



ROADMAP TO BETTER CARE TRIBAL VERSION



ROADMAP TO BETTER CARE

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

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

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

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

You can:

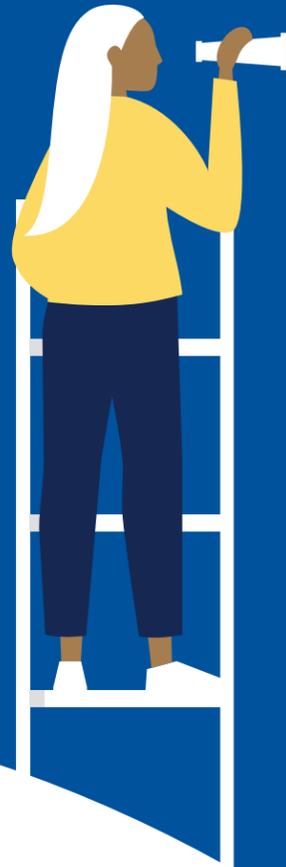
- Read the Roadmap from start to finish
- Jump to a step for quick reference

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

Start leading a healthier life now.



Start here.



CONTENTS

This version of the Roadmap has been updated to help members of the American Indian and Alaskan Native community connect to their health care, including benefits provided through the Indian Health Service (IHS), Medicare, Medicaid, Marketplaces, or private insurance. Unlike Medicare, Medicaid, the IHS is not an insurance program or an established benefits package. IHS cannot guarantee funds are available each year, and as a result sometimes needs to prioritize patients of greatest need.

The preservation of legacy, heritage, and traditions is vital. This roadmap is designed to help sustain cultural richness and strengthen the well-being of present and future American Indian and Alaska Natives for generations.

To learn more about enrollment in Marketplace, Medicare, or Medicaid see pages 4 and 5 or visit ihs.gov/forpatients.

Ensuring the Federal Trust Responsibility: Unique Protections for American Indians and Alaska Natives.	4
Step 1: Put Your Health First	10
Step 2 : Understand Your Health Coverage	13
Step 3 : Know Where to Go for Care	20
Step 4: Find a Provider	22
Step 5: Make an Appointment	26
Step 6: Be Prepared for Your Visit.	29
Step 7: Decide If the Provider is Right for You	33
Step 8: Next Steps After Your Appointment.	35
Resources: Glossary and Helpful Links	38

ENSURING THE FEDERAL TRUST RESPONSIBILITY:

Unique Protections for American Indians and Alaska Natives

When AI/ANs enroll in a Marketplace health plan, Medicaid, or Children’s Health Insurance Program (CHIP), they benefit themselves, their family and their community. AI/ANs enrolled in these programs can continue to receive services from the Indian Health Service (IHS), Tribal programs, or urban Indian programs (known as I/T/Us). By enrolling in the Marketplace, Medicaid or CHIP, this benefits the Tribal community, allowing I/T/Us to provide more services to others who are not covered or are uninsured.

Health insurance marketplace:

The Marketplace provides certain protections for members of federally recognized Tribes and shareholders in an Alaska Native Claims Settlement Act (ANCSA) corporation (ANCSA shareholders):



- **Special Enrollment Periods (SEP):** Members of federally recognized Tribes (or ANCSA shareholders) may enroll in coverage through the Marketplace throughout the year, not just during the annual Open Enrollment period. Members may also change plans as often as once a month.
 - A household that includes both members of federally recognized Tribes (or ANCSA shareholders), and persons who are not, may choose to enroll on the same Marketplace application. If all family members use the same application and one family member on the application is eligible for the SEP, all family members will benefit from the SEP.
 - However, family members who are not members of federally-recognized Tribes (or ANCSA shareholders) will not be able use the special cost-sharing plans. Therefore, federally recognized Tribal members (or ANCSA shareholders) and non-Tribal family members with a household income of under 300 percent of the federal poverty level (FPL) should consider enrolling in separate plans if they want to take advantage of all potential savings.
 - In State Marketplaces, using their own platforms, this flexibility may vary.



- **Zero cost sharing plan:** Members of federally recognized Tribes (including ANCSA shareholders) with household income between 100 percent and 300 percent of the FPL can enroll in a zero cost sharing plan, which means these consumers won’t have to pay any out-of-pocket costs such as copays, deductibles, or coinsurance when receiving care from I/T/Us or when receiving essential health benefits (EHB) through a Qualified Health Plan (QHP).
 - In addition, there is no need for a referral from an I/T/U to avoid a cost sharing obligation when receiving EHBs through the QHP.
 - These consumers can enroll in a zero cost sharing plan at any metal level.



- **Limited cost sharing plan:** Members of federally recognized Tribes (including ANCSA shareholders) with household income below 100 percent and above 300 percent of the FPL can enroll in a limited cost sharing plan, which means no copays, deductibles, or coinsurance when receiving care from I/T/Us.
 - EHBs provided by a non-Indian health care provider under a referral from an I/T/U are not subject to copays, deductibles, or coinsurance
 - These consumers can enroll in a limited cost sharing plan at any metal level.



- **Individuals who qualify for cost sharing reductions are not exempt from premiums.** However, they may qualify for Advance Premium Tax Credits depending on income.





MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) PROTECTIONS:

American Indians and Alaska Natives (AI/AN), who are eligible for services from IHS, have the following Medicaid and CHIP protections:

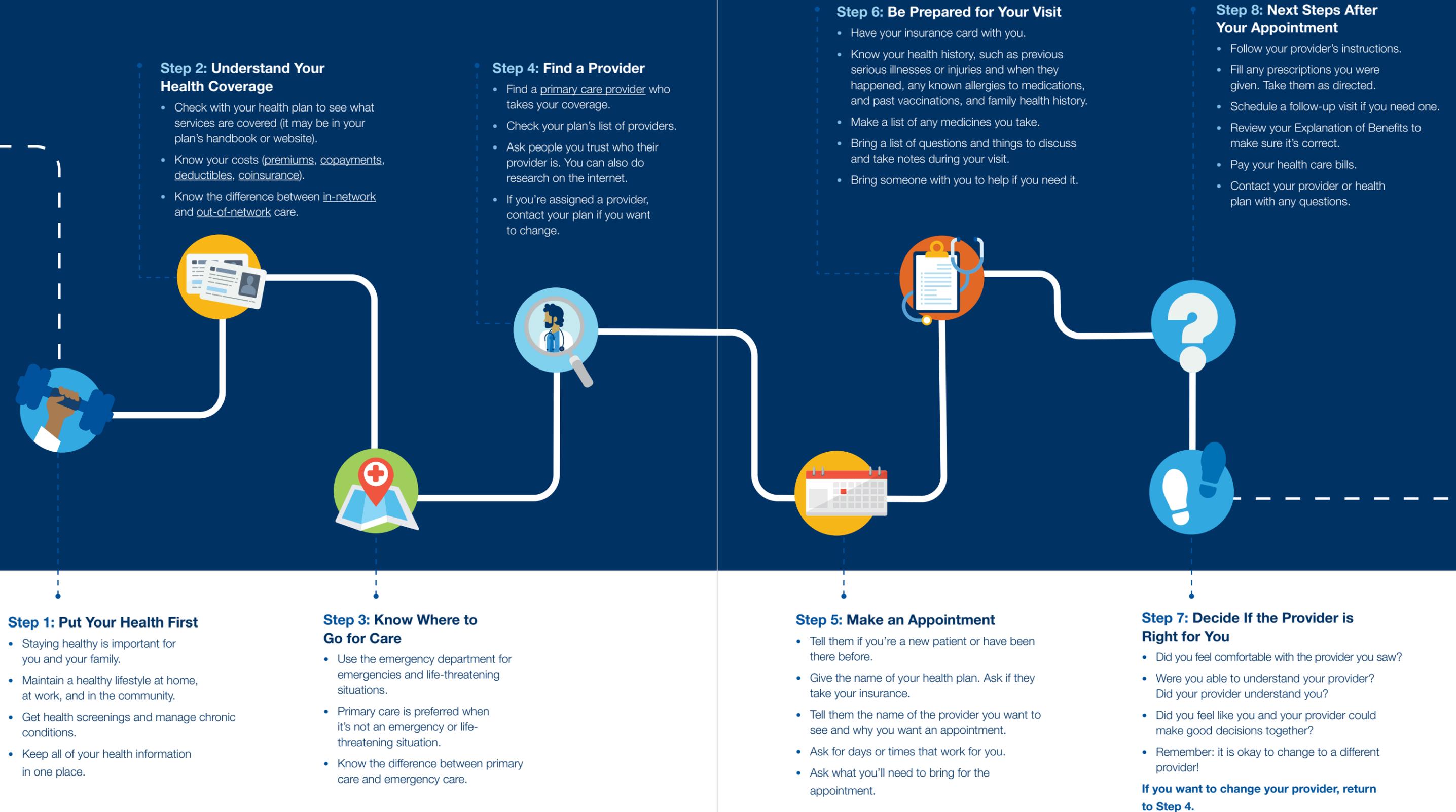
- Do not have to pay Medicaid premiums or enrollment fees; if they are eligible to receive or have received care from an I/T/U or through a Purchased/Referred Care (PRC) referral to a non-Indian provider.
- Do not have to pay any cost sharing, such as co-payments, deductibles, or co-insurance for any Medicaid service from any Medicaid provider if they are currently receiving or have ever received care from an I/T/U or through a PRC Program.
- Certain types of Indian income and resources are not counted when determining Medicaid or CHIP eligibility*.

For more information visit healthcare.gov/tribal or contact your local tribal health care provider or I/T/U.

- healthcare.gov/american-indians-alaska-natives/
- cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/AIAN-Trust-Income-and-MAGI.pdf

QUICK REFERENCE

VIEW YOUR PATH TO BETTER HEALTH



Step 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 first

- Make time for physical activity, healthy eating, relaxing, and sleep.
- Find out how to manage and prevent stress.
- Get [preventive services](#) such as routine screenings and vaccinations.
- Take an active role in your health. Take your medicines. Keep track of your family's health history when possible.
- Learn more about what you can do to stay healthy. Share what you learn with your family and friends.

Why is preventive care important?

Preventive care is used to:

- Prevent health problems
- Detect illness at an early stage, when treatment is likely to work best

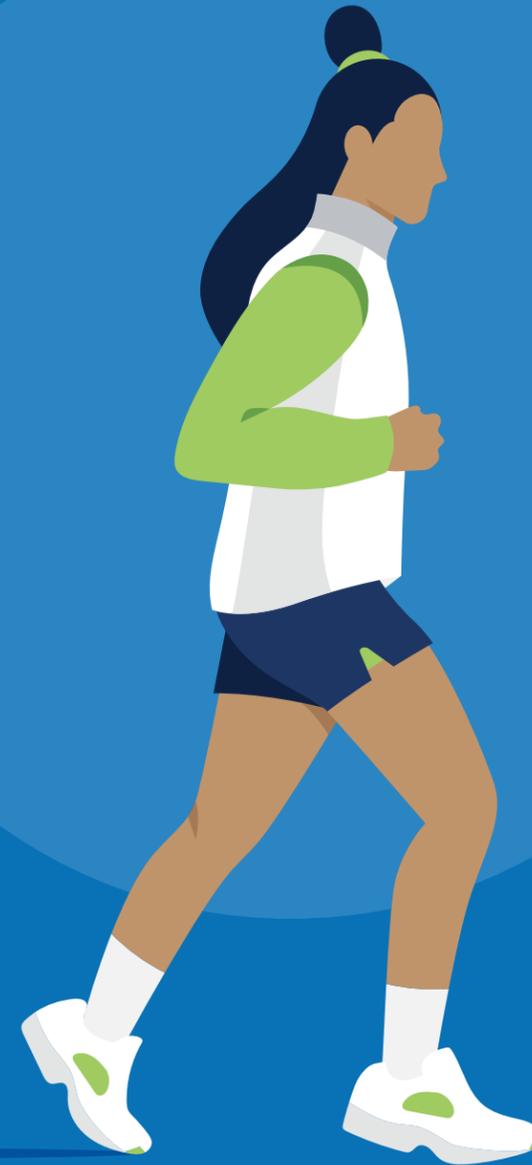
Preventive care includes:

- Screenings,
- Check-ups, and
- Patient counseling that prevents illnesses, disease, or other health problems.

Getting preventive care and making healthy lifestyle choices are key steps to good health.

Having a provider who you can trust and knows your health needs can help you:

- Ensure you get the right preventive care
- Make healthy lifestyle choices
- Improve your mental and emotional well-being
- Reach your health and wellness goals



Where do I get preventive care?

Your primary care provider will be the provider you see the most. They will get to know you and help you monitor your health over time. They will usually provide you with preventive care. This may be a doctor, nurse practitioner, physician assistant, behavioral health professional, or another health care professional you see.

Keep all of your health information in one place.

Use this booklet to keep track of your health information. Keep this information up-to-date. You may want to carry a copy with you for an emergency. Protect your identity by keeping your personal information safe!

If you're having problems with your mood or with alcohol or drug use, your provider can help. Remember, your provider can help with your mental well-being, not just physical problems. Refer to the Roadmap to Behavioral Health for more information.



Step 2:

UNDERSTAND YOUR HEALTH COVERAGE

Health coverage generally pays for provider services, medicines, hospital care, and special equipment when you're sick. It can also provide important screening and preventive services when you're not sick.

Most coverage includes vaccinations for children and adults, annual well checkups, and more without out-of-pocket costs. Keep your coverage by paying your monthly premiums (if you have them).

Health plans may differ by which providers you may be able to see and how much you have to pay.

- What services and providers your plan will pay for
- How much each visit or medicine will cost you out-of-pocket

Ask for a Summary of Benefits and Coverage that gives the key features of your coverage, as this information can vary based on your plan.

You have the right to see pricing information. Under the Transparency in Coverage rule, many employer health plans and commercial health insurance plans must:



- Post information for the public about their pricing for covered items and services (starting in 2022).
- Give you real-time information about your out-of-pocket costs (starting in 2023 and 2024).

Here are some words you may hear about your health plan. More key words are explained in the back of this booklet.

A Premium is the amount that must be paid for most types of health plans. You and/or your employer usually pay it monthly, quarterly, or yearly. It is not included in your [deductible](#), your [copayment](#), or your [coinsurance](#). If you don't pay your premium, you could lose your coverage.

A Network is the group of providers your health plan has contracted with to provide health care.

- Contact your health plan 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 pay for covered services before your health plan begins to pay.

EXAMPLE: If you have a \$1,000 deductible, you will pay \$1,000 out-of-pocket for health care services before your plan starts to pay.

After you pay your deductible, you usually pay only a [copay](#) or [coinsurance](#) for covered services. Your health plan pays the rest. Some services are usually available without [copays](#) or [coinsurance](#), even before you pay the deductible. See above for more on those services.

Generally, plans with lower monthly [premiums](#) have higher deductibles. Plans with higher monthly [premiums](#) usually have lower deductibles.

Coinsurance is the share you pay for a covered service after you've paid your deductible. The amount is given as a percentage (for example, 20%).

EXAMPLE: Your provider charges \$100 for an office visit (as allowed under their contract with your health plan). Your [copay](#) is 20%. If you've met your [deductible](#), then your [coinsurance](#) payment of 20% would be \$20. The health plan pays the other 80%.

A Copayment or copay is a fixed amount you pay for a covered health care service after you've paid your deductible, if your plan has one.

EXAMPLE: Your provider charges \$100 for an office visit (as allowed under their contract with your health plan). Your copay is \$20. If you've paid your [deductible](#), then you pay \$20, usually at the time of your visit.

Copays can vary for different services within the same plan, like drugs, lab tests, and visits to specialists. Generally, plans with lower monthly [premiums](#) have higher copays. Plans with higher monthly [premiums](#) usually have lower copays.

See "Ensuring the Federal Trust Responsibility: Unique Protections for American Indians and Alaska Natives to learn more about copays in the Zero Cost Sharing Plan" to learn more about copays in the Zero Cost Sharing Plan.



Out-of-pocket maximum/limit is the most you pay for covered services in a plan year with most health coverage. After you spend this amount on deductibles, copays, and [coinsurance](#), your health plan pays 100% of the costs of covered services.

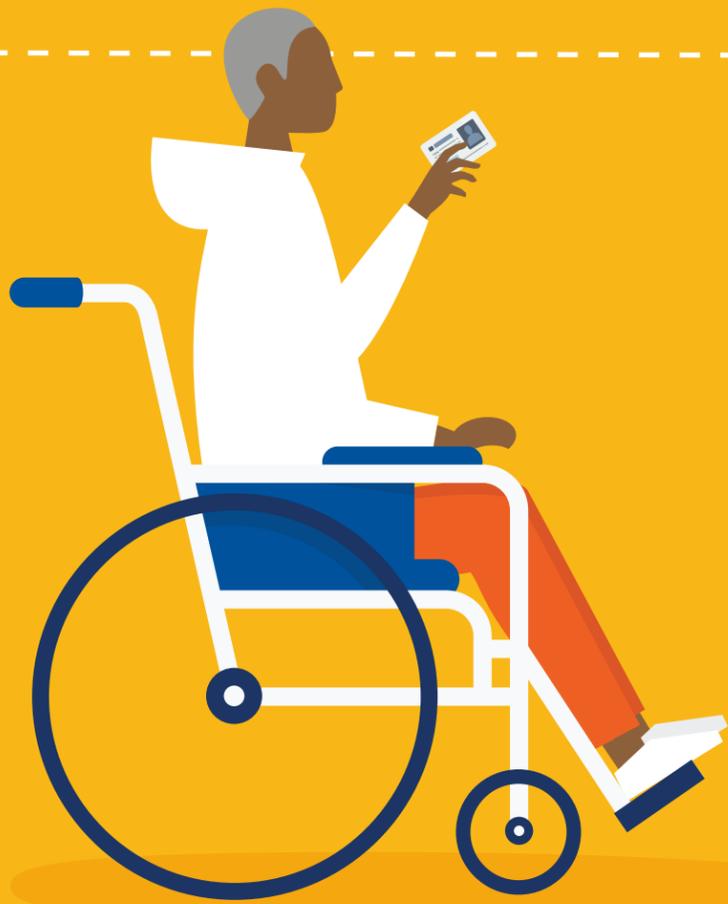
The out-of-pocket limit doesn't include:

- Your premium
- Anything you spend for services your plan does not cover
- Out-of-network services
- Costs above the allowed amount for a service that a provider may charge, where legally permitted.

Your health plan will send you an [Explanation of Benefits \(or EOB\)](#) after you see a provider or get a service. It is not a bill. It is a record of:

- The care you received; and
- How much your provider is charging your health plan.

If you have to pay more for your care, you will get a bill from your provider.



Your Insurance Card

Your health plan probably sent you an insurance card with information about your coverage. Hold on to it. You will need it when you see a provider or if you call your health plan to ask a question.

Your card may look different from the one on the next page but should have the same type of information. Some health plans don't provide cards but should give you this information in another way.

Contact your plan if you did not receive a card or cannot understand it.

Your card may include:

1. Member Name
This is usually printed on your card.

2. Member Number
This number is used to identify you. It tells your provider 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 your plan offers.

4. Copayment
These are the amounts that you will owe when you get health care.

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

6. Plan Type
Your card might have a label like HMO or PPO to describe the type of plan you have. These labels tell you what type of network your plan has, so you can see which providers are "in-network" for you.

7. Prescription Copayments
These are the amounts that you will owe for each prescription you have filled.

8. Pricing Information
New pricing information will be shown on any physical or electronic insurance identification card provided (usually found on the back of the card) to you including, applicable [deductibles](#), applicable [out-of-pocket maximum](#) limitations, and a telephone number and website where you can get help or more information.

Insurance Company	
Member Name: Jane Doe	Plan Type: 134
Member Number: XXX XXX XXXX	Effective Date: 1/1/21
Group Number: XXX XXX XXXX	Prescription Group #: 123456789
PCP Copay: \$15.00	Prescription Copay: \$15.00 Generic
Specialist Copay: \$25.00	\$25.00 Name brand
Emergency Room Copay: \$25.00	
Member Service: 800 XXX XXXX	

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

- How much will I have to pay for a primary care visit? A specialty visit? A behavioral health visit?
- Would I have to pay a different amount if I see an “in-network” or “out-of-network” provider?
- How much do I have to pay for prescription drugs?
- Are there limits on the number of visits to a provider?
- How much will it cost me to go to the emergency room if it's not an emergency?
- What is my deductible?
- Do I need a referral to see a [specialist](#)?
- What services are not covered by my plan?



Prevent Health Care Fraud

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



Never let anyone use your insurance card.



Keep your personal information safe.



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

Your health plan website or portal

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

Here are examples of how your health plan might use the terms discussed in this section to cover your medical care.

- All health plans must provide you with a Summary of Benefits and Coverage.
- Your actual costs and care will vary by your health needs and your coverage.
- Contact your health plan to learn more.

Managing type 2 diabetes (1 year of routine maintenance of a well-controlled chronic condition)		Having a baby (normal delivery)	
• Amount owed to providers:	\$5,400	• Amount owed to providers:	\$7,540
• Plan pays	\$3,520	• Plan pays	\$5,490
• Patient pays	\$1,880	• Patient pays	\$2,050
Sample care costs:		Sample care costs:	
Prescriptions	\$2,900	Hospital charges (mother)	\$2,700
Medical equipment and supplies	\$1,300	Routine obstetric care	\$2,100
Office visits and procedures	\$700	Hospital charges (baby)	\$900
Education	\$300	Anesthesia	\$900
Laboratory test	\$100	Laboratory test	\$500
Vaccines, other preventive	\$100	Prescriptions	\$200
Total	\$5,400	Radiology	\$200
Patient pays:		Vaccines, other preventive	\$40
Deductibles	\$800	Total	\$7,540
Copays	\$500	Patient pays:	
Coinsurance	\$580	Deductibles	\$700
Total	\$1,880	Copays	\$30
		Coinsurance	\$1,320
		Total	\$2,050

These numbers are not real costs and don't include all key information. Source: [cms.gov/CCIIO/ Resources/Files/Downloads/sbc-sample.pdf](https://cms.gov/CCIIO/Resources/Files/Downloads/sbc-sample.pdf)

Step 3:

KNOW WHERE TO GO FOR CARE



NEED HELP?

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

Although you can get health care from many different places, it's best for you to get routine care and preventive services from a primary care provider.

There are big differences between visits to your primary care provider and visits to the emergency department. These include cost, time spent waiting for care, and follow up.

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



Private medical groups and practices



Ambulatory care centers



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 to: ensure they get the right preventive care, manage their chronic conditions, and improve their health. Some places may offer community-based services and support, behavioral health, dental, vision services, transportation, and language interpretation.

Some may offer community-based services and support behavioral health, dental, vision services, transportation, and language interpretation.

Know before you go

Not all providers and facilities take all types of health plans. Check with the office before your appointment to make sure they accept 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, coinsurance, 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 see the provider after you arrive. But you will usually 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 your health record.	The provider who sees you probably won't have access to your health records.
Your provider works with you to take care of your chronic conditions and 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 primary care provider can help you make a plan, get your medicines, and find specialists.	When your visit is over you will get instructions to follow up with your provider. There may not be any follow-up support.

What about urgent care?

In some areas, you may be able to go to an Urgent Care Center. Call your health plan before you go to find out how much you will have to pay. Typically, Urgent Care Centers may have more flexible hours or walk-in visits and are able to handle many sick visits and other types of care. However, urgent care usually has a higher copay or coinsurance than a provider's office, and you may not see the same provider each time. You can share the medical records from Urgent Care visits with your primary care provider so that your provider has all of your health information.

Step 4: FIND A PROVIDER

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

What is a provider?

This Roadmap uses the term "provider" to mean a health care professional. This may be a doctor, nurse practitioner, physician assistant, behavioral health professional, or another health care professional you see.

You're looking for someone you can trust and work with to improve your health. So, take your time and think about what you need. Depending on your health care needs, 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 manage your chronic conditions
- 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's or teenager's provider may be called a pediatrician.

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 to ask how.

A specialist will see you for certain health services or conditions. Specialists include cardiologists, oncologists, psychologists, allergists, podiatrists, and orthopedists.

You may need a **referral** from your primary care provider before you go to a specialist. If you don't have a referral, your health plan might not pay for your visit.

For some services, your health plan may require you to first get [preauthorization](#). This means your health plan decides that a service is medically necessary. This may also be called prior authorization, prior approval, or precertification. It can be required for a treatment plan, prescription drug, or medical service or equipment before your health plan will pay for the item or service.



The right provider

Follow these 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 health plan, visit their website, or check your member handbook to find providers in your [network](#).
- Tell them if you have any requests. For example, you may want a provider who speaks a language other than English, or who can accommodate any disabilities you may have. Or you may want to be sure they're prepared to accommodate any disabilities you may have.
- If you currently have a provider who you like and want to keep, call their office and ask if they accept your coverage.
- Keep in mind that you'll usually 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 for recommendations.
- Ask them what type of provider they are and what they like about them.
- Sometimes you can find providers online and see how others in your community feel about them.

Quick tip:

Telehealth allows you to visit with your provider by phone, computer, or other device. Ask your provider if they offer [telehealth](#) and if your plan will cover it, then be sure you have the right technology for the appointment.

Ask your health plan if you need prior authorization BEFORE you visit your provider. Without [preauthorization](#), you may have to pay for things your health plan would otherwise cover.

COST
TIP



3. Pick a Provider.

Call the provider's office. Ask questions to help you decide if you want to see them. You may want to consider:

- Does the provider accept new patients? Do they take 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 travel there?
- Will the appointment times work with your schedule?
- Does the provider speak your language or have a translator available?
- Which hospital(s) does the provider work with? Can you travel there?
- Is the person who you speak with from the provider's office respectful and helpful?



4. Give Them a Try!

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



Step 5:

MAKE AN APPOINTMENT



When you make an appointment, you may be asked for:

- **Your name and if you're a new patient.**
- **Why you want to see the provider.** You may want to tell them you're looking for a new [primary care provider](#) for a "yearly exam" or "wellness visit." You may also have a specific concern, like the flu, allergies, or depression.
- **The name of your health plan.** You will need your insurance card to find this information. Ask if the provider is in your [network](#).
- **The name of the provider you'd like to see.** It may take longer to request an appointment with a specific provider. The office may recommend or refer you to another provider in your network if you feel sick or need to schedule your appointment sooner.
- **If you have a specific need, ask if they can meet that need.** For example, can they provide you with a translator if you need one? Accessible medical equipment? If not, ask them if there's another provider in the office who can.
- **The days and times that work for you.** Some offices have weekend or evening appointments.



If you have a specific need, you can also ask:

- **If they can send you any forms you need to fill out before you arrive.**
- **How you can pay for your visit.** Do they take cash, checks, or credit cards?

If you have a disability, tell the office about your needs for the appointment. Ask what to expect during the appointment. This will help you and your provider get ready.

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.

COST
TIP

Know your rights

People with disabilities have the right to access the same health care as everyone else.

Providers must:

- Give you access to care. They can't deny you care because buildings, exam rooms, or equipment aren't accessible.
- Give you information in a way you understand.
- Offer qualified sign language interpreters, assistive listening devices, or materials in braille or large print.
- Ensure equal access to [telehealth](#) and telecommunications technology for those with disabilities. To provide these individuals with effective communications, covered providers must provide auxiliary aids and services when needed.

If you have a disability, see [Getting the Care You Need: Guide for People with Disabilities](#) for more tips.





Step 6:

BE PREPARED FOR YOUR VISIT

If this is your first visit to a new provider, or you're 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.

Show up early for your appointment!

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

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

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

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

- Your medical records and health history (including things like known allergies to any medications), and your family health history, if you have them. You may want to ask your family questions about your health history before your visits. It's okay if you don't know all your family health history.
- Medicines you are taking. Write down the information or just bring the medicines so your provider knows the 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 a friend or family member with you if you need help talking with the provider.

Take charge!

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

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? How much do I take? Are there any side effects? Is a generic available? Are there any programs available that might help me pay for my medicine?

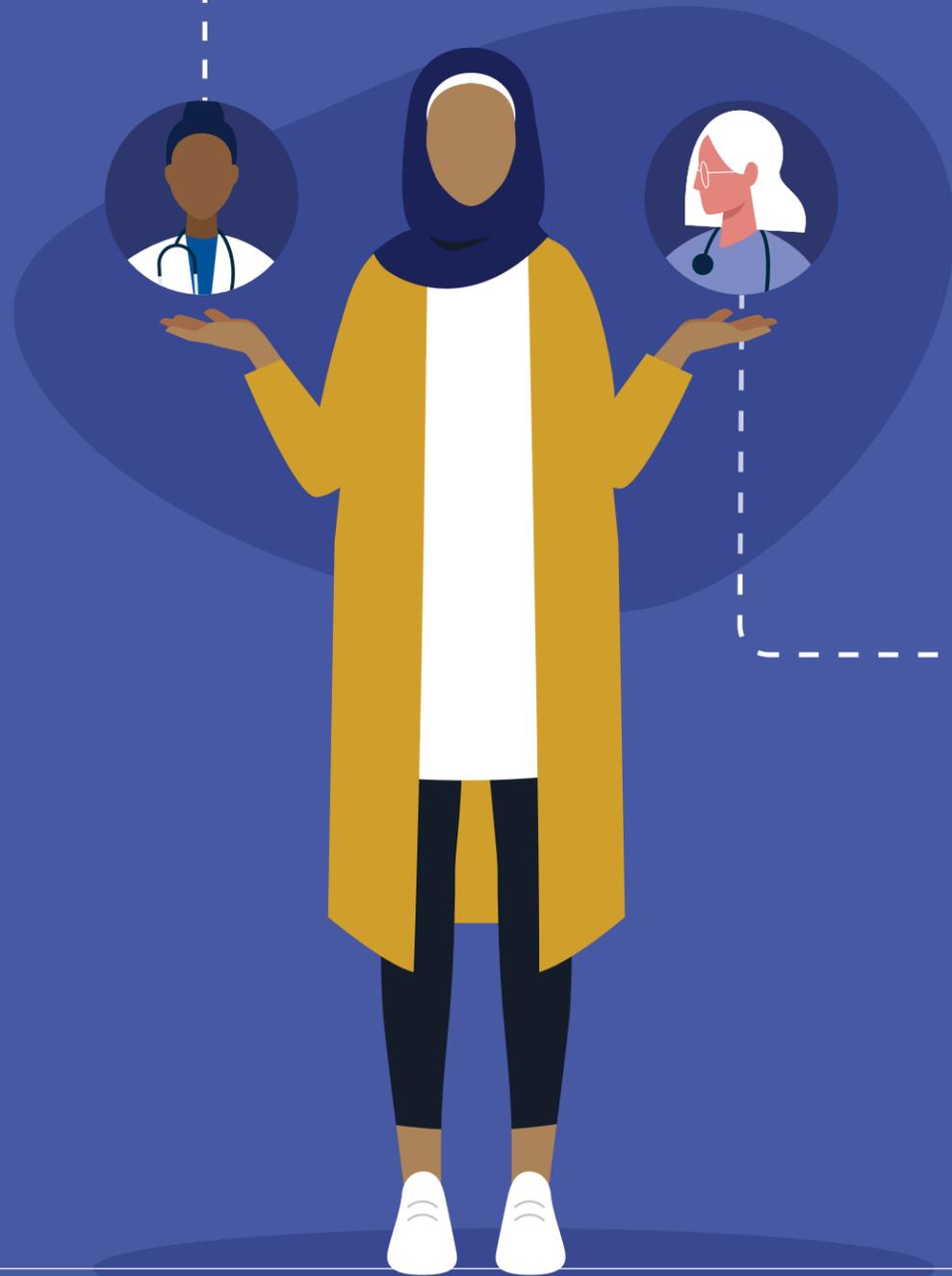
Ask

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?

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.





If you want to try a new provider — or you were assigned one and want to try a different one — check with your health plan or the provider's office first to be sure you won't be charged or know when you can go for another appointment. Make sure you choose a provider in your network (use Step 4) so you don't pay more.

**COST
TIP**

Step 7:

DECIDE IF THE PROVIDER IS RIGHT FOR YOU

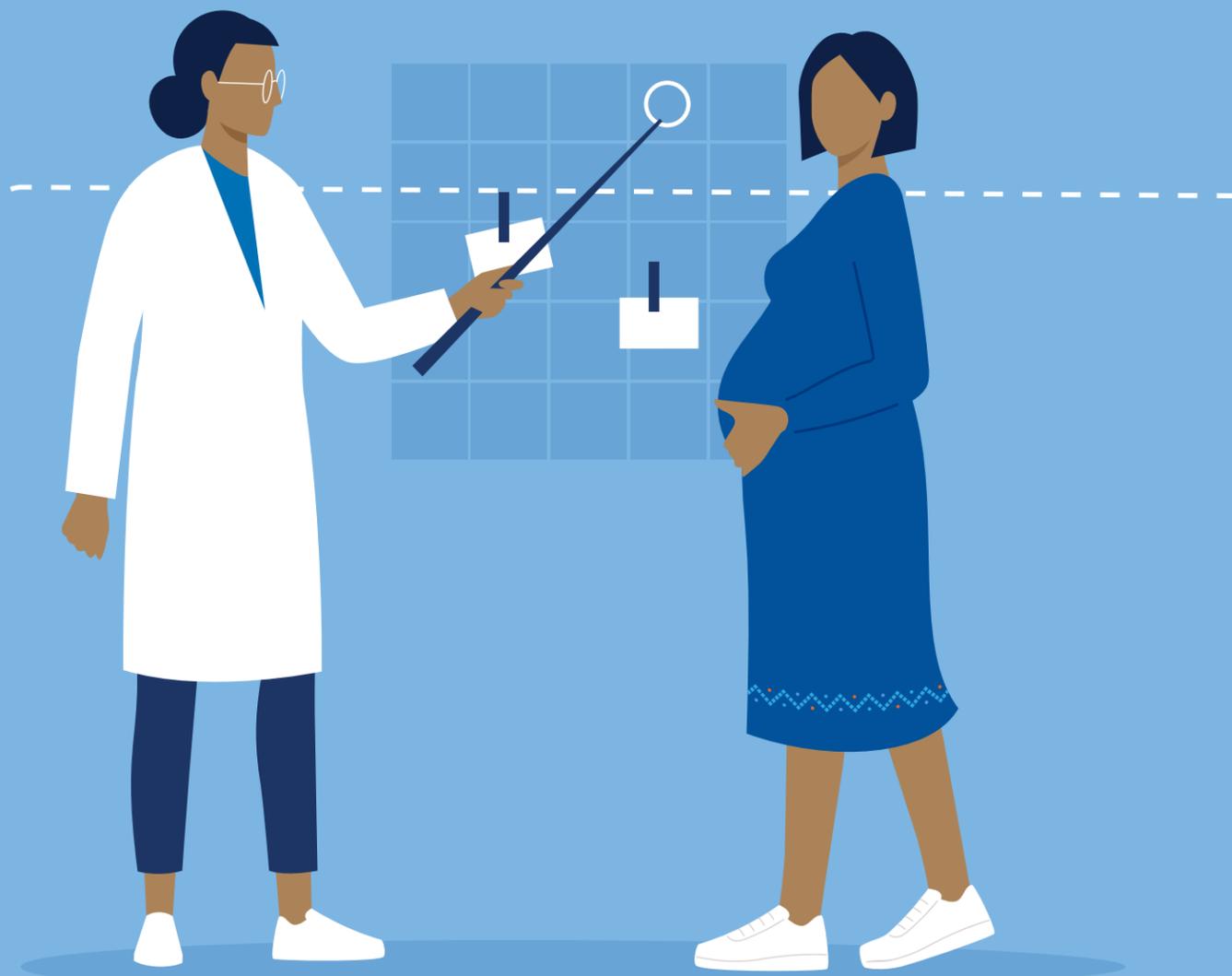
Your health and well-being are important and personal. It's important to find a provider that meets your needs. You should have a provider that you can work with, trust, and feel comfortable talking to. If you're not comfortable with your provider, say something! It is okay to ask for changes or to look for another provider.

After your first visit, think about these questions:

- Did you trust your provider? Did you feel they cared about your health? About you as a person?
- Did you feel that you were listened to? Were your health needs addressed?
- Did your provider answer your questions in a way that you could understand?
- Did your provider use words you could understand? Speak slowly enough? Pay attention to what you had to say? 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, consider seeing another provider within that office or find another provider in your network.



Step 8:

NEXT STEPS AFTER YOUR APPOINTMENT

After your appointment, here's how to keep up with your health.

Fill any prescriptions your provider gave you. If your health or drug plan has preferred pharmacies with lower costs, ask them for a list. You can also ask your provider to recommend a pharmacy. Some pharmacies offer delivery.



You'll see your primary care provider for 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 screening should happen. Make an appointment for that visit as soon as you can. Write it down someplace where you'll remember it, or in the back of this book.



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



Keep track of your health. You may be able to read a summary of your visit, follow-ups, care plan, medications, and any screening or test results on the provider's website or portal. This can vary depending on your health plan and coverage.



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



- **Set a reminder.** Put it on your calendar, or use a smartphone app.
- **Have a question?** Call your provider. Ask them questions until you understand the next steps you need to take. Consider having someone you trust come with you to your next visit.
- **Remember to put your health first, and make time.** Some providers offer extended weekday or weekend hours.
- **If you are worried you cannot afford your care, there may be ways to lower the cost.** Your provider may be able to give you a cheaper medicine. Or you may qualify for programs to help with your costs. Ask about them.
- **If the way your provider or office staff spoke or acted made you not want to return or listen to them, speak up or consider changing providers.** The right provider will treat you with respect and meet your language, cultural, mobility, or other needs.
- **Remember that by getting the preventive care that is right for you, your provider is more likely to find an illness or problem early and help you get better faster.**

Reading your Explanation of Benefits (EOB)

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

Pay your bills

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

Appeals

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

Quick tip:

Contact your health plan if you have questions about your [EOB](#).

Here's an example of an Explanation of Benefits

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

1. Phone Numbers

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

2. Payee

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

EXPLANATION OF BENEFITS

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

Statement Date: XXXXXX **Member Name:**

Document Number: XXXXXXXXXXXX **Address:**

THIS IS NOT A BILL **City, State, Zip:**

Subscriber Number: XXXXXXXXXXXX **ID:** XXXXXXXX **Group:** ABCDE **Group Number:** XXXXX

Patient Name: XXXXXX **Provider:** **Claim Number:** XXXXXXXX

Date Received: XXXXXXXXXXXX **Payee:** **2** **Date Paid:** XXXXXXXX

3. Service Description

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

4. Provider Charges

is the amount your provider bills for your visit.

5. Allowed Charges

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

Claim Detail				What your Provider Can Charge You		Your Responsibility			Total Claim Cost		
Line No.	Date of Service	Service Description	Claim Status	Provider Charges	Allowed Charges	Co Pay	Deductible	Coinsurance	Paid by Insurer	What You Owe	Remark Code
1	3/20/22-3/20/22	Medical care	Paid	\$31.60	\$2.15	\$0.00	\$0.00	\$0.00	\$2.15	\$0.00	PDC
2	3/20/22-3/20/22	Medical care	Paid	\$375.00	\$118.12	\$35.00	\$0.00	\$0.00	\$83.12	\$35.00	PDC
			Total	\$406.60	\$120.27	\$35.00	\$0.00	\$0.00	\$85.27	\$35.00	PDC

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

6. Paid by Insurer

is the amount your health plan will pay to your provider.

7. What You Owe

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

8. Remark Code

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



American Recovery & Reinvestment Act (ARRA)

Section 5006 of ARRA provides Protections for American Indians and Alaska Natives under Medicaid/CHIP:

- Exempts AI/ANs from Medicaid coinsurance, deductibles and copayments for services if they have received services from an I/T/U or through Contract Health Services/Purchased and Referred Care. Any AI/AN eligible for I/T/U services or referral is exempt from premiums and enrollment fees. Exempts Indian trust income and resources in determining eligibility for Medicaid and CHIP.
- Exempts Indian trust income and resources from Medicaid estate recovery in Medicaid.
- Allows AI/ANs enrolled in Managed Care to go to I/T/Us, whether in or outside of the network, protects payments for I/T/Us when AI/AN in managed care seek services there and establishes criteria for Indian Managed Care Entities.
- Requires States to solicit advice from I/T/Us on Medicaid and CHIP issues that have a direct effect on Indian Health Programs.

Appeal

A request for your health plan to review a decision that denies a benefit or payment.

Coinsurance

The percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible.

Contract Health Services or Purchased/Referred Care (CHS or PRC)

Contract Health Services (CHS) means “any health service that is, (A) delivered based on a referral by, or at the expense of an Indian health program, IHS, a Tribe or Tribal Organization carrying out a CHS program of the IHS under the Indian Self-Determination and Education Assistance Act, including for this purpose a referral made by an Urban Indian organization (as that term is defined in 25 U.S.C. 1603(h); and, (B) provided by a public or private medical provider or hospital that is not a provider or hospital of the Indian health program. The name was changed to Purchased/Referred Care (PRC) in 2014. Under the ACA, a person enrolled in a limited cost sharing plan through the Marketplace will need to obtain a CHS/PRC referral or a referral from an urban Indian organization in order to avoid co-payments and deductibles when receiving essential health benefits outside the IHS or Tribal facility.

Copayment (also called Copay)

A fixed amount (\$20, for example) you pay for a covered health care service after you've paid your deductible.

Deductible

The amount you owe for health care services your health plan covers before your health plan starts to pay. With a \$2,000 deductible, for example, you pay the first \$2,000 of covered services yourself.

Emergency Medical Condition

An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Services

Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services

Services that your health plan doesn't pay for or cover.

Explanation of Benefits (or EOB)

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

Federally Recognized Tribe

Any Indian or Alaska Native tribe, band, nation, pueblo, village or community that the Department of the Interior acknowledges to exist as an Indian tribe. For updated information visit: bia.gov/service/tribal-leaders-directory.

Formulary

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

Hospital Outpatient Care

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

I/T/U

This term includes the Indian Health Service (IHS), a Tribe (or tribal organization) carrying out a program of the IHS under the Indian Self-Determination and Education Assistance Act, or an urban Indian health organization

Indian Health Service (IHS)

Individuals of Indian descent belonging to the Indian community served by the local facilities and program of the Indian Health Service are eligible for services. An individual may be regarded as within the scope of the Indian Health Service program if he or she is regarded as an Indian by the community in which he or she lives as seen by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction. Eligibility based on one's status as a California Indian, Eskimo, Aleut, or other Alaska Native is included within this framework.

In-network Coinsurance

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

In-network Copayment

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

Network (also called In-network)

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

Non-Indians

The following non-Indians are eligible for services from the Indian Health Service:

- A child under the age of 19 who is the natural child, adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian,
 - Spouses of an eligible Indian, if the tribe passed a tribal resolution that makes spouses eligible to receive services from the Indian Health Service, or
 - Non-Indian women who are pregnant with the child of an eligible Indian.
-

Out-of-network

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

Out-of-network Coinsurance

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

Out-of-network Copayment

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

Out-of-pocket Maximum

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

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

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

Premium

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

Preventive Services

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

Primary Care Provider

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

Specialist

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

Telehealth

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

Urban Indians

The Indian Health Service also contracts with urban Indian organizations to provide services to urban populations for which special statutory eligibility criteria apply. To be eligible for the exemption as an urban Indian, an individual must reside in an urban center where an IHS funded urban Indian health program is located and meet one or more of the following four criteria:

- Be a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member,
 - Be an Eskimo or Aleut or other Alaska Native,
 - Be considered by the Secretary of the Interior to be an Indian for any purpose
 - Be determined to be an Indian under regulations promulgated by the Secretary
-

HELPFUL LINKS

Getting coverage

Children's Health Insurance Program (CHIP)

insurekidsnow.gov

Health Insurance Marketplace¹

healthcare.gov/quick-guide/one-page-guide-to-the-marketplace

Medicare

medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan



¹ Health Insurance Marketplace[®] is a registered service mark of the U.S. Department of Health & Human Services.

Getting care

Finding a Provider

Reviews and ratings of local providers
[healthgrades.com](https://www.healthgrades.com)

For People with Disabilities

[cms.gov/files/document/getting-care-you-need-guide-people-disabilities.pdf](https://www.cms.gov/files/document/getting-care-you-need-guide-people-disabilities.pdf)

Behavioral Health Care

[cms.gov/About-CMS/Agency-Information/OMH/Downloads/Roadmap-to-Behavioral-Health-508-Updated-2018.pdf](https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Roadmap-to-Behavioral-Health-508-Updated-2018.pdf)

Telehealth

[cms.gov/files/document/c2c-telehealth-patient-toolkitdigital508c.pdf](https://www.cms.gov/files/document/c2c-telehealth-patient-toolkitdigital508c.pdf)
telehealth.hhs.gov/patients

Medicines

Guide for Safe Medicine Use
[health.gov/myhealthfinder/topics/everyday-healthy-living/safety/use-medicines-safely](https://www.health.gov/myhealthfinder/topics/everyday-healthy-living/safety/use-medicines-safely)

Manage Costs

My Health Coverage at-a-Glance
[cms.gov/About-CMS/Agency-Information/OMH/Downloads/MyHealthCoverage.pdf](https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/MyHealthCoverage.pdf)

Accessing Tribal Resources

CMS American Indian/Alaskan Native information

[go.CMS.gov/AIAN](https://www.go.CMS.gov/AIAN)

CMS Native American Contacts

[cms.gov/files/document/cms-native-american-contact.pdf](https://www.cms.gov/files/document/cms-native-american-contact.pdf)

CMS Division of Tribal Affairs

Email: tribalaffairs@cms.hhs.gov

Indian Health Service

[ihs.gov](https://www.ihs.gov)

Health Insurance Enrollment

[healthcare.gov/tribal](https://www.healthcare.gov/tribal)
1-800-318-2596



Follow your path.



go.cms.gov/c2c

This communication was printed, published, or produced
and disseminated at U.S. taxpayer expense.

Revision Date: May 2024

Publication # 11813