

APPENDIX



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Regional Director

How the Health Care Law is Making a Difference for the People of New Jersey

The Affordable Care Act is working to make health care more affordable, accessible, and high quality for the people of New Jersey by:

Better Options

The Health Insurance Marketplace

Through the Health Insurance Marketplace New Jerseyans can compare qualified health plans, get answers to questions, find out if they are eligible for lower costs for private insurance or health programs like Medicaid and the Children's Health Insurance Program (CHIP), and enroll in health coverage.

At the end of the first annual open enrollment period, enrollment in the Marketplace surged to eight million people nationwide. In New Jersey alone, 161,775 individuals **selected a Marketplace plan** between October 1, 2013 and March 31, 2014 (including additional special enrollment period activity through April 19, 2014).

Of the 161,775 New Jerseyans who selected a plan:

- 53% are female and 47% are male;
- 32% are under age 35;
- 25% are between the ages of 18 and 34;
- 69% selected a Silver plan, while 14% selected a Bronze plan; and,
- 84% selected a plan with financial assistance.

The second open enrollment period began on November 15, 2014 for coverage that can begin as early as January 1, 2015. This current open enrollment period runs through February 15, 2015.

New Jersey has received \$8,897,316 in **grants** for research, planning, information technology development, and implementation of its Marketplace.

Medicaid

Thanks to the Affordable Care Act, states have new opportunities to **expand Medicaid coverage** to individuals with family incomes at or below 133 percent of the federal poverty level (generally \$31,322 for a family of four in 2013). This expansion includes non-elderly adults without dependent children, who have not previously been eligible for Medicaid in most states. New Jersey has seized this opportunity to expand Medicaid and, as of July 2014, more than 278,632 New Jerseyans have gained Medicaid or Children's Health Insurance Program (CHIP) coverage since the beginning of the Health Insurance Marketplace's first open enrollment period in October, 2013. Across the nation, 8 million more Americans are now enrolled in Medicaid and CHIP.

Mental Health

The Affordable Care Act increases access to comprehensive coverage by requiring most health plans to cover ten essential health benefit categories, to include hospitalization, prescription drugs, maternity and newborn care, and mental health and substance use disorder services. The health care law expands mental health and substance use disorder benefits and federal parity protections for **62 million** Americans nationwide, including 1,550,543 New Jerseyans.

New coverage options for young adults

Under the health care law, if your plan covers children, you can now add or keep your children on your health insurance policy until they turn 26 years old. Thanks to this provision, over **3 million** young people who would otherwise have been uninsured have gained coverage nationwide.

Ending discrimination for pre-existing conditions

As many as 3,847,727 non-elderly New Jerseyans have some type of pre-existing health condition, including 485,006 children. Today, most insurers can no longer deny coverage to anyone because of a pre-existing condition, like asthma or diabetes, under the health care law. And they can no longer charge women more because of their gender.

Better Value

Providing better value for your premium dollar through the 80/20 Rule

Health insurance companies now have to spend at least 80 cents of your premium dollar on health care or improvements to care, rather than administrative costs like salaries or marketing, or they have to provide you a refund. This means that 42,300 New Jerseyans with private insurance coverage benefited from \$3,434,390 in refunds from insurance companies, for an average refund of \$142 per family because of the Affordable Care Act.

Scrutinizing unreasonable premium increases

In every State and for the first time under Federal law, insurance companies are required to publicly justify their actions if they want to raise rates by 10 percent or more. New Jersey has received \$5,146,261 under the new law to help fight unreasonable premium increases. Since implementing the law, the fraction of requests for insurance premium increases of 10 percent or more has dropped dramatically, **from 75 percent to 14 percent** nationally. To date, the rate review program has helped save Americans an estimated **\$1 billion**.

Removing lifetime limits on health benefits

The law bans insurance companies from imposing lifetime dollar limits on health benefits – freeing cancer patients and individuals suffering from other chronic diseases from having to worry about going without treatment because of their lifetime limits. Already, 3,274,000 people in New Jersey, including 1,214,000 women and 877,000 children, are free from worrying about lifetime limits on coverage. The law also restricts the use of annual limits and bans them completely starting in 2014.

Better Health

Covering preventive services with no deductible or co-pay

The health care law requires many insurance plans to provide coverage without cost sharing to enrollees for a variety of preventive health services, such as colonoscopy screening for colon cancer, Pap smears and mammograms for women, well-child visits, and flu shots for all children and adults.

Because of the Affordable Care Act, **76 million** Americans with private health insurance gained preventive service coverage with no cost-sharing, including 2,282,000 in New Jersey. And women can now get coverage without cost-sharing of even more **preventive services** they need. Of the 76 million Americans with expanded access to free preventive services, **29.7 million are women**, including 869,000 in New Jersey receiving expanded preventive services without cost-sharing.

Increasing support for community health centers

The Affordable Care Act increases the funding available to community health centers nationwide. Health Center grantees in New Jersey have received \$119,055,614 under the health care law to offer a broader array of primary care services, extend their hours of operations, hire more providers, and renovate or build new clinical spaces.

Of the \$119,055,614 awarded to New Jersey, \$5,178,537 was awarded to New Jersey health centers to help enroll uninsured Americans in the Health Insurance Marketplace. New Jersey health centers used these funds to train 690 outreach and enrollment assistance workers who helped more than 168,910 New Jersey residents with enrollment into affordable health insurance coverage. These investments ensure that health centers continue to be a trusted resource for assistance with enrollment in the Marketplace, Medicaid and CHIP in New Jersey.

In New Jersey, 20 health centers operate 130 sites, providing preventive and primary health care services to 483,113 New Jerseyans, including 221,553 Latinos and 150,813 African Americans.

Investing in the primary care workforce

As a result of historic investments through the health care law and the Recovery Act, the numbers of clinicians in the National Health Service Corps are near all-time highs with 8,900 Corps clinicians providing care to more than 9.3 million people who live in rural, urban, and frontier communities. The National Health Service Corps repays educational loans and provides scholarships to primary care physicians, dentists, nurse practitioners, physician assistants, behavioral health providers, and other primary care providers who practice in areas of the country that have too few health care professionals to serve the people who live there. As of September 30, 2013, there were 26 Corps clinicians providing primary care services in New Jersey, compared to 16 in 2008.

Preventing illness and promoting health

Through Fiscal Year 2013, New Jersey has received \$38,330,491 in grants from the Prevention and Public Health Fund created by the health care law. This fund was created to support effective policies in New Jersey and nationwide, such as initiatives focused on tobacco cessation, obesity

prevention, health coverage enrollment assistance, and increasing the primary care and public health workforce, so that all Americans can lead longer, more productive lives.

A Stronger Medicare Program

Making prescription drugs affordable for seniors

In New Jersey, people with Medicare have saved nearly \$610,459,797 on prescription drugs because of the Affordable Care Act. In 2013 alone, 192,572 individuals in New Jersey saved over \$215,463,959, or an average of \$1,119 per beneficiary. In 2014, people with Medicare in the "donut hole" received a 53 percent discount on covered brand name drugs and a 28 percent discount on generic drugs. And thanks to the health care law, coverage for both brand name and generic drugs will continue to increase over time until the coverage gap is closed. Nationally, over 8.2 million people with Medicare have saved over \$11.5 billion on prescription drugs since the law's enactment, for an average savings of \$1,407 per beneficiary.

Covering preventive services with no deductible or co-pay

With no deductibles or co-pays, cost is no longer a barrier for seniors and people with disabilities who want to stay healthy by detecting and treating health problems early. In 2013 alone, an estimated 37.2 million people benefited from Medicare's coverage of preventive services with no cost-sharing. In New Jersey, 1,080,217 individuals with Medicare used one or more free preventive service in 2013.

Protecting Medicare's solvency

Medicare is stronger today because of the Affordable Care Act. The **Medicare Trustees** projected that the trust fund that finances Medicare's hospital insurance coverage will remain solvent until 2030, four years beyond what was projected in last year's report. Just a few years ago, the Medicare Trust Fund was projected to run out of money by 2017.

The health care law helps stop fraud with tougher screening procedures, stronger penalties, and new technology. Over the last five years, the administration's fraud enforcement efforts have recovered **\$19.2 billion** from fraudsters. For every dollar spent on health care-related fraud and abuse activities in the last three years the administration has returned \$8.10.

(Source: <http://www.hhs.gov/healthcare/facts/bystate/nj.html#>)



How State Legislators Can Help Their Communities Get Health Coverage in the Health Insurance Marketplace

From October 2013 through March 2014, hundreds of state legislators across the country helped connect residents in their communities to quality, affordable health coverage through the Health Insurance Marketplace.

Georgia House Minority Leader Stacey Abrams said the following in a December 2013 op-ed about the role she played in explaining the Affordable Care Act to her constituents:

"I have worked with our caucus members to host a multitude of ACA townhalls across the state of Georgia where we have explained what the Exchanges will do and why Medicaid Expansion is an imperative that we are sadly forsaking. If you've ever attended a state legislator's convening event, you'll know that seats are always available. Yet we have been pleased by the robust turn-out and the level of engagement. The citizens who leave work a few minutes early to join our discussions come ... because they understand what Healthcare.gov really is -- a proxy for a safety net sorely lacking for too long."

<http://www.huffingtonpost.com/rep-stacey-abrams/getting-it-right-2-b-4155759.html>

The next open enrollment period for health insurance will run from **November 15, 2014 through February 15, 2015**. There are several ways that local officials can ensure that residents in their community get the information and assistance to enroll. The most effective practices for state legislators include:

- ✓ Make your office an information center for enrollment information – referring residents to appropriate local help locations
- ✓ Leverage local resources, like city/county facilities, to provide enrollment opportunities
- ✓ Partner with community organizations on a local enrollment coalition
- ✓ Generate media coverage, via press conferences, local access TV/radio, or PSAs to raise awareness and promote enrollment sites
- ✓ Host community enrollment events

And even prior to open enrollment, many of these activities will also be effective to reach out to people who qualify for a special enrollment period or those who qualify for CHIP or Medicaid which have year round enrollments. It is important to remember that even though low-income individuals can enroll in Medicaid anytime during the year, the open enrollment period is a good opportunity to reach out to individuals who might be eligible but unenrolled.

This packet includes information and best practices from local officials during the first enrollment period to help you accomplish these goals. We encourage you to share your ideas and questions through the ten HHS Regional Offices. Contact information for the Regional Offices can also be found at the end of this packet.



DEPARTMENT OF HEALTH & HUMAN SERVICES

How State Legislators Can Use Existing Local Resources to Help Enroll Residents in Health Coverage

There are a number of ways that local officials can use existing city and county resources to help enroll residents in quality, affordable health coverage. Below are some of the methods and specific examples of activities that elected officials utilized during the first open enrollment period in 2013-14.

- ☐ **Utilize public spaces for enrollment activities:** Set regular office hours for enrollment at recreation centers, libraries, workforce development sites and other city/county offices. Work with your HHS Regional Office to identify trained assisters who can staff these sites, or train legislative staff to assist consumers.
 - Florida State Representative Daphne Campbell enrolled constituents at her office from 9 am to 5 pm Monday through Friday in the month leading up to March 31st.
 - Pennsylvania State Representative Dan Frankel hosted numerous information sessions at a local library in Pittsburgh.
- ☐ **Use robocalls to refer consumers to enrollment assistance locations and/or healthcare.gov.**
 - A number of Texas legislators to provide information to their constituents about enrollment via automated phone calls. Constituents were asked if they had health insurance, and if they answered no, they were directed to the call center or given information about where they could enroll locally.
- ☐ **Host a press conference to kick off open enrollment and before large enrollment events to let residents know about upcoming enrollment opportunities and generate local earned media.** In addition, include information on the Marketplace in remarks at other events to continue to push the message.
 - Texas State Representative Eddie Rodriguez visited a 211 call center to highlight one of the many local efforts underway to inform consumers about their options in the Health Insurance Marketplace in the days leading up to the end of enrollment.
- ☐ **Include informational inserts in regular mailings to residents**
 - New Jersey State Senator Nia Gill worked with county and municipal officials to include ACA information in local water bill mailings.
- ☐ **Record a PSA encouraging residents to enroll in the marketplace and work with local television and radio stations to air the announcements.**
 - Florida State Senator Geraldine Thompson recorded a video PSA and disseminated it through her distribution list.
- ☐ **Work with the local school district and PTA to include information for parents through school newsletters, back-to-school events, open houses and take home pamphlets.**

- ☐ **Use email and telephone networks** to reach consumers with enrollment information including regular newsletters.
 - PA State Senator Vincent Hughes sent several emails to his constituents to educate them on the ACA and provide information on upcoming enrollment events.
- ☐ **Apply to become a Certified Application Counselor (CAC) designated organization** and have staff trained to become CACs to provide assistance in your legislative office. You can apply to be a CAC organization at <http://marketplace.cms.gov/help-us/cac.html>
 - In Pennsylvania, the Democratic caucus received a staff training to learn how to enroll constituents.
- ☐ **Serve as "door openers" or conveners** for city, county, or regional roundtables targeting special populations, chambers of commerce, school boards, and hard-to-reach populations.
 - In Texas, State Representative Garnet Coleman and State Senator Rodney Ellis organized a "sign up Sunday" event in which navigators were at local churches to help sign people up.
 - Nebraska State Senator Jeremy Nordquist organized a college tour and visited every college in the state to ensure that young people understood their health coverage options.
- ☐ **Be creative and do what works for your community.** You know your constituents best, and we encourage you to find innovative ways to help people enroll.
 - Florida State Representative Kionne McGhee created a program called "Souls to Enroll" and worked with churches in the Miami area to ensure that there was ACA information following Sunday services. The program spread and a number of state legislators became involved.
 - In Texas, State Senator Kirk Watson hosted a "meme contest" to encourage young people to learn more about the ACA.



DEPARTMENT OF HEALTH & HUMAN SERVICES

How State Legislators Can Work with a Community Coalition to Enroll Residents in Health Coverage

During the 2014 Open Enrollment period, one of the most important roles that local officials played was to convene and support local coalitions of business leaders, non-profit organizations, and health care providers to coordinate on outreach and enrollment strategies. It is critical to maintain and strengthen these coalitions and continue the outreach work in the community as we move into the next Open Enrollment.

Keys to a successful enrollment coalition:

- **Local leadership** – As a leader within your community, your participation can help elevate the work of the coalition. Designate a staff member to be the primary point of contact for the coalition, and utilize your communications staff and infrastructure to support press efforts.
- **Broad representation** – The most effective coalitions have representatives from all the relevant partners; a suggested list of organizations is below. Think beyond the typical healthcare stakeholders!
- **Communication** – Many coalitions benefited from regular communications leading up to and during enrollment. Weekly meetings or calls and portals for group collaboration (shared calendars, access to shared data, regular reports) helped regions divide responsibilities and reduce duplicative efforts.

Some organizations and partners that you may want to consider including:

- Hospitals
- Chamber of Commerce
- Insurance brokers
- Grassroots organizations like Enroll America, Organizing for Action, Planned Parenthood
- Labor unions
- Faith leaders and interfaith coalitions
- Community health centers
- Healthcare providers or organizations, such as doctors, nurses, or social workers
- Colleges and universities including community colleges and technical colleges
- Fraternities and sororities
- Representation from key populations specific to the local community
- Public school district representatives
- Libraries
- HHS Regional Office



How State Legislators Can Use Enrollment Events to Help Enroll Residents in Health Coverage

While many individuals will enroll online at healthcare.gov or through the call center at 1-800-318-2596, many residents will want in-person assistance to help explain their coverage options and walk through the enrollment process. One way to help connect residents to this assistance is by hosting enrollment events. Below are some tips on how to host a successful enrollment event.

Creating an enrollment event

- Decide what type of enrollment activity you will host. You can host information-only sessions, town halls where residents can ask questions of experts, open houses where residents can walk in to meet with an assister, or an event where residents register for an appointment in advance.
- It can be helpful to integrate Marketplace information and enrollment into appropriate existing community events, to take advantage of a built-in audience and shared logistical support.
- Planning enrollment events can take time – most have found that planning four weeks in advance of the event provides adequate time to coordinate logistics, volunteers and promotion.

Location and timing

- The ideal location is one that is easy to access, has ample parking, and is recognizable to the community. Libraries, recreation centers, sports complexes and city or county hall can be ideal locations to host events. Many hospitals also have space available for use.
- Ensure that there are adequate safeguards (physical and electronic) in place to protect consumers' information, and that there is strong internet connection at the site. Have a backup internet connection plan such as air cards.
- Events that reach the most residents are held either in the evening or on weekends.
- The best venues have multiple spaces to meet the different needs of consumers, such as a room for a video or PowerPoint presentation on the marketplace while consumers wait, computer banks for group account creation, and a one-on-one room for enrollment appointments.

Materials & Assisters

- It is helpful to provide attendees with an enrollment checklist ([available online](#)) in advance of the event so they can come prepared with the necessary information and documentation.
- You will need computers with Internet access for residents to enroll and a way for consumers to print the pertinent information from their enrollment when completed.
- Identify local assisters at <https://localhelp.healthcare.gov/> or work with your [HHS regional office](#) to confirm CAC and Navigator support for your event

Promoting the event

- Partner with local media outlets such as local television or radio stations to help spread the word and increase attendance. Use your social media channels to promote the event.
- Identify event spokespeople who speak the language of the intended audience for your enrollment event.
- Enlist known local leaders or celebrities to attend or promote the event.
- Encourage attendees to create an email address and an online account at HealthCare.Gov before the event to reduce waiting time on site.



US Department of Health and Human Services Regional Directors Contact Information

<http://www.hhs.gov/iea/regional/index.html>

Region 1 - Boston

*Connecticut, Maine, Massachusetts, New Hampshire,
Rhode Island, Vermont*

Regional Director: Christie Hager

R1-ORD@hhs.gov

John F. Kennedy Federal Building

Government Center - Room 2100

Boston, MA 02203

Office: (617) 565-1500

Fax: (617) 565-1491

Region 2 - New York City

New Jersey, New York, Puerto Rico, US Virgin Islands

Regional Director: Jackie Cornell-Bechelli

Jackie.Cornell-Bechelli@hhs.gov

Jacob K. Javits Federal Building

26 Federal Plaza - Room 3835

New York, NY 10278

Office: (212) 264-4600

Fax: (212) 264-3620

Region 3 - Philadelphia

*Delaware, District of Columbia, Maryland,
Pennsylvania, Virginia, West Virginia*

Regional Director: Joanne Grossi

Joanne.Grossi@HHS.gov

The Public Ledger Building

150 South Independence

Mall West - Suite 436

Philadelphia, PA 19106-3499

Office: (215) 861-4633

Fax: (215) 861-4625

Region 4 - Atlanta

*Alabama, Florida, Georgia, Kentucky, Mississippi,
North Carolina, South Carolina, Tennessee*

Regional Director: Pamela Roshell

Pamela.Roshell@HHS.gov

Atlanta Federal Center

61 Forsyth Street, Room 5B95

Atlanta, GA 30303-8909

Office: (404) 562-7888

Fax: (404) 562-7899

Region 5 - Chicago

Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin

Regional Director: Kathleen Falk

Kathleen.Falk@hhs.gov

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Chicago, IL 60601

Office: (312) 353-5160

Fax: (312) 353-4144

Region 6 - Dallas

Arkansas, Louisiana, New Mexico, Oklahoma, Texas

Regional Director: Marjorie McColl Petty

Marjorie.Petty@HHS.gov

1301 Young Street, Suite 1124

Dallas, TX 75202

Office: (214) 767-3301

Fax: (214) 767-3617

Region 7 - Kansas City

Iowa, Kansas, Missouri, Nebraska

Regional Director: Stephene Moore

Stephene.Moore@HHS.gov

601 East 12th Street, Room S1801

Kansas City, MO 64106

Office: (816) 426-2821

Fax: (816) 426-2178

Region 8 - Denver

*Colorado, Montana, North Dakota, South Dakota, Utah,
Wyoming*

Regional Director: Kim Gillan

Kim.Gillan@hhs.gov

999 18th Street

South Terrace, Suite 400

Denver, CO 80202

Office: (303) 844-3372

Fax: (303) 844-4545

Region 9 - San Francisco

Arizona, California, Hawaii, Nevada

American Samoa, Commonwealth of the Northern

Mariana Islands, Federated States of Micronesia, Guam,

Marshall Islands, Republic of Palau

Acting Regional Director: Kenneth Shapiro

Kenneth.Shapiro@hhs.gov

90 Seventh Street

Federal Building, Suite 5-100

San Francisco, CA 94103

Phone: (415) 437-8500

Fax: (415) 437-8505

Region 10 - Seattle

Alaska, Idaho, Oregon, Washington

Regional Director: Susan Johnson

Susan.Johnson@HHS.gov

701 Fifth Avenue, Suite 1600, MS-01

Seattle, Washington 98121

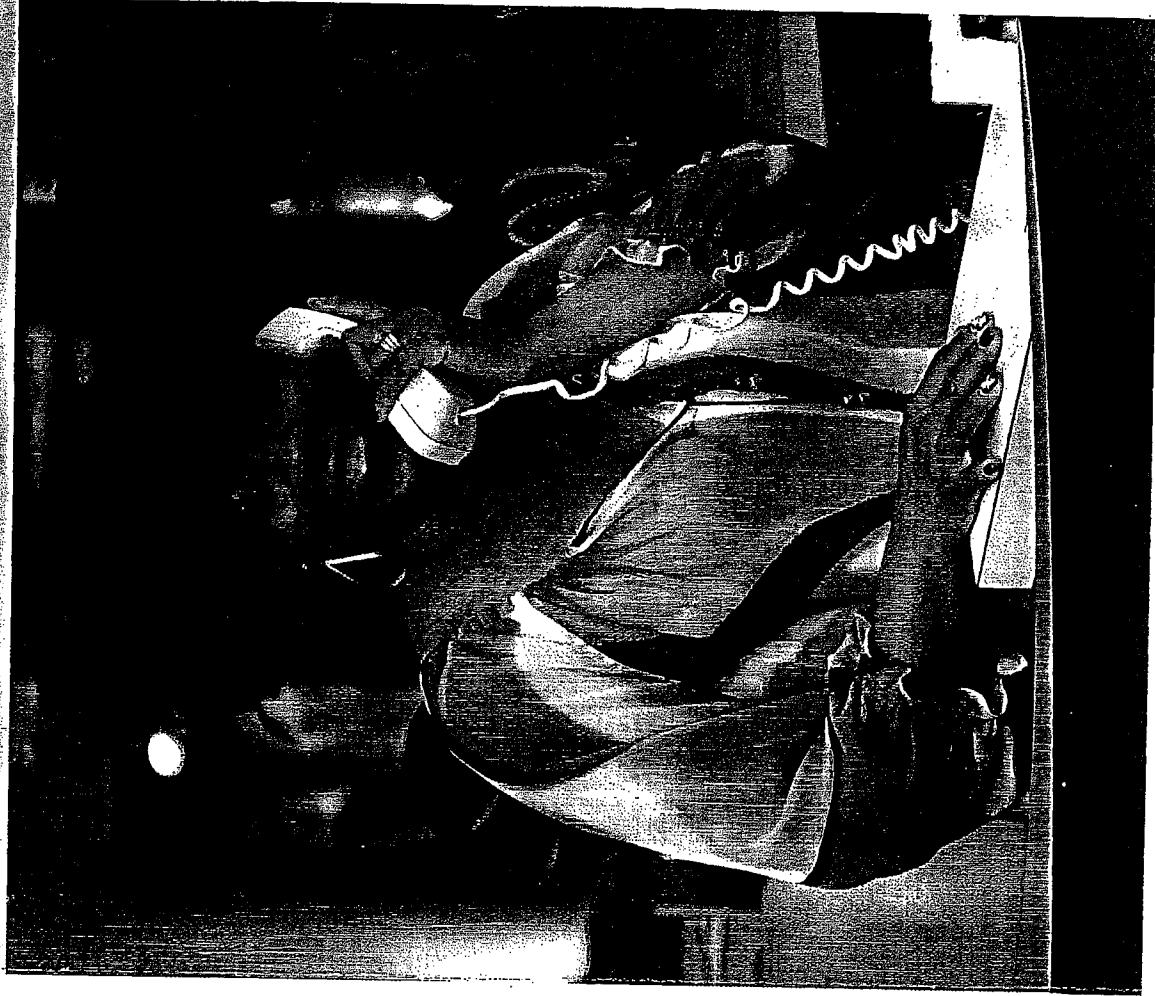
Office: (206) 615-2010

Fax: (206) 615-2087

8 things you can do to get ready

1. **Learn about SHOP.** You'll want to understand how SHOP works, which businesses qualify, and how using SHOP can benefit you and your employees. Use the SHOP Full-time Equivalent Employee Calculator at HealthCare.gov/ftc-calculator/ to see if you qualify.
2. **Talk to your employees.** Find out your employees' coverage needs. This will help you with your coverage decision and you'll get an idea of how many employees might participate.
3. **Preview health plans that may be available to you.** Use the Premium Estimator Tool at HealthCare.gov/find-premium-estimates/ to see plans and get premium estimates to help you set your budget.
4. **Set your budget.** Think about how much money you're able to spend for group coverage. You'll also need to consider how much your employees can spend for their coverage.
5. **Think about when to start coverage.** You'll need to choose a month to start coverage. Consider what timing would work best for you and your employees.
6. **Find out if you may be eligible for a tax credit.** The SHOP Tax Credit Estimator can help determine if your business may qualify for the Small Business Health Care Tax Credit, and if it does, how much it could be worth to you. Visit HealthCare.gov/small-business-tax-credit-calculator/.
7. **Get organized.** You'll want to have basic information about your business organized and available, like a list of employees you plan to cover, both full-time and part-time, and your tax ID number.
8. **Look for help.** Licensed agents and brokers may be able to help you with your SHOP options at no additional cost to you and your employees. You also may continue using your current licensed agent or broker to buy health coverage through SHOP.

About the SHOP Marketplace



Health Insurance Marketplace

CMS Product No. 11630
Revised August 2014

The SHOP Marketplace is open for business

Today, small employers like you have a simpler way to find and buy health coverage that meets the needs of your employees and fits your budget. Through the Small Business Health Options Program (SHOP), you have more choice and control over your health insurance spending.

You control the coverage you offer, and how much you pay toward employees' premiums.

Access to tax benefits

You can get the Small Business Healthcare Tax Credit only when you buy coverage through SHOP. To qualify, you must have fewer than 25 full-time employees (FTEs) making an average of about \$50,000 a year or less. You must also pay at least 50% of your full-time employees' premium costs. The tax savings is worth up to 50% of your contribution toward employees' premium costs (up to 35% for tax-exempt employers).

SHOP makes it easy for you to take advantage of other cost savings, like the chance for you and your employees to use pre-tax dollars to make your premium payments.

Consumer protections for you and your employees

With SHOP, you and your employees will benefit from consumer protections that help you get real value for your premium dollars. There are limits on the higher premiums insurance companies can charge businesses with older employees, and employees with high health care costs won't increase your group's premium. There are also limits on the share of premiums going to insurance companies' profits and administrative costs.

Health plans run by private companies

Health plans available through SHOP are run by private health insurance companies, the same way small group plans are run. All plans offer the same set of essential health benefits, like doctor visits, preventive care, hospitalization, and prescriptions.

New plan information for 2015 coverage

Starting November 2014, plans will present new cost and coverage information in a standard format, using simple language that's clear and easy to understand. You'll be able to easily compare plans based on price, benefits, quality, and other features that are important to you and your employees.

NEW! Enroll online November 2014

Starting November 2014, you and your employees will be able to visit **HealthCare.gov** to enroll online for coverage starting January 2015. To apply, you can complete a single application and choose the coverage that works for your business. You can also work with an agent or broker to enroll.

Visit HealthCare.gov for more information

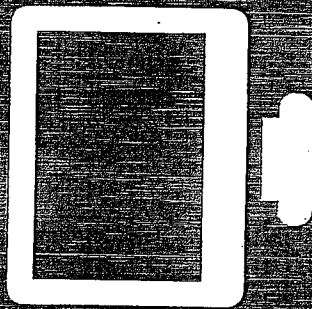
Get answers to your questions and sign up for e-mail or text updates at **HealthCare.gov/subscribe/**. You can also call the SHOP Call Center at 1-800-706-7893. TTY users should call 711 to access a SHOP call center representative.



4 Ways to Get Marketplace Coverage

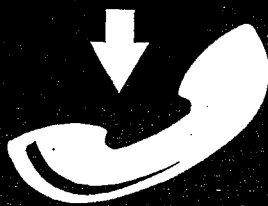
Online

Visit **HealthCare.gov** to apply and enroll on the web.



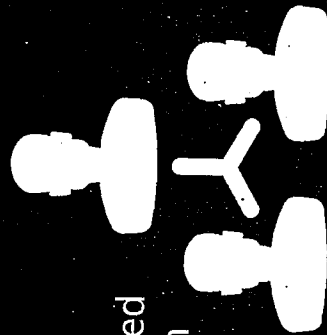
Over the phone

Call the Marketplace Call Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**. A customer service representative can help you apply and enroll over the phone.



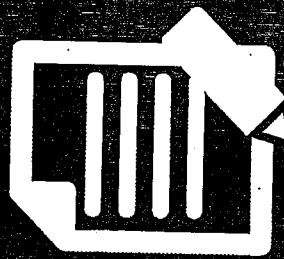
In-person help

Get help from people in your community trained and certified to help you apply and enroll in the Marketplace. Visit **Localhelp.HealthCare.gov**, or call the Marketplace Call Center.



Paper application

If you don't have a computer or time to apply and enroll over the phone, you can fill out a paper application. Call the Marketplace Call Center to get an application or download a copy from **HealthCare.gov**.



Health Insurance Marketplace

CMS Product No. 11793
August 2014



No computer? You can still get Marketplace coverage.

There are several ways to get Health Insurance Marketplace coverage, even if you don't have a computer.

GET READY



CALL



DECIDE



**ENROLLMENT
COMPLETE**



Get this information ready for you and anyone else in your household who needs coverage:

- Social Security number (SSN)
- Document number (if you're an eligible immigrant who wants health coverage)
- Birth date
- Paystubs, W-2 forms, or other info about your income
- Employer's phone number
- Policy/member numbers for any current health coverage

Call the Marketplace call center.

- **1-800-318-2596.** TTY users should call **1-855-889-4325.**
- If your state is running its own Marketplace, you'll be directed to call their toll-free number.

Decide how you want to apply and enroll.

- Apply and enroll over the phone
- Fill out the application yourself
- Get in-person help applying and enrolling

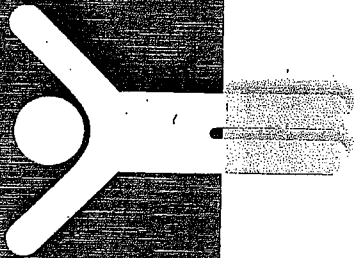
A customer service representative can help talk you through the application, fill it out for you, and help you enroll in a plan. If you don't have time to do this, you can ask them to mail you a paper application. Or, you might decide you need in-person help. The representative can give you contact information for help in your area.

If you fill out and mail in an application, we'll be in touch. Once we process your application, we'll mail you information that lets you know what coverage you qualify for and if you can get any help paying for it. We'll also tell you about your next steps, including how to compare plans, choose one that works for you, and enroll.

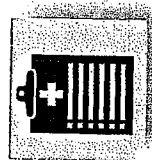
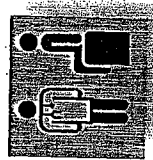
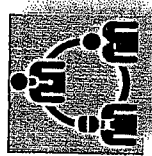
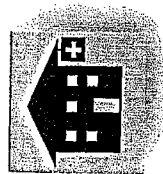
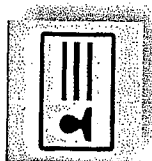
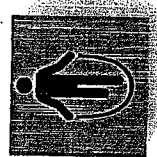


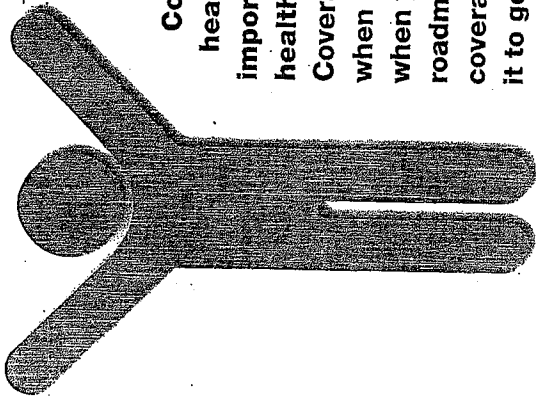
Health Insurance Marketplace

**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

Your Roadmap to health



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Why are prevention and health coverage important?



Step 2: Understand your health coverage 8
What words should I know? How much will it cost me to get care?



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Your ROADMAP to health

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.

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.

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

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.

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.

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.

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!

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.

Visit marketplace.cms.gov/c2c for more information



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, nurse, pharmacist, 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:

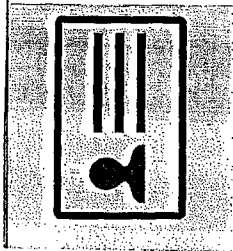
- ensure you get the preventive services that are right for you
- make healthy lifestyle choices
- improve your mental and emotional well-being
- reach your health and wellness goals.

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.

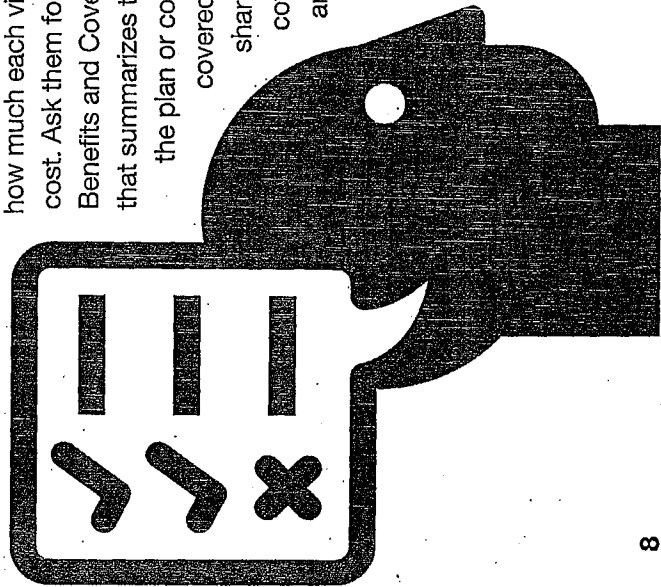


Understand your health coverage.

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.

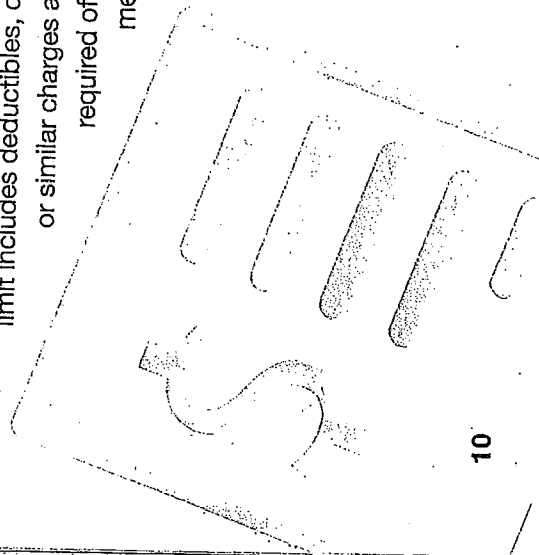
For example, if the health insurance or plan's allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.



- **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.

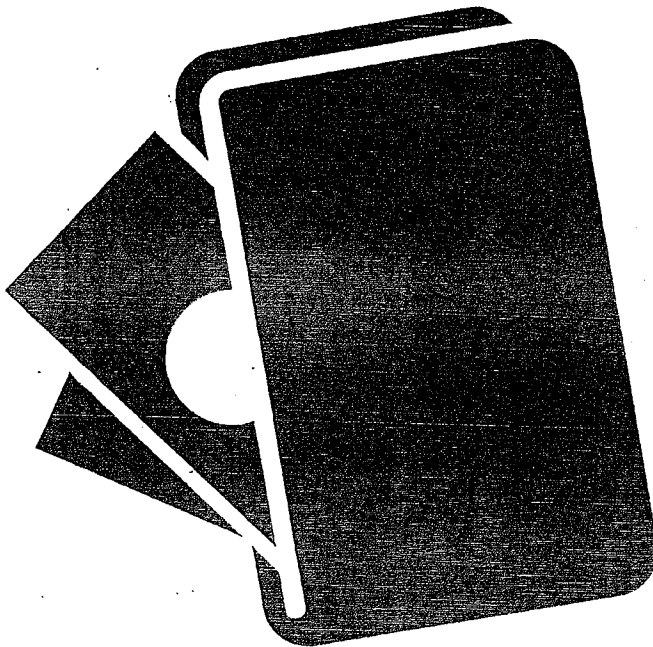
- **A Premium** is the amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly. It is not included in your deductible, your copayment, or your co-insurance. If you don't pay your premium, you could lose your coverage.

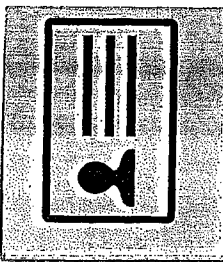
- **Out-of-pocket maximum** is the most you pay during a policy period (usually one year) before your health insurance or plan starts to pay 100% for covered essential health benefits. This limit includes deductibles, co-insurance, copayments, or similar charges and any other expenditure required of 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
\$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.

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:

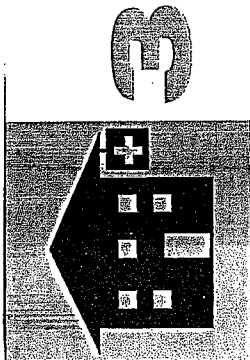
Prescriptions	\$2,900
Medical equipment and supplies	\$1,300
Office visits and procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

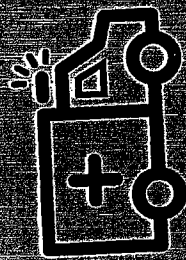
Deductibles	\$800
Copays	\$500
Co-insurance	\$580
Total	\$1,880

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>

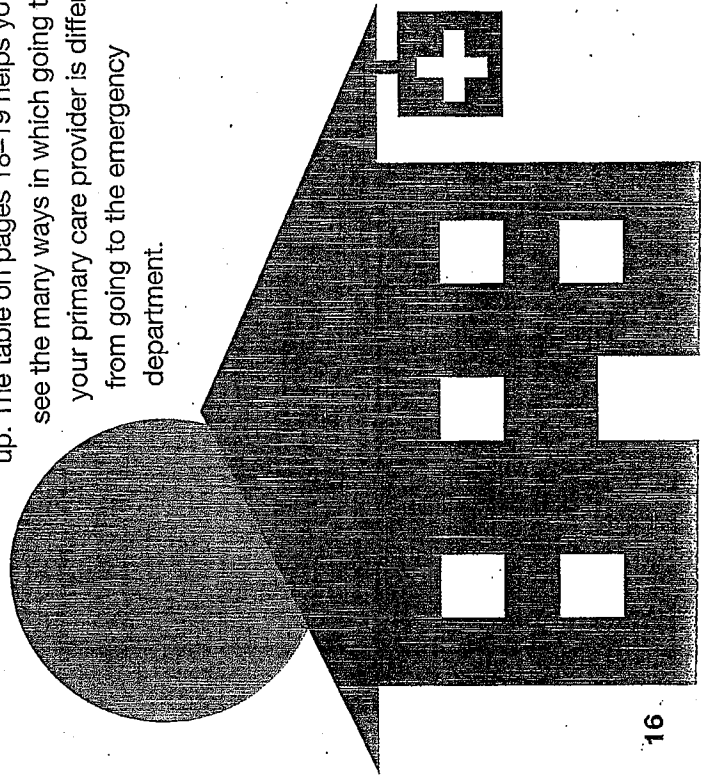


Know where to go for care.



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.



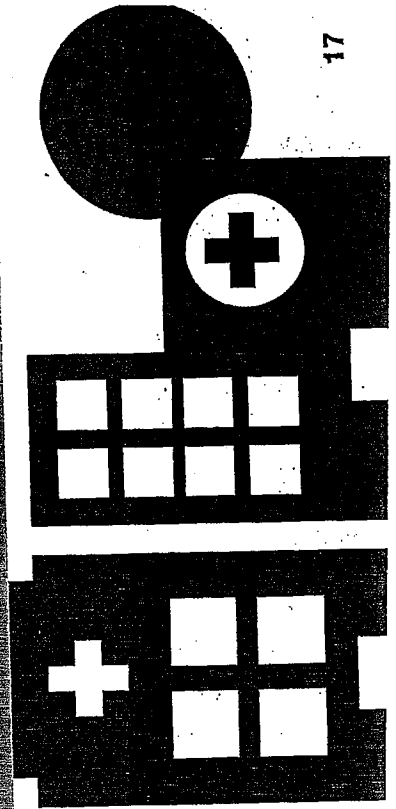
You can find primary care providers in offices, clinics, and health centers nationwide. Depending on your coverage and personal circumstances, you might find a primary care provider in:

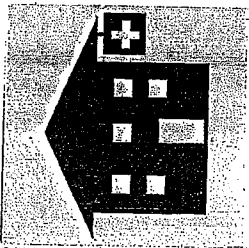
- Private medical groups and practices
- Ambulatory care centers and outpatient clinics
- Federally Qualified Health Centers
- Community clinics and free clinics
- School-based health centers
- Indian Health Service, Tribal, and Urban Indian Health Program facilities
- Veterans Affairs medical centers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

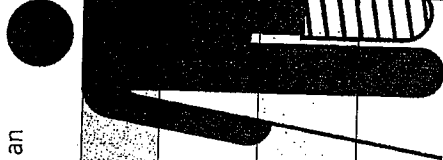
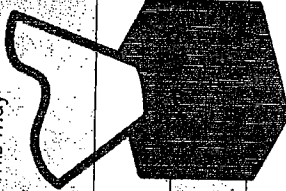
Not all types of providers and facilities take all insurance plans or types of coverage. Call the office before you go to make sure they see patients with your coverage.



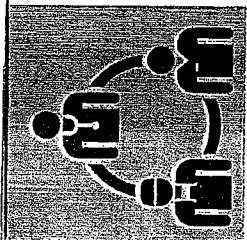


Differences Between Your Provider's Office and the Emergency Department

Primary Care Provider	Emergency Department
You'll pay your primary care copay , if you have one. This may cost you between \$0 and \$50.	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 go when you feel sick and when you feel well .	You should only go when you're injured or very sick .
You call ahead to make an appointment.	You show up when you need to and wait until they can get to you.
You may have a short wait to be called after you arrive but you will generally be seen around your appointment time .	You may wait for several hours before you're seen if it's not an emergency.
You'll usually see the same provider each time .	You'll see the provider who is working that day .
Your provider will usually have access to your health record.	The provider who sees you probably won't have access to your health records.
Your provider works with you to monitor your chronic conditions and helps you improve your overall health.	The provider may not know what chronic conditions you have .
Your provider will check other areas of your health , not just the problem that brought you in that day.	The provider will only check the urgent problem you came in to treat but might not ask about other concerns.
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.	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.
In some areas, you may be able to go to an Urgent Care Center . If Urgent Care is available in your area, call your health plan before you go to find out how much you will have to pay.	Care is available in your area, call your health plan before you go to find



25x



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.

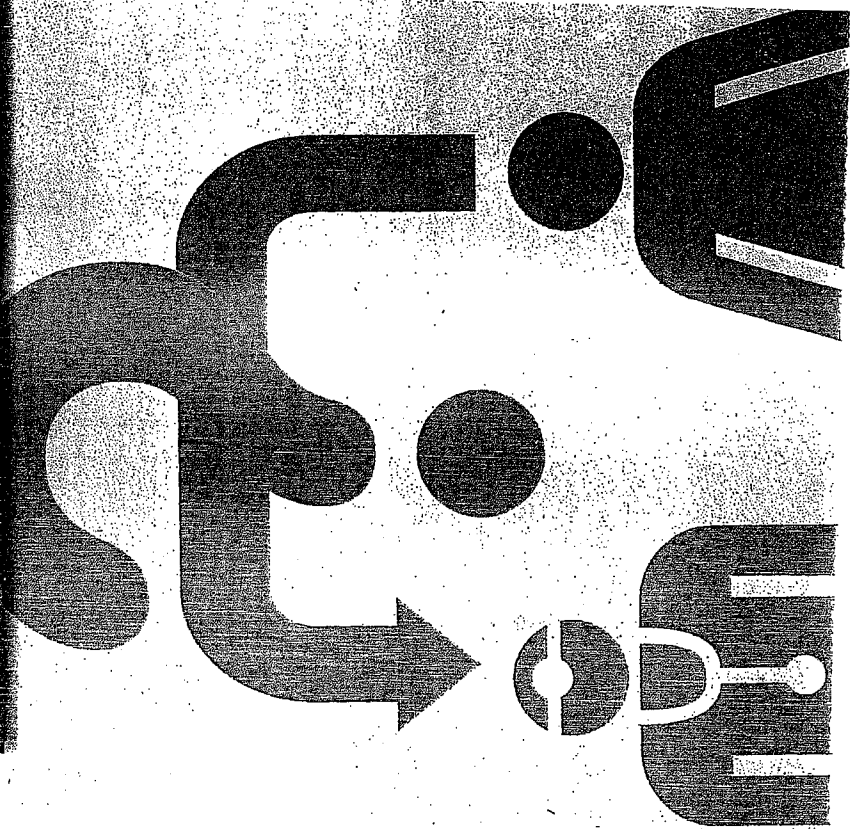
In some cases your health plan may assign you to a provider. You can usually change providers if you want to. Contact your health plan for how to do this.

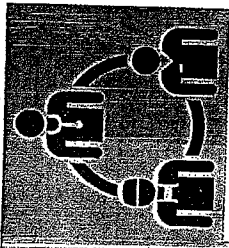
A **Specialist** will see you for certain services or to treat specific conditions. Specialists include: cardiologists, oncologists, psychologists, allergists, podiatrists, and orthopedists.

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.





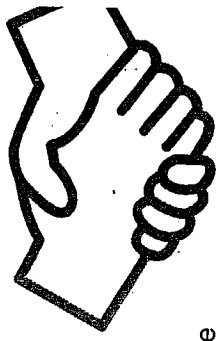
Follow these four steps to find a provider you can trust and partner with to live a long, healthy life.

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:

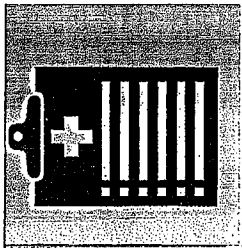
- Is the provider accepting new patients, or patients with your health coverage? This may change during the year, so you should always ask.
- Is the office close to your home or your work? How would you get there?
- Will the appointment times work with your schedule?
- Does the provider speak your language 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:

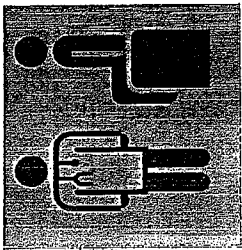
- Your name and if you're a new patient.
- Why you want to see the provider. You might want to tell them you are looking to find a new primary care provider and ask for a "yearly exam," or a "wellness visit," or you might ask to come in because you have a specific concern, like the flu, allergies, or 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.



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:

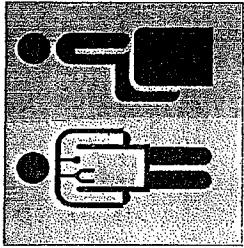
- Your family health history and medical records, if you have them.
- Medications you are taking (and the bottles so your provider knows what dose you take). If you need a refill, ask for one.
- Questions or concerns you have about your health — write them down so you don't forget to ask.

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.

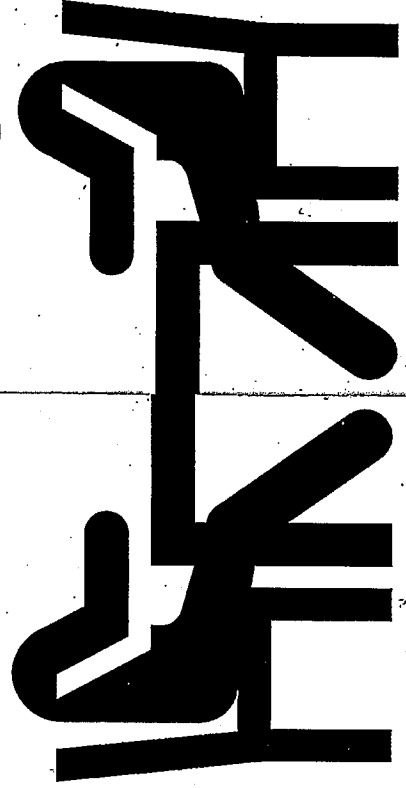
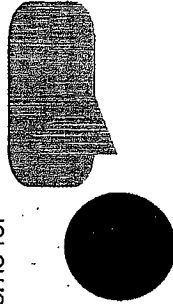


Don't be shy!

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?



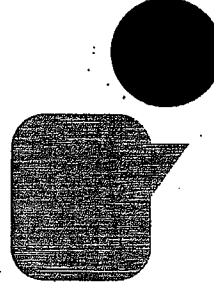
ASK

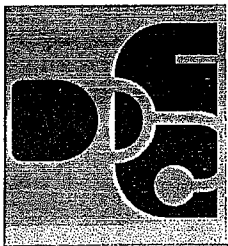
Ask your provider for written materials you can take home and read, and if there's a phone number you can call if you have questions. Don't leave until all of your questions have been answered and you understand what to do next.

- 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:

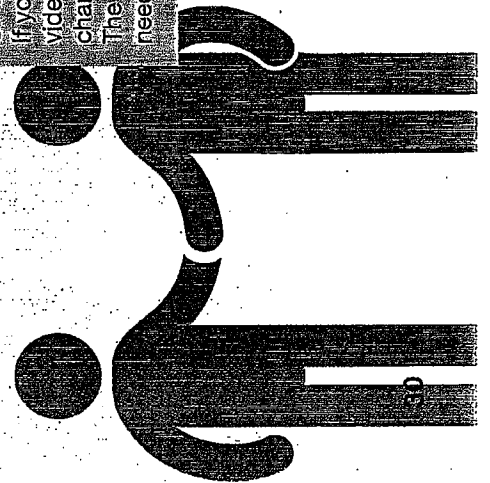
- It's important to find a provider that meets your needs.
- If you're not happy with your first visit, consider giving them another try. You can call the provider's office and share your concerns. You may also be able to see another provider in that office.

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:

- 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?

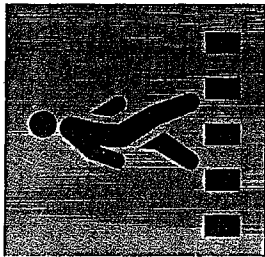
If you answered **"Yes"** to each of these questions, then you may have found a provider that's right for you!

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.

Yes?

No?



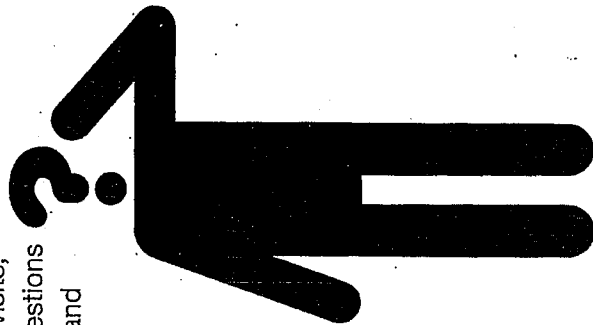
8 Next steps after your appointment.

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 somewhere 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 Explanation 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.

Customer service: 1-800-123-4567

Explanation of Benefits (EOB)

Statement date: XXXXXX
 Document number: XXXXXXXXXXXXXXXXXXXX
 THIS IS NOT A BILL
 Subscriber number: XXXXXXXXXXXX ID: XXXXXXXXXXXX Group: ABCDE Group number: XXXXXX
 Member name:
 Address:
 City, State, Zip:
 Claim number: XXXXXXXXXXXX
 Date paid: XXXXXXXXXXXX

Patient name: _____										Date paid: XXXXXXXXXX	
Date received: _____										Provider: _____	
Payee: _____											
Claim Detail				What your provider can charge you		Your responsibility			Total Claim Cost		
Line No.	Date of Service	Service Description	Claim Status	Provider Charges	Allowed Charges	Co-pay	Deductible	Co-insurance	Paid by Insurer	What You Owe	Remark Code
1	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	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 centers 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

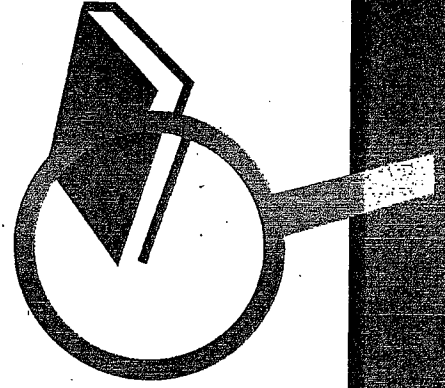
Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems or to detect illness at an early stage, when treatment is likely to work best (this can include services like flu and pneumonia shots, vaccines, and screenings like 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 you may receive. You can make a checklist specific to your needs based on your age, gender, and pregnancy status by going to www.healthfinder.gov.

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

Health Screening	Date	Result	Notes (Is this result good or bad? What should I do about it?)
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			

37x

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 _____

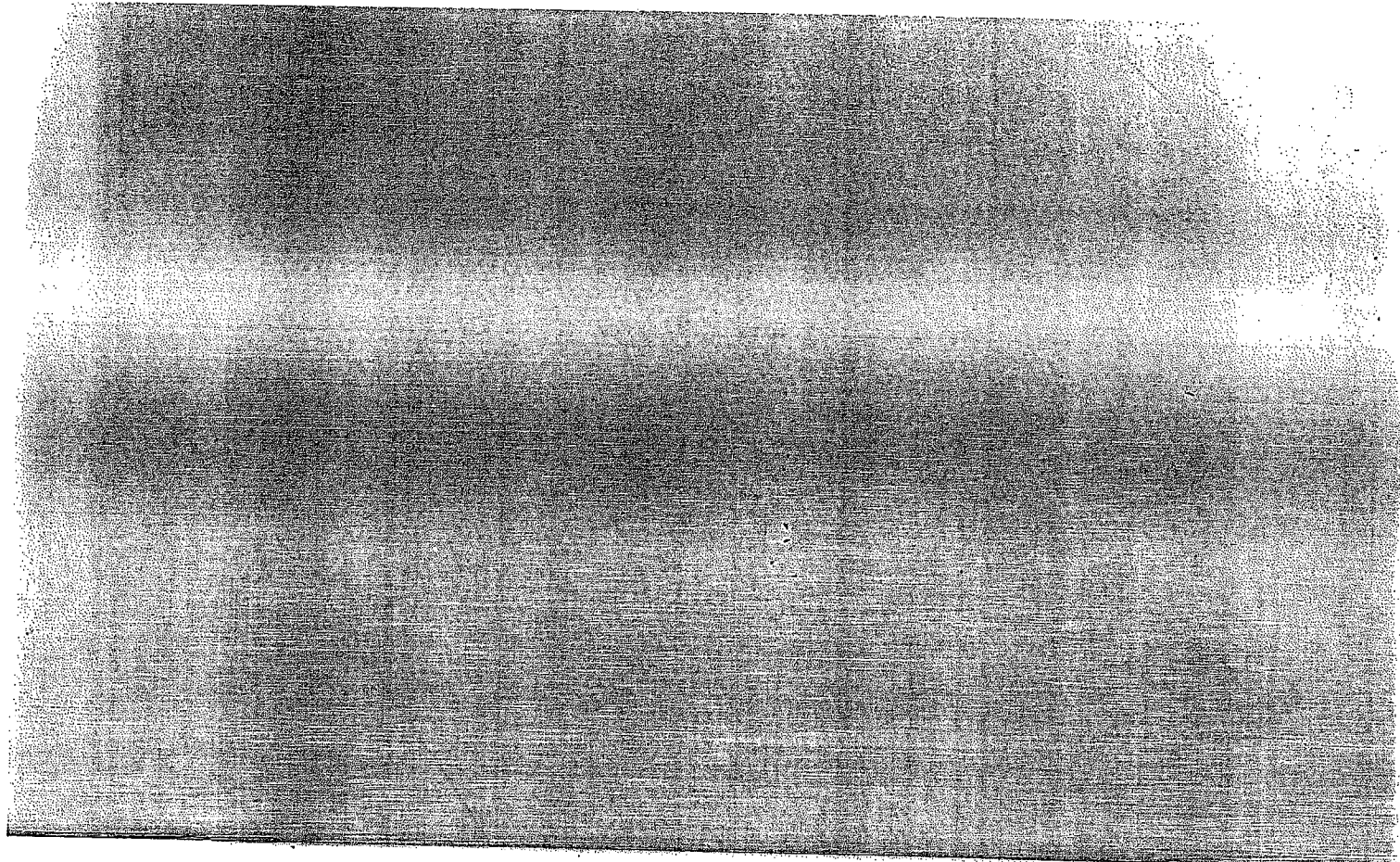
Emergency Contact _____

Medications _____

Other _____

Cut here

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.



Health Insurance Marketplace

CMS Product No.11813
June 2014

marketplace.cms.gov/c2c