

SHOPPER ESTIMATE FAQ

WHAT IS A SHOPPER ESTIMATE?

A Shopper Estimate is designed with the intent to make it easier for consumers to shop and compare prices across hospitals and estimate the cost of their care before going to the hospital.

ARE ALL 70 CMS SHOPPABLE SERVICES AVAILABLE?

Unfortunately, UW Medicine does not perform eight of the services in CMS' Shoppable Services list.

WHICH UW MEDICINE LOCATIONS ARE AVAILABLE?

Through this portal you can find Shopper Estimates for services at Harborview Medical Center, University of Washington Medical Center at Montlake and Northwest campuses, and Seattle Cancer Care Alliance.

To access information for Valley Medical Center please go to <https://www.valleymed.org/estimate/>

WHY DO I NEED TO SELECT A MEDICAL CENTER LOCATION?

Medical Center/ hospital location selection is important as charges vary between the campuses.

WHAT DOES THE "YOU PAY" SECTION MEAN?

The "you pay" section will reflect your expected out-of-pocket costs, which will either be a product of our fully loaded rates after a self-pay discount, or a balance of your benefit allowance (*e.g. Deductible, co-pay, co-insurance, etc.*) after your insurance has paid their negotiated rate in consideration of your plan benefit.

HOW LONG IS MY ESTIMATE AVAILABLE?

The estimate you retrieve from this website, MyChart, will be valid for only **30 days**. After that, you will need to create a new one.

WHY IS MY ESTIMATE NO LONGER AVAILABLE?

Estimates expire after 30 days from creation due to a variety of reasons, the primary being due to charges that may occur in pricing, coding, or billing data, contract terms, as well as storage and safety concerns.

WHAT DOES IT MEAN IF MY INSURANCE IS NOT CONTRACTED WITH THIS FACILITY AND PROVIDER?

You may be required to pay a larger out-of-pocket amount, possibly up to the entire billed amount.

HOW ARE ESTIMATES CALCULATED?

Estimates are calculated using current pricing modeled against historical charge data. If you have insurance benefits and we are contracted with that company, then they may take into consideration our reimbursement rates along with your benefit terms.

WHAT DOES THE “LOW” VERSUS “HIGH” PRICING MEAN?

Since our estimates are designed to consider the median or average patient experience the “low” and “high” pricing is provided to reflect those patients who had more or less care requirements, which resulted in more or less charges for that service, as a reference to the potential charge range that could result from having that service rendered.

WHY ARE THERE HOSPITAL FEES AND PHYSICIAN FEES?

The Hospital fees reflect the costs associated with the use of the hospital and employed personnel. For example, the cost for the office/ clinic space, equipment, ancillary services, and nursing/ PA-C/ Pharmacist staff.

Physician fees reflect the work/ time that your provider spends with you during the care process. Either during a visit, surgical procedure, or test.

WHAT IF I HAVE MET MY DEDUCTIBLE?

The information we receive from your insurance company may not reflect the most recent payments made to other providers/ hospitals. We recommend that you contact your insurance company to confirm your benefits met to date.

DO I GET A DISCOUNT AS AN UNINSURED PATIENT?

As an uninsured patient UW Medicine offers a 30% uninsured discount. In addition to the 30% uninsured discount, uninsured patients may be eligible for an additional 10% discount for prompt payment on the remaining balancing if payment is made in full before or upon date of service.

CAN INTERNATIONAL PATIENTS USE THE SELF-SERVICE ESTIMATE TOOL AS WELL?

Yes, the self-service estimate tool is available to local and international patients.

DOES THE 30% UNINSURED DISCOUNT APPLY TO INTERNATIONAL PATIENTS?

Yes. International Patient Services at both campuses will work with patients to provide estimates for complete care and coordinate pre-service payment. However, we require payment in full prior to the date of service and we would expedite any refunds due after discounts are applied.

GENERAL DEFINITIONS

ALLOWED/ NEGOTIATED AMOUNT

The maximum amount your insurance plan will pay for a service agreed upon with the provider rendering the service. Allowed amounts may differ between contracted entities and they may also be present for out-of-network benefits.

DEDUCTIBLE

Amount an insured patient is required to pay (*annually*) for services before the insurance plan makes payment on a claim.

CO-INSURANCE

A percentage of services you pay for a covered benefit (*e.g. 20% for an eye exam*) against the allowed amount after you have met your deductible.

CO-PAYMENT

A fixed amount you pay for a service after you have met your deductible (*e.g. \$20 for an office visit*).

MAXIMUM OUT-OF-POCKET (OOP)

Annual cap you will have to pay on covered services in a plan year. This amount typically takes into consideration all deductibles, co-insurance, and co-payments.

NOTE: These components of insurance coverage vary by payer and plan.