Understanding Medical Insurance

THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

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Health care is complicated, and so is insurance. It is easy to get overwhelmed when learning about your insurance coverage.

Use this workbook as a guide when asking your insurance company questions. This will help you know what costs to expect before a doctor's appointment so you can spend more time focusing on your care.

First Step

Call your insurance company and ask if you have access to health care services at MD Anderson. All patients are responsible for paying their medical bills for the services they receive at MD Anderson.

The insurance company may ask for a Tax ID or NPI number:

- The University of Texas MD Anderson Cancer Center: Tax ID 74-6001118, NPI 1174582050
- Physicians Referral Service: Tax ID 76-0273984, NPI 1073574810

It is helpful to write down as much information as possible when speaking to your insurance company. Always write down:

- Date and time of call _____
- Name of the insurance agent _____
- Call reference number _____
- Reason for the call _____

Understanding Your Insurance Plan

What type of insurance plan do I have? _____

Is MD Anderson Cancer Center considered in-network for my health plan? ☐ yes ☐ no

If MD Anderson is an In-Network Provider

Does my insurance plan cover physician services? ☐ yes ☐ no

Does my insurance plan cover inpatient and outpatient hospital services? ☐ yes ☐ no

Does my insurance plan cover prescription medications and chemotherapy infusions? ☐ yes ☐ no

What percentage of my bill does my insurance cover?

- Insurance percent: _____

What percentage am I required to pay?

- My percent obligation: _____

What, if any, is my co-payment amount? _____

What, if any, is my co-insurance amount? _____

What, if any, is my deductible amount? _____

Have I met my out-of-pocket requirements? ☐ yes ☐ no

If yes, date out-of-pocket met: _____

How much out-of-pocket requirement is remaining for my benefit year? _____

If MD Anderson is Out-of-Network

Does my plan offer access to The University of Texas MD Anderson Cancer Center? ☐ yes ☐ no

What is my out-of-pocket maximum? _____

What is my deductible at an out-of-network provider?

_____

Does my plan have out-of-network benefits? ☐ yes ☐ no

If my plan has out-of-network benefits and I choose to go out-of-network to receive services at The University of Texas MD Anderson Cancer Center, what percentage of my bill will be paid by:

- My insurance: _____
- My payment obligation: _____

Additional Questions

Does my insurance plan offer any additional coverage through special networks for treating medical conditions such as cancer? ☐ yes ☐ no

Does my policy have an out-of-pocket maximum? ☐ yes ☐ no

- If yes, ask: If my out-of-pocket expenses reach the maximum, will the insurance reimburse at 100%? ☐ yes ☐ no
- If yes, does that mean that my claims will then be paid in full, or will I still be responsible for the difference? ☐ yes ☐ no

Before I see a doctor at The University of Texas MD Anderson Cancer Center, do I need a referral from my primary care physician? ☐ yes ☐ no

Will I need an authorization from my insurance prior to the service? ☐ yes ☐ no

If You Have Medicare

When you turn 65, you are eligible for Medicare. Medicare is the federal health insurance program for people aged 65 or older and certain younger people with disabilities. Get detailed information on Medicare's website Medicare.gov or call 1-800-633-4227 to learn more.

Costs of Services

Cancer care may involve hospital stays, doctor visits and procedures. Costs will vary depending on the coverage you choose, and the services provided. Talk to someone at Medicare to understand coverage options:

- What Medicare may pay
- What you will pay
- Options for a supplemental plan or Medigap plan as a secondary insurance to Medicare

Types of Medicare

Medicare Part A, or **Hospital Insurance**, covers hospital stays, hospice care, skilled nursing facilities and some home health care. This is often called original or traditional Medicare.

Medicare Part B, or **Medical Insurance**, covers doctor visits, preventive care and screening, and medical supplies. This is also referred to as original or traditional Medicare.

Medicare Parts A and B are both accepted at MD Anderson.

Medicare Part C, or **Medicare Advantage**, is a Medicare-approved plan from a private company. This option is different from original Medicare Part A and Part B. An Advantage plan often "bundles" services that include Medicare Part A, Part B and usually Part D for prescription medicines.

- In many cases, you can only use doctors and other providers who are in the plan's network and service area for routine care. Some plans offer non-emergency coverage out of network, but typically at a higher cost.
- You may need to get approval from your Advantage plan before it will cover certain medicines or services.
- Plans often have different out-of-pocket costs than original Medicare.

Learn more about **Medicare Part C, Advantage Plans** accepted at MD Anderson at MDAnderson.org/InsuranceAndBilling.

Medicare Part D, or **Prescription Medicine** coverage, is offered to anyone with Medicare. It is an optional program that you can choose to join or not. If you don't select a Medicare Part D plan when you first join Medicare, you will need to pay a late enrollment fee.

Before you decide to enroll with a Medicare Advantage plan or any type of health care insurance, be sure to check that MD Anderson is a **contracted, in-network, participating provider** when you are selecting your insurance coverage.

Screening or Diagnostic Exams

Before any type of screening exam, call your insurance company to ask about your benefits for preventive medicine visits. Ask about benefits and costs if the screening becomes diagnostic during the exam, meaning the doctor determines a need for additional treatment like a biopsy or removal of suspicious moles, patches or spots.

- If your screening detects a potential finding, your doctor may order a diagnostic test or ultrasound.
- Based on your health benefit plan and the type of facility, the biopsy, removal or treatment may result in out-of-pocket costs related to your copay, deductible and coinsurance.

Before and during the screening exam, ask questions. Talk to your doctor and ask them to explain the type of exam they recommend and what it entails.

- Remember you can always ask to speak with someone about charges or additional expenses **before** additional testing or procedures are performed.

- You also can call your insurance company directly if you have questions about your benefits and to review details of your coverage, once you know more about the exam.

Mammograms

If your screening mammogram detects a potential finding, your doctor may order a diagnostic mammogram or ultrasound.

- Based on your health benefit plan and the type of facility, a diagnostic mammogram, ultrasound and MRI may result in out-of-pocket balances related to your deductible and coinsurance. Insurance companies **do not** consider ultrasounds and MRIs to be services used in screening exams.

Colonoscopy or Endoscopy

The exam may become a diagnostic colonoscopy if the doctor finds a sign or symptom of colon cancer during the screening, or if you have a history of cancer or polyps.

- Diagnostic colonoscopies are not covered as preventive care. Based on your health benefit plan and the type of facility, you may have to pay out-of-pocket costs related to your copay, deductible and coinsurance.

- If you need to have both the upper and lower GI tract examined, an EGD (esophagogastroduodenoscopy) may be performed. Insurance classifies EGDs as diagnostic care. You may have to pay extra out-of-pocket costs related to your copay, deductible and coinsurance.
- Regardless of screening type, your doctor will send the polyps to a pathologist to be tested to determine if they are cancerous or precancerous. This testing is subject to your policy benefits. This means you may have to pay copays, deductibles and co-insurance.
- Colonoscopies require anesthesia, which is subject to plan benefits.

Skin Cancer Screenings

The initial estimate for your skin screening only includes the skin screening office visit evaluation.

Diagnostic Imaging

If you are having diagnostic imaging, such as X-rays, MRI, CT, PET CT, ultrasound or bone density testing you also need to ask about your benefits for diagnostic imaging visits.

- Diagnostic imaging **is not considered preventive care**. Based on your health benefit plan and the type of facility, you may have to pay out-of-pocket costs related to your copay, deductible and coinsurance.
- Diagnostic testing requires anesthesia, which is subject to plan benefits.

Service Coding

Coding is based on the clinical documentation for the services provided. MD Anderson cannot change the CPT code or diagnosis for the purpose of insurance reimbursement or coverage determination. Your final bill will include charges for the services documented and received.

Charges for Facilities and Physicians

MD Anderson is one organization with many locations. This allows you to get the cancer care you need, at a location convenient for you. Outpatient services are provided at all locations. At the Texas Medical Center Campus, both inpatient and outpatient services are provided.

For billing purposes, MD Anderson facilities are called **provider-based locations**. Another term is **hospital outpatient clinic**.

Based on your insurance plan benefits, your insurance company may process separate claims with coinsurance and deductible amounts for doctors and for hospital services (also called facility resources) provided at MD Anderson locations.

This means you may receive two bills for each service received:

- One for the doctor's services
- Another for the hospital or facility resources

Contact your insurance company directly if you have questions about your benefits.

Good Faith Estimates

Uninsured or self-pay patients can get an estimate for the total expected costs of any non-emergency services. This includes related costs like medical tests, prescription medicines, equipment and hospital fees. This is called a Good Faith Estimate. It is a right protected by the federal No Surprises Act.

Uninsured or self-pay individuals must receive the estimate in writing for scheduled medical services. A staff member will give you charge estimates for the evaluation and any treatment plans created by your doctor. They will also answer any financial questions you may have. Be sure to get financial counseling before your medical services.

Insured patients may choose to receive care from non-contracted, out-of-network providers. When insured patients are covered by non-contracted, out-of-network insurance plans, receiving non-emergency services and paying for their own care, they are entitled to receive an estimate.

To inquire about a Good Faith Estimate at MD Anderson, send the Financial Clearance Center a message in MyChart or call them at 713-745-9998 or 1-844-331-9998.

Self-Service Estimate

You can use MyChart.MDAnderson.org or the MyChart mobile app to create your own service estimates for more than 400 common services. If you are a self-pay patient, you may create a service estimate to better understand your financial responsibility.

Service estimate information is based on past charges for the service. The estimate may not include all professional fees or additional tests needed for your care. Your final bill will include charges for the actual services you receive. Charge information is based on current data and is only an estimate of charges for the service and is subject to change without notice.

Contact your insurance company to review details of your coverage. This may help you better understand which charges will be your responsibility to pay.

Guests who are not MD Anderson patients can create an estimate for comparison use by going to MyChart.MDAnderson.org/MyChart/GuestEstimates.

Patient Financial Assistance

Patient financial assistance is available for self-pay balances for uninsured patients and for patients who have a balance after an insurance claim. If you cannot afford the cost of your care and are a Texas resident, you may request a Patient Financial Assistance application from your patient access representative or financial specialists. Eligibility for patient financial assistance is based on the Federal Poverty Index.

Payment Plans

If you are a United States resident, not eligible for Patient Financial Assistance, and unable to pay 100% of the cost for your care upfront, you may be eligible for a payment plan. For more information, contact the Patient Business Services team by sending a message in MyChart or calling 1-800-527-2318 or 713-792-2991, Monday through Friday, 8 a.m. to 6 p.m.

Making Payment for Your Care

You can conveniently pay your bill online through MyChart, over the phone, by U.S. mail or in person. Be sure to verify your name, address and insurance information before you pay.

MyChart

1. Log into MyChart.
2. Go to **Billing**.
3. Select **Billing Summary**.
4. Click the **Pay Now** button on the left. This is also available through the **View Account** link under the **Pay Now** button.
5. Select Amount Due, Outstanding Balance or Other Amount to pay.

Helpful Hint: Be careful when selecting the account balance you wish to pay in the drop down "Apply to Payment" portion of the screen. The default selection allows you to pay the full balance on your account or the balance on a specific account.

U.S. Mail

You can pay with a personal or cashier's check from United States bank branches only. Mail the payment to:

MD Anderson Cancer Center
P.O. Box 4461
Houston, TX 77210-4461

Write your Medical Record Number (MRN) in the memo section of your check. If you have a payment coupon, include it with your check.

Phone

Patient Business Services specialists can accept credit card payments by phone at 713-792-2991 or 1-800-527-2318. Visa, MasterCard, American Express and Discover cards are all accepted.

In-Person Cashier

Main Campus
1515 Holcombe Boulevard
Main Building, Floor 1, near the Café Corner
Monday through Friday, 8 a.m. to 5 p.m.

Mays Clinic
1220 Holcombe Boulevard
Mays Clinic, Floor 2, near the Tree Sculpture
Monday through Friday, 8 a.m. to 5 p.m.

Payments can be made by Visa, MasterCard, American Express and Discover credit cards, pre-printed personal checks or cashier checks.

MD Anderson Resources

Insurance Coverage, Financial Assistance

Financial Clearance Center

1-844-294-4322 or 713-792-4322
Monday through Friday, 8 a.m. to 6 p.m.

The Financial Clearance Center (FCC) answers questions about insurance coverage and health care costs, including price estimates, upfront payment requirements, payment options and the Texas Resident Financial Assistance application process. You can contact the FCC team by sending a message in MyChart or calling them.

Billing and Accounts

Patient Business Services

1-800-527-2318 or 713-792-2991
Monday through Friday, 8 a.m. to 6 p.m.

Patient Business Services (PBS) can help you understand your bills. They assist patients by reviewing itemized statements and patient account summaries. They can help resolve account issues. You can send PBS a message in MyChart, call them, or visit them at the Texas Medical Center location in the Main Building, Floor 2, near Elevator D, Monday through Friday, 8 a.m. to 5 p.m.

MD Anderson Online Resources

Find more information at MDAnderson.org/InsuranceAndBilling.

The Learning Center patient library

Visit MDAndersonTLC.LibGuides.com/Financial to find resources on financial and legal topics related to cancer care, treatment and assistance programs.

Glossary

Claim: A request for a benefit, including reimbursement of a health care expense, made by you or your health care provider to your health insurer or plan for items or services you think are covered. Physician services are billed on a CMS-1500 and hospital/facility services are billed on a UB-04.

Co-insurance: A method of cost-sharing between you and your insurance provider. You pay a percentage of costs as part of your contract with your insurance provider. You pay this amount even if your deductible has been met. For example, you may pay 20% of the costs of your services even after you have met your deductible.

Coordination of Benefits (COB): This is the process used by insurance companies to determine how to cover medical expenses when a person has more than one health insurance plan. Most health plans have rules to determine which plan will pay primary (first) and which plan will pay secondary. These rules are outlined in the "coordination of benefit" summary plan description. Your health plan or provider may request that you complete a COB form when you have dual insurance coverage, health coverage for your dependents, Medicare or other insurance, COBRA and employer coverage. It is important to complete

the COB right away as your insurance plan may hold payment for services while they wait for the completed COB form.

Co-payment: The fixed dollar amount that you must pay yourself, known as out-of-pocket, before or at the time of service. This amount is pre-determined and varies by insurance provider. It is based on your plan type and the type of service being provided. MD Anderson is required to collect co-payments from patients when a co-payment applies to the services being provided.

Cost sharing: The portion of healthcare costs that you pay out of your own pocket, such as deductibles, coinsurance, and copayments. Cost sharing does not include premiums, balance billing amounts, or the cost of services that are not covered.

Deductible: The specified amount you must pay for health care expenses before insurance covers the remaining costs. It is your part of the contract with your insurance provider.

In network: The hospitals, doctors or other health care providers who have a contract with your insurance provider. The plan you have covers the costs of these health care providers. You may still have to pay a co-payment, coinsurance or deductible based on your benefit plan.

Insurance provider: A company you pay to help you cover your health care costs. This company has different plans and policies for its members. It makes payments to hospitals and health care providers on your behalf.

Out of network: Hospitals, doctors or other health care providers who may not have a contract with your insurance provider. Your insurance may not cover the costs, so you will be responsible for paying for the services provided to you. You may have a much higher deductible and coinsurance based on your benefit plan.

Out-of-pocket costs: Health care costs, such as deductibles, co-payments and co-insurance, that are not covered by insurance. Out-of-pocket costs do not include premium costs.

Out-of-pocket maximum: A yearly limit on the amount of money you are required to pay out-of-pocket for health care costs before your health plan starts to cover the services. This does not include the premium cost.

Preauthorization: Also known as pre-approval, precertification, prior approval or prior authorization. This is a process where your health insurer or plan requires providers to get approval before delivering certain non-emergency medical services or medications. This is not to determine medical necessity. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium: The amount you pay, often monthly, for health insurance. The patient may share the cost of the premium with employers and government purchasers.

Referral: A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Shoppable Service Estimate: An estimate of standard charges for common shoppable services created by you from a price estimator tool. These estimates have not been reviewed or verified because services provided to each individual patient and their cost may vary due to treatment decisions, unforeseen complications, additional tests or services ordered by your provider, as well as the individual needs and condition of each patient.

Standard charge: The standard charge amount is a fixed fee. The combination of services will determine the estimate of the total charged amount.

Notes

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