How to read your Medicare Advantage

Explanation of Benefits (EOB)

PeakHealth

PeakHealth

Explanation of Benefits

THIS IS NOT A BILL

Summit A Tapestry // Member ID: 1640084601 — Sent: November 1, 2023

Claim Information

Reference Number: CLM-2174672

Date: 11/1/23

Provider: Dorian J Williams

Location: 1 MEDICAL CENTER DRIVE

Paid to: WVU MEDICAL CORP DBA UHA

Total Cost of Services	$150.00
Savings (amount over allowed)	$-64.35
Allowed Amount	$85.65
Paid by Peak Health	$83.94
Your responsibility	$0.00

Learn More: Medicare.PeakHealth.org — Have Questions? 1.855.962.7325 (PEAK)

Peak Health Member Service • 1085 Van Voorhis Road, Suite 300 • Morgantown, WV 26505

Each claim starts with the claim (reference) number and provider name.

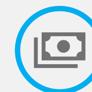
This section lists each claim processed by your Peak Advantage Medicare Advantage plan. Each claim has a breakdown of the original provider charge, what your Peak Advantage plan paid, any denied amounts, and the portion you may owe.

If you have questions

about a claim or think there might be a mistake, call your doctor's office or service provider and ask them to explain the claim. If you still have questions, call Member Service at **1-855-962-7325 (PEAK)**.

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 — or if we approve a claim but you disagree with how much you are paying.



If you owe anything,

your doctor or other health care provider will send you a bill. If that bill is higher than the amount under "**Your responsibility,**" call Member Service at **1-855-962-7325 (PEAK)**.

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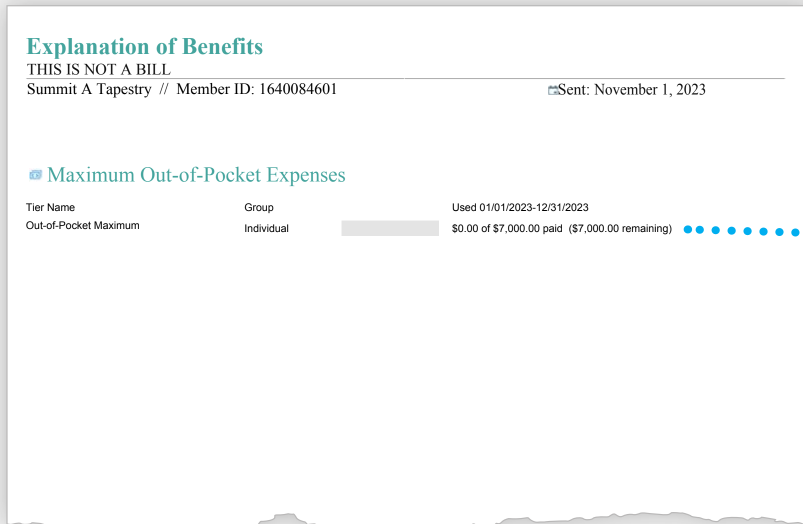

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Maximum Out-of-Pocket Expenses

Tier Name	Group	Used 01/01/2023-12/31/2023
Out-of-Pocket Maximum	Individual	$0.00 of $7,000.00 paid ($7,000.00 remaining)

This shows your out-of-pocket limit, how much has been applied to date, and how much is left to reach the limit.

Did you know?

With your Peak Advantage Medicare Advantage plan member account (MyPeak), you can view your claims, find doctors and pharmacies, view your member ID card, and more.

Register or log in at:

MyPeak.PeakHealth.org

Yearly Limit

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

The 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.

Once you have reached your limit in out-of-pocket costs, you stop paying out of pocket for all Medicare-covered services. You keep getting your covered medical services as usual, and your Peak Advantage Medicare Advantage plan will pay the full cost for the rest of the year.

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Service Details

Date	Service	Billed	Allowed	Not Covered	Copay	Deductible	Co-Insurance	Paid Amount	Patient Total	Reason Code
11/1/23	Office/Outpt Visit,Est,Levl III	150.00	85.65	0.00	0.00	0.00	0.00	83.94	0.00	C
	Claim Totals:	**150.00**	**85.65**	**0.00**	**0.00**	**0.00**	**0.00**	**83.94**	**0.00**	

Code Summary

C - Contracted Rate Payment

Billed - Full charge for services
Allowed - Discounted amount that in-network providers accept as payment
Not Covered - Amount not covered by your plan
Copay - A set amount that you pay each time you receive a covered service
Deductible - The initial portion of payment applicable to certain services for which you are responsible
Coinsurance - A specified percentage of the allowed amount that is your responsibility
Paid Amount - Amount paid by your health plan
Patient Total - Amount that you may owe or have paid the provider (may include any deductible, co-insurance, copay, or not covered amounts)
Reason Code - Explanation for adjustment or reduced payment

This provides service details for every claim included in the EOB.

Definitions of the terms you'll see in the EOB.

Privacy Protection

Super-detailed service descriptions are not on EOBs for privacy reasons. But you have the right to know which codes your provider submitted and what they mean.

Get more information about the medical codes used in your claims and what they mean by calling your provider or Peak Health Member Service at **1-855-962-7325 (PEAK)**.

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Here's what to do if you need additional assistance.

This tells you what it means to make an appeal, what to expect, and what your rights are. It also has contact information should you need help.

Additional Information

Thank you for choosing Peak Health. For additional assistance in reading your Explanation of Benefits (EOB), please log into your member portal at **MyPeak.PeakHealth.org** or call the Member Service number at 1.855.962.7325 (1.855.9MA.PEAK). Peak Health Member Service will be available Monday through Friday 8:00 a.m. to 5:00 p.m. ET, excluding holidays.

Appeal Rights

Level 1 Appeal: Request for Reconsideration

A member, member's representative or provider to an adverse initial claim determination has a right to a reconsideration by Peak Health. A reconsideration (hereinafter referred to as a level 1 appeal) consists of a review of an adverse initial claim determination, the evidence and finding upon which it was based, and any other evidence that the parties submit or that is obtained by the plan. A member, member's representative, or provider may request a level 1 appeal by filing a written request with the plan. Peak Health also accepts verbal requests for expedited appeals and may accept verbal requests for standard appeals. The appeal must be filed within 60 calendar days of receipt of the initial determination on a claim. If you miss the deadline, you must provide a reason for filing late.

In the written request, include the following:

- Your name, address and the Medicare Number on your Peak Health Member Id card
- The items or services for which you're requesting a reconsideration, the dates of service, and the reason(s) why you're appealing.
- The name of your representative and proof of representation if you've appointed a representative.
- Any other information that may help your case.

Written Requests can be sent to:

Peak Health
Attn: Appeals and Grievances
1085 Van Voorhis Rd, Suite 300
Morgantown, WV 26505

Fax: 304-974-3470

Peak Member Services is ready to help.

Call them at 1-855-962-7325 (TTY: 711).

Hours from October 1 to March 31: 8 a.m. to 8 p.m., 7 days a week.
Hours from April 1 to September 30: 8 a.m. to 5p.m., Monday through Friday.
Messages received on holidays and outside of our business hours will be returned within one business day.

You may also contact:

1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call:

d help in your community.

hin:

ealth in situations where the standard
gain maximum function. Peak Health must
r plan, that waiting for a standard decision
tion. If you are receiving services in an
sive rehabilitation facility, you may request
e with Peak Health's decision to discharge

Level 2 of the appeals process in the

d your appeal to an independent review

le in your favor, it is required to forward

Peak Health to MAXIMUS Federal
external reviews. MAXIMUS will notify
or provider does not have to make a request

one: 585-348-3300
x: 585-425-5292

ht to appeal to OMHA (Level 3). You may

You are dissatisfied with the MAXIMUS's decision, and
The amount in controversy is $180 or more (in 2023), and
Less than 60 days have passed since you received the reconsideration determination.

lee and Peak Health, unless a party files a
ator. Pursuant to 42 CFR §422.600, any
right to request a level 3 review if the
except the MA plan, has a right to a hearing.
nd other person/entity whose rights with
by the Administrative Law Judge or OMHA

tion or reconsidered determination), you or
MHA adjudicator. At Level 3 of the
you may have a hearing before an

ppeal to a new person who will
rtial decision in accordance with the

or example, if all the parties who would be
a hearing, or if the documentary evidence
her party to the appeal is financially
s that do not require a hearing may be

astern Time. If calling at other times or if
e a voicemail with your name and phone

ll Free Line above.

or dismissal, including the MA plan.
est that the Medicare Appeals Council

Part of the Departmental Appeals Board of the Department of Health and Human Services (HHS), and is
Independent of OMHA and its adjudicators.

djudicator's remand to a QIC, dismissal of a
smissal of a request for reconsideration.

ter or file electronically.

ion and the amount in controversy is at least
ent Organization), you may file a civil
ouncil will give you information about

thin 60 days of receiving the Medicare

*only for the Level 3 claims appeals and
s not responsible for levels 1, 2, 4, and 5 of
of appeals to help you understand the*