Cleveland Clinic

Your financial journey with Cleveland Clinic

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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Preparing for your visit

To help ensure a smooth billing process, we encourage you to take these steps before your Cleveland Clinic visit.

- Confirm that your insurance is accepted at Cleveland Clinic.
- Check your insurance plan to find out what is and isn't covered.
- Confirm the copay amount for your visit, as well as your deductible, coinsurance and out-of-pocket maximum, if applicable.
- Update your coordination of benefits with your insurance plan.
- If you do not have insurance, review our financial assistance options at https://my.clevelandclinic.org/patients/accepted-insurance

How can I find out if my insurance is accepted at Cleveland Clinic?

- Look for your insurance plan on our Accepted Insurance list at https://my.clevelandclinic.org/patients/billing-finance/financial-assistance
- Ask a scheduler if your insurance is accepted when you call to schedule your visit or procedure.
- Call your insurance company to find out if it has a contract with Cleveland Clinic.

How do I find out if services will be covered by my insurance?

- Call your insurance plan to find out what is and isn't covered.
- If your service requires prior authorization, Cleveland Clinic will work with your insurance company to initiate the authorization.
- If your insurance company does not approve the service, we will notify you.

If you choose to proceed with the service, you will be required to make a deposit and payment arrangements for charges not paid by your insurance.

How do my deductible, coinsurance, copay and out-of-pocket maximum work together?

- If your plan has a deductible, you are responsible for 100% of your medical costs until your deductible is met.
- Anything you pay out of pocket counts toward your deductible. (Note that monthly premiums do not count toward your deductible.)
- Once you have reached your deductible, your insurance plan begins to pay for some of the costs. The amount you pay is your coinsurance, if applicable.
- Once you have reached your out-of-pocket maximum, your insurance plan pays for 100% of your medical costs. You may still have to pay copays after reaching your out-of-pocket maximum.

Should I expect to receive an estimate?

If you have an accepted insurance plan, you will receive an estimate for surgeries and diagnostics, like CT scans and MRIs, at the time of scheduling. You can also request an estimate from a patient financial advocate. Call 855.831.1284 or visit clevelandclinic.org/pfacallback.

If you do not have coverage, or your coverage is not accepted at Cleveland Clinic, you will receive an estimate for all services.

You can produce your own estimate for certain services through MyChart or through our self-service estimate tool at clevelandclinic.org/costestimate.

How can I get help understanding if I'm eligible for Medicaid?

Cleveland Clinic partners with Medicaid Eligibility Vendors (MEV) to assist patients in getting help to pay for their care. Medicaid Eligibility Vendors that we partner with are listed at clevelandclinic.org/financialassistance. If a vendor representative contacts you, please reply. To be considered for financial assistance at our facilities, you are required to cooperate with our Medicaid screening process. When one of these vendors attempts to contact you, respond to calls, letters or text messages promptly. Cooperation and completion of the screening is mandatory. If you do not fully cooperate, you will receive a bill from Cleveland Clinic for services provided.

MEV screening is a service offered free of charge. MEV is not a collection agency or a bill collector. The staff can help you find out if you qualify for help. Then they'll walk you through enrolling in government or other benefits programs that offer:

- Help paying for medical expenses
- Help with your bills while you're on disability
- Resources for transportation, food and housing in your community

What are my options for financial assistance?

If you do not have insurance, you may qualify for financial assistance. Even if you have insurance, financial assistance may be available under certain circumstances. If your employment status has changed, you may qualify for our COBRA assistance program.

Our patient financial advocates and customer service staff can tell you about our financial assistance programs and how to apply.

A summary of the Cleveland Clinic financial assistance policy and application can be found at clevelandclinic.org/billing. These are only applicable to their intended location and do not apply to all Cleveland Clinic facilities.

Medicaid Screening and Other Assistance Programs

Uninsured patients seeking care may be contacted by a representative for screening to determine whether they may qualify for Medicaid or other government assistance programs. Uninsured patients must cooperate with the screening process before determining the patient's eligibility for financial assistance under this policy. In certain circumstances, Cleveland Clinic may determine eligibility for financial assistance under this policy before screening.

What is Cleveland Clinic MyChart?

MyChart is our secure, online tool that connects you to your electronic medical record, allowing you to:

- Schedule, request and cancel clinical and financial appointments
- Securely message your provider's office
- Keep track of your test results and medications
- Complete your registration prior to your appointment, including insurance updates and document signatures
- Pay your copay and bill

New features are added regularly. Visit clevelandclinic.org/mychart to learn more and to sign up.

DEFINITIONS

Coinsurance: the amount a patient must pay for covered healthcare services after they have satisfied the deductible required by their health insurance plan. Coinsurance is typically in the form of a percentage.

Coordination of Benefits: The process of determining which of two or more insurance policies will have the primary responsibility of paying a medical claim.

Copay: a fixed amount that the patient is expected to pay at the time of service for their care based on their benefit plan. The amount of the copayment may vary based on the visit type.

Deductible: the amount a patient owes for covered healthcare services before their insurance company begins to share the costs. Deductibles are different for individuals vs. families. Out-of-network deductibles are generally separate and higher than in-network deductibles.

In Network Insurance: insurance coverage that is contracted with Cleveland Clinic. Also known as accepted insurance or contracted insurance.

Out-of-Network Insurance: Insurance coverage that is not contracted with Cleveland Clinic. Also known as non-accepted insurance, non-contracted insurance.

Out-of-Pocket Maximum: The most a patient will have to pay for medical expenses in a plan year. Deductibles, copays and coinsurance all contribute to the out-of-pocket maximum.

Premium: The amount policy-holders or their employers pay for insurance coverage when they purchase health coverage. Monthly premium costs do not count toward deductibles.

What to expect during your visit

Please bring the following items with you when you arrive for every visit at Cleveland Clinic:

- Your most recent insurance card(s)
- Photo identification
- Payment for your copay, deductible estimate or outstanding balance, if applicable

What will I owe at the time of my visit?

Copays are due at time of service, per your insurance plan. If an estimate was provided to you before your visit, a portion of that amount may be requested at the time of service. If you have any outstanding balances, you may be asked to pay your balance or make payment arrangements.

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

Check with your insurance company. Many plans require a referral from a primary care physician before they will cover a visit to a specialist.

What should I expect if I am placed in observation status?

Insurance companies require that Cleveland Clinic bill all observation status care as outpatient services. This means that your outpatient benefits will apply and your copay, coinsurance and/or deductible may apply to these services. You will be notified when you are placed in observation status. If you have questions about how your insurance plan treats observation services, please contact your insurance company.

DEFINITIONS

Observation Status: In observation, clinical staff closely monitors a patient for several hours or days. Based on clinical criteria, observation status is considered an outpatient service and falls under outpatient benefits.

Primary Care Provider (PCP): A health care professional who is responsible for monitoring a patient's overall health care needs.

Specialist: a physician who is focuses on a specialized area of healthcare, such as cardiology, ophthalmology, obstetrics and more.

After you receive care

When will I receive a bill?

If your insurance determines that you are financially responsible for a portion of services, based on your deductible and coinsurance, you will receive a Cleveland Clinic billing statement. You will receive a billing statement only after your services have been processed by your insurance company.

Will I receive one bill for all services provided at Cleveland Clinic?

Nearly all Cleveland Clinic sites are on a single billing statement. However, there are services that continue to bill separately, such as some physicians who practice at our community hospitals and some radiology, anesthesiology and laboratory services.

If you were transported to the hospital by ambulance or helicopter, you may receive a separate bill from the medical transport company.

You may also receive an explanation of benefits (EOB) from your insurance company informing you of claims submitted, how much is being covered by the insurance company, and how much you will owe.

Why are there two charges for the same service listed on my bill?

One charge is for the professional services provided by your physician. The other charge is the facility fee, which is for the use of the room, supplies and equipment.

How do I make a payment?

- You will receive your statement and can pay your bill through MyChart. You have the opportunity to store your credit card or other payment mechanisms for your convenience.
- You can pay in person at any of our check-in desks or with our patient financial advocates.

- You can pay by phone at 216.445.6249 or toll free at 866.621.6385.
- Pay by mail using the detachable portion of your billing statement.

Learn about electronic payment options at clevelandclinic.org/paymentoptions

What forms of payment do you accept?

- Cash, check or money order
- All major credit cards
- Wire transfer
- Electronic checks
- Health Savings Account (HSA)

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 866.621.6385 to learn more about zero interest payment options.

What if I have questions about my bill?

If you have a question about a charge on your billing statement or you would like an itemized statement, call 216.445.6249 or toll free at 866.621.6385.

You can also send written correspondence to:

Cleveland Clinic Customer Service
9500 Euclid Ave., RK2-4
Cleveland, OH 44195

Follow a visual guide to understanding your billing statement at clevelandclinic.org/billing.

What are my rights against surprise medical bills?

When you receive emergency care at an out-of-network facility or are treated by an out-of-network provider at an in-network hospital, you are protected from surprise billing.

To learn more about your rights against surprise billing, visit clevelandclinic.org/billing.

DEFINITIONS

Explanation of Benefits (EOB): the insurance company's written explanation of a claim, showing what they paid and what the patient must pay.

Good Faith Estimate: a calculation of your expected financial liability based on known information at the time of estimate creation. The final financial liability may vary from the good faith estimate when additional and/or unexpected treatment or services are required.

Physician/Professional Charges: charges for the healthcare professional who performed the services.

Technical/Hospital Charges: charges for the procedure, room, supplies and equipment.

Surprise Billing: an unexpected balance bill, which can happen when you can't control who is involved in your care — such as when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Medicare information

For more detailed information, please visit the Medicare website at medicare.gov or call 1.800.633-4227 (1.800.MEDICARE).

What is a Medicare Wellness Visit?

If you've had Medicare Part B for longer than 12 months, you can have an annual wellness visit once every 12 months.

You and your provider will complete a health risk assessment and develop a personalized prevention plan to help you stay healthy. You pay nothing for this visit. Your Part B deductible may apply if your doctor performs tests or services during this visit.

To understand the limitations of a free Medicare wellness visit, please visit medicare.gov.

How will I be covered if I am placed under observation status as a Medicare patient?

You will be provided a document summarizing your observation status. 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.

Part B covers observation status, and the annual deductible and copay apply.

Medicare does not pay for self-administered drugs while you are in observation status. These will be billed to you.

Why am I being asked to sign an advance beneficiary notice (ABN)?

Sometimes, Medicare will not pay for tests even if your doctor believes they are medically necessary. When that happens, Cleveland Clinic must ask the patient to pay for these services. Signing the ABN is an acknowledgment of Medicare's possible non-coverage and your financial responsibility. For more information, visit medicare.gov/coverage.

DEFINITIONS

Advance Beneficiary Notice (ABN): a notice a provider gives a patient before receiving a service if, based on Medicare coverage rules, the provider has reason to believe Medicare will not pay for the service. The notice includes the estimated cost to the patient.

Observation Status: In observation, clinical staff will closely monitor a patient for several hours or days. Based on clinical criteria, observation status is considered an outpatient service and falls under outpatient benefits.

Self-Administered Drugs: medications that you would normally take on your own, such as medications that you take every day to control blood pressure or diabetes.

Contact information

Appointment Scheduling

Ohio: 866.320.4573

Florida: 877.463.2010

Nevada: 702.483.6000

Patient Financial Advocate

Ohio/Nevada: 855.831.1284

Florida: 954.689.5610 Option 2

Schedule a phone call with a Patient Financial Advocate at clevelandclinic.org/pfacallback

Customer Service

216.445.6249 or toll free at 866.621.6385

Schedule a phone call with a customer service representative at clevelandclinic.org/billing

Visit clevelandclinic.org/billing for more information on billing and financial assistance or to communicate with us via chat.

Cleveland Clinic

25-FIN-6000158
PWO 11307 Rev. 7/25