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

MSA, 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 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. Indica qué ha pagado el plan y cuánto ha pagado usted (o puede esperar que se le facture). Use este documento para llevar un registro de lo que ha gastado “de su bolsillo” en el deducible. * 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. * 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.]* |
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| 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. Amounts for claims for optional supplemental benefits should be excluded from the totals section.]*

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| **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]* |

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| **DEPÓSITO:**  En *[insert year]*, Medicare depositó $*[insert deposit amount]* en su cuenta de ahorro para gastos médicos. Puede usar el dinero de su cuenta para pagar los costos de atención médica, incluidos los costos de atención médica que no estén cubiertos por Medicare. (Sin embargo, solo los fondos utilizados para pagar los servicios de la Parte A y la Parte B de Medicare se tendrán en cuenta para su deducible anual).  A partir del *[insert reporting period end date]*, usted tendrá *[insert MSA balance]* disponible en su cuenta de ahorro para gastos médicos  *[If the member has moved their account from the MSA trustee, replace the paragraph above with:*  Debido a que ya no utiliza a *[insert MSA trustee name]* para su cuenta de ahorro para gastos médicos, no tenemos información sobre el saldo de su cuenta. Para averiguar el saldo de su cuenta, comuníquese con el banco o la institución financiera que haya elegido]. |  | **DEDUCIBLE:**  **En *[insert year]*, su deducible del plan será de $*[insert yearly deductible amount]***. Una vez que haya pagado este monto por los servicios cubiertos por Medicare, el plan pagará el 100% de los costos por los servicios cubiertos por Medicare durante el resto del año.  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 |