Navigating Healthcare and Maximizing Insurance Benefits

Although we generally expect our health care providers to understand our insurance plans, it is actually your responsibility as a patient to understand what your health insurance does or does not cover. The following tips are designed to help you minimize medical debt where possible, navigate through our complex healthcare system, and empower you as a patient.

Take time to understand your health insurance coverage

The Affordable Care Act (ACA) requires insurance companies to provide beneficiaries with a Summary of Benefits and Coverage (Summary of Benefits) as well as a Uniform Glossary of terms (Glossary). The Summary of Benefits provides an easy-to-understand summary of important features of your plan, such as the covered benefits, your out of pocket responsibility (also known as cost-sharing), and coverage exceptions and limitations. The Summary of Benefits is a good place to start understanding your insurance coverage to avoid surprise costs, or to help you compare health insurance plans. Your insurance company should provide you with a copy within seven days of requesting it. The Glossary defines terms that health insurance companies commonly use, such as deductible or co-payment. You can also often find this information online, if your insurance plan offers an online portal. If you still have trouble understanding what exactly is covered, contact your insurance company directly to get clarification, or talk to your employer’s benefits manager if you get your insurance through work.

Ask providers whether they accept your insurance plan before making an appointment

Most insurance plans offer different levels of coverage for providers who have contracted with the insurance company to accept certain rates for services (in-network) vs. providers who have not contracted with your plan (out-of-network). In most circumstances, seeing an in-network provider will maximize the benefits you can receive through your insurance policy. Your health plan may have a list of in-network providers on its website; however, these lists are often out of date or inaccurate. Before you make an appointment with a new health care provider, contact the provider directly to confirm whether they accept your insurance policy, regardless of whether they are on your plan’s list and regardless of whether the provider’s website lists your health plan. When you call a provider to ask whether they accept your insurance plan, be specific about the type of coverage you have. Do not just give the name of the insurance company (for example, Blue Shield) because some providers may accept employer-sponsored plans, but not plans from the state Marketplace or Medicaid. For example, if you have a Blue Shield plan from the California Marketplace, ask, “Do you accept Covered California Blue Shield PPO plans?”

Read forms carefully before signing

Always read any forms a doctor’s office or hospital gives you to sign. Do not sign anything that you do not understand. If you sign something you have not fully read, you might be agreeing to
pay for services and treatments without realizing it, or you could be signing privacy forms that may give people access to your medical records. If you are not sure about a document that you have been asked to sign, ask your health care provider to explain what they are asking you to sign, why, and whether signing the document is required in order to receive services/treatment.

**Make sure providers have your current health insurance and contact information**

You should always make sure your health care providers know whether you have health insurance and that the health insurance information they have on file for you is current. Take your insurance card to all appointments and to the pharmacy, in case there are any questions about your coverage. This is especially important if your insurance coverage has recently changed, so that providers do not bill your old insurance plan.

If you have more than one type of insurance coverage (such as a supplemental policy), be sure to tell your health care provider about any secondary coverage. Make sure all of your health care providers (doctors, facilities, pharmacies) have your current contact information, including the address and phone number where you can be reached.

**Take detailed notes when you speak to your doctor, billing office, or health plan**

It is important to keep your own record of what is going on with your health and finances. Take notes during conversations with your doctors or ask whether they can write down important information for you or print a summary of your visit with notes. Similarly, if you have a phone conversation with your doctor’s office about billing, take careful notes with dates, amounts, and first and last names (or ID numbers if they will not give you a last name). If you make a payment by phone, make a note for yourself of how you paid, the date, the amount paid, and to whom you spoke; write down any confirmation numbers provided, and always ask for written confirmation of payment as well. If you talk with someone from your insurance company, take careful notes and ask for written confirmation of any information shared over the phone. These notes might be a helpful reference if issues come up or when you start receiving medical bills. It may be helpful to keep a list of any doctor visits along with dates, names of providers, and note any payment you made in the office so that when you get a bill, you can look to see if it matches with your own records.

**Talk to your healthcare provider about your concerns and/or seek a second opinion**

If you are unhappy with your treatment or do not understand your treatment plan, ask questions and talk with your healthcare provider about your concerns. Often, communicating with your healthcare provider can help clarify and resolve your concerns. However, if you do not agree with or are unsure about your health care provider’s diagnosis or suggested course of treatment, you can get a second medical opinion. First, check to see if second medical opinions are covered by your insurance plan. The law varies by state, but you can find out from your health insurance plan or from your state department of insurance whether your insurance policy is required to cover a second opinion. If you have Medicare, you can contact your local State Health Insurance Assistance Program (SHIP) office for information on second opinion coverage. If your insurance covers the cost of a second opinion, you would need to visit an in-network provider for maximum
coverage and pay applicable copays, coinsurance, and deductibles. If your insurance does not cover second opinions or if you want to see an out-of-network doctor, you would likely need to pay for the visit out of pocket.

**Keep copies of everything**

Keep a copy of all communications from your providers and insurance company. If you get a “prior authorization” (approval for medically necessary treatment) from your insurance company, save a copy of it in case you are later denied coverage. Other important documents to save include, but are not limited to: medical bills from providers; Explanation of Benefits (EOBs); any other communications with insurance companies or providers; and summary of visits from any admissions to hospitals or clinics. It may be helpful to compile a folder or file where you can keep and organize all of your medical paperwork. Some of this information is also likely accessible on your insurance company’s website.

**Review all of your medical bills and Explanation of Benefits**

This may sound like a lot of work, but review all medical bills or EOBs that you receive. If you have taken careful notes and kept all paperwork, compare your bills to EOBs to make sure you are being charged the right amount for the right treatments or services. If you do not agree with a bill, question your provider or insurance company; even professionals make mistakes. For more information about medical billing and medical debt, please see additional fact sheets on the Cancer Legal Resource Center’s website.

**Make sure you submit the right paperwork in a timely manner**

It is important that you and/or your health care providers submit all bills to your health insurance company in a timely manner. While most of the time medical providers will submit a bill to your insurance company directly, it is still the patient’s responsibility to make sure that it was submitted and paid for by the insurance company. Many health insurance policies require providers to submit claims within a specified time period, often within 90 days of the service or treatment. If your provider submits a claim outside of this time frame, your health insurance plan may deny payment. One way to avoid this is to be on the lookout in your mail for an Explanation of Benefits (EOB). If you have not received an EOB within 60 days of your doctor visit, you may want to follow up with the provider directly to confirm that the claim was submitted to your insurance plan.

**Open and review all mail, even if you cannot afford to pay bills**

As simple as this may sound, checking (and opening!) your mail regularly is very important. For people facing large amounts of medical debt, it can be tempting to avoid opening mail for fear that it may just be another bill; however, ignoring bills can result in serious consequences, such as negative credit reporting, repossession of property, or debt collection lawsuits and default judgments. Medical providers and insurance companies send a lot of important information by mail, not only medical bills. If you do not open mail, you may not know whether you have an outstanding bill that is at risk of going into collections or whether there is a deadline to submit an
appeal for a health insurance claim. If you do not have the time or energy to manage your mail, you may want to ask a friend or family member to help sort your mail for you.

Ask for assistance if you need it

If dealing with health insurance, medical bills, or other paperwork is becoming too difficult, do not be afraid to ask for help. A loved one, physician, or social worker may be able to provide you with assistance. If you need to contact your insurance company regularly, you can ask for a case manager or patient navigator who can talk to your social workers and medical providers to make sure you are getting the care you need. If your insurance company does not provide case managers, you can ask to speak to the same person each time you call, so that you do not have to repeat your story every time you call. Cancer support groups may have additional resources, as do other national and local nonprofit organizations. We have included other resources below.

Resources

For a comprehensive list of questions that you may want to ask your health insurance or health care providers, please see “Cancer Support Community’s Frankly Speaking About Cancer: Coping with the Cost of Care.” [https://orders.cancersupportcommunity.org/](https://orders.cancersupportcommunity.org/)

**Patient Advocate Foundation**  
(800) 532-5274  
[https://www.patientadvocate.org/](https://www.patientadvocate.org/)  
(Patient Advocate Foundation helps guide patients through complex healthcare challenges.)

**LIVESTRONG**  
(877) 220-7777  
[https://www.livestrong.org/we-can-help](https://www.livestrong.org/we-can-help)  
(Provides free personalized support for those affected by cancer.)

**Patient Rising**  
(800) 685-2654  
[askusanything@patientrising.org](mailto:askusanything@patientrising.org)  
[https://patientsrising.org/](https://patientsrising.org/)  
(Patient Rising helps patients, family members, caregivers, and supporters find the tools they need to advocate for the right treatment.)

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