail benefit information within the 271 transaction, they should respond with an EB segment with EB01 = 'U' for the service type specified in EB03.

**Service Types and associated Limitations Information  
Provided in the 271 Transaction**

HIPAA Service Type Description	Operational Description of Benefit	HIPAA Service Type Code	Maximum Possible Set of Limitations Information provided in the 271 Transaction				Other
			Need for Pre-Auth	Date Limitations Around Benefit Period	Benefit Maximums	Benefit Accumulators	
Acupuncture	Services provided by a licensed acupuncturist.	64		Y	Y	Y	
Allergy Testing	Testing to determine the substance to which a person is allergic.	79					
Ambulatory Service Center Facility	Facility fee for services provided in a free standing ambulatory surgery center.	13					
Anesthesia	Local or general insensibility to pain with or without the loss of consciousness induced by an anesthetic.	7	Y for Dental				
Audiology Exam	Hearing exams by a licensed provider to determine the need for corrective treatment.	71		Y	Y	Y	
(Baby) Newborn Care	Medical facility and related professional charges for an infant during the initial period of confinement following birth.	65		Y	Y	Y	Must notify health plan w/in 24 hrs of baby's birth
(Baby) Well Baby Care	Preventive office visits and immunizations during the first year of life.	68		Y	Y	Y	
Cardiac Rehabilitation	Rehabilitation therapy following an acute cardiac event.	BG			Y	Y	
Chemotherapy	The treatment of disease by chemical or biological antineoplastic agents.	78			Y	Y	Must notify health plan of drug type/dose

HIPAA Service Type Description	Operational Description of Benefit	HIPAA Service Type Code	Maximum Possible Set of Limitations Information provided in the 271 Transaction				Other
			Need for Pre-Auth	Date Limitations Around Benefit Period	Benefit Maximums	Benefit Accumulators	
Chiropractic	Services provided by a licensed chiropractor.	33		Y	Y	Y	
Dental Care	The prevention and treatment of diseases of the teeth, gums, and related structures of the mouth.	35	Y	Y	Y	Y	
<i>(Diagnostic)</i> Diagnostic X-Ray	Radiology to diagnose specific symptoms or rule out medical conditions.	4			Y	Y	
<i>(Diagnostic)</i> Diagnostic Lab	Laboratory and pathology tests to diagnose specific symptoms or rule out medical conditions.	5			Y	Y	
<i>(Diagnostic)</i> MRI/Cat Scan	Testing used to diagnose or evaluate a condition. <ul style="list-style-type: none"> <li>• A non invasive procedure that causes magnets and radio waves to construct pictures of the body.</li> <li>• Computerized tomography of body imaging in which a thin x-ray beam rotates around the patient.</li> </ul>	62	Y		Y	Y	
<i>(Diagnostic)</i> Diagnostic Medical	Tests/services used to diagnose specific symptoms or rule out medical conditions.	73			Y	Y	
DME - Purchase	The purchase of new medical equipment which can withstand repeated use, is not disposable, and is used to service a medically necessary therapeutic purpose.	12	Y	Y	Y	Y	
DME – Rental	The monthly rental of medical equipment which can withstand repeated use, is not disposable, and is used to service a medically necessary therapeutic purpose.	18	Y	Y	Y	Y	
DME - Used	The purchase of previously used medical equipment which can withstand repeated use, is not disposable, and	11	Y	Y	Y	Y	

			Maximum Possible Set of Limitations Information provided in the 271 Transaction				
HIPAA Service Type Description	Operational Description of Benefit	HIPAA Service Type Code	Need for Pre- Auth	Date Limita- tions Around Benefit Period	Benefit Max- imums	Benefit Accum- ulators	Other
	is used to service a medically necessary therapeutic purpose.						
Home Health Care	Home care for homebound patients who require skilled care services. Includes nursing services, physical therapy, occupational therapy, speech therapy, home health aide, and medical social worker.	42	Y		Y	Y	
Hospice	Care when a provider has determined that life expectancy is 6 months or less and a palliative, supportive care treatment approach has been chosen.	45	Y		Y		
Hospital - Inpatient	Care and services provided in a hospital setting after admission	48	Y		Y	Y	
Hospital - Outpatient	Care and services provided in a hospital setting without admission	50	Y				
Hospital – Emergency Medical	Care and services provided in a hospital emergency department	52					
Immunizations	Vaccination to prevent disease.	80			Y	Y	
Massage Therapy	Services provided by a licensed massage therapist.	BE		Y	Y	Y	
Maternity	Prenatal and postnatal visits as well as the facility fee for the delivery.	69			Y	Y	
Occupational Therapy	Constructive activities designed and adapted to promote the functional restoration of the person’s daily living abilities that are lost or impaired by disease or accidental injury.	AD	Y	Y	Y	Y	
Oral Surgery	Surgery to the jaw, sound natural teeth, mouth, or face.	40	Y		Y	Y	
Orthodontics	Treatment to correct and align irregularities of the teeth.	38	Y	Y	Y	Y	

HIPAA Service Type Description	Operational Description of Benefit	HIPAA Service Type Code	Maximum Possible Set of Limitations Information provided in the 271 Transaction				Other
			Need for Pre-Auth	Date Limitations Around Benefit Period	Benefit Maximums	Benefit Accumulators	
Periodontics	Treatment of periodontal disease.	24			Y	Y	
Pharmacy	Coverage for prescription drugs and related supplies.	88					
Physical Medicine	Services provided by a licensed Physical Therapist.	AE	Y	Y	Y	Y	
Podiatry	Diagnosis, treatment, and prevention of diseases of the human foot.	93			Y	Y	
Professional (Physician) Visit-Office	An outpatient visit with a licensed care provider for treatment of an illness or condition	98					
Prosthetic Device	Artificial substitutes which replace parts of the human body.	75	Y		Y	Y	
Psychiatric - Inpatient	Inpatient facility treatment for psychiatric/mental conditions.	A7	Y	Y	Y	Y	
Psychiatric - Outpatient	Outpatient treatment for psychiatric/mental conditions.	A8	Y	Y	Y	Y	
Rehabilitation - Inpatient	Inpatient rehabilitative treatment for patients recovering from injuries or illnesses that severely impair their physical functioning or understanding.	AB	Y	Y	Y	Y	
Rehabilitation - Outpatient	Outpatient therapy services to restore and significantly improve function that was previously present but lost due to acute injury or illness.	AC	Y	Y	Y	Y	
Respite Care	Temporary residential care for patients that provides relief for the permanent caregivers.	46	Y	Y	Y	Y	
Routine Physical	Exam to screen for diseases, assess risk of future medical problems, and update vaccinations.	81		Y	Y	Y	
Skilled Nursing Care	Services provided in a licensed skilled nursing facility.	AG	Y	Y	Y	Y	

HIPAA Service Type Description	Operational Description of Benefit	HIPAA Service Type Code	Maximum Possible Set of Limitations Information provided in the 271 Transaction				Other
			Need for Pre-Auth	Date Limitations Around Benefit Period	Benefit Maximums	Benefit Accumulators	
Smoking Cessation	Treatment to aid in quitting smoking.	67		Y	Y	Y	
Speech Therapy	Treatment of speech defects and disorders.	AF	Y	Y	Y	Y	
Substance Abuse	Treatment for the dependence of an addictive substance, including alcohol or a narcotic drug.	AI	Y	Y	Y	Y	
Surgical	Invasive procedure for diagnosis and treatment of injury, deformity, and disease.	2	Y				
Transplants	The grafting of a tissue/organ.	70	Y	Y	Y	Y	
<i>(Transportation)</i> Air Transportation	Transportation via helicopter or plane in order to transport a sick or injured patient to the nearest appropriate hospital/facility.	57			Y	Y	
<i>(Transportation)</i> Cabulance	Transportation by a licensed cabulance service.	58			Y	Y	
<i>(Transportation)</i> Licensed Ambulance	Transportation by a licensed ambulance service.	59			Y	Y	
<i>(Transportation)</i> Medically Related Transportation	Other medically related transportation.	56			Y	Y	
Vision (Optometry)	Eye examination, determination of visual abilities, diagnosis of eye diseases and conditions, and the prescription of lenses and other corrective measures.	AL		Y	Y	Y	

## Legend:

- **HIPAA Service Type Description:** Description used in the HIPAA Implementation Guide. Organizational Categories (which are not included in the Implementation Guide) are denoted in *(italics)*.

- **Operational Description of Benefit:** Best Practice Recommended description of the benefit to be used in common practice by health plans and providers.
- **HIPAA Service Type Code:** From the EQ01 field in the 270 or the EB03 field in the 271
- **Need for Pre-Auth:** If 'Y' then benefits may need to be pre-authorized
- **Date Limitations Around Benefit Period:** If 'Y' then limitations around the benefit period may be different than the general eligibility period. For example, for a specific service, a member's policy may only allow a maximum of 4 visits for an episode of care.
- **Benefit Maximums:** If 'Y' then there may be specific benefit maximums for the service type. Benefit maximum information may include:
  - Maximum Dollar Amount
  - Maximum Number of Treatments/Visits
  - Maximum Number of Days
- **Benefit Accumulators:** If 'Y' then the benefit remaining may be tracked
- **Other:** Other types of benefit related information needed by providers. (There is currently not a place for this information in the 271 transaction.)

### A. CoPay, CoInsurance and Overriding Deductible Information

The following table identifies how the EB segment of Loop 2110C (for Subscriber) and 2110D (for Dependent) will be coded.

*Note 1:* Co-pay information will not be available in the 271 for the following situations:

- The health plan provides tiered benefits for the service type, e.g Pharmacy.. (The 4010A1 version of this transaction cannot accommodate the tiered structure of tiered benefits.)
- The health plan would like the provider to call customer service for benefit specific information. This is designated when EB01 = 'U' for the service type specified in EB03.

Except in these two situations, there will **ALWAYS** be at least one EB segment for co-pay whenever one of the above services are offered as a benefit for the covered patient. If there is no co-pay for that service, or if the co-pay is waived, the co-pay value will be '0'. Other EB segments will be included as appropriate to the benefit.

	Standard Co-Pay Values	Standard Co-Insurance Values	Standard Deductible Values
EB01	'B'	'A' *3	'C'
EB02	V*3	V*3	V*3
EB03	V*5	V*5	V*5
EB04	V*1a	V*1a	V*1a
EB05	V*1b	V*1b	V*1b
EB06	V*2	V*2	V*2
EB07	CoPay Amount due from the patient or '0' if no co-pay or co-pay waived.	Blank	V*4
EB08	Blank	CoInsurance Percent -due from the patient – from .0-1	Blank
EB09	Blank	Blank	Blank
EB10	Blank	Blank	Blank
EB11	• 'Y' – if pre-auth required	• 'Y' – if pre-auth required	• 'Y' – if pre-auth required
EB12	• 'Y' – In-Network • 'N' – Out of Network • Blank – both	• 'Y' – In-Network • 'N' – Out of Network • Blank – both	• 'Y' – In-Network • 'N' – Out of Network • Blank – both

	<b>Standard Co-Pay Values</b>	<b>Standard Co-Insurance Values</b>	<b>Standard Deductible Values</b>
	In-Network and Out of Network	In-Network and Out of Network	In-Network and Out of Network

V<sup>\*1a</sup> - Will contain Blank or a standard value

V<sup>\*1b</sup> - Check with the health plan for values and meanings

V<sup>\*2</sup> - Will contain Blank or the time period appropriate to the benefit

V<sup>\*3</sup> - Will contain Blank or appropriate value from the Implementation Guide

V<sup>\*4</sup> - Only put a deductible amount if it is different than the amount specified in the contract level deductible information. In other words,

- If a deductible amount does not need to be met for the specific benefit to apply, the deductible amount, EB07, will be '0'.
- If a deductible amount does need to be met and the deductible amount is different than the general information, then EB07 will contain a value greater than '0'.

V<sup>\*5</sup> - EB03 will contain the service type code supplied in EQ01 or may contain a service type that is related to but different than what was supplied in EQ01. For example – EQ01 in the 270 may contain a 33 (chiropractic). The health plan may respond in the 271 with an EB03=33 (chiropractic) and an EB03 = 4 (diagnostic xray)

Blank – No value is put between the field delimiters

\*3 – WDS will use 'D' rather than 'A'

## B. Maximum Benefit Limit and Accumulator Information

For each service type specified in EQ01 in the 270 request,

### *If the service type has maximum benefit limitations*

In the 271, an EB segment pair will identify the benefit maximum limitations (benefit \$ amount, # of visits, # of days) and the remaining benefit for each of those limitations. There will be at least two EB segments, with EB01 = 'F' (Limitation).

- *The first EB segment of the pair* will identify the benefit maximum limitation for the service type. EB06 will indicate the benefit period -- a calendar year (EB06='23') or a contract year (EB06='25') or an episode of care (EB06 = '26'). The following fields will be used depending upon the type of benefit limitation for that period:
  - EB07 will contain any maximum benefit dollar amount. By convention this field will only be used for the benefit dollar amount, if one exists. It will not be used for any other limitation as EB06 doesn't qualify that limitation. (EB06 defines the benefit period.)
  - EB09 will identify whether there is a benefit maximum limitation related to number of days or number of visits.

- EB10 will contain the benefit maximum limitation related to EB09  
For example, if the benefit maximum limitations for a contract year are \$5000 and 12 visits then EB06 = 25, EB07 = 5000, EB09 = VS, EB10 = 12
- *The second EB segment of the pair* will identify the benefit remaining for the service type (EB06 will = '29'). The following fields will be used depending upon the type of benefit limit
  - EB07 will contain any remaining benefit dollar amount. By convention this field will only be used for the benefit dollar amount, if one exists. It will not be used for any other limitation as EB06 doesn't qualify that limitation. (EB06 defines the benefit period.)
  - EB09 will identify whether there is a benefit remaining related to number of days or number of visits.
  - EB10 will contain the benefit remaining related to EB09

For example, if the benefit maximum remaining for the contract year are \$2000 and 4 visits then EB06 = 29, EB07 = 2000, EB09 = VS, EB10 = 4

If a service type has more than two benefit limitations, e.g. benefit \$ amount and number of visits and number of days, then an additional pair(s) of EB segments will be required. The first EB segment of the second pair will specify the benefit maximum limitation(s) that can't fit in the first pair. The second EB segment of the second pair will specify benefit remaining that can't fit in the first pair.

Benefit Description Values	
EB01	'F'
EB02	Blank
EB03	See Note 1 above
EB04	Blank
EB05	Blank
EB06	<ul style="list-style-type: none"> <li>➤ '23' – For benefit limitations for the calendar year</li> <li>➤ '25' - For benefit limitations for the contract year</li> <li>➤ '26' – For benefit limitations for an episode of care</li> <li>➤ '29' – For a benefit remaining</li> </ul>
EB07	Blank or Benefit \$ Amount
EB08	Blank
EB09	Blank or <ul style="list-style-type: none"> <li>• 'DY' – Days</li> <li>• 'VS' - Visits</li> </ul>
EB10	Blank or EB09-related quantity for benefit limitation or benefit remaining

Benefit Description Values	
EB11	<ul style="list-style-type: none"> <li>• 'Y' – if pre-auth required</li> </ul>
EB12	<ul style="list-style-type: none"> <li>• 'Y' – In-Network</li> <li>• 'N' – Out of Network</li> <li>• Blank – In-Network &amp; Out of Network</li> </ul>

Blank – No value is put between the field delimiters

### C. Service Delivery Limitations

For some benefit plans, there may be limitations pertaining to the frequency and timeframe in which the services must be delivered, e.g. 12 visits, 3 visits per week for 1 month. In these cases, the HSD segment will be used to specify those limitations.

Service Delivery Values	
HSD01	<ul style="list-style-type: none"> <li>• 'DY' – Days</li> <li>• 'VS' - Visits</li> </ul>
HSD02	Quantity of HSD01 (same as EB09)
HSD03	<ul style="list-style-type: none"> <li>• 'DA' – Days</li> <li>• 'MO' – Months</li> <li>• 'VS' – Visits</li> <li>• 'WK' – Week</li> <li>• 'YR' – Years</li> </ul>
HSD04	Quantity of HSD01 within the time period of HSD03
HSD05	<ul style="list-style-type: none"> <li>• '21' – Years</li> <li>• '26' – Episode</li> <li>• '27' – Visit</li> <li>• '32' – Lifetime</li> <li>• '34' – Month</li> <li>• '35' – Week</li> </ul>
HSD06	HSD05 Duration in which benefits need to be delivered
HSD07	Blank
HSD08	Blank

For the example of 12 visits, 3 visits per week for 1 month

<b>Service Delivery Values</b>	
HSD01	<b>'VS'</b> - Visits
HSD02	12
HSD03	<b>'WK'</b> – Week
HSD04	3
HSD05	<b>'34'</b> – Month
HSD06	1
HSD07	Blank
HSD08	Blank

# Appendix

## Transaction Implementation Practices

### 1. Use of EB12 to indicate 'In Network' and 'Out of Network'.

In the 271 transaction, an EB Loop is used to present detail information about benefits. In that loop, EB12 is used to differentiate whether the benefit information relates to an 'In Network' provider or an 'Out of Network' provider. Whenever the loop is being used to convey deductible information, that loop should be used as follows;

- a. ***If the deductible amounts are different***, then they should always be reported separately. For example, if there is a \$500 deductible for in-network and a \$1000 deductible for - out of network then two different EB loops should be used; one where E07 = \$1000 & EB12 = N and a second EB loop where EB07=\$500 and EB12 = Y.
- b. ***If the deductible amounts are the same but they accumulate separately***, i.e. the patient's payment to one does not affect the other, then they should be reported separately. For example, there is a \$500 deductible for in-network and a \$500 deductible for - out of network and a \$100 payment to an out-of-network provider does not affect the deductible when an in-network provider is seen (and visa versa), then two different EB loops should be used, one where E07 = \$500 & EB12 = N and a second EB loop where EB07=\$500 and EB12 = Y.
- c. ***If the deductible amounts are the same and they DON'T accumulate separately***, i.e. the patient's payment to one also applies to the other, then they should NOT be reported separately. For example, there is a \$500 deductible for in-network and a \$500 deductible for - out of network and a \$100 deductible payment to one applies equally to the other, then only one EB loop should be used, where E07 = \$500 & EB12 = blank.

### 2. Use of Messages

Use of Messages within the transaction should ONLY be used to convey information that is a) critical for the provider to know and b) cannot be conveyed using standard codes in EB01. For example, rather than include a MSG segment tell the provider to call Customer Service, an EB segment can be sent with EB01=U.

Disclaimers are examples of when messages should not be used. Informing a provider when limits are combined is an example of when messages should be used.

### 3. Dual Coverage

To be defined . . .