



Understanding Insurance and Our Billing Process



Thank you for choosing
Cleveland Clinic for your
healthcare needs. We
appreciate the confidence
you have placed in us.

The purpose of this brochure is to address common questions related to insurance, billing and financial assistance for our services. Please let us know if we can answer additional questions to help make the financial side of your experience with us as easy as possible, so you can focus on your health and wellness.

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Understanding Insurance and Our Billing Process

Not sure about what your insurance covers? Having a hard time figuring out your physician and hospital bill? Cleveland Clinic's Revenue Cycle Management (RCM) team has prepared this pamphlet to answer questions you may have about insurance, billing, financial assistance and related topics.

If you need more information, we are here to help. Please call us at 216.445.6249 or toll free at 1.866.621.6385, Monday through Friday, 8 a.m.–6 p.m.

Our website also provides information on insurance and billing. See us at <http://my.clevelandclinic.org/patients-visitors/billing-insurance/default.aspx>.

Insurance

1. **When do I make a co-payment or deductible payment?**

Most insurance companies require patients to pay a portion of their doctor's visit or hospitalization costs. This is called a co-payment or a deductible, and these payments are generally made before your appointment, procedure or admission. If these payments are not made, we may have to reschedule your appointment. If you have questions when you come in for care, the patient financial advocate in that area can help.

- **Premium:** The amount a policy-holder or their employer pays for the health plan when he/she purchases health coverage.
- **Co-payment:** A fixed amount that the patient is expected to pay for their healthcare service based on the plan

provisions of their insurance carrier. “The amount of the co-payment may vary based on the visit type. The same patient may pay a \$20 co-pay to see “their primary care provider, a \$50 co-pay to see a specialist and a \$200 co-pay for an emergency room visit.

- **Deductible:** The amount a patient owes for covered healthcare services before their insurance company begins to share the costs. For example, if you have a plan with a \$2,000 deductible, your health insurance will not start paying for your covered services until you have paid the first \$2,000 in healthcare costs.

- Monthly premium costs for healthcare plans do not count toward deductibles.
- Deductibles are different for individuals vs. families – while you may have a \$2,000 individual deductible, your family deductible may be \$4,500.
- Out-of-network deductibles are generally higher than in-network deductibles and separate from them.

- **Coinsurance:** The amount a patient must pay for covered healthcare services after they have satisfied any co-payment or deductible required by their health insurance plan. Coinsurance is typically expressed as a percentage of the charge or allowable charge for a service. For example, if the insurance company covers 80% of the allowable charge for a specific service, the patient may be required to cover the remaining 20% as coinsurance.

- **Out-of-Pocket Maximum:** The maximum a patient will have to pay for covered medical expenses in a plan year. Deductibles, co-pays, and coinsurance all contribute toward the out-of-pocket maximum. After reaching the out-of-pocket maximum amount, the patient's insurance company begins to pay 100% of covered visits.

2. **I have surgery scheduled soon.**

How do I know it will be covered?

Many insurance plans require prior authorization (sometimes called pre-certification) for services such as inpatient surgery. When Cleveland Clinic schedules these services, we check with the patient's insurance company. If they do not approve the service, we notify the patient before the service takes place. Patients who decide to proceed with the service are responsible for payment.

If you are scheduled for surgery at any Cleveland Clinic inpatient or outpatient surgery location, you can also view a free online video that can help you figure out what your insurance covers, including referrals, pre-certifications and out-of-pocket costs. To access this video, please visit <http://my.clevelandclinic.org/patients-visitors/billing-insurance/default.aspx>.

3. **Why would I need to call my insurance company?**

During a discussion with your insurance company, we identified a possible discrepancy with the personal information your insurance company has such as:

- Social Security Number – may not match for the subscriber or dependent.
- Name – may be misspelled or different.

- Date of Birth – may be different for the subscriber or dependent.
- Coordination of Benefits (COB) – the order in which your insurance(s) should be billed may not match. This could cause your insurance company to refuse to pay for your visit because they believe another insurance policy that you hold has primary responsibility to pay.

4. My primary care physician wants me to see a specialist. How do I know I'll be covered?

You should check with your insurance company. Most managed care plans, health maintenance organizations (HMOs) and point of service (POS) plans require a referral from a primary care physician before they will cover a visit to a specialist. Please discuss this with your primary care physician before scheduling an appointment with a Cleveland Clinic specialist – and if a referral is required, make sure you get one. If a referral is necessary and you do not get one, your appointment with the specialist may have to be rescheduled, or you may be responsible for paying for the visit.

5. How would I be covered if I'm placed under *observation status*?

When your physician places you under observation status, this means our clinical staff will closely monitor you for the next several hours. Your observation period will be used to determine if you can be sent home or need to be admitted as a hospital inpatient. Observation status includes medically reasonable and necessary services such as ongoing short term treatments, assessments and monitoring, tests and certain procedures. Observation status

for 24–48 hours is generally covered by healthcare plans. If it extends beyond that, you may be financially liable for the additional care. Insurance companies require that we bill all observation status care as outpatient services. If you have questions about how your healthcare plan treats observation services and whether these are covered as outpatient care, please contact your insurance company.

If you are a Medicare subscriber, observation status is not considered a hospitalization and does not affect your Medicare Part A benefits. No hospital days are used, and the Part A deductible is not required. This also means that observation status does not count toward the three-day qualifying stay requirement for admission to a skilled nursing facility.

Observation status is covered by Medicare Part B. There is an annual deductible and co-pay for these services. In addition, you should know that while you are in the hospital during an outpatient observation period, Medicare does not pay for “self-administered drugs” such as oral medications, eye drops, creams, ear drops, ointments, inhalers, suppositories, and insulin – even if a nurse administers them to you. Self-administered drugs could possibly be covered by your prescription plan, contact them to find out what might be covered and how to submit a claim. If you have questions about observations status services covered by Medicare, please call 1.800.MEDICARE (1.800.633.4227).

6. I don't have health insurance. What are my options?

Please call Customer Service at 216.445.6249 or toll free at

1.866.621.6385, and we will be glad to tell you about financial assistance programs available through the government and Cleveland Clinic and how to apply for them.

A summary of the Cleveland Clinic financial assistance policy and the application for financial assistance can be found at www.ccf.org/financialassistance.

For more information, please view our free online video at <http://my.clevelandclinic.org/patients-visitors/billing-insurance/financial-assistance.aspx>.

7. Do I have any options if I recently lost my job?

If you are unemployed and no longer covered by insurance, you may be eligible for COBRA, an insurance program established by the federal government to provide out of work individuals with temporary healthcare benefits. If you cannot make the monthly payments, you may be eligible for a program where Cleveland Clinic pays COBRA on your behalf for a specific course of treatment and period of time. If you do not qualify, you will be evaluated for other assistance programs.

For more information, please view our free online video at <http://my.clevelandclinic.org/patients-visitors/billing-insurance/financial-assistance.aspx>.

8. What is an Advance Beneficiary Notice?

An Advance Beneficiary Notice (ABN) is a form for you to sign that lets you know beforehand that you may have to pay for a test your doctor has ordered. By law, Medicare will only pay for services that are determined to be “reasonable and necessary.” Cleveland Clinic believes that doctors are in the best position to know what their patients need. However, in

some cases, Medicare will not pay for tests even though the doctor believes they are necessary. If Medicare does not pay for these services, then you will be responsible for the balance.

9. Why do you want me to sign an ABN?

Although Medicare pays for most lab tests and x-rays, it won't pay for some tests under certain circumstances. When that happens, Cleveland Clinic must ask the patient to pay for these services.

The reason you are being asked to sign an ABN now is that we believe, based on the information we received from your doctor, that Medicare will deny payment for your test. Medicare requires that we notify you in writing whenever it is likely that you will have to pay the bill.

10. Why do you think Medicare will not pay for this test?

Medicare only pays for tests that it considers to be "medically necessary." Most tests are medically necessary only under certain circumstances, depending on the patient's diagnosis. For instance, Medicare doesn't pay for physicals. Some tests have limits on how often they can be performed, and Medicare will only pay for a certain number of tests over a specific period of time. To find out if your test or service is covered you can go to <http://www.medicare.gov/coverage/your-medicare-coverage.html>.

If you have questions, feel free to discuss this with your physician or patient financial advocate.

Billing

1. Will I receive one bill – or separate bills – for the care I receive at Cleveland Clinic?

When you receive care at any of our Cleveland Clinic inpatient or outpatient facilities, you will receive one billing statement for all Cleveland Clinic physician and hospital services. This same bill will include charges for medical or technical services, supplies and equipment as well as physician and clinical professionals, treatment and procedures. The statement will show any co-payments or deductible payments you made.

One exception: If you receive care from an independent physician who is affiliated with Cleveland Clinic but not part of our group practice, you will receive a separate bill for these services along with contact information for their billing department.

2. How do I make a payment?

You have several options at myaccount.clevelandclinic.org

- Cash, check or money order
- All major credit cards
- Electronic checks
- Zero interest payment options

3. Can I pay my bill online?

Yes. You can sign up for MyAccount to receive your billing statement electronically and pay online.

- Enroll at myaccount.clevelandclinic.org
- Choose: Enroll
- Complete: Demographic screens

4. What can I do to ensure a smooth billing process?

We encourage you to take these steps:

- Bring your most recent insurance cards and picture ID to your health visit.
- When making an appointment and arriving for your health visit, make sure we have your correct address.
- Check your insurance plan to find out what is and isn't covered. If you have questions, please contact your insurance company before your health visit.
- Confirm with your insurance company that Cleveland Clinic health system is a contracted provider of services for your plan.
- If your insurance company requires a co-payment or deductible payment for your health visit, be prepared to pay. Services may be postponed if a payment isn't made.

5. On my bill, why did I get charged a facility charge when I was seen in a doctor's office?

Since 2009, Cleveland Clinic's physician offices and outpatient clinics have been considered hospital outpatient departments (also called provider-based) by Medicare. This means you will see a facility and/or treatment room charge under the Hospital Services section of your billing statement.

6. Why am I being charged twice for the same service?

There will always be two types of charges for one date of service at Cleveland Clinic:

- The Physician/Professional charges are the "who did what" charges. This would

be charges for the healthcare professional who performed the services.

- The Hospital/Technical charges are the “where and what happened” charges. This includes the actual procedure, room, supplies and equipment.

7. What does “provider-based” mean?

Provider-based is a Medicare classification. It means that hospitals have met specific Medicare regulations to have their outpatient doctors’ offices and clinics classified as provider-based. Most large hospital systems are classified as provider-based by Medicare, which results in consistent billing.

8. Does provider-based billing apply to me if I am not covered by Medicare?

Yes. Provider-based billing applies to all patients, not just to those covered by Medicare.

9. How does provider-based billing affect me if I have Medicare?

The hospital services, physician and clinical professional services will be charged to Medicare. If you have **secondary or supplemental insurance**, we will submit any balance to that insurance plan. If your secondary insurance does not cover the balance, or if you do not have secondary or supplemental insurance, the balance will be billed to you.

10. I am covered by Medicare but don’t have supplemental insurance. How can I find out what my Part A and Part B charges will be?

Medicare requires that we give you an **estimate** of your Part A and Part B charges if you do not have secondary insurance. These amounts may be different, depending on the services you receive.

You can get an additional estimate by calling Customer Service at 216.445.6249 or toll free at 1.866.621.6385 or by seeing one of our patient financial advocates.

11. How does provider-based billing affect me if I am not covered by Medicare?

The way your insurance company handles provider-based charges may be different from Medicare. Some insurance companies may apply these charges to your annual deductible. To find out what will be covered, contact your insurance company.

12. If I am unable to make full payment immediately, can I set up a payment plan?

Yes, please contact Customer Service at 216.445.6249 or toll free at 1.866.621.6385 to establish a payment plan or to learn about zero interest payment options.

Please be aware that patients who don't qualify for financial assistance are responsible for account balances, and payment is due upon receipt of the bill. Cleveland Clinic employs third-party collection agencies to help us resolve unpaid balances. If you are unable to pay your bill, you may be eligible for financial assistance.

13. I was given an estimated cost of services and I made the required deposit for half that amount. How will that be handled once the actual bill is determined?

You will receive a statement for the remaining balance. Payment is due upon receipt. If the deposit turns out to be more than your final bill, you will be refunded once the insurance balance has been settled. If there was no insurance involved, we will refund your money once all charges have been totaled.

Remember this is just an estimate. If additional services are provided, there may be an additional cost to you.

14. Whom should I contact with questions about my billing statement?

If you have questions, need to update your insurance information, or would like an itemized statement, please call Customer Service at 216.445.6249 or toll free at 1.866.621.6385.

Financial Assistance

1. Is financial assistance available?

Yes. The Cleveland Clinic health system has a generous financial assistance program that provides assistance for emergency and other medically necessary care to patients **without insurance** whose incomes do not exceed 400% of the federal poverty guidelines (FPG), and who meet certain other requirements:

- At Ohio facilities, must be a resident of Ohio.
- At Florida facilities, must be a resident of Broward County and be seeking emergency care services inside the hospital.
- At Nevada facilities, must be a resident of Nevada.

The Cleveland Clinic financial assistance program will not provide assistance for expenses for your physician (including but not limited to your personal physician, the radiologist, pathologist, anesthesiologist and emergency room physician) if you are seen at any one of our regional hospitals (Akron General, Avon, Euclid, Fairview, Hillcrest, Lutheran, Marymount, Medina or South Pointe).

2. **How does financial assistance work?**

You may qualify for assistance with all or part of your bill under the Cleveland Clinic financial assistance program, the Ohio Hospital Care Assurance Program (HCAP) or Medicaid.

Please contact a patient financial advocate for more information to see if you qualify for any of these programs.

A patient financial advocate will ask you a few questions to see if you meet the initial requirements. If you do, you will be referred to one of our Medicaid representatives. They will work with you and the state to secure Medicaid coverage.

Important point: Until patients are approved for Medicaid or are determined to qualify for financial assistance at 100% coverage, they will continue to receive billing statements from Cleveland Clinic.

Please be aware that Cleveland Clinic does not contract with most out-of-state Medicaid plans. Patients covered by Medicaid in other states will need to seek medical services within their home states.

3. **How do I apply for financial assistance?**

To get a financial assistance application and more information, Ohio and Nevada patients can call 216.445.6249 or 1.866.621.6385 or visit <http://my.clevelandclinic.org/patients-visitors/billing-insurance/financial-assistance.aspx>.

Florida patients can call 954.689.5166. If you apply, you will receive a letter explaining if you qualify for financial assistance and the level of coverage that will be provided.

You may also obtain a copy of our policy and the financial assistance application form

in our emergency departments or in any of our patient financial advocates or cashier's offices.

Our patient financial advocates, located at any of our locations, are available by phone or in person to walk you through the process.

4. If I qualify for financial assistance, will I need to re-apply at some point?

Yes. You will be asked to reapply for every inpatient service and every 90 days for outpatient services. You will also be required to reapply if your family income changes. If you qualify for less than 100% financial assistance coverage, you will be asked to pay 50% of the estimated patient balance for both inpatient or outpatient services prior to scheduling and to make arrangements for payment of remaining balances after services are provided.

5. Can I receive financial assistance if my income is too high?

A patient may qualify for financial assistance in exceptional situations, even if their annual family income is greater than 400% of the federal poverty guidelines (FPG). The patient must provide information to support the exceptional medical circumstances and will be considered on a case-by-case basis for assistance regardless of income status if 100% of incurred charges of the total annual medical expenses are greater than 15% of their annual family income.

6. I have a child with special healthcare needs. Are there financial assistance programs that can help?

The Bureau for Children with Medical Handicaps (BCMh) is a healthcare program offered by the Ohio Department of Health (ODH). BCMh links families of children with special healthcare needs to a network of quality providers and helps families obtain payment for the services their children need. These needs can include care for medical conditions that require ongoing treatments, such as diabetes, heart defects, chronic lung disease, cancer and hearing loss. BCMh may pay for some services that are not covered by insurance and/or Medicaid.

If your child needs special support and services through BCMh, our patient financial advocates and social workers will refer you to our BCMh representative who will work with you to establish eligibility for BCMh coverage. If your child is not eligible for BCMh, your family may be eligible for other financial assistance.

Special Topics

1. I am an international visitor to the United States. Are there special services for patients like me?

Yes. Global Patient Services (GPS) offers a wide range of support services for international patients and their families. GPS has a full-time, multi-lingual staff who can help facilitate all financial aspects of an international patient's visit, including insurance verification and pre-payment arrangements for patients who will be paying their charges themselves.

GPS can also help with scheduling medical appointments, airline and hotel arrangements and ground transportation, as well as activities for family members assisting the patient. For more information, please contact Global Patient Services in Cleveland at 216.444.6404 or send an email to gpsappointments@ccf.org. In Florida, call 954.659.5080.

2. I don't speak English. Can I get an interpreter?

Yes. Our Global Patient Services (GPS) area provides interpreters to assist with communication in many languages. To arrange for these services, please contact GPS in Ohio at 216.444.6404 or send an email to gpsappointments@ccf.org. In Florida, call 954.659.5080. The registration staff also can assist in obtaining interpreter support.

3. Does Cleveland Clinic offer any educational courses to help patients or family members understand insurance and billing?

Yes – we offer several online educational videos. Here are some of the topics:

- **Healthcare Resources for the Unemployed or Uninsured**

This nine part video series discusses healthcare options for people who have lost jobs or health insurance at <http://my.clevelandclinic.org/patients-visitors/billing-insurance/financial-assistance.aspx>

- **Billing and Insurance Basics**

provides details about the billing and insurance process at <http://my.clevelandclinic.org/patients-visitors/billing-insurance/billing-checklist.aspx>

- **Be Financially Prepared**
guides you through the payment process before your visit at <http://my.clevelandclinic.org/patients-visitors/billing-insurance/default.aspx#>
- **Need Help Understanding Your Bill?**
Example bill with explanations of each line item at <http://my.clevelandclinic.org/Documents/Patients/understanding-your-bill.pdf>

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ATTENTION: Language assistance services, free of charge, are available to you. Call 1.833. 858.1813..

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.833. 858.1813.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1.833. 858.1813.

Chinese Languages (Mandarin & Cantonese):
注意：如果您使用繁體中文，
您可以免費獲得語言援助服務。請致電
1.833.858.1813.

Additional Questions

If you have questions about any of the information in this brochure, your bill or financial assistance, please contact Customer Service. We will be happy to assist you.

Customer Service

216.445.6249 | 866.621.6385

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