



FROM COVERAGE TO CARE

A Roadmap to Better Care and a Healthier You



Step 2 – Understand your health coverage

Your ROADMAP to health



1



Start here

Put your health first

- Staying healthy is important for you and your family.
- Maintain a healthy lifestyle at home, at work, and in the community.
- Get your recommended health screenings and manage chronic conditions.
- Keep all of your health information in one place.

2



Understand your health coverage

- Check with your insurance plan or state Medicaid or CHIP program to see what services are covered.
- Be familiar with your costs (premiums, copayments, deductibles, co-insurance).
- Know the difference between in-network and out-of-network.

4



Find a provider

- Ask people you trust and/or do research on the internet.
- Check your plan's list of providers.
- If you're assigned a provider, contact your plan if you want to change.
- If you're enrolled in Medicaid or CHIP, contact your state Medicaid or CHIP program for help.

3



Know where to go for care

- Use the emergency department for a life-threatening situation.
- Primary care is preferred when it's not an emergency.
- Know the difference between primary care and emergency care.


5

Make an appointment

- Mention if you're a new patient or have been there before.
- Give the name of your insurance plan and ask if they take your insurance.
- Tell them the name of the provider you want to see and why you want an appointment.
- Ask for days or times that work for you.


6

Be prepared for your visit

- Have your insurance card with you.
- Know your family health history and make a list of any medicines you take.
- Bring a list of questions and things to discuss, and take notes during your visit.
- Bring someone with you to help if you need it.


7

Decide if the provider is right for you

- Did you feel comfortable with the provider you saw?
- Were you able to communicate with and understand your provider?
- Did you feel like you and your provider could make good decisions together?
- Remember: it is okay to change to a different provider!


8

Next steps after your appointment

- Follow your provider's instructions.
- Fill any prescriptions you were given, and take them as directed.
- Schedule a follow-up visit if you need one.
- Review your explanation of benefits and pay your medical bills.
- Contact your provider, health plan, or the state Medicaid or CHIP agency with any questions.

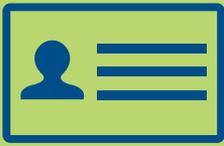
If you want to change your provider, return to Step 4.

No



Yes



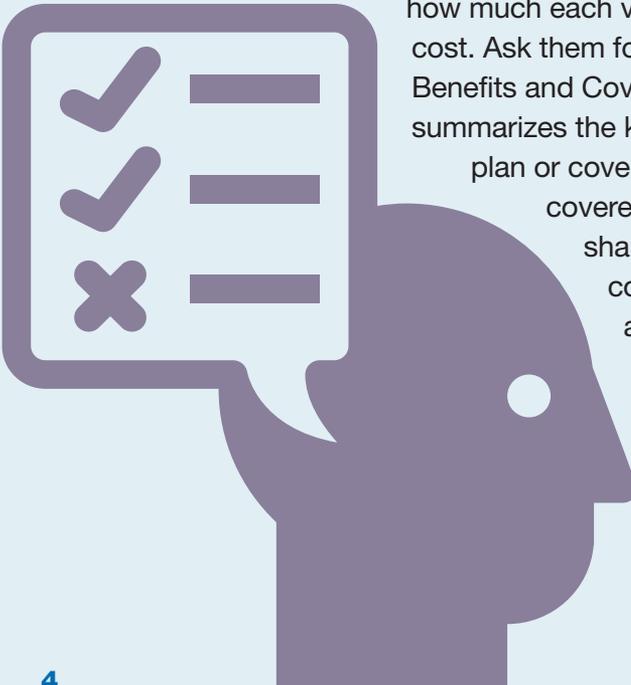


2 Understand your health coverage.

Health coverage pays for provider services, medications, hospital care, and special equipment when you're sick. It is also important when you're *not* sick. Most coverage includes immunizations for children and adults, annual visits for women and seniors, obesity screening and counseling for people of all ages, and more for free. Keep your coverage by paying your monthly premiums (if you have them).

Insurance plans can differ by the providers you see and how much you have to pay. Medicaid and CHIP programs also vary from state to state. Check with your insurance company or state Medicaid and CHIP program to make sure you understand what services

and providers your plan will pay for and how much each visit or medicine will cost. Ask them for a Summary of Benefits and Coverage document that summarizes the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.



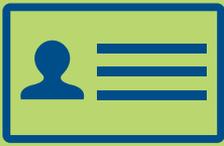
Here are explanations of some key health insurance words that you may hear. Other key words are explained in the back of this booklet.

- **A Network** is the facilities, providers, and suppliers your health insurer has contracted with to provide health care services.
 - Contact your insurance company to find out which providers are “in-network.” These providers may also be called “preferred-providers” or “participating providers.”
 - If a provider is “out-of-network” it might cost you more to see them.
 - Networks can change. Check with your provider each time you make an appointment, so you know how much you will have to pay.
- **A Deductible** is the amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay.

For example, if your deductible is \$1,000, your plan won't pay anything until you've met your \$1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

- **Co-insurance** is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe.

For example, if the health insurance or plan's allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.



- **A Copayment** or copay is an amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage.

For example, you might pay \$10 or \$20 for a doctor's visit, lab work, or prescription. Copayments are usually between \$0 and \$50 depending on your insurance plan and the type of visit or service.

- **A Premium** is the amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly. It is not included in your deductible, your copayment, or your co-insurance. If you don't pay your premium, you could lose your coverage.

- **Out-of-pocket maximum** is the most you pay during a policy period (usually one year) before your health insurance or plan starts to pay 100% for covered essential health benefits. This limit includes deductibles, co-insurance, copayments, or similar charges and any other expenditure required of an individual for a qualified medical expense. This limit does not have to include premiums or spending for non-essential health benefits.

The maximum out-of-pocket cost limit for any individual Marketplace plan for 2014 can be no more than \$6,350 for an individual plan and \$12,700 for a family plan.

- **Explanation of Benefits (or EOB)** is a summary of health care charges that your health plan sends you after you see a provider or get a service. It is not a bill. It is a record of the health care you or individuals covered on your policy got and how much your provider is charging your health plan. If you have to pay more for your care, your provider will send you a separate bill.





Your Insurance Card or Other Document

You probably received a membership package with information about your coverage from either your health plan or your state Medicaid or CHIP program. Read this information because you will need it when you see a provider or if you call your insurance company to ask a question. If you can't read or understand it, call your health plan or state Medicaid or CHIP program and ask them to explain it to you.

You may have received a card or other document as proof of your insurance. Your card may look different from this one, but should have the same type of information. Some health plans don't have cards, but you should have received this information in another way. If you didn't receive a card, contact your health plan to see if you should have.

INSURANCE COMPANY NAME

Plan type **4**

Effective date

Prescription Group # XXXXX

Prescription Copay **7**
\$15.00 Generic
\$20.00 Name brand

Member Name: Jane Doe **1**

Member Number: XXX-XX-XXX **2**

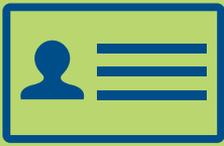
Group Number: XXXXX-XXX **3**

PCP Copay \$15.00 **5**
Specialist Copay \$25.00
Emergency Room Copay \$75.00

Member Service: 800-XXX-XXXX **6**

The following information may be included on your insurance card or another document from your health plan or state Medicaid or CHIP program.

- 1 Member name and date of birth.** These are usually printed on your card.
- 2 Member number.** This number is used to identify you so your provider knows how to bill your health plan. If your spouse or children are also on your coverage, your member numbers may look very similar.
- 3 Group number.** This number is used to track the specific benefits of your plan. It's also used to identify you so your provider knows how to bill your insurance.
- 4 Plan type.** Your card might have a label like HMO, PPO, HSA, Open, or another word to describe the type of plan you have. These tell you what type of network your plan has and which providers you can see who are “in-network” for you.
- 5 Copayment.** These are the amounts that you will owe when you get health care.
- 6 Phone numbers.** You can call your health plan if you have questions about finding a provider or what your coverage includes. Phone numbers are sometimes listed on the back of your card.
- 7 Prescription copayment.** These are the amounts that you will owe for each prescription you have filled.



The questions below can help you better understand your coverage and what you will pay when you get health care. If you don't know the answers to these questions, contact your insurance plan or state Medicaid or CHIP agency.

- How much will I have to pay for a primary care visit? A specialty visit? A mental/behavioral health visit?
- Would I have to pay a different amount if I see an “in-network” or “out-of-network” provider?
- How much do I have to pay for prescription medicine?
- Are there limits on the number of visits to a provider, like a behavioral health provider or physical therapist?
- How much will it cost me to go to the Emergency Room if it's not an emergency?
- What is my deductible?
- Do I need a referral to see a specialist?
- What services are not covered by my plan?

PREVENT HEALTH CARE FRAUD

If someone else uses your insurance card or member number to get prescription drugs or medical care, then they're committing fraud. Help prevent health care fraud.

- Never let anyone use your insurance card.
- Keep your personal information safe.
- Call your insurance company immediately if you lose your insurance card or suspect fraud.

Here are some examples of how your insurance plan or state Medicaid or CHIP program might use the terms discussed in this section to cover your medical care.

- All health plans must provide you with a Summary of Benefits and Coverage, which will have these examples showing how the plan might help pay for services.
- The actual costs and care will vary by your health care needs and your coverage.
- Contact your health plan or state Medicaid or CHIP program to get more information.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,490
- Patient pays \$2,050

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$700
Copays	\$30
Co-insurance	\$1,320
Total	\$2,050

Managing type 2 diabetes (1 year of routine maintenance of a well-controlled chronic condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,520
- Patient pays \$1,880

Sample care costs:

Prescriptions	\$2,900
Medical equipment and supplies	\$1,300
Office visits and procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$800
Copays	\$500
Co-insurance	\$580
Total	\$1,880

The numbers are not real costs and don't include all key information.

Source: <https://www.cms.gov/CCIIO/Resources/Files/Downloads/sbc-sample.pdf>

GLOSSARY

Appeal

An appeal is the action you can take if you disagree with a coverage or payment decision by your health plan. You can appeal if your health plan denies one of the following:

- Your request for a health care service, supply, or prescription drug that you think you should be able to get
- Your request for payment for health care or a prescription drug you already got
- Your request to change the amount you must pay for a prescription drug
- You can also appeal if you're already getting coverage and your plan stops paying.

Co-insurance

An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Co-insurance is usually a percentage (for example, 20%).

Copayment

An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription.

Deductible

The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay.

Emergency Services

Evaluation of an illness, injury, symptom, or condition so serious that a reasonable person would seek care right away and treatment to keep the condition from getting worse.

Excluded Services

Health care services that your health coverage or plan doesn't pay for.

Explanation of Benefits (or EOB)

A summary of health care charges that your insurance company sends you after you see a provider or get a service. It is not a bill. It is a record of the health care you or individuals covered on your policy got and how much your provider is charging your insurance company.

Formulary

A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance

The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Copayment

A fixed amount (for example, \$15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Network (also referred to as in-network)

The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

Out-of-network

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to use them.

Out-of-network Co-insurance

The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Copayment

A fixed amount (for example, \$30) you pay for covered health care services from providers who don't contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-pocket Maximum

The most you pay during a policy period (usually one year) before your health insurance or plan starts to pay 100% for covered essential health benefits. The out-of-pocket maximum includes the yearly deductible and may also include any cost sharing you have after the deductible. For most health plans for 2014, the highest out-of-pocket maximum for an individual is \$6,350 and \$12,700 for a family. These numbers will rise in 2015.

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium

The periodic payment to an insurance company or a health care plan for health or prescription drug coverage.

Preventive Services

Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems or to detect illness at an early stage, when treatment is likely to work best (this can include services like flu and pneumonia shots, vaccines, and screenings like mammograms, depression/behavioral health screenings, or blood pressure tests, depending on what is recommended for you).

Primary Care Provider

The doctor you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many health plans, you must see your primary care doctor before you see any other health care provider.

Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.



YOUR IMPORTANT INFORMATION



This Roadmap
Belongs To _____

Health Plan Name _____

Policy Number _____

Group Number _____

Health Plan Phone Number _____

Primary Care Provider _____

Other Providers _____

Pharmacy _____

Allergies _____

Emergency Contact _____

Medications _____

Other _____

Protect Your Identity: Keep your personal information safe, whether it is on paper, online, or on your computers and mobile devices. Store and dispose of your personal information securely, especially your Social Security number.

Cut here



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