When you or someone you love is diagnosed with cancer, it can be overwhelming at times. Not only are you concerned about your physical & emotional well being, but there are also many questions about your medical insurance coverage and what other services are available to help. The following information is to provide basic information about what is available to patients & caregivers. Not everyone will need to use all the services listed or will be qualified to receive them. Your employer, hospital or cancer center will also be able to help answer some of your questions and concerns.

Understanding Your Medical Insurance

Medicare - Is a type of health insurance available to those who are age 65 or older. Medicare Part A covers inpatient expenses, skilled nursing homes, and some home health care services. Medicare Part B covers outpatient health care expenses including physician fees, equipment, and some supplies. You will need to pay 20% of costs after your yearly deductible is met for Part B. It is a good idea to have a supplemental health insurance that can pick up some of the co- payments.

Medicare Coverage for Inpatient Hospital Stays - Medicare pays all covered costs except the $1,068 yearly deductible during day 1 - 60 of an inpatient hospital stay. Medicare will pay $267 per day for days 61- 90 and $534 (life time reserve days) for day 91- 150 for a hospital stay. The patient will pay all costs for 150 -365 days of an inpatient hospital stay. * based on 2009 rates.

Medicare Coverage for Hospice Programs - Hospice is a program of care and support for people who are terminally ill. Hospice is generally given in your home. It includes drugs, physical care, counseling both emotional & spiritual needs, equipment, & supplies. It focuses on comfort to live out the time that they have remaining to the fullest extent not on curing an illness.

- Medicare Part A will pay for hospice services when your Doctor & the Hospice Medical Director certify that you have six months or less to live. You will sign a statement choosing hospice to treat your illness. Medicare will no longer cover treatment intended to cure your illness.
- You have a right to stop Hospice Care at any time & receive the same Medicare coverage that you had before you choose Hospice.
- With Hospice, you will pay no more than $5 for each prescription drug or products for pain relief or symptom control
- Medicare will also pay for a short term inpatient hospital or skilled nursing home stay if you or your caregiver need a break. This is called Respite Care. You will pay 5% of the Medicare approved amount for inpatient respite care.
- If you live longer than 6 months, you can still receive Hospice Care as long as the Hospice Medical Director recertifies that you are terminally ill.

Medicare Prescription Drug coverage - is an optional insurance that covers both brand name - generic prescription drugs at participating pharmacies in your area. It helps people with very high drug costs or unexpected drug bills in the future. Everyone with Medicare is eligible for coverage. You need to sign up for prescription drug coverage or have a plan that offers it. You will pay a monthly premium, which varies plan to plan, and a yearly deductible. You will also pay for part of your prescription costs called co- payments. The cost varies depending on the plan you choose.

- Medicare beneficiaries are eligible for extra help with prescription drug coverage if you have limited income & resources. You qualify, you need to contact your local Social Security Office to see if you are eligible.

Social Security Disability - Social Security pays benefits to people who cannot work because they have a medical condition that is expected to last at least one year. You must meet requirements for recent work and duration of work to qualify. You should apply for Social Security benefits as soon as you are unable to work. Family members may qualify for benefits based on your work.

- Your spouse, 62 or older
- Your spouse, at any age, if they are caring for your children who are younger than 16, are disabled, or under the age of 19 who are a full time student.

Skilled Nursing Facility - About half of all nursing home residents pay for nursing home costs out of their own savings. After these savings & other resources are spent, many people who stay in a nursing home for a long period of time become eligible for Medicaid. Medicare pays only for medically necessary skilled services. After a 3 day hospital stay, Medicare pays day 1 -20 of a skilled nursing facility at 100%, day 21- 100 are paid 80% as long as you are receiving skilled services. Medicare does not pay for custodial care such as dressing, bathing, and toileting.

- Long Term Care Insurance is a private policy that can help pay for the cost of a Skilled Nursing Facility.

Program All Inclusive Care for the Elderly (PACE)- Is available in certain states. You must be 55 year old & live in an area where PACE is offered. You must meet the requirements of needing skilled care. It is a benefit available under both Medicaid & Medicare that permits a patient to live at home and receive in home services as an alternative to being in a skilled nursing facility. It offers medical, social, rehabilitative, personal care, nutritional, meals, and counseling services. It is available 24 /7/ 365.

Medicaid Health Insurance - Is a state and federally government program that helps people with low incomes and limited assets. Who is eligible and what services are covered varies from state to state. It pays for some health services & nursing home care.

Medicare Ombudsman - Is a person who provides help to Medicare participants regarding insurance complaints, grievances, and requests for information. They can also help explain your Medicare options, rights, and protection.

Legal Services - It is a good idea to update your power of attorney, living will & estate, and have a health care proxy in the state where you reside. If you already have these legal documents, it is a good idea to review them every few years to make sure there are no changes in your wishes.

Second Medical Opinions - Most insurances will provide coverage for an office visit in connection with a second medical opinion for a cancer diagnosis, recurrance, or treatment options.

Commercial Insurance (BSBS, Aetna, United Health Care etc) - Because each insurance company has different policies, it is a good idea to check with your carrier to find out the specific details of your coverage. Be sure to ask what your policy covers for labs, x- rays, medications, and diagnostic testing.

- If you do not have insurance, ask to speak to your hospital's (or center's) financial advisor to discuss options with you.

- Other Commercial Insurance resources are to contact your Employee Benefit Representative or Human Resources Department with your employer.

- Also ask if your Insurance Plan provides coverage for a Medical Case Manager who can help answer questions and make referrals to other community resources that could help you.

- Many insurance plans require you select a Primary Care Physician (PCP). Choosing your PCP is important. All in- network care except for emergency & certain other services must be provided, arranged, or authorized by your PCP. Many plans require the PCP to make a referral to see a specialist. Your insurance company will send you a letter confirming the referral.

- You will receive the highest level of coverage when you receive in- network benefits. If you choose to see a specialist who does not participate with your insurance plan or who is outside the network, you will have to pay higher costs. You will also pay higher costs if you do not have the appropriate referral or authorization.

- Having a referral doesn't necessarily mean a service is covered. Your insurance company will only pay for services that are part of your health plan as defined in your contract. Also if a service is subject to a benefit limit (# of visits per year), they will not cover services in access of that limit.

Other Social Services that can help -

- Support Groups - many support groups are available for cancer patients & their caregivers. Check with your local hospital, social worker, or American Cancer Society for more information.

- Gilda's Club - if a free, non-profit support community for anyone touched by cancer. They offer support groups run by trained professionals, stress reduction & relaxation, lectures, workshops, social events, and a special playroom & program for kids. The whole family meets to discuss living with cancer together.

- KATS (Kids Adjusting Through Support) - Helps children & families cope with serious illness or loss. In addition to coping support groups, they provide family camping retreat with Camp Good Days, the Memory Tree Project, and various workshops & community services.

- Sometimes the best Doctors and cancer treatment centers are away from home. There are several non-profit groups that can provide help with transportation to / from treatments, help with lodging or airfare.

- American Cancer Society - 1-800-227-2345- Provides information about cancer, treatment options, insurance concerns, support groups, transporation, lodging through Hope Lodge, clinical trials, hospitals, & other programs.

- Angel Flight - 918-749-8992

- Corporate Angel Network - 866-328-1313

- National Patient Travel Center - 800-296-1217

- Joe's House - 787-563-7486