Plantilla de Explicación de beneficios de la Parte C aprobada por los CMS

PFFS, versión trimestral del resumen

# General Instructions

This is a Centers for Medicare and Medicaid Services (CMS) approved Part C Explanation of Benefits (EOB) template. CMS views Part C EOBs as ad-hoc information materials; therefore, they are not subject to CMS review and approval. However, CMS reserves the right, as with other ad-hoc communication, to request and review a sample of the materials to ensure compliance with our requirements.

* Organizations that choose to send per claim EOBs must also send this quarterly summary document to non-dual eligible members.
* Plans are not required to send an EOB to dual eligible members.
* Plans are responsible for ensuring that members receive appeal rights within the timeframes specified by CMS. If notification with   
  an EOB would hinder the plan’s ability to provide timely notification, it must be delivered separately, within the required timeframes specified in the MA program regulations.
* The quarterly EOB must be sent to members each quarter there is claims activity, whether or not there is member liability.

**HPMS submission:**

* All plans may be required to submit a Part C EOB to HPMS. CMS will provide more information when available.

Format Instructions

* Organizations that choose to send per claim EOBs may use their own format for those.
* Minor grammar or punctuation changes, as well as changes in font type or color, are permissible.
* Text and numbers must be in font size 12 or larger.
* With the exception of charts, which should generally be in landscape formation, either landscape or portrait may be used.
* With the exception of the chart that gives the details on claims, the remaining sections of the document are to be formatted as   
  two-column or three-column text (the main title of a section may extend beyond the first column) to keep line lengths easy to read.   
  Plans may adjust the width of the columns in the template.
* The document may be printed double-sided and, in lieu of a paper mailing, may be sent electronically to members who elect the paperless format.
* The document must have a header or footer that includes the page number. In addition, if desired, plans may also include any of the following information in the header or footer: member identifiers, month and year, title of the document.
* Charts that continue from one page to the next should be marked with “continue” at the bottom on the page that continues. In an actual EOB, rows of a chart should not break across the page. Note: in the template language in this document, rows sometimes break across   
  a page because of the instructions and substitution text.

Content Instructions

* CMS encourages MAOs to use the HCPCS code descriptors and American Medical Association’s CPT code descriptors, followed by the HCPCS or CPT billing code shown in parentheses. Other appropriate billing codes, such as ADA approved dental codes, Medicare revenue codes for in-patient facility claims, and other widely recognized code descriptors may also be used.
* When providing claim information, plans may use date ranges to combine multiple occurrences of a service or item into a single row.
* All claim information provided in the EOB must be HIPAA compliant to protect member health information.

Claims that must be included within the EOB:

* Plans must include all Part C claims processed during the reporting period, including all claims for Part A and Part B covered services, mandatory supplemental benefits, and optional supplemental benefits. If applicable, claims for optional supplemental benefits are to be displayed separate from medical and hospital claims. Information for all claims includes: billing codes and descriptors, amount providers have billed the plan, total cost (amount the plan has approved), plan’s share, and member’s share (your share). Any benefit information that cannot be included timely must be accounted for in a subsequent reporting period.
* For plans that need additional time to develop systems for obtaining cost information from capitated entities, we are delaying until January 1, 2015 the required implementation of reporting that information in the “Total cost” and “Plan’s share” columns of the templates. In lieu of dollar amounts in the “Total cost” and “Plan’s share” columns, plans may use the following sentence: “This rate   
  has been pre-negotiated. For more information, please contact your health care provider.”

Instructions within the template:

* All black text is required information that must be included as shown in the attached EOB template.
* Italicized blue text in square brackets is instruction and guidance specifically for MA plans. This information is not to be included in   
  the beneficiary’s EOB.
* Non-italicized blue text in square brackets is text to be inserted as applicable.
* The first time the plan name is mentioned, the plan type designation (i.e., HMO, PPO, etc.) must be included.
* When instructions say “*[insert month]*”, use a format that spells out the full name of the month, e.g., “January.”
* Plans should make every effort to use a reporting period that aligns with a complete calendar month, however, if your plan uses a reporting period that does not correspond exactly to a calendar month, you may substitute the date range for your reporting period   
  (e.g., “1/1/12 to 2/3/12” OR “January 1 – February 3, 2013”) whenever instructions say to “*[insert month] [insert year]*.”

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| --- | --- | --- |
| [[*Insert start month for reporting period*]] hasta el [[*Insert end month for reporting period*]] *[insert year]* Resumen de los  gastos de su bolsillo para reclamaciones médicas y hospitalarias  Para *[insert member name]*  *[If desired, plans may also insert a member ID number and/or other member numbers typically used in member communications.]*  **Esto no es una factura:**   * Este informe muestra los totales de las reclamaciones que hemos tramitado. Este resumen indica qué ha pagado el plan y cuánto ha pagado de su bolsillo (o puede esperar que se le facture). * Si usted tiene alguna deuda, los médicos u otros proveedores de atención médica le enviarán una factura. * Este informe cubre solo la atención médica y la hospitalaria. *[MA-only plans omit the next sentence.]* Enviamos un informe separado sobre los medicamentos con receta de la Parte D. * Si advierte algo sospechoso que podría ser una facturación fraudulenta, puede informar de ello llamando al 1-800-MEDICARE (1-800-633-4227), durante las 24 horas, los 7 días de la semana. (Los usuarios de TTY deben llamar al 1-877-486-2048).   *[Plans may include the member’s mailing address on this cover page.]* |  | [Insert plan name and/or logo]  *[Insert Federal contracting statement]*  *[Plans may insert their Web site URL]* |
|  |
| Servicios para los miembros de *[Insert plan name]*  Si tiene alguna pregunta, llámenos: *[Insert phone number]*  Estamos disponibles *[insert days and hours of operation]*.  (Solo para usuarios de TTY/TDD: *[Insert TTY/TDD number]*). *[Plans may insert other Member Services numbers, e.g., a Spanish customer service number]*  --------------------------  [*Plans that meet the 5% threshold, insert:*Esta información está disponible sin cargo en otros idiomas. Comuníquese con Servicios para los miembros al número anterior.] Servicios para los miembros de [*plans that meet the 5% threshold, insert:* también] ofrece un servicio gratuito de interpretación para las personas que no hablan inglés.  *[Plans that meet the 5% threshold, insert the disclaimer about the availability of non-English translations in all applicable languages.]* |
|  |
| La información suministrada sobre los beneficios es un resumen breve, no una descripción completa de los beneficios. Para obtener más información, póngase en contacto con el plan. *[Omit terms in the following sentence that are not applicable to the plan:]* Los beneficios, el formulario, la red de farmacias, la red de proveedores, la prima, los copagos y el coseguro pueden cambiar cada año.  *[Insert material ID]* Aceptado |

*[In the “totals” section, plans must insert the total amounts for all claims for Part A and Part B services and mandatory supplemental benefits. Amounts for claims for optional supplemental benefits should be excluded from the totals section.]*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **TOTALES**  **para reclamaciones médicas y hospitalarias** | | | Montos que los proveedores han facturado al plan | Costo total (monto que el plan ha aprobado) | **Parte del plan** | | **Su parte** |
| **Totales para este trimestre** (para las reclamaciones tramitadas desde el *[insert reporting period start date]* hasta el *[insert reporting period end date]*) | | | $*[insert total billed amount for the reporting period]* | $*[insert total approved amount for the reporting period]*  *[Plans with capitated arrangements prior to January 1, 2015 may insert:* Esta tarifa ha sido negociada previamente. Para obtener más información, comuníquese con su proveedor de atención médica.*]* | $*[insert total plan share amount for the reporting period]*  *[Plans with capitated arrangements prior to January 1, 2015 may insert:* Esta tarifa ha sido negociada previamente. Para obtener más información, comuníquese con su proveedor de atención médica.*]* | | $*[insert total member liability amount for the reporting period]* |
| **Totales para *[insert year]*** (todas las reclamaciones tramitadas hasta el *insert reporting period end date]*) | | | $*[insert total billed amount for the year]* | $*[insert total approved amount for the year]*  *[Plans with capitated arrangements prior to January 1, 2015 may insert:* Esta tarifa ha sido negociada previamente. Para obtener más información, comuníquese con su proveedor de atención médica.*]* | $*[insert total plan share amount for the year]*  *[Plans with capitated arrangements prior to January 1, 2015 may insert:* Esta tarifa ha sido negociada previamente. Para obtener más información, comuníquese con su proveedor de atención médica.*]* | | $*[insert total member liability amount for the year]* |
| *[Plans with no deductibles, omit this section.]*  **DEDUCIBLE:**  *[Plans with an overall deductible insert the text below. If the plan has both an overall deductible and service category deductible(s), insert information about both deductibles.]*  Para la mayor parte de servicios cubiertos, el plan paga la parte que le corresponde del costo después de que usted haya pagado su deducible anual del plan.  Desde el *[insert reporting period end date]* hasta el día de hoy, usted ha pagado *[insert as applicable: [insert amount member has paid toward deductible if less than the full deductible amount] [*por *OR* el monto total de*]* su deducible anual del plan de *[insert deductible amount]*.  *[Plans are permitted, but not required, to include a graphic, such as the one shown below,*  *to illustrate the member’s*  *progress toward the deductible:*  *Leyenda del gráfico de barras ($0 – $250)*  $ 0 $250  = su deducible anual del plan  *[Plans with service category deductibles, include the text below about each.]*  El plan paga la parte que le corresponde del costo de *[insert service category]* solo después de que usted haya pagado un deducible.  Desde el *[insert reporting period end date]* hasta el día de hoy, usted ha pagado *[insert as applicable: [insert amount member has paid toward deductible if less than the full deductible amount] [*por *OR* el monto total de*]* su deducible de *[insert deductible amount]* para *[insert service category]*.  *[Plans are permitted, but not required, to include a graphic, such as the one shown below, to illustrate the member’s progress toward the deductible:*  *Leyenda del gráfico de barras ($0 – $250)*  $ 0 $250  = su deducible para *[insert service category*]] |  | **LÍMITE ANUAL: este límite le proporciona protección financiera** | | | | | |
| Este límite indica el monto máximo que deberá pagar en *[insert year]* en los costos “que paga de su bolsillo” (*[Delete references to deductibles, copayments, or coinsurance if not applicable for the plan:]* copagos, coseguro y su deducible) por [*insert as applicable:* los servicios médicos y hospitalarios cubiertos por el plan *OR* los servicios cubiertos de la Parte A y la Parte B].  Este límite anual se llama su “máximo que paga de su bolsillo”. Establece un límite sobre cuánto tiene que pagar, pero no establece un límite sobre cuánta atención puede recibir.  El gasto que paga de su bolsillo por [*insert service]* no se tendrá en cuenta para el máximo anual que paga de su bolsillo.Esto significa lo siguiente:   * Una vez que haya alcanzado el límite de los costos que paga de su bolsillo, **deja de pagar de su bolsillo por todos los servicios *[insert, if applicable:*** excepto por ***[insert service]***. * Usted sigue recibiendo sus *[insert as applicable:*  servicios médicos y hospitalarios cubiertos *OR* los servicios cubiertos de la Parte A y la Parte B] como de costumbre, y **el plan pagará el costo completo durante el resto del año.** *[Insert if applicable:*  Los gastos a pagar de su bolsillo por servicios no cubiertos por Medicare no cuentan respecto a su máximo a pagar de su bolsillo.] | | | | Desde el *[insert reporting period end date]* hasta el día de hoy, **ha gastado *[insert amount paid toward MOOP as of reporting period end date]*** en costos que paga de su bolsillo que se tienen en cuenta para el máximo que paga de su bolsillo de *[insert MOOP amount]* por los servicios cubiertos.  *[Plans are permitted, but not required, to include a graphic, such as the one shown below to illustrate the member’s progress toward the MOOP:*  **Leyenda del gráfico de barras ($0 – $3,400)**  $ 0 $3,400] | |