



FROM COVERAGE TO CARE

A Roadmap to Better Care and a Healthier You





Congratulations on getting health coverage—it's an important first step to better health and well-being!

Coverage isn't only important when you are sick, it's helpful when you don't feel sick. This roadmap explains what health coverage is, and how to use it to get the primary care and preventive services to help you and your family live long, healthy lives.

How it works:

Read the Roadmap from start to finish, or jump to a step for quick reference. You'll find helpful examples throughout the Roadmap, and at the end of it you will find definitions for common health care terms and resources.

Start leading a healthier life now...

QUICK REFERENCE

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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 lifethreatening situation.
- Primary care is preferred when it's not an emergency.
- Know the difference between primary care and emergency care.

Visit marketplace.cms.gov/c2c for more information


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.

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

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.



1 Put your health first.

Staying healthy increases the chances you'll be there for your family and friends for many years to come. Use your health coverage when you are sick and when you are well, to help you live a long, healthy life. While coverage is important, there's no substitute for living a healthy lifestyle.

Here's what you can do to put your health and well-being first:

- Make time for physical activity, healthy eating, relaxation, and sleep.
- Get the preventive services that are right for you.
- Take an active role in your health.
- Learn more about what you can do to stay healthy and share what you learn with your family and friends.

WHAT IS A PROVIDER?

We use the term “provider” throughout this booklet to mean a health care professional. This may be a doctor, a nurse practitioner, behavioral health professional, or another health care professional you see. Your **Primary Care Provider** will be the provider you see the most, and they will get to know you and help you keep track of your health over time.



Why is preventive health care important?

Preventive services include health care like screenings, check-ups, and patient counseling that are used to prevent illnesses, disease, and other health problems, or to detect illness at an early stage when treatment is likely to work best. Getting recommended preventive services and making healthy lifestyle choices are key steps to good health and well-being.

Having a provider who knows your health needs, and whom you trust and can work with, can help you:

- ensure you get the preventive services that are right for you
- make healthy lifestyle choices
- improve your mental and emotional well-being
- reach your health and wellness goals.

Keep all of your health information in one place.

Use this booklet to keep track of your coverage information, your providers, and your health. It is important to keep this information up to date, and you may want to carry a copy with you for an emergency. Remember to protect your identity by keeping your personal information safe!

COST TIP

You may be able to receive an annual visit or some recommended preventive services for free like the flu vaccine, obesity screening and counseling, and depression screening. Talk to your provider about what's right for you, and use the Personal Health Checklist in the back of this booklet to track your results.





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

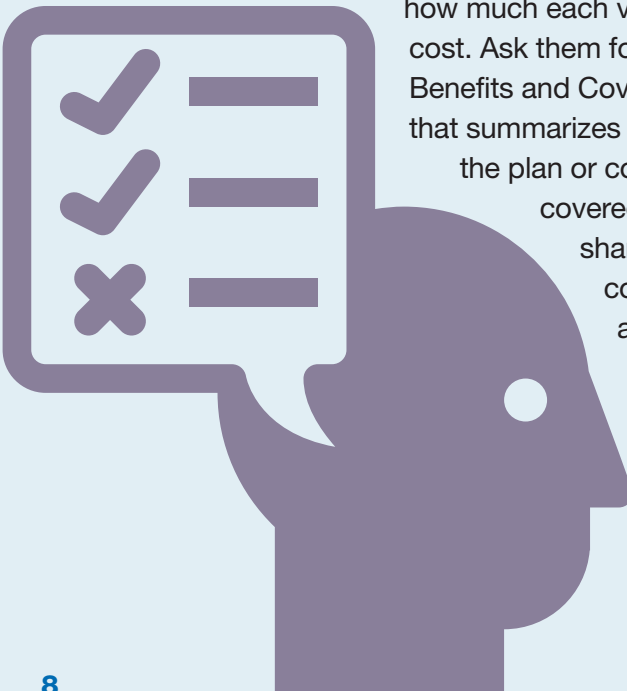
the plan or coverage, such as the

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.

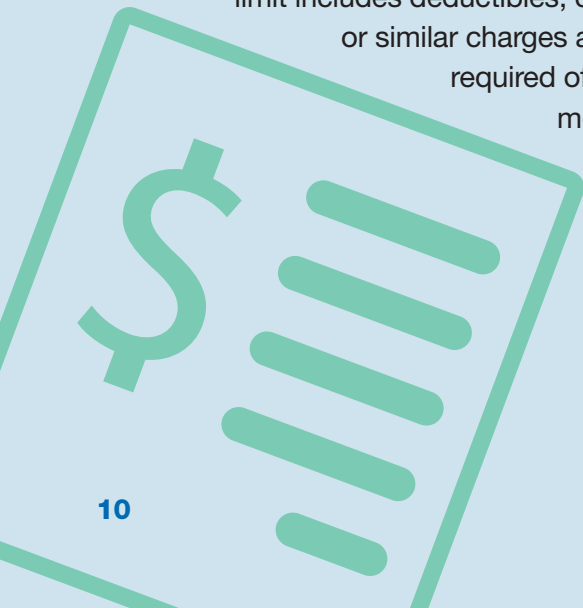


- **A Copayment** or copay is an amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage.

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>

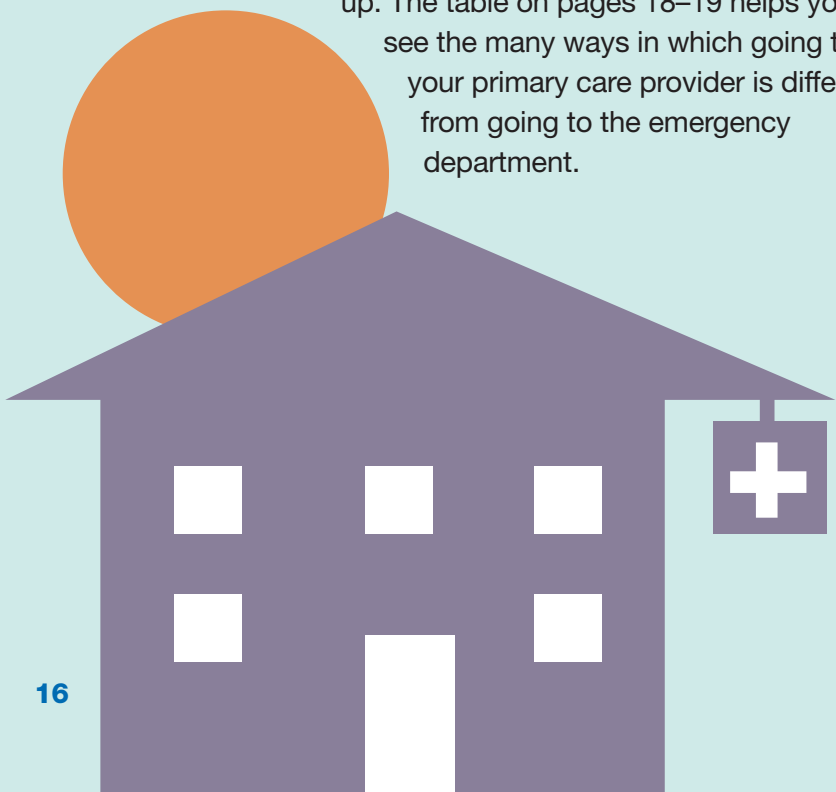


3 Know where to go for care.



NEED HELP?
Call 9-1-1 if you have an emergency or life-threatening situation.

Although you can get health care many different places, including the emergency department, it's best for you to get routine care and recommended preventive services from a primary care provider. There are some big differences between visits to your primary care provider and visits to the emergency department, such as cost, time spent waiting for care, and follow up. The table on pages 18–19 helps you see the many ways in which going to your primary care provider is different from going to the emergency department.



You can find primary care providers in offices, clinics, and health centers nationwide. Depending on your coverage and personal circumstances, you might find a primary care provider in:

- Private medical groups and practices
- Ambulatory care centers and outpatient clinics
- Federally Qualified Health Centers
- Community clinics and free clinics
- School-based health centers
- Indian Health Service, Tribal, and Urban Indian Health Program facilities
- Veterans Affairs medical centers and outpatient clinics.

Primary care providers work with patients every day to ensure they get the right preventive services, manage their chronic conditions, and improve their health and well-being. Some places may offer services and supports that vary based on the needs of the community they serve, like community-based services and supports, mental health, dental, vision services, transportation, and language interpretation.

KNOW BEFORE YOU GO

Not all types of providers and facilities take all insurance plans or types of coverage. Call the office before you go to make sure they see patients with your coverage.





Differences Between Your Provid

Primary Care Provider

You'll **pay your primary care copay**, if you have one. This may cost you between \$0 and \$50.

You go when you **feel sick and when you feel well**.

You **call ahead** to make an appointment.

You may have a short wait to be called after you arrive but you will generally **be seen around your appointment time**.

You'll usually see the **same provider each time**.

Your provider **will** usually have access to your health record.

Your provider works with you to **monitor your chronic conditions** and helps you improve your overall health.

Your provider will **check other areas of your health**, not just the problem that brought you in that day.

If you need to see other providers or manage your care, **your provider can help you make a plan**, get your medicines, and schedule your recommended follow-up visits or find specialists.

In some areas, you may be able to go to an **Urgent Care Center**. If Urgent out how much you will have to pay.



er's Office and the Emergency Department

Emergency Department

You'll likely **pay a copay, co-insurance, and have to meet your deductible** before your health plan pays for your costs, especially if it's not an emergency. Your copay may be between \$50 and \$150.

You should only go when you're **injured or very sick**.

You **show up when you need to and wait** until they can get to you.

You may **wait for several hours** before you're seen if it's not an emergency.

You'll see the **provider who is working that day**.

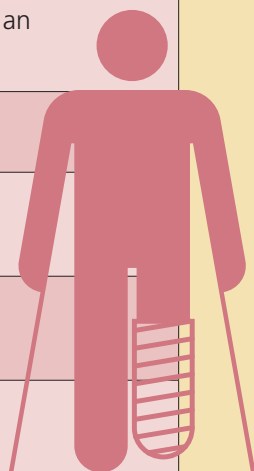
The provider who sees you probably **won't** have access to your health records.

The provider **may not know what chronic conditions you have**.

The provider **will only check the urgent problem** you came in to treat but might not ask about other concerns.

When your visit is over you will be **discharged with instructions to follow up** with your primary care provider and/or specialist. There may not be any follow-up support.

Care is available in your area, call your health plan before you go to find





4 Find a provider.

Choosing the right provider is one of the most important decisions you'll make about your health care, and finding the right one can take a little work.

Remember, you're looking for a partner you can trust and work with to improve your health and well-being, so take time to think about what you need. Depending on how complicated your health care needs are, you may need to see more than one type of provider. Two common provider types are listed below.

A **Primary Care Provider** is who you'll see first for most health problems. They will also work with you to get your recommended screenings, keep your health records, help you manage chronic conditions, and link you to other types of providers if you need them. If you're an adult, your primary care provider may be called a family physician or doctor, internist, general practitioner, nurse practitioner, or physician assistant. Your child or teenager's provider may be called a pediatrician. If you're elderly, your provider may be called a geriatrician.

In some cases your health plan may assign you to a provider. You can usually change providers if you want to. Contact your health plan for how to do this.

A **Specialist** will see you for certain services or to treat specific conditions. Specialists include: cardiologists, oncologists, psychologists, allergists, podiatrists, and orthopedists.

You may need a **Referral** (or get a specific instruction) from your primary care provider before you go to a specialist in order to have your health plan pay for your visit. For some services, your health plan may require you to first get **Preauthorization**—a decision by your coverage or health plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. This is also called prior authorization, prior approval, or precertification.

THE RIGHT PROVIDER

It might take more than one visit to figure out if a provider is the right one for you.





Follow these four steps to find a provider you can trust and partner with to live a long, healthy life.

1. Identify providers in your network.

- Call your insurance company or state Medicaid and CHIP program, look at their website, or check your member handbook to find providers in your network who take your health coverage.
- Tell them if you're looking for something particular, like a provider who speaks a language other than English, or one who can accommodate your mobility or other functional impairment.
- If you already have a provider you like and want to keep working with, call their office and ask if they accept your coverage.
- Keep in mind that most of the time, you'll pay more to see a provider who isn't in your network than a provider who is in your network.

2. Ask around.

- Ask your friends or family if they have providers they like.
- Ask them what type of provider they are and what they like about them.
- Sometimes you can look up providers on the Internet to see what other people in the community say about them.

3. Pick a provider.

Call the provider's office and ask them questions to help you decide whom you want for your primary care provider. Some things you might think about include:



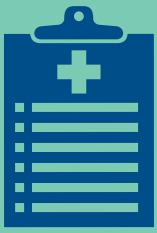
- Is the provider accepting new patients, or patients with your health coverage? This may change during the year, so you should always ask.
- Is the office close to your home or your work? How would you get there?
- Will the appointment times work with your schedule?
- Does the provider speak your language or have an interpreter available?
- If you have limited mobility or another functional impairment, are you able to get into the provider's office, access the exam tables and scales, and get key information in ways that meet your needs?
- Which hospital(s) does the provider work with and can you get there?
- Is the office staff respectful and helpful?

4. Give them a try!

Sometimes it takes more than one visit to figure out if a provider is the right one for you.

COST TIP

Ask your plan if you need prior authorization before you visit your provider. If you don't get preauthorization, you may be charged for things your health plan would have paid for.



5 Make an appointment.

When you make your appointment, have your insurance card or other documentation handy and know what you want.

Here are some things you should mention when you call and what you might be asked for.

You should say:

- Your name and if you're a new patient.
- Why you want to see the provider. You might want to tell them you are looking to find a new primary care provider and ask for a “yearly exam,” or a “wellness visit,” or you might ask to come in because you have a specific concern, like the flu, allergies, or depression.
- The name of your insurance plan or that you have Medicaid or CHIP coverage and make sure you have the correct information about which providers in the office are in your network.
- The name of the provider you'd like to see. You may have to wait longer for an appointment if you request a specific provider, so they might recommend another provider in your network if you're feeling sick and need to come in sooner.
- If you have a specific need—like translation or accessible medical equipment—ask whether the provider and the office can meet that need. If they cannot, ask if there's another provider in the office who can.
- The days and times work for you. Some offices have weekend or evening appointments.

You should also ask:

- If they can send you any forms you need to fill out before you arrive. This will save you time on the day of your visit.
- If you need to bring anything to the visit, like medical records or current medications.
- What to do if you need to change or cancel your appointment. Some offices charge a fee for missed appointments, late appointments, or appointments canceled less than 24 hours before they start.

What to expect when you make an appointment:

- They might ask you for information about you and your coverage, so have your card or other documentation handy when you call.
- You may have to wait a few weeks to get an appointment, especially if you're a new patient.
- If you call your provider's office because you're sick, you may be able to see them the same day.



6 Be prepared for your visit.

If this is your first visit to a new provider or you are using new health coverage, you will need to bring a few things with you.

This will help your provider understand your health and lifestyle, and help you work together to improve your health and well-being during your visit and after you leave.

It is important to show up early for your appointment!

When you get to your provider's office, check in with the front office staff. You may be asked to provide the following:

- Insurance card or other documentation.
- Photo identification (e.g., driver's license, government or school ID, passport, etc.).
- Completed forms.
- Your copay, if you have one. Ask for a receipt for your records.

The staff may ask you to fill out additional forms and to read over their privacy policy, which tells you how they will keep your information private. It is required by law.

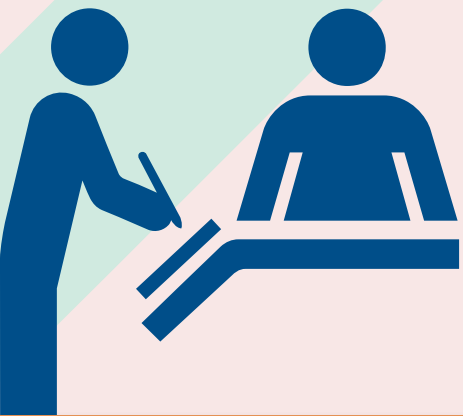
COST TIP

If you need to change your appointment, contact your provider's office as soon as possible. Many providers charge a fee if you're late, don't show up for your appointment, or cancel less than 24 hours before it starts. Most health plans will not pay these fees.

When you see your provider, it is helpful to share:

- Your family health history and medical records, if you have them.
- Medications you are taking (and the bottles so your provider knows what dose you take). If you need a refill, ask for one.
- Questions or concerns you have about your health—write them down so you don't forget to ask.

You may want to bring someone with you, like a friend or family member, to help you talk to the provider.



KNOW YOUR RIGHTS

You should be treated with respect and your information kept private. If you're not happy with how you were treated, ask to speak with an office manager or the provider and tell them your concerns. If things aren't resolved, then this office may not be the right place for you.



Don't be shy!

Your provider is there to help you stay healthy. They can provide better care if you talk with them about your health and well-being and share any questions or concerns you have. If your provider says something you don't understand, speak up!

You should be able to answer these questions before you leave your provider's office:

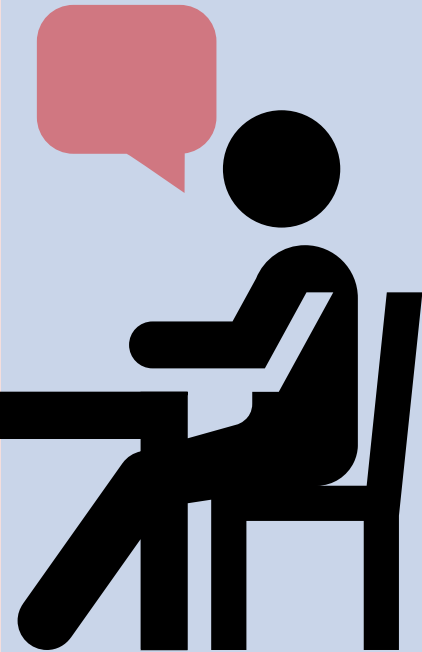
- How is my health? What can I do to stay healthy?
- What do I do next? Do I need blood work or another test? If so, what is it for? When and how will I get the results?
- If I have an illness or chronic condition, what are my treatment options? What are the benefits and concerns for each option? What will happen if I don't take care of it?
- If I need to take medicine, when do I take it and how much do I take? Are there any side effects? Is a generic available?



ASK

Ask your provider for written materials you can take home and read, and if there's a phone number you can call if you have questions. Don't leave until all of your questions have been answered and you understand what to do next.

- Do I need to see a specialist or another provider? Did I ask my provider for a suggestion? Do I need a referral? If so, do I have it?
- When do I need to come back for my next visit?
- What do I do if I have questions when I get home?



COST TIP

If you have to take medicine and you're concerned about how much it will cost, tell your provider. They may have cheaper options for your medicine, or know of programs that help patients pay for their medicines.



7 Decide if the provider is right for you.

Your health and well-being are important and personal and you should have a provider that you can work with, trust, and feel comfortable talking to.

Remember:

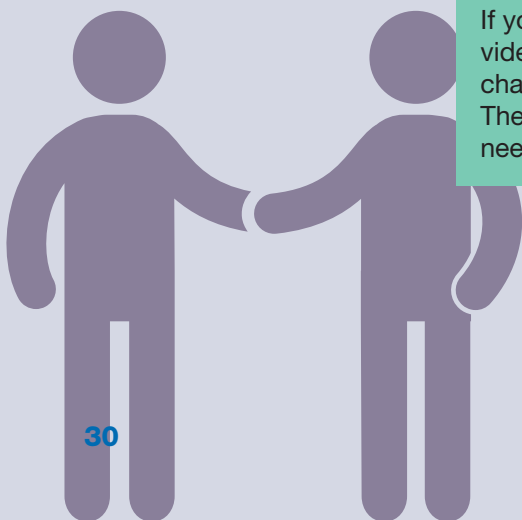
- It's important to find a provider that meets your needs.
- If you're not happy with your first visit, consider giving them another try. You can call the provider's office and share your concerns. You may also be able to see another provider in that office.

COST TIP

If you were assigned a provider and you want to try someone else, call your health plan or go to their website to make that change. Make sure you choose a provider in your network or you will pay more for your care.

SPEAK UP

If you're not comfortable with your provider, say something! It is okay to ask for changes or to look for another provider. The right provider for you will meet your needs when you ask.



After your first visit, think about these questions:

Yes?

No?

- Did you trust your provider, and feel they cared about your health and about you as a person?
- Did you feel that you were listened to and your health needs were addressed?
- Did your provider answer your questions in a way that you could understand?
- Did your provider use words you could understand, speak slow enough, pay attention to what you had to say, and speak in a way that made you comfortable?
- Did you feel that your provider showed an interest in your concerns?
- When they examined you and talked to you about your health, was the provider respectful of your opinions, culture and beliefs? Is this a place you'd feel comfortable going back?
- Did they provide any assistance you asked for, like an interpreter, translation or alternate form of written materials? Could you move around in the office and use the medical equipment without barriers?
- Did you feel you were treated fairly by your provider and the office staff?
- Could you contact your provider or the office staff if you needed to ask a question?

If you answered **“Yes”** to each of these questions, then you may have found a provider that's right for you!

If you answered **“No”** to any of these questions, ask yourself if you think the provider or staff would make changes if you spoke up. Sometimes asking for what you need is the best way to get it.

If you want to change providers, **Go Back to Step 4** and look again at your list of “in-network” providers to find someone you can trust and work with.



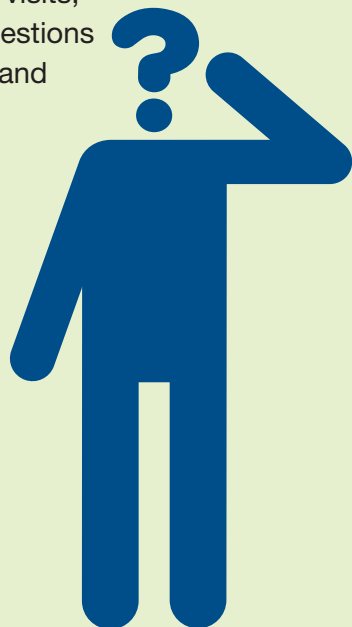
8 Next steps after your appointment.

Now that you have found a provider and had your first visit, where do you go from here?

You'll see your primary care provider for your recommended preventive care and for help managing chronic conditions, as well as when you feel sick. Even if you see a specialist for a specific service or condition, you'll always come back to your primary care provider.

Ask your provider or their staff to notify you when your next visit or recommended health screenings should happen. Make an appointment for that visit as soon as you can and write it down someplace where you'll remember it, or in the back of this book.

If you have questions or concerns between visits, call your provider. They can help answer questions you have about your health and well-being and adjust any medications you are taking.



Follow through with your provider's recommendations. For example, if they told you to go to a specialist, did you call for an appointment?

If not, is it because:

You forgot. Do you need a reminder? Put it on your calendar, or use a smartphone app.

You didn't understand what you were supposed to do. Call your provider. Ask them questions until you understand, and take notes. Consider having someone you trust come with you to your next visit.

You were too busy. Remember to put your health first, and make time. Some providers offer extended weekday or weekend hours.

You didn't have the money. If you are worried you cannot afford your care, there may be ways to lower the cost. Your provider may be able to give you a cheaper medication, or you may qualify for programs to help with your costs. Ask about them.

You didn't feel like you were treated with respect and dignity. If the way your provider or office staff spoke or acted made you not want to return or listen to them, speak up or consider changing providers. The right provider will treat you with respect and meet your language, cultural, mobility, or other needs.

You were scared. Many people are worried about getting bad news. Remember that by getting the preventive care that is right for you, your provider is more likely to find an illness or problem early and help you get better faster.



Reading your Explanation of Benefits

After you visit your provider, you may receive an Explanations of Benefits (EOB) from your insurer. This is an overview of the total charges for your visit and how much you and your health plan will have to pay. An EOB is NOT A BILL and helps to make sure that only you and your family are using your coverage. You may get a bill separately from the provider.

Here’s an example of an Explanation of Benefits

Your insurance plan’s or Medicaid or CHIP agency’s **Customer Service Number** may be near the plan’s logo or on the back of your EOB .

Explanation of Benefits (EOB) Customer service: 1-800-123-4567

Statement date: XXXXXX Member name:
 Document number: XXXXXXXXXXXXXXXXXXXX Address:
THIS IS NOT A BILL City, State, Zip:

Subscriber number: XXXXXXXXX ID: XXXXXXXXX Group: ABCDE Group number: XXXXXX

Patient name:		5	Provider:		Claim number: XXXXXXXXXXXX		
Date received:			Payee:		Date paid: XXXXXXXXX		

Claim Detail				What your provider can charge you		Your responsibility			Total Claim Cost		
Line No.	Date of Service	1	Claim Status	2	3	Co-Pay	Deductible	Co-Insurance	4	6	7
		Service Description		Provider Charges	Allowed Charges				Paid by Insurer	What You Owe	Remark Code
1	3/20/14–3/20/14	Medical care	Paid	\$31.60	\$2.15	\$0.00	\$0.00	\$0.00	\$2.15	\$0.00	PDC
2	3/20/14–3/20/14	Medical care	Paid	\$375.00	\$118.12	\$35.00	\$0.00	\$0.00	\$83.12	\$35.00	PDC
Total				\$406.60	\$120.27	\$35.00	\$0.00	\$0.00	\$85.27	\$35.00	

Remark Code: PDC—Billed amount is higher than the maximum payment insurance allows. The payment is for the allowed amount.

Pay your bills and keep any paperwork. Some providers will not see you if you have unpaid medical bills. You may be able to go online to look up your own health information, such as screening and test results or prescribed medications. This can help you take charge of managing your health.

APPEALS AND GRIEVANCES

If you have a complaint or are dissatisfied with a denial of coverage for claims under your health plan, you may be able to appeal or file a grievance. For questions about your rights, or assistance, you can contact your insurance plan or state Medicaid or CHIP program. If you think you were charged for tests or services your coverage is supposed to pay for, keep the bill and call the phone number on your insurance card or plan documentation right away. Insurance companies have call and support centers to help plan members.

- 1 Service Description** is a description of the health care services you received, like a medical visit, lab tests, or screenings.
- 2 Provider Charges** is the amount your provider bills for your visit.
- 3 Allowed Charges** is the amount your provider will be reimbursed; this may not be the same as the Provider Charges.
- 4 Paid by Insurer** is the amount your insurance plan will pay to your provider.
- 5 Payee** is the person who will receive any reimbursement for over-paying the claim.
- 6 What You Owe** is the amount the patient or insurance plan member owes after your insurer has paid everything else. You may have already paid a portion of this amount, and payments made directly to your provider may not be subtracted from this amount.
- 7 Remark Code** is a note from the insurance plan that explains more about the costs, charges, and paid amounts for your visit.

Contact your health plan if you have questions about your EOB.

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.



HELPFUL LINKS

Getting Coverage

How to get coverage through the Health Insurance Marketplace

<https://www.healthcare.gov/blog/4-steps-to-getting-covered-in-the-health-insurance-marketplace/>

How much will health insurance cost?

<http://kff.org/interactive/subsidy-calculator/>

What plans are available in my area?

<https://www.healthcare.gov/find-premium-estimates/>

Contact Your Insurance Plan

Contacting your health plan's customer service phone number

<http://marketplace.cms.gov/outreach-and-education/contact-health-plan.pdf>

Value of Prevention

Understanding prevention and the Affordable Care Act

<https://www.healthcare.gov/prevention/>

Finding a Provider

Reviews and ratings of local providers

<http://www.healthgrades.com/>

Planning Your First Visit

Steps to help you plan your first visit

<http://www.ahrq.gov/patients-consumers/patient-involvement/ask-your-doctor/questions-before-appointment.html>

Questions to Ask Your Provider

Topics and questions to discuss with the provider during your visit

<http://www.ahrq.gov/patients-consumers/patient-involvement/ask-your-doctor/questions-during-appointment.html>

Patient-Provider Relationship

The importance of communicating with your provider

<http://www.ahrq.gov/patients-consumers/patient-involvement/ask-your-doctor/videos/index.html>

Tracking Your Medicine

Patient guide and wallet card to keep a record of all medications

<http://www.ahrq.gov/patients-consumers/diagnosis-treatment/treatments/safemeds/yourmeds.html>

Personal Health Checklist

This checklist has some common screenings and preventive services that on your age, gender, and pregnancy status by going to www.healthfinder.gov

Protect Your Identity: Keep your personal information safe, whether it is to dispose of your personal information securely, especially your Social Security

<i>Health Screening</i>	<i>Date</i>	<i>Result</i>
Height and Weight _____		
Body Mass Index (BMI) _____		
Blood Pressure _____		
Cholesterol _____		
Vaccinations and Immunizations _____		
Cervical Cancer Screening (sometimes called a Pap Test)		
Colorectal Cancer Screening (colonoscopy)		
Breast Cancer Screening (mammogram)		
Other Screenings Recommended for Me		

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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