



Phase I CORE 154: Eligibility and Benefits 270/271 Data Content Rule  
version 1.1.0 March 2011

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**BACKGROUND**

*This CORE rule specifies the CORE minimum requirements for using the HIPAA-adopted ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter v5010 270) to inquire about health plan insurance coverage and to respond to such an inquiry using the HIPAA-adopted ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter v5010 271). This Phase I CORE rule covers the following content in the v5010 271.*

1. *The required response to an inquiry when the individual is located in the health plan's system under the following conditions:*
  - a) *A generic v5010 270 inquiry*
  - b) *A specific inquiry for a Service Type not supported by the health plan*
  - c) *A specific inquiry for one of the CORE required service types*
2. *The mandated response components include:*
  - a) *the dates of eligibility at the health plan (contract) level for past and future dates and the dates of eligibility at the benefit level if different from the contract level*
  - b) *the patient financial responsibility for each specified benefit at the base contract amounts for both in-network and out-of-network*
  - c) *the name of the health plan when it exists in the health plan's system*

*The requirements specified in this CORE rule address certain situational elements and codes and are in addition to requirements contained in the v5010 270/271 implementation guides.*

**RULE**

**Section 1: v5010 271 Eligibility Inquiry Response<sup>1</sup>**

**Subsection 1.1: Health Plan Name**

When the individual is located in the health plan's (or information source's) system the health plan name must be returned (if one exists within the health plan's or information source's system) in EB05-1204 Plan Coverage Description. Neither the health plan nor the information source is required to obtain such a health plan name from outside its own organization.

**Subsection 1.2: Patient Financial Responsibility**

The patient financial responsibility for co-insurance, co-payment and deductibles must be returned as specified below by a CORE-certified health plan (or information source) for each of the service type codes returned.

**Subsection 1.2.1: To specify the co-insurance responsibility**

Use code "A" Co-Insurance in EB01-1390 Eligibility or Benefit Information data element and use EB08-954 Percent data element for each reported type of service.

If the patient financial responsibility amounts differ for in and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as appropriate.

The health plan (or information source) may, at its discretion, elect not to return co-insurance information for the following services specified in EB03-1365: 1 – Medical Care; 30 – Health Plan Benefit Coverage; 35 – Dental Care; 88 – Pharmacy; AL – Vision (Optometry); MH – Mental Health. This optional reporting does not preempt the health plan's (or information source's) requirement to report patient co-insurance responsibility for the remaining 7 CORE required service types (33 – Chiropractic, 47 – Hospital; 48 – Hospital Inpatient, 50 – Hospital Outpatient, 86 – Emergency Services, 98 – Professional (Physician) Visit – Office, UC – Urgent Care), that must be reported in a generic request for eligibility (Service Type Code 30) or a service type not supported by the health plan.

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<sup>1</sup> This Phase I CORE rule is not intended to be a comprehensive companion document specifying the complete content of either the v5010 270 or v5010 271 transactions. The focus on this Phase I CORE rule is on specifications for the v5010 271 to address the Phase I CORE data requirements for benefit coverage.

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**Subsection 1.2.2: To specify the co-payment responsibility**

Use code “B” Co-Payment in EB01-1390 Eligibility or Benefit Information data element and use EB07-782 Monetary Amount element for each reported type of service.

If the patient financial responsibility amounts differ for in and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as appropriate.

The health plan (or information source) may, at its discretion, elect not to return co-payment information for the following services specified in EB03-1365: 1 – Medical Care; 30 – Health Plan Benefit Coverage; 35 – Dental Care; 88 – Pharmacy; AL – Vision (Optometry); MH – Mental Health. This optional reporting does not preempt the health plan’s (or information source’s) requirement to report patient co-payment responsibility for the remaining 7 CORE required service types (33 – Chiropractic, 47 – Hospital, 48 – Hospital Inpatient, 50 – Hospital Outpatient, 86 – Emergency Services, 98 – Professional (Physician) Visit – Office, UC – Urgent Care), that must be reported in a generic request for eligibility (Service Type Code 30) or a service type not supported by the health plan.

**Subsection 1.2.3: To specify the deductible responsibility**

Use code “C” Deductible in EB01-1390 Eligibility or Benefit Information data element and use EB07-782 Monetary Amount to indicate the dollar amount of the deductible for the type of service specified in EB03-1365 service type code.

If the patient financial responsibility amounts differ for in and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as appropriate.

If the deductible amount varies by the benefit coverage level specified in EB02-1207 Coverage Level Code, place the appropriate code in EB02 and use additional occurrences of the EB Eligibility or Benefit Information segment as necessary for each benefit coverage level for each type of service, e.g. individual or family coverage.

The health plan (or information source) may, at its discretion, elect not to return deductible information for the following services specified in EB03-1365: 1 – Medical Care; 30 – Health Plan Benefit Coverage; 35 – Dental Care; 88 – Pharmacy; AL – Vision (Optometry); MH – Mental Health. This optional reporting does not preempt the health plan’s (or information source’s) requirement to report patient deductible responsibility for the remaining 7 CORE required service types (33 – Chiropractic, 47 – Hospital, 48 – Hospital Inpatient, 50 – Hospital Outpatient, 86 – Emergency Services, 98 – Professional (Physician) Visit – Office, UC – Urgent Care), that must be reported in a generic request for eligibility (Service Type Code 30) or a service type not supported by the health plan.

**Subsection 1.3: Eligibility Dates**

The v5010 270 may request a benefit coverage date 12 months in the past or up to the end of the current month. If the inquiry is outside of this date range and the health plan (or information source) does not support eligibility inquiries outside of this date range, the v5010 271 must include the AAA segment with code “62” Date of Service Not Within Allowable Inquiry Period in the AAA03-901 Reject Reason Code data element.

**Subsection 1.4: Support for CORE Required Service Types**

The health plan (or information source) must support an explicit request for each of the CORE required service types. The CORE required service type codes are: “1”, “33”, “35”, “47”, “48”, “50”, “86”, “88”, “98”, “AL”, “MH”, “UC” submitted in the v5010 270 EQ01 by providing the content identified in subsections 1.1 through 1.3 above for the submitted service type(s).

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**CONFORMANCE**

*The CORE test suite for this rule includes the following types of tests:*

1. *Receipt by a health plan or information source of a valid generic request for eligibility v5010 270 transaction created using the CORE master test bed data.*
2. *The creation of a v5010 271 transaction generated using the CORE master test bed data.*
  - a) *The CORE master test bed data will contain all of the values necessary to generate a response transaction covering each of the requirements in the following paragraphs of the v5010 271 Eligibility Inquiry Response section of this rule:*
    - i) *Subsection 1.1: health plan name*
    - ii) *Subsection 1.2: patient financial responsibility for co-insurance, co-payment, and deductible, including in-network and out-of-network*

*The CORE test suite will not include comprehensive testing requirements to test for all possible permutations of health plan benefit status or patient financial responsibility for all of the CORE required benefits addressed in the v5010 271.*

*Conformance with this rule must be demonstrated through successful completion of the approved CORE test suite for this rule with a CORE-authorized testing vendor.*