1. GET IT
   - Get your ID card in the mailed at home after successfully applying for medical coverage.
   - Remember not to use it until the date your coverage begins.
   - Read what you receive about your insurance plan benefits.

2. LEARN THE PERKS
   - Your coverage has much to offer when you’re sick, but also when you’re well.
   - As a new member, go to the insurance website shown on your ID card.
   - Set up your member account & profile.
   - Look up member perks you may qualify for, like fitness discounts, hearing or vision discounts, savings on vitamins, & wellness incentives.
   - Explore the doctor/hospital finder tool—to locate those that are right for you.
   - Check out more on-line tools, like treatment cost estimators & personal health assessments.

3. USE IT
   - Present your new ID card when you go to a hospital, doctor or pharmacy for a prescription.
   - Know your portion of cost that may be due at the time of your medical or pharmacy visit. Perhaps you have an office visit copay, prescription copay, or annual deductible to meet.

4. WHAT’S NEXT
   - Your doctor will file a claim to the insurance company & possibly send you a bill.
   - Your insurance company will send you an explanation of benefits showing how much you saved & how much you owe.
   - Compare these two documents to see what to pay.
   - Remember—you may have already paid some or all costs at the time of the visit.
   - Keep an insurance folder—with all of your insurance information together in one place.
PUT YOUR HEALTH FIRST
- Staying healthy is important for you and your family
- Maintain a healthy lifestyle at home, at work, & in the community
- Get your recommended health screenings & manage chronic conditions
- Keep all of your health information in one place

UNDERSTAND YOUR HEALTH COVERAGE
- Check with your insurance plan 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
- As a new member, go to the insurance website shown on your ID card

KNOW WHERE TO GO FOR CARE
- Use the emergency room for a life-threatening situation
- Primary care is preferred when it’s not an emergency
- Know the difference between primary care and emergency care

FIND A PROVIDER
- Ask people you trust &/or do research on the internet
- Check your plan’s list of providers

MAKE AN APPOINTMENT
- Mention if you’re a new patient or have been there before
- Give the name of your insurance 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

BE PREPARED FOR YOUR VISIT
- Have your insurance ID card with you
- Know your family health history & make a list of any medications you take
- Bring a list of questions & things to discuss, & take notes during your visit

DECIDE IF THE PROVIDER IS RIGHT FOR YOU
- Did you feel comfortable with the provider you saw?
- Were you able to communicate with & understand your provider?
- Did you feel like you & 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, & take them as directed
- Schedule a follow-up visit if you need one
- Review your explanation of benefits & pay your medical bills

Source: marketplace.cms.gov/c2c
**Glossary of Terms**

**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 insurance plan contracts 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 INTERNET LINKS

*From Coverage to Care—A Roadmap to Better Care and a Healthier You*

Getting Coverage
How to get coverage through 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

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

Questions to Ask Your Provider
Topics and questions to discuss with the provider during your visit

Patient-Provider Relationship
The importance of communicating with your provider

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

Source: marketplace.cms.gov/c2c
FREE ADULT PREVENTIVE SERVICES

All Marketplace plans and many other plans must cover the following list of preventive services without charging you. This applies only when these services are delivered by a network provider.

Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
Alcohol Misuse screening and counseling

Aspirin use to prevent cardiovascular disease for men and women of certain ages
Blood Pressure screening for all adults

Cholesterol screening for adults of certain ages or at higher risk
Colorectal Cancer screening for adults over 50

Depression screening for adults
Diabetes (Type 2) screening for adults with high blood pressure

Diet counseling for adults at higher risk for chronic disease

HIV screening for everyone ages 15 to 65, and other ages at increased risk
Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
Hepatitis A and Hepatitis B
Herpes Zoster
Human Papillomavirus
Influenza (Flu Shot)
Measles, Mumps, Rubella
Meningococcal
Pneumococcal
Tetanus, Diphtheria, Pertussis

Varicella

Obesity screening and counseling for all adults
Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
Syphilis screening for all adults at higher risk
Tobacco Use screening for all adults and cessation interventions for tobacco users

Source: marketplace.cms.gov/c2c
FREE WOMEN’S PREVENTIVE SERVICES

All Marketplace plans and many other plans must cover the following list of preventive services without charging you. This applies only when these services are delivered by a network provider.

**Anemia screening** on a routine basis for pregnant women

**Breast Cancer Genetic Test Counseling (BRCA)** for women at higher risk for breast cancer

**Breast Cancer Mammography screenings** every 1 to 2 years for women over 40

**Breast Cancer Chemoprevention counseling** for women at higher risk

**Breastfeeding comprehensive support and counseling** from trained providers, and access to breastfeeding supplies, for pregnant and nursing women

**Cervical Cancer screening** for sexually active women

**Chlamydia Infection screening** for younger women and other women at higher risk

**Contraception**: FDA-approved contraceptive methods, sterilization procedures, & patient education & counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). Not applicable to health plans sponsored by certain exempt “religious employers.”

**Domestic and interpersonal violence screening and counseling** for all women

**Folic Acid** supplements for women who may become pregnant

**Gestational diabetes screening** for women 24-28 weeks pregnant & those at high risk of developing gestational diabetes

**Gonorrhea screening** for all women at higher risk

**Hepatitis B screening** for pregnant women at their first prenatal visit

**HIV screening and counseling** for sexually active women

**Human Papillomavirus (HPV) DNA Test** every 3 years for women with normal cytology results (age 30+)

**Osteoporosis screening** for women over age 60 depending on risk factors

**Rh Incompatibility screening** for all pregnant women and follow-up testing for women at higher risk

**Sexually Transmitted Infections counseling** for sexually active women

**Syphilis screening** for all pregnant women or other women at increased risk

**Tobacco Use screening & interventions** all women, & expanded counseling for pregnant tobacco users

**Urinary tract or other infection screening** for pregnant women

**Well-woman visits** to get recommended services for women under 65

Source: marketplace.cms.gov/c2c
FREE CHILD PREVENTIVE SERVICES

All Marketplace plans and many other plans must cover the following list of preventive services without charging you. This applies only when these services are delivered by a network provider.

**Alcohol and Drug Use assessments for adolescents**

**Autism screening** for children at 18 and 24 months

**Behavioral assessments** for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

**Blood Pressure screening** for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

**Cervical Dysplasia screening** for sexually active females

**Depression screening** for adolescents

**Developmental screening** for children under age 3

**Dyslipidemia screening** for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

**Fluoride Chemoprevention supplements** for children without fluoride in their water source

**Gonorrhea preventive medication** for the eyes of all newborns

**Hearing screening** for all newborns

**Height, Weight and Body Mass Index measurements** for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

**Hematocrit or Hemoglobin screening** for children

**Hemoglobinopathies or sickle cell screening** for newborns

**HIV screening** for adolescents at higher risk

**Hypothyroidism screening** for newborns

**Immunization vaccines** for children from birth to age 18 —doses, recommended ages, and recommended populations vary:

- Diphtheria, Tetanus, Pertussis
- Haemophilus influenzae type b
- Hepatitis A
- Hepatitis B

Source: marketplace.cms.gov/c2c
All Marketplace plans and many other plans must cover the following list of preventive services without charging you. This applies only when these services are delivered by a network provider.

Human Papillomavirus
Inactivated Poliovirus
Influenza (Flu Shot)
Measles, Mumps, Rubella
Meningococcal
Pneumococcal
Rotavirus
Varicella

- **Iron supplements** for children ages 6 to 12 months at risk for anemia
- **Lead screening** for children at risk of exposure

**Medical History** for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

**Obesity screening and counseling**

**Oral Health risk assessment** for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.

**Phenylketonuria (PKU) screening** for this genetic disorder in newborns

**Sexually Transmitted Infection (STI) prevention counseling and screening** for adolescents at higher risk

**Tuberculin testing** for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

**Vision screening** for all children.