CMS 승인 파트 C 혜택 설명 템플릿

PFFS, 분기별 요약 버전

# 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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| 기간: [*Insert start month for reporting period*] ~ [*Insert end month for reporting period*] *[insert year]* 의료비 및 병원비 청구에 대한  본인 부담금 지출 요약서  대상자: *[insert member name]*  *[If desired, plans may also insert a member ID number and/or other member numbers typically used in member communications.]*  **이 보고서는 청구서가 아닙니다.**   * 이 보고서는 당사에서 처리한 청구 건의 합계를 보여줍니다. 이 보고서는 플랜에서 지불한 비용과 귀하가 지불한 본인 부담금 비용(또는 청구될 것으로 예상되는 금액)에 대해 설명합니다. * 지불해야 할 금액이 있다면 담당 의사와 다른 의료 서비스 제공자가 귀하에게 청구서를 보낼 것입니다. * 이 보고서는 의료 및 병원 치료만 다룹니다. *[MA-only plans omit the next sentence.]* 당사는 파트 D 처방약에 대해 별도의 보고서를 발송합니다. * 부정 청구가 의심되는 경우 연중무휴 운영하는  1-800-MEDICARE(1-800-633-4227)로 전화를 걸어 신고하실 수 있습니다. (TTY 사용자는  1-877-486-2048로 전화해 주십시오.)   *[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]* |
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| *[Insert plan name]* 가입자 서비스  궁금하신 사항은 *[Insert phone number]*(으)로 문의해 주십시오.  도움이 필요하시면 도와드리겠습니다(*[insert days and hours of operation]*).  TTY / TDD 전용: *[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:* 본 정보는 다른 언어로 무료로 이용하실 수 있습니다. 위의 전화번호로 가입자 서비스부에 문의해 주십시오.] 가입자 서비스부는 비영어권 이용자를 위해 무료로 통역 서비스 [*plans that meet the 5% threshold, insert:*또한] 제공하고 있습니다.  *[Plans that meet the 5% threshold, insert the disclaimer about the availability of non-English translations in all applicable languages.]* |
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| 본 혜택 정보는 대략적인 내용으로서, 혜택을 설명한 상세 전문은 아닙니다. 더 자세한 정보는 플랜에 문의해주십시오. *[Omit terms in the following sentence that are not applicable to the plan:]* 혜택, 처방집, 약국 네트워크, 의료 서비스 제공자 네트워크, 보험료, 코페이 및 공동보험액은 매년 변경될 수 있습니다.  *[Insert material ID]* 허용됨 |

*[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.]*

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| **합계**  **의료비 및 병원비 청구** | 의료 제공자가  플랜에  청구한 금액 | 총 비용(플랜이 승인한 금액) | **플랜 부담금** | **가입자 부담금** |
| **이번 분기 합계**(*[insert reporting period start date]*부터 *[insert reporting period end date]*까지 처리된 청구 건) | $*[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:* 이 요율은 사전 협상되었습니다. 자세한 정보는 의료 서비스 제공자에게 문의해 주십시오.*]* | $*[insert total plan share amount for the reporting period]*  *[Plans with capitated arrangements prior to January 1, 2015 may insert:* 이 요율은 사전 협상되었습니다. 자세한 정보는 의료 서비스 제공자에게 문의해 주십시오.*]* | $*[insert total member liability amount for the reporting period]* |
| ***[insert year]*에 대한 총 금액**(*insert reporting period end date]*까지 처리된 모든 청구 건) | $*[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:* 이 요율은 사전 협상되었습니다. 자세한 정보는 의료 서비스 제공자에게 문의해 주십시오.*]* | $*[insert total plan share amount for the year]*  *[Plans with capitated arrangements prior to January 1, 2015 may insert:* 이 요율은 사전 협상되었습니다. 자세한 정보는 의료 서비스 제공자에게 문의해 주십시오.*]* | $*[insert total member liability amount for the year]* |

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| *[Plans with no deductibles, omit this section.]*  **공제액:**  *[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.]*  대부분의 보장 서비스의 경우, 플랜은 귀하가 연간 플랜 공제액을 지불한 후에만 비용의 분담액을 지급합니다.  *[insert reporting period end date]* 기준 귀하는 연간 플랜 공제액 *[insert deductible amount]* 전체에 대해 *OR [insert as applicable: [insert amount member has paid toward deductible if less than the full deductible amount] [*의 금액을*]* 지불했습니다.  *[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:*  *막대 차트 범례($0 – $250)*  $ 0 $250  = 가입자의 연간  플랜 공제액]  *[Plans with service category deductibles, include the text below about each.]*  플랜은 귀하가 공제액을 지불한 후에만 *[insert service category]*에 대한 분담액을 지급합니다.  *[insert reporting period end date]* 기준 귀하는 *[insert service category]*에 대한 공제액 *[insert deductible amount]* 전체에 대해 *[insert as applicable: [insert amount member has paid toward deductible if less than the full deductible amount] [*의 전체 금액을  *OR ]* 지불했습니다.  *[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:*  *막대 차트 범례($0 – $250)*  $ 0 $250  = 가입자의  *[insert service category*]]에 대한 공제액 |  | **연간 한도 – 이 한도로 재정적 보호가 보장됩니다.** | |
| 이 한도는 [*insert as applicable:*플랜이 보장하는 *OR*파트 A 및 파트 B 서비스가 보장하는 의료 및 병원 서비스]에 대해 귀하가 *[insert year]*에 "본인 부담금" 비용(*[Delete references to deductibles, copayments, or coinsurance if not applicable for the plan:]* 코페이, 공동보험액 및 공제액)으로 지불해야 하는 최대 금액을 알려줍니다.  이 연간 한도를 "최대 본인 부담금"이라고 합니다. 귀하가 지불해야 하는 금액에는 제한을 두지만, 얼마나 많은 치료를 받을 수 있는지에는 제한을 두지 않습니다.  [*insert service]* 에 대한 귀하의 본인 부담 비용 지출은 연간 본인 부담 비용 한도에 포함되지 않습니다. 그 의미는 다음과 같습니다.   * 본인 부담 비용 한도에 도달했으면 ***[insert, if applicable: [insert service]*을(를) 제외한 모든 서비스에 대한 본인 부담 비용의 지불이 중단됩니다.** * 귀하는 평소처럼 *[insert as applicable:* 보장되는 의료 및 병원 서비스*OR*보장되는 파트 A 및 파트 B 서비스]를 받으시게 되며 **나머지 기간에 대해서는 플랜이 전체 비용을 지불합니다**. *[Insert if applicable:* Medicare가 보장하지 않는 서비스에 대한 귀하의 본인 부담 비용 지출은 본인 부담 비용 한도에 포함되지 않습니다.] | *[insert reporting period end date]* 기준 귀하는 보장 서비스의 본인 부담 비용 한도인 *[insert MOOP amount]*에 포함되는 ***[insert amount paid toward MOOP as of reporting period end date]*의 본인 부담 비용이 있었습니다**.  *[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:*  **막대 차트 범례($0 – $3,400)**  $ 0 $3,400] |