Committee on Operating Rules for Information Exchange (CORE™)

Certification/Testing Subgroup Draft

Phase III CORE Eligibility & Benefits Data Content (270/271) Rule

Certification/Testing Subgroup Draft – May 24, 2010

DOCUMENT CHANGE HISTORY

Description of Change	Name of Author	Date Published
Note: This rule is a combination of individual rules focused on specific issues developed by the Eligibility& Benefit Subgroup. Items below are the history of the both the Explicit Service Type Code Rule that forms the basis for this combined Eligibility Data Content Rule and the Lifetime Maximum and Annual Out-of-Pocket Maximum Rules.		
Explicit Service Type Code Rule Document Change History in Eligibility & Benefit Subgroup		
Outline & Discussion of Rule Requirements	Eligibility & Benefits Subgroup	Refer to Nov-Dec Subgroup Call Documentation on CAQH Calendar
First Review Draft	CAQH Staff	December 15, 2009
Subgroup Straw Poll Version	Eligibility & Benefits Subgroup	December 16, 2009
Second Review Draft	Eligibility & Benefits Subgroup	February 09, 2010
Lifetime Maximum and Annual Out-of-Pocket Maximum Rule Document Change History in Eligibility & Benefit Subgroup		
Outline of Rule Requirements	CAQH Staff	Refer to Nov-Dec Subgroup Call Documentation on CAQH Calendar
First Review Draft	CAQH Staff	January 5, 2010
Subgroup Straw Poll Version	Eligibility & Benefits Subgroup	January 5, 2010
Second Review Draft	Eligibility & Benefits Subgroup	February 9, 2010
Combined Eligibility & Benefits Data Content Rule Document Change History in Eligibility & Benefit Subgroup		
Initial Rules Work Group Review Draft: Consolidated Data Content Rule	CAQH Staff	February 22, 2010
Rules Work Group Straw Poll Version	Rules Work Group	February 25, 2010
Subgroup Review Draft Following Rules Work Group Survey	Eligibility & Benefits Subgroup	May 14, 2010
Rules Work Group Review	Eligibility & Benefits Subgroup	May 24, 2010
Certification/Testing Subgroup Draft	N/A	May 24, 2010

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1 Background Summary

CORE determined that CORE Phase I should focus on improving electronic eligibility and benefits verification, as eligibility is the first transaction in the claims process. Thus, if eligibility and benefits are accurately known to healthcare providers, all the associated electronic transactions that follow will be more effective and efficient. The CORE Phase I Eligibility and Benefits Data Content (270/271) Rule primarily outlined a set of requirements for health plans to return base (not remaining or accumulated) patient financial responsibility related to the deductible, co-pay and co-insurance for a set of 9 services in the ASC X12N v4010A1 271 eligibility response transaction, and for vendors, clearinghouse and providers to transmit and use this financial data.

The CORE Phase II Eligibility and Benefits Data Content (270/271) Rule extended and enhanced the Phase I 271 eligibility response transaction by requiring the provision of remaining deductible and in and out of network amounts for both the Phase I required 9 service type codes and an additional set of 39 other service type codes.

2 Issue to Be Addressed and Business Requirement Justification

In order to electronically determine a patient's eligibility and benefits, providers need to have a robust 271 eligibility response. This robust response includes the health plans providing financial information, especially remaining deductible amounts, coverage, and annual out-of-pocket information for those service types that are heavily used by patients.

HIPAA provides a foundation for the electronic exchange of eligibility and benefits information, but does not go far enough to ensure that today's paper-based system can be replaced by an electronic interoperable system. HIPAA's current mandated data scope for eligibility, the ASC X12 005010X279 Eligibility Benefit Inquiry and Response (270/271) Technical Report Type 3 implementation guide (hereafter referred to as v5010 270/271) only recommends but does not require all financial information needed by providers. Separate from HIPAA, the CORE participants agree that operating rules addressing other requirements beyond the scope of the data content of administrative transactions is necessary. Such operating rules address response time, real time requirements, system availability, connectivity and the standard use of acknowledgements. While CORE continues to build on the HIPAA-mandated requirements, businesses are seeking solutions that can be used today.

Continuing to build on Phase I and Phase II CORE rules, CORE determined that CORE Phase III should further extend financials for more service types. These additional service type codes include those that support evolving market direction, such as:

- Ability to support ARRA/HITECH meaningful use goals and HITSP's efforts to integrate clinical and administrative health care data;
- Represent high volume medical services, e.g., oncology.

Additionally, CORE determined that CORE Phase III should be extended further to continue to move the industry forward by delivering information necessary for providers to more fully understand a patient's financial information and other aspects of delivering health care to a patient. Knowing the annual out-of-pocket maximum is one other pieces of such information.

3 Scope

3.1 What the Rule Applies To

This CORE rule conforms with and builds upon the HIPAA-adopted ASC X12 005010X279 Eligibility Benefits Inquiry and Response (270/271) Technical Report Type 3 implementation guide (hereafter referred to as v5010 270/271 response).

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This rule builds upon and extends the CORE 260 Eligibility and Benefits 270/271 Data Content Rule Version 2.0.0 (and any revised versions[1]) by requiring the v5010 271 response to:

- support several service type codes in addition to those required to be supported for explicit v5010 270 inquiries in the corresponding v5010 271 response. (See §3.6.1.)

And

- report the annual out-of-pocket maximum patient liability.

3.2 When the Rule Applies

This rule applies when:

- The individual is located in the health plan's (or information source's) eligibility[2] system

And

- A health plan (or information source) receives an explicit 270 eligibility inquiry for a specific service type as required in §4.1.5 of this rule.

3.3 What the Rule Does Not Require

This rule does not require any CORE-certified entity to modify its use and content of:

- Other loops, segments, and data elements that may be submitted in the 270 eligibility inquiry transaction not addressed in this rule (see §3.4)

And

- Other loops, segments, and data elements that may be returned in the 271 eligibility response transaction not addressed in this rule (see §3.4).

3.4 Applicable Loops & Data Elements

All loops, segments and data elements covered in the CORE 154 Eligibility and Benefits Data Content 270/271 Rule Version 1.0.0 (and any revised versions) and CORE 260 Eligibility and Benefits Data Content 270/271 Rule Version 2.0.0 (and any revised versions) rules are hereby incorporated into this rule by reference.

3.5 Outside the Scope of this Rule

This rule does not:

- Require CORE-certified entities to internally store the data elements listed in §3.4 or any other data elements in conformance with this rule, but rather requires that all CORE-certified entities conform to this rule when conducting the v5010 270/271 eligibility transactions electronically. Entities may store data internally any way they wish, but must ensure the data conform to applicable CORE rules when inserting that data into outbound transactions.
- Require a CORE-certified health plan to offer a health plan that may include an annual out-of-pocket maximum.

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[1] *All CORE rules do not merely repeat federal requirements but rather seek to go above and beyond the bare minimum requirements in order to advance the industry. When federal requirements on which CORE rules are based change, relevant CORE rules are reviewed and updated as appropriate.*

[2] *Some health plans (or information sources) use the term "membership" when referring to the system that maintains eligibility for the members of a health plan. For purposes of this rule the terms "eligibility system" and "membership system" are considered to be synonymous.*

73 ### *3.6 Assumptions*

74 The following assumptions apply to this rule:

75–76
- This rule is a component of the larger set of CORE Phase III rules; as such, all the CORE Guiding Principles apply to this rule and all other rules;

77–78
- All entities seeking Phase III certification must be Phase I and Phase II certified, as CORE Phase I and Phase II provide a foundation for CORE Phase III;

79–80
- Requirements for the use of the applicable loops, segments, and data elements apply only to the v5010 270/271 TR3;

81–82
- Health plans (and information sources) are able to accurately maintain benefit and eligibility data received or created in a reasonable timeframe;

83
- The terms used in this rule are defined in §3.7.

84–87
- This rule is not a comprehensive companion document specifying the complete content of either the v5010 270 Eligibility Inquiry or v5010 271 Eligibility Response transaction sets. The focus in this rule is on specifying requirements for the v5010 271 Eligibility Response to address the CORE Phase III data content requirements for health plan benefits and services and related patient financial responsibility.

88 #### 3.6.1 Builds on Phase I and Phase II Eligibility and Benefits Data Content 270/271 Rules

89–92 This rule builds upon and extends the CORE 154 Eligibility and Benefits Data Content 270/271 Rule Version 1.0.0 (and any revised versions) and CORE 260 Eligibility and Benefits Data Content 270/271 Rule Version 2.0.0 (and any revised versions) by extending requirements and adding new CORE constraints to the v5010 271 Response content.

93–98 Given that any entity seeking Phase III certification will need to be Phase I and Phase II certified (see CORE Phase I and Phase II Guiding Principles) and because this Phase III Data Content rule is built upon the Phase I and Phase II Eligibility and Benefits Data Content Rules, this Phase III Data Content rule incorporates by reference all the requirements of the CORE 154 Eligibility and Benefits Data Content 270/271 Rule Version 1.0.0 (and any revised versions) and CORE 260 Eligibility and Benefits Data Content 270/271 Rule Version 2.0.0 (and any revised versions) rules.

99 ### *3.7 Abbreviations and Definitions Used in this Rule*

100–102 ***Health Plan Base Deductible:*** *The dollar amount of covered services based on the allowed benefit that must be paid by an individual or family per benefit period before the health benefit plan begins to pay its portion of claims. The benefit period may be a specific date range of one year or other as specified in the plan.*

103–106 ***Benefit-specific Base Deductible:*** *The dollar amount of a specific covered service based on the allowed benefit that is separate and distinct from the Health Plan Base Deductible that must be paid by an individual or family before the health benefit plan begins to pay its portion of claims. The specific benefit period may be a specific date, date range, or otherwise as specified in the plan.*

107–111 ***Combination Inquiry:*** *A 270 Health Care Eligibility Benefit Inquiry that contains both Service Type Code 30 and any other Service Type Code* ***NOT*** *required by CORE in the EQ01 segment of the transaction. A Combination Inquiry asks about both coverage of a specific type of benefit, for example, "AF" (Speech Therapy) and general coverage benefits of the health plan. (Note: While this definition is included in this rule, the rule does not address any requirements for a health plan's (or information source's) response to this inquiry type.)*

112–114 ***Explicit Inquiry:*** *A 270 Health Care Eligibility Benefit Inquiry that contains a Service Type Code other than and not including "30" (Health Benefit Plan Coverage) in the EQ01 segment of the transaction. An Explicit Inquiry asks about coverage of a specific type of benefit, for example, "78" (Chemotherapy). (See §4.1.5.)*

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115 ***Generic Inquiry:*** *A 270 Health Care Eligibility Benefit Inquiry that contains only Service Type Code "30" (Health Benefit Plan Coverage) in the EQ01 segment of the transaction. A Generic Inquiry asks about the general coverage benefits of the health plan. (See §4.1.4.)*

118 ***Hybrid Inquiry:*** *A 270 Health Care Eligibility Benefit Inquiry that contains both Service Type Code 30 and any other CORE-required Service Type Code in the EQ01 segment of the transaction. A Hybrid Inquiry asks about both coverage of a specific type of benefit, for example, "78" (Chemotherapy) and general coverage benefits of the health plan. (Note: While this definition is included in this rule, the rule does not address any requirements for a health plan's (or information source's) response to this inquiry type.)*

123 ***Health Plan Coverage Date for the Individual:*** *The effective date of health plan coverage actually in operation and in force for the individual.*

125 ***Support [Supported] Service Type:*** *Support [or Supported] means that the health plan (or information source) must have the capability to receive a 270 inquiry for a specific Service Type Code and to respond in the corresponding 271 response in accordance with this rule.*

128 ***Annual Out-of-Pocket Maximum:*** *The limit on the amount of money a beneficiary (member) spends on out-of-pocket costs for covered services during a health plan benefit period. Charges in excess of the approved amount for covered services are not applied toward this maximum. The limit may be applied to both in-network or out-of-network covered services separately or be combined for both in-network and out-of-network covered services as determined by the health plan. This amount may be in the form of deductibles, co-payments or co-insurance or any combination of those amounts.*

134 ***Carve-Out Benefit:*** *Certain services (benefits) or a group of services (benefits) that are administered by a third party vendor (e.g. vision, pharmacy.) As such the specific benefit information, such as patient financial responsibility, may not be available to the health plan.*[3]

137 4 Draft Rule Requirements

138 *4.1 Basic Requirements for Health Plans and Information Sources*

139 A CORE-certified health plan (or information source) is required to comply with all requirements specified in this rule when returning the 271 eligibility response transaction when the individual is located in the health plan's (or information source's) system.

142 4.1.1 Specifying Health Benefits Coverage

143 4.1.2 Specifying Status of Health Benefits Coverage

144 All requirements of the CORE 154 Eligibility and Benefits Data Content 270/271 Rule Version 1.0.0 (and any revised versions) and CORE 260 Eligibility and Benefits Data Content 270/271 Rule Version 2.0.0 (and any revised versions) rules for specifying status of health benefits coverage are hereby incorporated into this rule by reference.

[3] *Definitions developed during Phase II CORE Eligibility Data Content rule development were based on an industry-wide research effort to obtain a more detailed and authoritative information about terms and concepts as they apply to a health benefit plan. Several resources were used to develop the definitions as no one single source was identified during this research effort that defines the businesses terms being used. While there was relative consistency among the various sources, no one definition from a single source is used. Rather these definitions represent an amalgamation of definitions from multiple sources. These multiple sources were: CareFirst BlueCross BlueShield, Affinity Health Plan Glossary of Terms, Aflac Glossary of Terms, CIGNA Medical Claim Glossary and CIGNA Glossary, Delaware Healthcare Association Glossary of Health Care Terms, Empire Blue Cross Blue Shield Glossary, Medicare Glossary, National Association of Health Underwriters Glossary of Terms.*

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148 **4.1.3 Specifying Dates**

149 The date reporting requirements in this rule hereby incorporate by reference the CORE 154 Eligibility and
150 Benefits Data Content 270/271 Rule Version 1.0.0 (and any revised versions) and CORE 260 Eligibility and
151 Benefits Data Content 270/271 Rule Version 2.0.0 (and any revised versions) rules.

152 ***4.1.3.1 Specifying Health Plan Coverage Dates for the Individual***

153 All requirements of the CORE 154 Eligibility and Benefits Data Content 270/271 Rule Version 1.0.0 (and any
154 revised versions) and CORE 260 Eligibility and Benefits Data Content 270/271 Rule Version 2.0.0 (and any
155 revised versions) rules for specifying health plan coverage dates for the individual for each of the service type
156 codes returned are hereby incorporated into this rule by reference.

157 ***4.1.3.2 Specifying Benefit-specific Coverage Dates***

158 All requirements of the CORE 154 Eligibility and Benefits Data Content 270/271 Rule Version 1.0.0 (and any
159 revised versions) and CORE 260 Eligibility and Benefits Data Content 270/271 Rule Version 2.0.0 (and any
160 revised versions) rules for specifying benefit-specific coverage dates for the individual for each of the service type
161 codes returned are hereby incorporated into this rule by reference.

162 ***4.1.3.3 Specifying the Health Plan Base Deductible Dates***

163 All requirements of the CORE 154 Eligibility and Benefits Data Content 270/271 Rule Version 1.0.0 (and any
164 revised versions) and CORE 260 Eligibility and Benefits Data Content 270/271 Rule Version 2.0.0 (and any
165 revised versions) rules for specifying Health Plan Base deductible dates for the individual for each of the service
166 type codes returned are hereby incorporated into this rule by reference.

167 ***4.1.3.4 Specifying Benefit-specific Base Deductible Dates***

168 All requirements of the CORE 154 Eligibility and Benefits Data Content 270/271 Rule Version 1.0.0 (and any
169 revised versions) and CORE 260 Eligibility and Benefits Data Content 270/271 Rule Version 2.0.0 (and any
170 revised versions) rules for specifying benefit-specific base deductible dates for the individual for each of the
171 service type codes returned are hereby incorporated into this rule by reference.

172 ***4.1.3.5 Requirements for a Response to an Inquiry for Past and Future Dates***

173 All requirements of the CORE 154 Eligibility and Benefits Data Content 270/271 Rule Version 1.0.0 (and any
174 revised versions), CORE 260 Eligibility and Benefits Data Content 270/271 Rule Version 2.0.0 (and any revised
175 versions) for a response to an inquiry for past and future dates are hereby incorporated into this rule by reference.

176 **4.1.4 Requirements for Responding to a Generic Inquiry**

177 All requirements of the CORE 154 Eligibility and Benefits Data Content 270/271 Rule Version 1.0.0 (and any
178 revised versions) and CORE 260 Eligibility and Benefits Data Content 270/271 Rule Version 2.0.0 (and any
179 revised versions) rules for responding to a generic inquiry are hereby incorporated into this rule by reference.

180 **4.1.5 Requirements for a Response to an Explicit Inquiry for a CORE Required Service Type**

181 A CORE-certified health plan (or information source) must support an explicit 270 inquiry for each of the CORE
182 service types specified in Table 4.1.5 by returning a 271 response as specified in §4.1 through §4.2.6.

183 Table 4.1.5 specifies 48 Service Type Codes required in the CORE Phase I and II Rules for an explicit inquiry.
184 These 48 required service types specified in CORE 260 Phase II Eligibility and Benefits 270/271 Data Content
185 Rule are included in this rule by reference and are identified in Table 4.1.5 in italic font. The 30 additional Service
186 Type Codes added to the required service types for an explicit inquiry by this Phase III CORE rule are identified
187 in Table 4.1.5 in `Courier New` font.

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TABLE 4.1.5 CORE REQUIRED SERVICE TYPES FOR AN EXPLICIT INQUIRY	
CORE REQUIRED EXPLICIT INQUIRY SERVICE TYPES (v5010 270/271 Code and Definition)	**CORE SUPPLEMENTAL DESCRIPTION[4]**
1 Medical Care	*Medical care services to diagnose and/or treat medical condition, illness or injury. Medical services and supplies provided by physicians and other healthcare professionals.*
2 Surgical	*footnote 4*
3 Consultation	*footnote 4*
4 Diagnostic X-Ray	*footnote 4*
5 Diagnostic Lab	*footnote 4*
6 Radiation Therapy	*footnote 4*
7 Anesthesia	*footnote 4*
8 Surgical Assistance	*Assistant Surgeon/surgical assistance provided by a physician if required because of the complexity of the surgical procedures.*
12 Durable Medical Equipment Purchase	*Purchase of medically necessary equipment and supplies prescribed by a physician or other healthcare provider that can withstand repeated use, is medically necessary for the patient, is not useful if the patient is not ill or injured, and can be used in the home.*
13 Ambulatory Service Center Facility	*A freestanding facility that provides services on an outpatient basis, primarily for the purpose of performing medical or surgical procedures.*
18 Durable Medical Equipment Rental	*Rental of medically necessary equipment and supplies prescribed by a physician or other healthcare provider that can withstand repeated use, is medically necessary for the patient, is not useful if the patient is not ill or injured, and can be used in the home.*
20 Second Surgical Opinion	*footnote 4*
33 Chiropractic	*Professional services which may include office visits, manipulations, lab, x-rays, and supplies.*
35 Dental Care	*Benefits for services, supplies or appliances for care of teeth.*
40 Oral Surgery	*footnote 4*

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[4] *The CORE supplemental descriptions (clarification/meaning) are for guidance until definitive clarified definitions can be obtained within the ASC X12 standards. They provide a general understanding of the specific services which are included in each service type, but the description may not be all inclusive. No CORE description is provided for Service Type Codes where there was agreement among the CORE participants that the X12 Standard Code Definition is sufficiently clear and commonly understood.*

TABLE 4.1.5 CORE REQUIRED SERVICE TYPES FOR AN EXPLICIT INQUIRY	
CORE REQUIRED EXPLICIT INQUIRY SERVICE TYPES **(v5010 270/271 Code and Definition)**	**CORE SUPPLEMENTAL DESCRIPTION[4]**
42 Home Health Care	*footnote 4*
44 Home Health Visits	*Planned interaction between a healthcare professional and a patient, at the patient's place of residence, for the purpose of providing healthcare services.*
45 Hospice	*footnote 4*
47 Hospital	*footnote 4*
48 Hospital - Inpatient	*Hospital services and supplies for a patient who has been admitted to a hospital for the purpose of receiving medical care or other health services.*
50 Hospital - Outpatient	*Hospital services and supplies for a patient who has not been admitted to a hospital for the purpose of receiving medical care or other health services.*
51 Hospital - Emergency Accident	*Hospital services and supplies for the treatment of a sudden and unexpected injury that requires immediate medical attention.*
52 Hospital - Emergency Medical	*Hospital services and supplies for the treatment of a sudden and unexpected condition that requires immediate medical attention.*
53 Hospital - Ambulatory Surgical	*footnote 4*
62 MRI/CAT Scan	*footnote 4*
65 Newborn Care	*footnote 4*
67 Smoking Cessation	*footnote 4*
68 Well Baby Care	*footnote 4*
69 Maternity	*footnote 4*
73 Diagnostic Medical	*footnote 4*
76 Dialysis	*footnote 4*
78 Chemotherapy	*footnote 4*
79 Allergy Testing	*footnote 4*
80 Immunizations	*footnote 4*
81 Routine Physical	*footnote 4*
82 Family Planning	*footnote 4*

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TABLE 4.1.5 CORE REQUIRED SERVICE TYPES FOR AN EXPLICIT INQUIRY	
CORE REQUIRED EXPLICIT INQUIRY SERVICE TYPES (v5010 270/271 Code and Definition)	**CORE SUPPLEMENTAL DESCRIPTION[4]**
86 Emergency Services	*Medical services and supplies provided by physicians, Hospitals, and other healthcare professionals for the treatment of a sudden and unexpected medical condition or injury which requires immediate medical attention.*
88 Pharmacy	*Drugs and supplies dispensed by a licensed Pharmacist, which may include mail order or internet dispensary.*
93 Podiatry	*footnote 4*
98 Professional (Physician) Visit – Office (See §4.1.5.1 for Service Type Code grouping requirements for a response to this Service Type Code)	*footnote 4*
99 Professional (Physician) Visit - Inpatient	*footnote 4*
A0 Professional (Physician) Visit - Outpatient	*footnote 4*
A1 Professional (Physician) Visit - Nursing Home	*footnote 4*
A2 Professional (Physician) Visit - Skilled Nursing Facility	*footnote 4*
A3 Professional (Physician) Visit - Home	*footnote 4*
A6 Psychotherapy	*footnote 4*
A7 Psychiatric - Inpatient	*footnote 4*
A8 Psychiatric - Outpatient	*footnote 4*
AD Occupational Therapy	*footnote 4*
AE Physical Medicine	*footnote 4*
AF Speech Therapy	*footnote 4*
AG Skilled Nursing Care	*Services and supplies for a patient who has been admitted to a skilled nursing facility for the purpose of receiving medical care or other health services.*
AI Substance Abuse	*footnote 4*
AL Vision (Optometry)	*Routine vision services furnished by an optometrist. May include coverage for eyeglasses, contact lenses, routine eye exams, and/or vision testing for the prescribing or fitting of eyeglasses or contact lenses.*
B2 Brand Name Prescription Drug - Formulary	*footnote 4*

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TABLE 4.1.5 CORE REQUIRED SERVICE TYPES FOR AN EXPLICIT INQUIRY	
CORE REQUIRED EXPLICIT INQUIRY SERVICE TYPES (v5010 270/271 Code and Definition)	**CORE SUPPLEMENTAL DESCRIPTION[4]**
B3 Brand Name Prescription Drug - Non-Formulary	*footnote 4*
BG Cardiac Rehabilitation	*footnote 4*
BH Pediatric	*footnote 4*
BT Gynecological	*footnote 4*
BU Obstetrical	*footnote 4*
BV Obstetrical/Gynecological *(See §4.1.5.1 for Service Type Code grouping requirements for a response to this Service Type Code)*	*footnote 4*
BW Mail Order Prescription Drug: Brand Name	*footnote 4*
BX Mail Order Prescription Drug: Generic	*footnote 4*
BY Physician Visit - Office: Sick	*footnote 4*
BZ Physician Visit - Office: Well	*footnote 4*
CE Mental Health Provider - Inpatient	*footnote 4*
CF Mental Health Provider - Outpatient	*footnote 4*
CG Mental Health Facility - Inpatient	*footnote 4*
CH Mental Health Facility - Outpatient	*footnote 4*
CI Substance Abuse Facility - Inpatient	*footnote 4*
CJ Substance Abuse Facility - Outpatient	*footnote 4*
CO Flu Vaccination	*footnote 4*
GF Generic Prescription Drug - Formulary	*footnote 4*
GN Generic Prescription Drug - Non-Formulary	*footnote 4*
GY Allergy	*footnote 4*
MH Mental Health	*footnote 4*
PT Physical Therapy	*footnote 4*
UC Urgent Care	*footnote 4*

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188 ***4.1.5.1 Requirements for Grouping Service Type Codes in a Response to an Explicit Inquiry***

189 Table 4.1.5.1 specifies the required service type codes that must be included in the response to an explicit inquiry
190 for one or more of listed service type codes. The response must include all other requirements as specified in §4.1
191 through §4.2.6.

TABLE 4.1.5.1 CORE REQUIRED SERVICE TYPES FOR AN EXPLICIT INQUIRY	
SERVICE TYPE SUBMITTED IN AN EXPLICIT INQUIRY **(v5010 270/271 Code and Definition)**	**SERVICE TYPES REQUIRED IN THE RESPONSE**
BV Obstetrical/Gynecological	**BV Obstetrical/Gynecological**
	BT Gynecological
	BU Obstetrical
98 Professional (Physician) Visit – Office	**98 Professional (Physician) Visit – Office**
	BY Physician Visit - Office: Sick
	BZ Physician Visit - Office: Well

192

193 If the health plan's benefits do not fall into any of the more specific service type codes listed in Table 4.1.5.1, the
194 271 response must include the more general service type code shown in bold font in Table 4.1.5.1 and all
195 associated requirements as specified in §4.1 through §4.2.6.

196 **4.1.6 Requirements for a Response to an Explicit Inquiry for a Service Type not Required by this Rule**

197 All requirements of the CORE 154 Eligibility and Benefits Data Content 270/271 Rule Version 1.0.0 (and any
198 revised versions) and CORE 260 Eligibility and Benefits Data Content 270/271 Rule Version 2.0.0 (and any
199 revised versions) rules for responding to an explicit inquiry for a service type not required by a CORE rule are
200 hereby incorporated into this rule by reference.

201 ***4.2 Patient Financial Responsibility***

202 **4.2.1 Specifying Deductible Amounts**

203 All requirements of the CORE 154 Eligibility and Benefits Data Content 270/271 Rule Version 1.0.0 (and any
204 revised versions) and CORE 260 Eligibility and Benefits Data Content 270/271 Rule Version 2.0.0 (and any
205 revised versions) rules for specifying deductible amounts are hereby incorporated into this rule by reference.

206 ***4.2.1.1 Specifying the Health Plan Base Deductible***

207 All requirements of the CORE 154 Eligibility and Benefits Data Content 270/271 Rule Version 1.0.0 (and any
208 revised versions) and CORE 260 Eligibility and Benefits Data Content 270/271 Rule Version 2.0.0 (and any
209 revised versions) rules for specifying the Health Plan base deductible amounts are hereby incorporated into this
210 rule by reference.

211 ***4.2.1.2 Specifying the Health Plan Remaining Deductible***

212 All requirements of the CORE 154 Eligibility and Benefits Data Content 270/271 Rule Version 1.0.0 (and any
213 revised versions) and CORE 260 Eligibility and Benefits Data Content 270/271 Rule Version 2.0.0 (and any
214 revised versions) rules for specifying the Health Plan remaining deductible amounts are hereby incorporated into
215 this rule by reference.

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4.2.1.3 Specifying the Benefit-specific Base Deductible

All requirements of the CORE 154 Eligibility and Benefits Data Content 270/271 Rule Version 1.0.0 (and any revised versions) and CORE 260 Eligibility and Benefits Data Content 270/271 Rule Version 2.0.0 (and any revised versions) rules for specifying the Benefit-specific base deductible amounts are hereby incorporated into this rule by reference.

4.2.1.4 Specifying the Benefit-specific Remaining Deductible

All requirements of the CORE 154 Eligibility and Benefits Data Content 270/271 Rule Version 1.0.0 (and any revised versions) and CORE 260 Eligibility and Benefits Data Content 270/271 Rule Version 2.0.0 (and any revised versions) rules for specifying the Benefit-specific remaining deductible amounts are hereby incorporated into this rule by reference.

4.2.2 Specifying Co-Payment Amounts

All requirements of the CORE 154 Eligibility and Benefits Data Content 270/271 Rule Version 1.0.0 (and any revised versions) and CORE 260 Eligibility and Benefits Data Content 270/271 Rule Version 2.0.0 (and any revised versions) rules for specifying co-payment for each of the service type codes returned are hereby incorporated into this rule by reference.

4.2.3 Specifying Co-Insurance Amounts

All requirements of the CORE 154 Eligibility and Benefits Data Content 270/271 Rule Version 1.0.0 (and any revised versions) and CORE 260 Eligibility and Benefits Data Content 270/271 Rule Version 2.0.0 (and any revised versions) rules for specifying co-insurance amounts for each of the service type codes returned are hereby incorporated into this rule by reference.

4.2.4 Specifying Annual Health Plan Out-of-Pocket Maximum

4.2.4.1 Requirements for Specifying Base Annual Health Plan Out-of-Pocket Maximum

A CORE-certified health plan (or information source) must return the base annual Health Plan out-of-pocket maximum amount as defined in §3.7 of this rule, including both individual and family amounts (when applicable), in Loops 2110C/2110D only when the status of the health plan coverage is equal to one of the active coverage codes 1 through 5 and EB03=30–Health Benefit Plan Coverage as follows:

EB01 = G–Out of Pocket

EB02 = FAM–Family or IND–Individual as appropriate

EB03 = 30–Health Benefit Plan Coverage

EB06 = <Applicable Time Period Qualifier code>

EB07 = Monetary amount of annual Health Plan base out-of-pocket maximum

When a service type does not have a base out-of-pocket maximum separate and distinct from the base Health Plan out-of-pocket maximum, the base Health Plan out-of-pocket maximum must not be returned on any EB segment where EB03≠30−Health Benefit Plan Coverage.

When the base annual Health Plan out-of-pocket maximum amount differs for in- and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 as follows:

EB12 = N, Y as applicable

When the base annual Health Plan out-of-pocket maximum is the same for in- and out-of-network, one occurrence of the EB segment must be returned using EB12-1073 as follows:

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EB12 = W

When it is not known if the base annual Health Plan out-of-pocket maximum is the same for in- and out-of-network, one occurrence of the EB segment must be returned using EB12-1073 as follows:

EB12 = U

When the base annual Health Plan out-of-pocket maximum does not apply, do not return this segment.

4.2.4.2 Requirements for Specifying Remaining Annual Health Plan Out-of-Pocket Maximum

A CORE-certified health plan (or information source) must return the remaining annual Health Plan out-of-pocket maximum amount as defined in §3.7 of this rule, including both individual and family amounts (when applicable), in Loops 2110C/2110D only when the status of the health plan coverage is equal to one of the active coverage codes 1 through 5 and EB03=30–Health Benefit Plan Coverage as follows:

EB01 = G–Out of Pocket

EB02 = FAM–Family or IND–Individual as appropriate

EB03 = 30–Health Benefit Plan Coverage

EB06 = 29–Remaining

EB07 = Monetary amount of remaining annual Health Plan out-of-pocket maximum

When the remaining annual Health Plan out-of-pocket maximum amount differs for in- and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 as follows:

EB12 = N, Y as applicable

When the remaining annual Health Plan out-of-pocket maximum is the same for in- and out-of-network, one occurrence of the EB segment must be returned using EB12-1073 as follows:

EB12 = W

When it is not known if the remaining annual Health Plan out-of-pocket maximum is the same for in- and out-of-network, one occurrence of the EB segment must be returned using EB12-1073 as follows:

EB12 = U

The dollar amount expressed is the portion that is the patient's responsibility.

When the remaining annual Health Plan out-of-pocket maximum does not apply, do not return this segment.

4.2.4.3 Requirements for Specifying Base Annual Benefit-Specific Out-of-Pocket Maximum

A CORE-certified health plan (or information source) must return the base annual Benefit-specific out-of-pocket maximum as defined in §3.7 of this rule that is the patient financial responsibility, including both individual and family amounts (when applicable) in Loops 2110C/2110D only when the status of the health plan coverage and the status of the specific benefit is equal to one of the active coverage codes 1 through 5 and EB03≠30–Health Benefit Plan Coverage as follows:

EB01 = G–Out of Pocket

EB02 = FAM–Family or IND–Individual as appropriate

EB03 = <the Service Type Code indicating the specific benefit to which the out-of-pocket maximum applies>

EB06 = <Applicable Time Period Qualifier code>

EB07 = Monetary amount of base annual Health Plan out-of-pocket maximum

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293 When the base annual Benefit-specific out-of-pocket maximum differs for in- and out-of-network, two
294 occurrences of the EB segment must be returned using EB12-1073 as follows:

295 EB12 = N, Y as applicable

296 When the base annual Benefit-specific out-of-pocket maximum is the same for in- and out-of-network, one
297 occurrence of the EB segment must be returned using EB12-1073 as follows:

298 EB12 = W

299 When it is not known if the base annual Benefit-specific out-of-pocket maximum is the same for in- and out-of-
300 network, one occurrence of the EB segment must be returned using EB12-1073 as follows:

301 EB12 = U

302 When the base annual Benefit-specific out-of-pocket maximum does not apply, do not return this segment.

303 ***4.2.4.4 Requirements for Specifying Remaining Annual Benefit-Specific Out-of-Pocket Maximum***

304 A CORE-certified health plan (or information source) must return the remaining annual Benefit-specific out-of-
305 pocket maximum as defined in §3.7 of this rule that is the patient financial responsibility, including both
306 individual and family amounts (when applicable) in Loops 2110C/2110D only when the status of the health plan
307 coverage and the status of the specific benefit is equal to one of the active coverage codes 1 through 5 and
308 EB03≠30–Health Benefit Plan Coverage as follows:

309 EB01 = G–Out of Pocket

310 EB02 = FAM–Family or IND–Individual as appropriate

311 EB03 = <the Service Type Code indicating the specific benefit to which the deductible applies>

312 EB06 = 29–Remaining

313 EB07 = Monetary amount of remaining annual Benefit-specific out-of-pocket maximum

314 When the remaining annual Benefit-specific out-of-pocket maximum differs for in- and out-of-network, two
315 occurrences of the EB segment must be returned using EB12-1073 as follows:

316 EB12 = N, Y as applicable

317 When the remaining annual Benefit-specific out-of-pocket maximum is the same for in- and out-of-network, one
318 occurrence of the EB segment must be returned using EB12-1073 as follows:

319 EB12 = W

320 When it is not known if the remaining annual Benefit-specific out-of-pocket maximum is the same for in- and
321 out-of-network, one occurrence of the EB segment must be returned using EB12-1073 as follows:

322 EB12 = U

323 When the patient's portion of remaining annual Benefit-specific out-of-pocket maximum for a benefit does not
324 apply, do not return this segment.

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325 #### 4.2.5 Discretionary Reporting of Patient Financial Responsibility

326 A CORE-certified health plan (or information source) must return the patient financial responsibility for base and
327 remaining deductible, co-payment, co-insurance, and annual out-of-pocket maximum (including in- and out-of-
328 network variances[5]) as specified in §4.2.1 through §4.2.4 for each of the service type codes returned.

329 The health plan (or information source) may, at its discretion, elect not to return the remaining patient financial
330 responsibility information (deductible and annual out-of-pocket maximum) for the following service type codes
331 specified in EB03-1365.

332 When a service type code is too general for a meaningful response (e.g., 1-Medical Care) the health plan is not
333 required to return base and remaining patient financial responsibility for deductible, co-payment, co-insurance,
334 and annual out-of-pocket maximum.

335 (Note: Codes added to the discretionary reporting of patient financial responsibility information in this rule are
336 identified below in `Courier New` font.)

337 - 1 – Medical Care;
338 - `69 – Maternity;`
339 - `BT – Gynecological;`
340 - `BU – Obstetrical;`
341 - `BV – Obstetrical/Gynecological`
342 - A6 – Psychotherapy;
343 - A7 – Psychiatric – Inpatient;
344 - A8 – Psychiatric – Outpatient;
345 - AI – Substance Abuse;
346 - `CE – Mental Health Provider – Inpatient;`
347 - `CF – Mental Health Provider – Outpatient;`
348 - `CG – Mental Health Facility – Inpatient;`
349 - `CH – Mental Health Facility – Outpatient;`
350 - `CI – Substance Abuse Facility – Inpatient;`
351 - `CJ – Substance Abuse Facility – Outpatient;`
352 - `MH – Mental Health.`

353 The discretionary reporting of patient financial responsibility information does not preempt the health plan's (or
354 information source's) requirement to report patient financial responsibility for deductible, co-payment, co-
355 insurance, and annual out-of-pocket maximum for all other service type codes as specified in Table 4.1.5.

356 Service Type Code 30−Health Benefit Plan Coverage is not included in this group of discretionary service types
357 since this rule requires that a CORE-certified health plan (or information source) must return base and remaining
358 Health Plan Deductibles using Service Type Code 30.

359 CORE made codes discretionary for one of two main reasons:

360 - A code is too general for a response to be meaningful (e.g., 1 – Medical), especially given the new
361 specific codes added in Phase III, or

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[5] *All requirements of the CORE 154 Eligibility and Benefits Data Content 270/271 Rule Version 1.0.0 (and any revised versions) and CORE 260 Eligibility and Benefits Data Content 270/271 Rule Version 2.0.0 (and any revised versions) rules for specifying in/out-of-network variances are hereby incorporated into this rule by reference.*

- A code is related to behavioral health or substance abuse (e.g., AI - Substance Abuse) where privacy issues may impact a health plan or information source's ability to return information.

See §6.1 Appendix 1 for a visual view of Service Type Codes and reporting requirements.

All date and date range reporting requirements for Patient Financial Responsibility are specified in §4.1.3.

4.2.6 Discretionary Reporting of Patient Financial Responsibility for a Carve-Out Benefit

A health plan must return the patient financial responsibility information specified in §4.2.1 through §4.2.4 (i.e., deductible, co-payment, co-insurance, or annual out-of-pocket maximum) when this information exists within the health plan's or information source's organization ~~system~~ for the following service type codes specified in EB03-1365.

Neither the health plan or information source is required to obtain such patient financial responsibility information from outside its own organization.

- 35 – Dental Care;
- 88 – Pharmacy;
- AL – Vision (Optometry);
- `B2 Brand Name Prescription Drug – Formulary;`
- `B3 Brand Name Prescription Drug - Non-Formulary;`
- `BW Mail Order Prescription Drug: Brand Name;`
- `BX Mail Order Prescription Drug: Generic;`
- `GF Generic Prescription Drug – Formulary;`
- `GN Generic Prescription Drug – Non-Formulary.`

The discretionary reporting of patient financial responsibility information for a carve-out benefit does not preempt the health plan's (or information source's) requirement to report patient financial responsibility for deductible, co-payment, co-insurance, and annual out-of-pocket maximum for all other service type codes as specified in Table 4.1.5.

See §6.1 Appendix 1 for a visual view of Service Type Codes and reporting requirements.

All date and date range reporting requirements for Patient Financial Responsibility are specified in §4.1.3.

4.3 Basic Requirements for Submitters (Providers, Provider Vendors and Information Receivers)

The receiver of a v5010 271 response (defined in the context of this CORE rule as the system originating the v5010 270 inquiry) is required to detect and extract all data elements to which this rule applies as returned by the health plan (or information source) in the v5010 271 response.

The receiver must display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the v5010 271 data content.

5 Conformance Requirements

Note: Conformance with this rule is considered achieved when all of the required detailed step-by-step test scripts specified in the CORE Phase III Certification Test Suite are successfully passed.

The detailed requirements for the certification test scripts and CORE Phase III Certification Test Suite will be developed by the CORE Phase III Testing Subgroup and Technical Work Group.

For Phase III, the certification testing approach is similar to the Phase I and Phase II testing approach. In Phase I and Phase II, entities were not tested for their compliance with all sections of a rule, rather just certain sections as testing is not exhaustive and is paired with the CORE Enforcement policy. CORE certification requires entities

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402 *to be compliant with all aspects of the rule when working with all trading partners, unless the CORE-certified*
403 *entity has an exemption. Refer to the CORE Phase III Certification Test Suite for details.*

404 6 Appendix

405 The purpose of the Appendix is to provide additional background on the CORE Phase III Data Content rule. It is
406 non-normative information and in a case of conflict, the actual rule language applies.

407 *6.1 Appendix 1: CORE Phase III Service Type Codes*

408 Appendix 1 shows the combined list of service type codes required in CORE Phase I, II and III. It includes the
409 generic code 30 (Health Benefit Plan Coverage). Phase III adds 30 additional service type codes required to be
410 supported for explicit inquiries. The Phase I and II service type codes appear as green-shaded boxes.

411 Phase III continues the discretionary reporting of patient financial responsibility for the eight Phase I and Phase II
412 service type codes and adds thirteen of the 30 service type codes added in this rule to the list of service types for
413 which patient financial responsibility reporting is discretionary.

414 The right-hand column describes the required and discretionary status for returning patient financial responsibility
415 information (static co-pay and co-insurance information and remaining deductible amount) for each of the 30
416 service type codes added in this rule, including service type code 30 – Health Benefit Plan Coverage.

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Expanded Subset of Service Type Codes for Phase III (ASC X12 v5010 270/271 Code and Definition)	Service Type Codes Required by v5010 270/271 for a Generic Inquiry (financials not required)	Service Type Codes Required by CORE Rules for Generic and Explicit Inquiry (Coverage & Patient Financials)	CORE Required Response to a Generic and Explicit 270 Inquiry – Requirements to return patient financials
1 Medical Care	Y	Y (Phase I)	Discretionary
2 Surgical		Y	Mandatory
3 Consultation		Y	Mandatory
4 Diagnostic X-Ray		Y	Mandatory
5 Diagnostic Lab		Y	Mandatory
6 Radiation Therapy		Y	Mandatory
7 Anesthesia		Y	Mandatory
8 Surgical Assistance		Y	Mandatory
12 Durable Medical Equipment Purchase		Y	Mandatory
13 Ambulatory Service Center Facility		Y	Mandatory
18 Durable Medical Equipment Rental		Y	Mandatory
20 Second Surgical Opinion		Y	Mandatory
30 Health Benefit Plan Coverage	Y		Mandatory
33 Chiropractic	Y	Y (Phase I)	Mandatory
35 Dental Care	Y	Y (Phase I)	Mandatory when exists; else Discretionary
40 Oral Surgery		Y	Mandatory
42 Home Health Care		Y	Mandatory
44 Home Health Visits		Y	Mandatory
45 Hospice		Y	Mandatory
47 Hospital	Y	Y	Mandatory
48 Hospital - Inpatient	Y	Y (Phase I)	Mandatory
50 Hospital - Outpatient	Y	Y (Phase I)	Mandatory
51 Hospital - Emergency Accident		Y	Mandatory
52 Hospital - Emergency Medical		Y	Mandatory
53 Hospital - Ambulatory Surgical		Y	Mandatory

Expanded Subset of Service Type Codes for Phase III (ASC X12 v5010 270/271 Code and Definition)	Service Type Codes Required by v5010 270/271 for a Generic Inquiry (financials not required)	Service Type Codes Required by CORE Rules for Generic and Explicit Inquiry (Coverage & Patient Financials)	CORE Required Response to a Generic and Explicit 270 Inquiry – Requirements to return patient financials
62 MRI/CAT Scan		Y	Mandatory
65 Newborn Care		Y	Mandatory
67 Smoking Cessation		Y	Mandatory
68 Well Baby Care		Y	Mandatory
69 Maternity		Y	Mandatory
73 Diagnostic Medical		Y	Mandatory
76 Dialysis		Y	Mandatory
78 Chemotherapy		Y	Mandatory
79 Allergy Testing		Y	Mandatory
80 Immunizations		Y	Mandatory
81 Routine Physical		Y	Mandatory
82 Family Planning		Y	Mandatory
86 Emergency Services	Y	Y (Phase I)	Mandatory
88 Pharmacy	Y	Y (Phase I)	Mandatory when exists; else Discretionary
93 Podiatry		Y	Mandatory
98 Professional (Physician) Visit - Office	Y	Y (Phase I)	Mandatory
99 Professional (Physician) Visit - Inpatient		Y	Mandatory
A0 Professional (Physician) Visit - Outpatient		Y	Mandatory
A1 Professional (Physician) Visit - Nursing Home		Y	Mandatory
A2 Professional (Physician) Visit - Skilled Nursing Facility		Y	Mandatory
A3 Professional (Physician) Visit - Home		Y	Mandatory
A6 Psychotherapy		Y	Discretionary
A7 Psychiatric - Inpatient		Y	Discretionary
A8 Psychiatric - Outpatient		Y	Discretionary
AD Occupational Therapy		Y	Mandatory
AE Physical Medicine		Y	Mandatory
AF Speech Therapy		Y	Mandatory
AG Skilled Nursing Care		Y	Mandatory
AI Substance Abuse		Y	Discretionary
AL Vision (Optometry)	Y	Y (Phase I)	Mandatory when exists; else Discretionary
B2 Brand Name Prescription Drug - Formulary		Y	Mandatory when exists; else Discretionary
B3 Brand Name Prescription Drug - Non-Formulary		Y	Mandatory when exists; else Discretionary
BG Cardiac Rehabilitation		Y	Mandatory
BH Pediatric		Y	Mandatory
BT Gynecological		Y	Mandatory
BU Obstetrical		Y	Mandatory
BV Obstetrical/Gynecological		Y	Mandatory
BW Mail Order Prescription Drug: Brand Name		Y	Mandatory when exists; else Discretionary
BX Mail Order Prescription Drug:		Y	Mandatory when exists;

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Expanded Subset of Service Type Codes for Phase III (ASC X12 v5010 270/271 Code and Definition)	Service Type Codes Required by v5010 270/271 for a Generic Inquiry (financials not required)	Service Type Codes Required by CORE Rules for Generic and Explicit Inquiry (Coverage & Patient Financials)	CORE Required Response to a Generic and Explicit 270 Inquiry – Requirements to return patient financials
Generic			else Discretionary
BY Physician Visit - Office: Sick		Y	Mandatory
BZ Physician Visit - Office: Well		Y	Mandatory
CE Mental Health Provider - Inpatient		Y	Discretionary
CF Mental Health Provider - Outpatient		Y	Discretionary
CG Mental Health Facility - Inpatient		Y	Discretionary
CH Mental Health Facility - Outpatient		Y	Discretionary
CI Substance Abuse Facility - Inpatient		Y	Discretionary
CJ Substance Abuse Facility - Outpatient		Y	Discretionary
CO Flu Vaccination		Y	Mandatory
GF Generic Prescription Drug - Formulary		Y	Mandatory when exists; else Discretionary
GN Generic Prescription Drug - Non-Formulary		Y	Mandatory when exists; else Discretionary
GY Allergy		Y	Mandatory
MH Mental Health	Y	Y	Discretionary
PT Physical Therapy		Y	Mandatory
UC Urgent Care	Y	Y	Mandatory

417

418 ### 6.2 *Appendix 2: Abbreviations and Definitions Used in this Rule*

419 ***Health Plan Base Deductible:*** *The dollar amount of covered services based on the allowed benefit that must be*
420 *paid by an individual or family per benefit period before the health benefit plan begins to pay its portion of*
421 *claims. The benefit period may be a specific date range of one year or other as specified in the plan.*

422 ***Benefit-specific Base Deductible:*** *The dollar amount of a specific covered service based on the allowed benefit*
423 *that is separate and distinct from the Health Plan Base Deductible that must be paid by an individual or family*
424 *before the health benefit plan begins to pay its portion of claims. The specific benefit period may be a specific*
425 *date, date range, or otherwise as specified in the plan.*

426 ***Combination Inquiry:*** *A 270 Health Care Eligibility Benefit Inquiry that contains both Service Type Code 30*
427 *and any other Service Type Code* ***NOT*** *required by CORE in the EQ01 segment of the transaction. A*
428 *Combination Inquiry asks about both coverage of a specific type of benefit, for example, "AF" (Speech Therapy)*
429 *and general coverage benefits of the health plan. (Note: While this definition is included in this rule, the rule does*
430 *not address any requirements for a health plan's (or information source's) response to this inquiry type.)*

431 ***Explicit Inquiry:*** *A 270 Health Care Eligibility Benefit Inquiry that contains a Service Type Code other than and*
432 *not including "30" (Health Benefit Plan Coverage) in the EQ01 segment of the transaction. An Explicit Inquiry*
433 *asks about coverage of a specific type of benefit, for example, "78" (Chemotherapy).*

434 ***Generic Inquiry:*** *A 270 Health Care Eligibility Benefit Inquiry that contains only Service Type Code "30"*
435 *(Health Benefit Plan Coverage) in the EQ01 segment of the transaction. A Generic Inquiry asks about the general*
436 *coverage benefits of the health plan.*

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Hybrid Inquiry: *A 270 Health Care Eligibility Benefit Inquiry that contains both Service Type Code 30 and any other CORE-required Service Type Code in the EQ01 segment of the transaction. A Hybrid Inquiry asks about both coverage of a specific type of benefit, for example, "78" (Chemotherapy) and general coverage benefits of the health plan. (Note: While this definition is included in this rule, the rule does not address any requirements for a health plan's (or information source's) response to this inquiry type.)*

Health Plan Coverage Date for the Individual: *The effective date of health plan coverage actually in operation and in force for the individual.*

Support [Supported] Service Type: *Support [or Supported] means that the health plan (or information source) must have the capability to receive a 270 inquiry for a specific Service Type Code and to respond in the corresponding 271 response in accordance with this rule.*

Annual Out-of-Pocket Maximum: *The limit on the amount of money a beneficiary (member) spends on out-of-pocket costs for covered services during a health plan benefit period. Charges in excess of the approved amount for covered services are not applied toward this maximum. The limit may be applied to both in-network or out-of-network covered services separately or be combined for both in-network and out-of-network covered services as determined by the health plan. This amount may be in the form of deductibles, co-payments or co-insurance or any combination of those amounts.*

Carve-Out Benefit: *Certain services (benefits) or a group of services (benefits) that are administered by a third party vendor* (e.g. vision, pharmacy.) As such the specific benefit information, such as patient financial responsibility, may not be available to the health plan.

6.3 Appendix 3: Reference

- ASC X12 005010X279 Health Care Eligibility Benefit Inquiry and Response (270/271) Technical Report Type 3

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