Start here.

ROADMAP TO BETTER CARE

Knowing how to use your health coverage is an important step to better health and well-being. Health coverage isn't only important when you are sick, **it's also helpful even when you don't feel sick.**

This Roadmap explains what health coverage is—and how you can use it to get primary care to help you and your family live long, healthy lives.

The Roadmap uses the term "health plan" to refer to health coverage costs. Your family's health plan may be covered by:

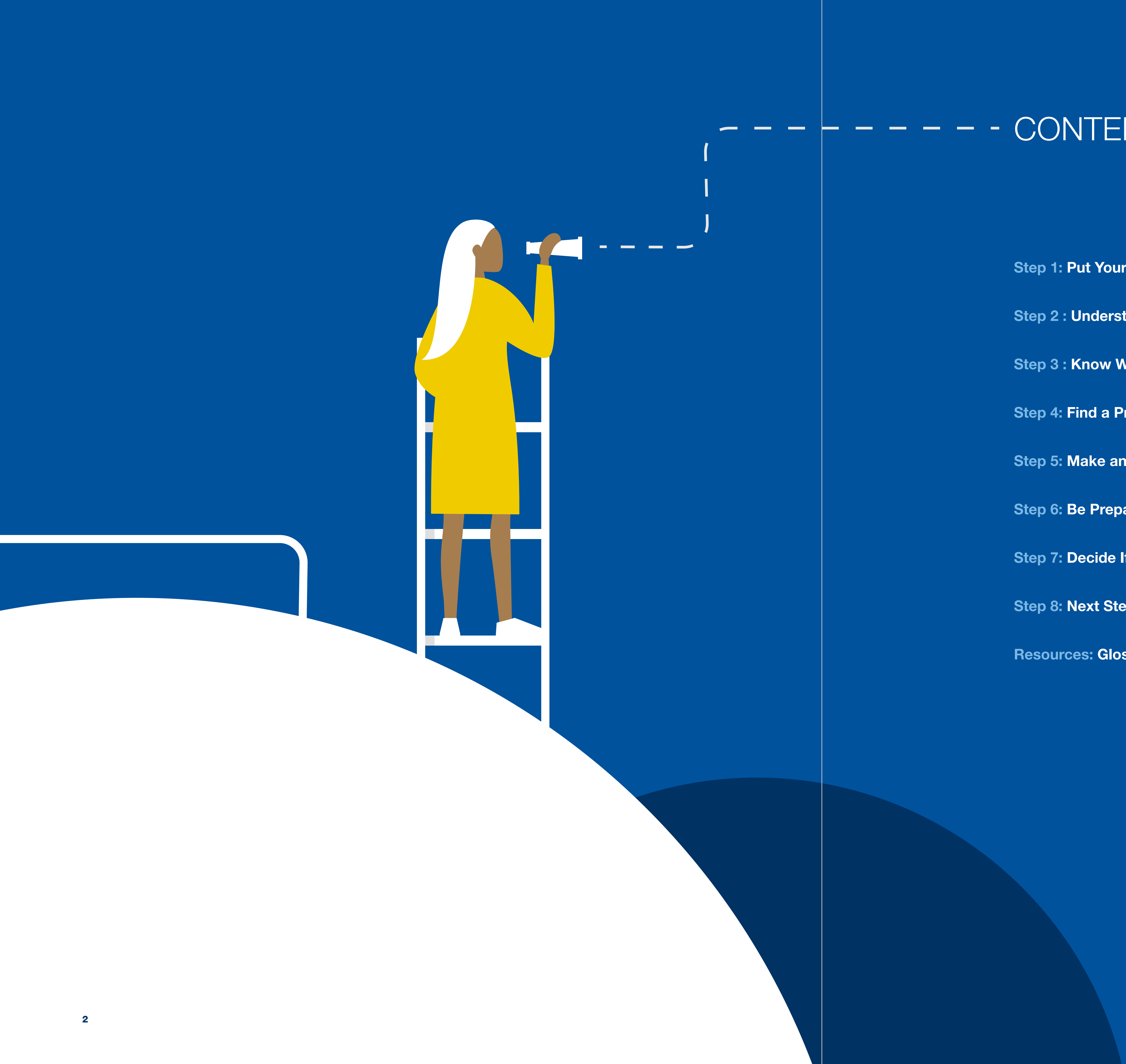
- Your employer, itself or through a private insurance company
- A Marketplace plan through HealthCare.gov
- A health insurance policy purchased directly from a private insurance company
- Medicare
- Medicaid
- Children's Health Insurance Program (CHIP)
- Other coverage sources

You can:

- Read the Roadmap from start to finish
- Jump to a step for quick reference

You'll find definitions for common health care terms and resources at the end of the Roadmap.

Start leading a healthier life now.



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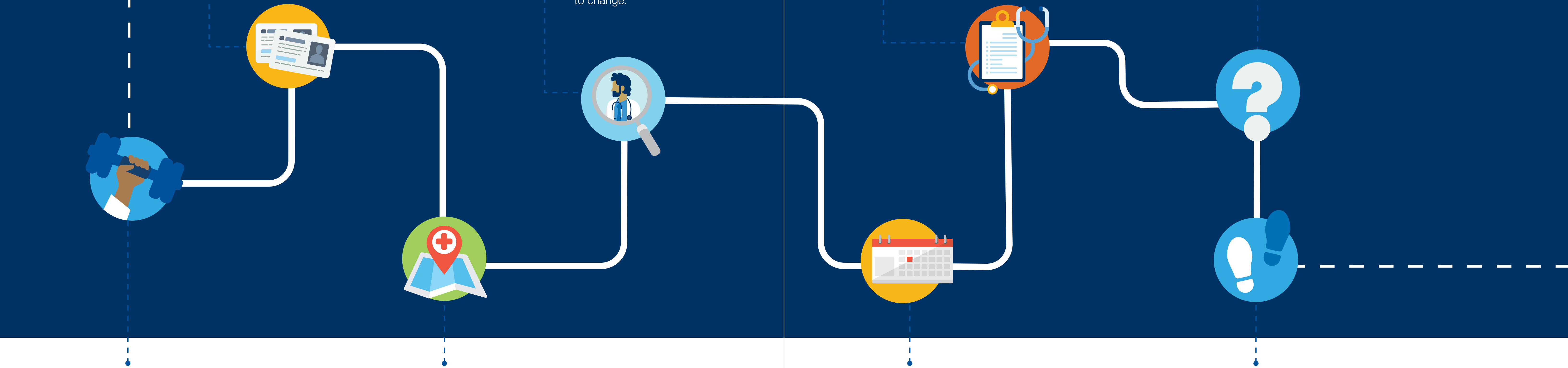
VIEW YOUR PATH TO BETTER HEALTH



Step 1: 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 health screenings and manage chronic conditions.
- Keep all of your health information in one place.

Step 2: Understand Your Health Coverage

- Check with your health plan to see what services are covered (it may be in your plan's handbook or website).
- Know your costs (premiums, copayments, deductibles, coinsurance).
- Know the difference between in-network and out-of-network care.

Step 3: Know Where to Go for Care

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

Step 4: Find a Provider

- Find a primary care provider who takes your coverage.
- Check your plan's list of providers.
- Ask people you trust who their provider is. You can also do research on the internet.
- If you're assigned a provider, contact your plan if you want to change.

Step 5: Make an Appointment

- Tell them if you're a new patient or have been there before.
- Give the name of your health plan. 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.
- Ask what you'll need to bring for the appointment.

Step 6: Be Prepared for Your Visit

- Have your insurance card with you.
- Know your health history, such as previous serious illnesses or injuries and when they happened, any known allergies to medications, and past vaccinations, and family health history.
- 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.

Step 7: Decide If the Provider is Right for You

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

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

Step 8: Next Steps After Your Appointment

- Follow your provider's instructions.
- Fill any prescriptions you were given. Take them as directed.
- Schedule a follow-up visit if you need one.
- Review your Explanation of Benefits to make sure it's correct.
- Pay your health care bills.
- Contact your provider or health plan with any questions.

The questions below can help you understand what you will pay when you get health care. Contact your health plan if you don't know the answers to these questions.

- How much will I have to pay for a primary care visit? A specialty visit? A 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 drugs?
- Are there limits on the number of visits to a provider?
- 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 for anyone other than you, then they're committing fraud. Help prevent health care fraud.

Never let anyone use your insurance card.

Keep your personal information safe.

Call your health plan right away if you lose your insurance card or suspect fraud.

Your health plan website or portal

Your health plan should have a website or portal that gives you more details about your coverage and health care. You may be required to sign-in to this website, especially if it offers personalized information. This website lists which providers are in your network. You may also be able to use the website to make appointments with your provider.

Here are examples of how your health plan 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.
- Your actual costs and care will vary by your health needs and your coverage.
- Contact your health plan to learn more.

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 test	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$800
Copays	$500
Coinsurance	$580
Total	**$1,880**

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 test	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$700
Copays	$30
Coinsurance	$1,320
Total	**$2,050**

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

Source: cms.gov/CCIIO/ Resources/Files/Downloads/sbc-sample.pdf

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

- **Set a reminder.** Put it on your calendar, or use a smartphone app.
- **Have a question?** Call your provider. Ask them questions until you understand the next steps you need to take. Consider having someone you trust come with you to your next visit.
- **Remember to put your health first, and make time.** Some providers offer extended weekday or weekend hours.
- **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 medicine. Or you may qualify for programs to help with your costs. Ask about them.
- **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.
- **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 (EOB)

You may receive an EOB from your health plan after your visit with the provider. It will show you the total charges for your visit and how much you and your health plan owe. An EOB is NOT A BILL. You can also use it to track how you and your family use your coverage. You may get a separate bill from the provider.

Pay your bills

Pay your bills and keep all paperwork in a safe place. Some providers will not see you if you have unpaid bills. You may be able to pay your bills online or over the phone. This can vary depending on your health plan and coverage.

Appeals

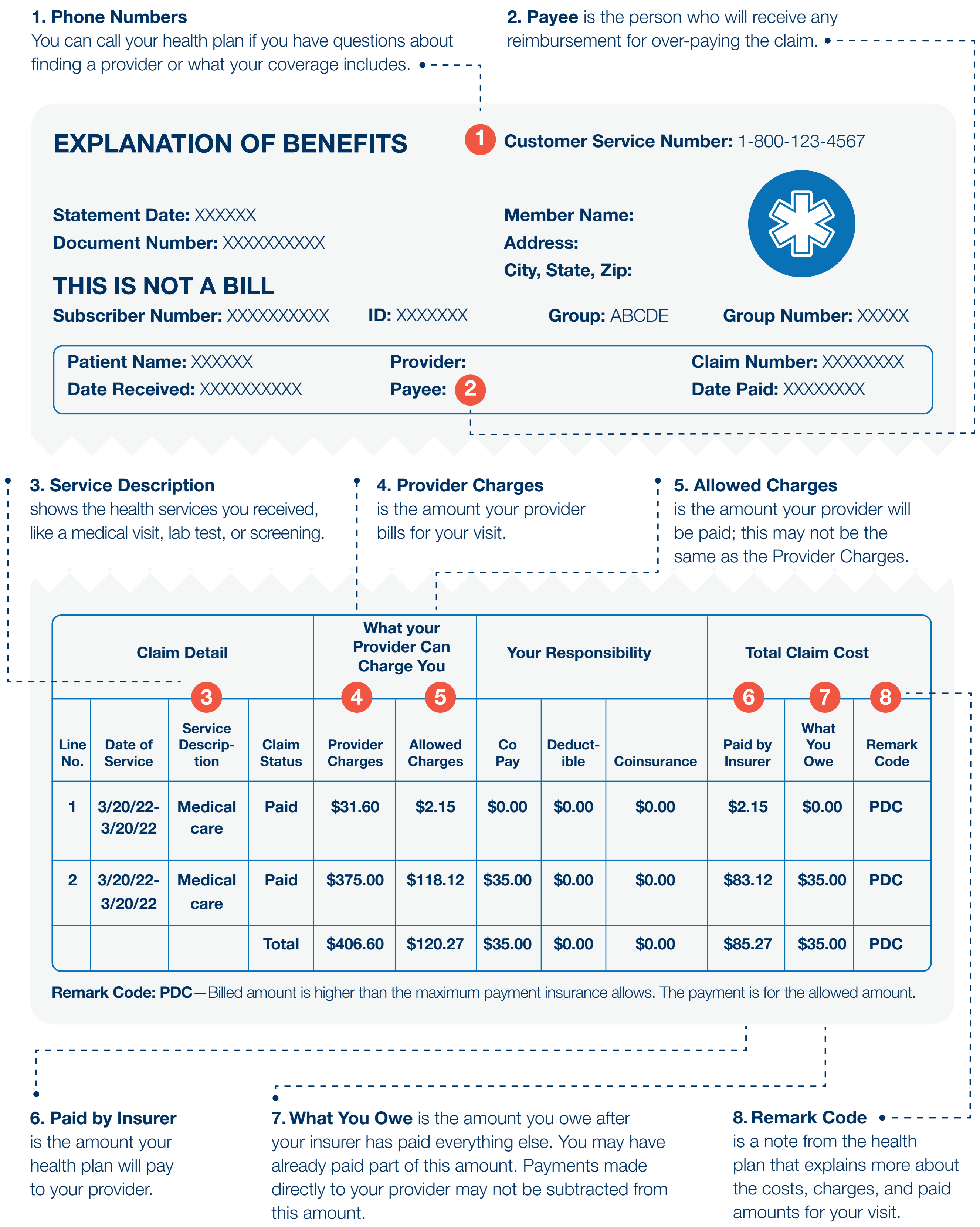
If you disagree with a coverage or payment decision by your health plan, you may be able to appeal. If you think you were charged for tests or services your coverage should pay for, keep the bill. Call your health plan right away. Health plans have call and support centers to help.

Quick tip:

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

Here's an example of an Explanation of Benefits

Your health plan's Customer Service Number may be near the plan's logo or on the back of your EOB.



1. Phone Numbers
You can call your health plan if you have questions about finding a provider or what your coverage includes.

2. Payee is the person who will receive any reimbursement for over-paying the claim.

EXPLANATION OF BENEFITS

① **Customer Service Number:** 1-800-123-4567

Statement Date: XXXXXX
Document Number: XXXXXXXXXX

Member Name:
Address:
City, State, Zip:

THIS IS NOT A BILL

Subscriber Number: XXXXXXXXXX **ID:** XXXXXXX **Group:** ABCDE **Group Number:** XXXXX

Patient Name: XXXXXX
Date Received: XXXXXXXXXX
Provider:
Payee: ②
Claim Number: XXXXXXXX
Date Paid: XXXXXXXX

3. Service Description shows the health services you received, like a medical visit, lab test, or screening.

4. Provider Charges is the amount your provider bills for your visit.

5. Allowed Charges is the amount your provider will be paid; this may not be the same as the Provider Charges.

Claim Detail				What your Provider Can Charge You		Your Responsibility			Total Claim Cost		
Line No.	Date of Service	③ Service Descrip-tion	Claim Status	④ Provider Charges	⑤ Allowed Charges	Co Pay	Deduct-ible	Coinsurance	⑥ Paid by Insurer	⑦ What You Owe	⑧ Remark Code
1	3/20/22-3/20/22	Medical care	Paid	$31.60	$2.15	$0.00	$0.00	$0.00	$2.15	$0.00	PDC
2	3/20/22-3/20/22	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	PDC

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

6. Paid by Insurer is the amount your health plan will pay to your provider.

7. What You Owe is the amount you owe after your insurer has paid everything else. You may have already paid part of this amount. Payments made directly to your provider may not be subtracted from this amount.

8. Remark Code is a note from the health plan that explains more about the costs, charges, and paid amounts for your visit.

Explanation of Benefits (or EOB)

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 care you got and how much your provider is charging your health plan.

Formulary

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

Hospital Outpatient Care

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

In-network Coinsurance

The share you pay for a covered health care service after you've paid your deductible. This amount is given as a percentage (for example, 20%). In-network copayments usually are less than out-of-network copayments.

In-network Copayment

A fixed amount you pay for a covered health care service after you've paid your deductible, if your plan has one (for example, $15). In-network copayments usually are less than out-of-network copayments.

Network (also called In-network)

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

Out-of-network

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

Out-of-network Coinsurance

The share you pay for services from providers who don't contract with your health plan. This amount is given as a percentage (for example, 40%). Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment

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

Out-of-pocket Maximum

The most you have to pay for covered services in a plan year. After you pay this amount for in-network care and services, your health plan pays 100% of the costs of covered benefits.

Preauthorization (also called Prior Authorization, Prior Approval, or Precertification)

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

Premium

The amount you pay for your health plan on a regular basis, such as every month.

Preventive Services

Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Primary Care Provider

A physician (MD – Medical Doctor, or DO – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health care services.

Specialist

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

Telehealth

Use of a computer, phone, or other device to receive health care when you and your provider are in different places.

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