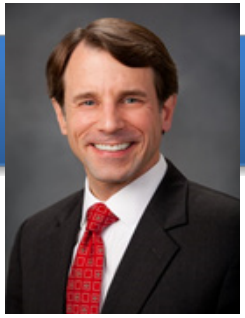
1-800-927-4357

www.insurance.ca.gov

Health Insurance

Dave Jones, Insurance Commissioner
California Department of Insurance



Dave Jones
Insurance Commissioner

Dear California Consumer:

The California Department of Insurance (CDI) is the nation's leading consumer protection agency and your best resource for honest and impartial answers to insurance questions.

We have knowledgeable insurance professionals staffing our consumer hotline. My staff is available to help you get answers to insurance related questions, file a request for assistance, or report suspected insurance fraud.

Call 800-927-HELP (4357) or visit www.insurance.ca.gov to view all of our consumer information guides and insurance resources. These tools are available to consumers for free.

Thank you for giving us the opportunity to serve you.

Sincerely,

Dave Jones

Dave Jones
California Insurance Commissioner

Table of Contents

Health Insurance Basics

Health insurance can help protect you from the high costs of illness or injury. It also helps you get regular health care, such as exams, preventive care and vaccines.

But health insurance can cost a lot. And it can be hard to choose the best insurance. Use this brochure to help choose health insurance.

This brochure can help you:

1. Choose health insurance;
2. Understand your health insurance policy; and
3. Know who to contact if you have questions

This brochure can also help you understand your health insurance policy. Your policy is a legal document, and it is important that you understand it.

How can I learn more about my health insurance?

- Ask your insurance company or employer for a Summary of Benefits. This is a short list of your benefits and costs.
- Make sure you have a copy of your policy. This has more information about your costs and benefits. It also tells you the services that are not covered.
- Most health insurance companies have a phone number you can call with questions. Or ask your health insurance agent, insurance company, or employer to explain things.

How can the California Department of Insurance (CDI) help me?

CDI regulates many health insurance companies.
This means that we make sure they follow the law.

- We can help you understand your health insurance policy.
- We can help you if you have a problem, or want to file a complaint (such as an appeal or grievance).
- You can call CDI with questions at **1-800-927-4357**
- For a list of other agencies that help people with health insurance problems, see page 35.

What if I have Medicare?

This brochure does not explain Medicare.

- For information on Medicare call **1-800-MEDICARE** or visit **www.medicare.gov.**
- You can also call California's Health Insurance Counseling and Advocacy Program (HICAP) at **1-800-434-0222.** HICAP provides free counseling and information on Medicare.
- If you have a question about Medicare Supplement (Medigap) policies plans, you can call CDI at **1-800-927-4357.**

Do I have to buy health insurance?

The Shared Responsibility provision of the Affordable Care Act (ACA) requires you to:

- Have health coverage that meets certain minimum essential coverage requirements;
- Qualify for an exemption; or
- Pay a penalty to the IRS when you file your taxes.

Your coverage can come from your job, a public program like Medi-Cal or Medicare or you can buy your own coverage for you and/or your family.

It is important to make sure that your coverage meets the minimum essential requirements standard before you buy. See page 6 for more details on health insurance benefits.

Thanks to healthcare reform, if you need to buy your own coverage, insurers cannot deny your application (during the annual open enrollment period) and you may qualify for financial assistance from the federal government.

Health Insurance Benefits

Benefits are the services your health insurance pays for. To use a benefit, you must need it. Your health insurance only pays for services that are medically necessary.

Most health insurance in California covers a wide range of basic services, including (also known as Essential Health Benefits):

- Hospital care
- Visits to a primary care doctor and specialists
- Outpatient procedures, like surgery
- Laboratory tests and diagnostic services, like x-rays, mammograms and blood tests
- Pregnancy and newborn care
- Preventive and routine care, like vaccinations and checkups
- Mental health care (including therapy for autism)
- Emergency and urgent care
- Rehabilitation therapy, such as physical, occupational, and speech therapy
- Some home health or nursing home care after a hospital stay

The benefits listed above are also called essential health benefits and only policies that cover these items qualify as minimum essential coverage.

Preventive Care

Preventive care helps you stay healthy. It also helps doctors catch health problems early. It includes:

- Blood pressure, diabetes, and cholesterol tests
- Birth control
- Cancer screening
- Routine vaccines
- Regular pediatrician visits
- Vision and hearing screening for children
- Counseling about obesity

Most policies are required to cover certain preventive care services without any out-of-pocket cost to you.

- This means that you do not have a co-pay or co-insurance for the preventive care.
- Even if you have not met your deductible yet, you do not have to pay for the preventive care.
- Policies that started before March 23, 2010 do not have to follow this rule. They are called "grandfathered" policies.

Some services must be covered.

California law says that many health insurance policies must cover essential health benefits which include services like diabetes supplies, maternity care, cancer screening, transgender health care, and substance abuse treatment.

Watch out for "discount plans" and "limited benefit plans."

These plans may not be insurance and may not cover all essential health benefits. See page 6.

Mental Health Coverage

All insurance policies sold in California are required to provide coverage for mental health and substance use disorder services.

Health insurers must provide equal coverage for mental and physical health issues. For example, your insurer cannot charge you more for a visit to a mental health provider than they do for a visit to a similar physical health provider. Insurers cannot limit your number of visits or put other restrictions on mental health treatment that are greater than those for other medical benefits.

As part of this requirement, insurers are required to cover Applied Behavioral Therapy for Autism Spectrum Disorder.

If you have any questions about your mental health coverage, contact the Consumer Hotline at the Department of Insurance (1-800-927-4357) for assistance.

Health Insurance Costs

Insurance helps pay for health care. But it does not pay all costs. Usually, you have to pay a share of the costs.

Premium: A fee to get and keep insurance. You may pay the whole premium or your employer may pay all or part of it.

Premium Assistance: You may qualify for help from the federal government to pay for your premium. You can only get the assistance if you purchase one of the plans offered through Covered California. Visit www.coveredca.com or call 1-800-300-1506 for more information.

Deductible: This is the amount you must pay each year before your insurance begins to pay. Some policies have separate deductibles for prescription drugs and hospital care. Some policies have no deductible. Check your policy to learn how your deductible works.

Co-insurance or Co-pay

Some policies have a co-pay and some have a co-insurance. Some policies have both.

- **Co-insurance:** This is the part of each bill that you must pay, after you've met your deductible. For example, if your insurance covers 80% of the charges for your surgery, you must pay the other 20%. This 20% is called the co-insurance.
- **Co-pay:** This is a flat amount you pay for each visit to a doctor or each prescription, such as $20 for a doctor visit or $15 to fill a prescription.

Annual out-of-pocket limit: After you reach this limit, you may not have to pay more co-pays or co-insurance for the year. This limit may not include prescription drugs. Check your policy to learn how this limit works.

Yearly and Lifetime Limits (Maximums)

Most insurance policies are not allowed to apply yearly or lifetime limits on the benefits you receive.

Keep track of your bills.

- Keeping track of your bills helps you protect yourself from fraud.
- You may get something in the mail that says, "This is not a bill." It may be called an Explanation of Benefits (EOB). You should not pay it.
- If you do not understand a bill, call the people who sent it to you. You have a right to get an explanation.
- If you think the bill is wrong, call your health insurance company. You can file a complaint or appeal if you disagree with the bill. See pages 28–29.
- If you have two insurance policies, usually one policy pays first. Talk to your insurance companies to make sure you understand what to do with your bills.

How much will I have to pay?

It can be hard to know how much you may owe. Call your insurance company and ask for an estimate before you get a costly service. Ask if you can compare the costs of different providers online.

Sometimes we have to make health care decisions without the best cost and quality information. Now you can use our California Healthcare Compare website, www.cahealthcarecompare.org to compare cost and quality for common services like knee replacements, diabetes treatment, and childbirth. In addition to asking your insurer, this tool can help you compare providers.

The Allowed Amount

Some policies have a limit on what they will pay for a service. This is called the "allowed amount" or "negotiated rate." If your provider charges more, you may get a bill for the extra amount. This is called balance billing.

A provider that is not in your PPO network may bill you for charges over the allowed amount. Learn about PPOs on page 18. However, a provider in your PPO's network can only bill you for your deductible, co-pay and/or co-insurance.

Group Health Insurance

Most people in California get group health insurance through a job. This is also called employee coverage. Employers with 100 employees buy large-group policies, and those with fewer than 100 buy small-group policies.

In most cases, group insurance is better than individual insurance. It gives you more benefits at a lower cost.

- Your employer may offer one group policy, or several choices.
- You may pay part of your premium.
- You may pay all of the premiums for your dependents.
- Most group policies must cover the basic services listed on page 6. Self-insured plans do not have to cover all these services.
- Group policies must cover care for pregnancy and delivery, whether you are pregnant when you join or become pregnant after you join.

For more information on your group insurance, see your Human Resources department or ask for an insurance handbook.

Pre-existing conditions: A pre-existing condition is a health condition you had before you enrolled in health insurance. Insurers cannot deny or limit your coverage for this reason.

Waiting periods: When you start a job, employers can have waiting periods of up to 90 days before your health insurance begins. During this time, you do not pay premiums or get any health care services from your employer.

Enrolling in Group Health Insurance

When you are hired, ask about your deadline for enrolling in your employer's health insurance. After this deadline, you must usually wait until the yearly open enrollment period to join.

However, you can enroll dependents after certain events, such as marriage, birth, or when your spouse or partner loses their job.

The open enrollment period is when you make decisions about the insurance choices your employer offers. Your employer will tell you when insurance choices, benefits, and costs change.

Self-insured Plans

Many large employers are self-insured. The employer sets aside a pool of money and uses it to pay for the health care of employees. Ask your employer if they are self-insured.

These plans work like health insurance in many ways. Often the employer will hire an insurance company to manage the plan.

- If you have a self-insured plan through your employer or union, you can get help from the U.S. Department of Labor, Employee Benefits Security Administration. Call the Employee Assistance Hotline at **1-866-444-3272.**
- If you have a self-insured health plan through your town or religious organization, you can file a complaint with the plan directly or you can file a lawsuit.

If You Lose Your Group Health Benefits

If you lose your job or your hours are cut, you may also lose your group health benefits.

- You may be able to buy continuation health coverage. (See below.)
- Or you may be able to buy an individual policy (see page 14).
- Or you may qualify for a public program (see page 17).
- Or you may be able to get on your spouse or partner's group insurance. Try to do this as soon as possible, to avoid a gap in coverage.

You can keep your employers health coverage

You and your dependents may be able to keep your existing health coverage even if you lose your group health benefits. These options are called continuation coverage.

If you lose your coverage, your employer must provide you with information on your options for continuing your existing coverage. You may see options with names like **COBRA**, **Cal-COBRA**, **Conversion** or **HIPPA**. If you choose one of these options:

- You have to pay all of the premium.
- After you use up one kind of continuation coverage, you may be eligible for another kind of coverage.
- There are deadlines and other requirements for each kind of continuation coverage.

If you have any questions about your options, contact the Consumer Hotline at the Department of Insurance (800) 927-4357 for assistance.

Continuation Coverage or an Individual Policy?

If you lose your job or your hours are cut, you may have the choice to enroll in continuation coverage or buy an individual/family policy. Compare the price, benefits, and physician networks carefully when you make this choice. For example, an individual plan is often less expensive than continuation coverage, but the benefits may be different and you may not be able to see the same doctors.

Buying Individual Health Insurance on Your Own

People usually buy individual health insurance because they do not have group insurance through a job and they do not qualify for any public program.

You can buy an individual policy from an insurance company, a licensed health insurance agent, or from Covered California-California's Healthcare Marketplace. You can reach Covered California at www.coveredca.com or call them at (800) 300-1506.

There are many kinds of individual policies, with different costs and benefits. You should study your choices carefully so that you can choose the one that best suits your needs. See pages 25–26 for tips on choosing a policy.

Medi-Cal

Medi-Cal is another option for getting health coverage for you and/or your family. Your county's social services offices or Covered California can tell you if you qualify for this free coverage. You can sign up for Medi-Cal year round. See page 17 for details.

When Can I Purchase Coverage?

Usually, you can only purchase a new individual/family policy or make changes to your existing policy during California's open enrollment period. That period usually begins during November and ends in January. Contact your insurer, licensed agent or the Department of Insurance for exact open enrollment dates.

You can purchase or change coverage outside of open enrollment if you have a ***Qualifying Life Event*** including, but not limited to:

- Lost or will soon lose your health insurance
- Permanently moved to California
- Had a baby or adopted a child
- Got married or entered into a domestic partnership
- Returned from active military service
- Gained citizenship/lawful presence
- Federally recognized American Indian or Alaska Native

For other qualifying life events, ask your insurer, licensed agent, or contact the Department of Insurance's Consumer Hotline at (800) 927-4357 (HELP).

You have sixty days from your qualifying life event to enroll or make changes to your policy. For example, if you adopt a child on June 1st, you will have until July 31st to enroll your child. If you miss this window, you will have to wait until the next open enrollment period.

When does my coverage start?

It is important to pay attention to enrollment deadlines to avoid gaps in your coverage.

If you are shopping for new coverage during the open enrollment period, your coverage will start on January 1st of the next calendar year. You do not typically have to pay your first month's premium when you enroll. Your insurer, licensed agent, or Covered California can tell you exactly when your first payment is due.

If you have a qualifying life event and are signing up outside of the open enrollment period, your coverage typically starts the first day of the following month. For example, if you sign up for coverage on May 5th, your coverage will start on June 1st. However, if you sign up after the 15th of the month, you may have to wait until the first day of the second month for your coverage to begin. For example, if you sign up on July 20th, your coverage may not begin until September 1st.

Premiums

- Your premium for individual health insurance depends on the type of plan you choose, your age, how many people are covered, and where you live.
- Your premium can be increased yearly. It can also be increased if you or members of your family have a birthday and move into a new age group.
- Premiums cannot be based on your race, ethnicity, sex, sexual orientation, gender identity, or health status.

Can I be denied coverage?

Health insurers cannot refuse to sell you a policy even if you have a pre-existing condition or are currently sick.

Can a policy limit services to people with pre-existing conditions? **No**

Can an insurer charge me more because I have a pre-existing condition? **No**

Programs for People with Low Incomes

Medi-Cal (California's Medicaid program)

Medi-Cal pays for health care for people with limited incomes. To find out if you qualify for Medi-Cal, contact the welfare or social services department in your county.
www.dhcs.ca.gov
www.medi-cal.ca.gov
1-800-541-5555

Covered California also screens for Medi-Cal eligibility when you apply for an individual/family policy.
www.coveredca.com
1-800-300-1506

AIM (The Access for Infants and Mothers Program)

AIM is low-cost health care for pregnant women whose income is too high for no-cost Medi-Cal. It is also for women who have health insurance with a maternity-only deductible or co-pay above $500.
www.aim.ca.gov
1-800-433-2611

Federally Funded Health Centers

If you do not have insurance and need health care now, these centers can help you. People pay what they can afford, based on income.
http://findahealthcenter.hrsa.gov
1-888-275-4772

Types of Health Insurance
Preferred Provider Organizations (PPOs)

For more information on comparing PPOs, HMOs, and EPOs see pages 21–22.

Which doctors, hospitals, and other providers can I use?

You can see "preferred" providers or "out-of-network" providers.

- A PPO has a network of preferred providers. You pay less if you see these providers. These providers have contracts with the PPO to provide care at certain rates.
- If you go to a doctor or hospital that is not on the preferred provider list, you pay more. This is called going out-of-network. The plan pays less or nothing at all.

What are my costs if I have a PPO?

Costs can vary a lot, depending on the providers you see. If you stay in the PPO's preferred provider network, your costs are less.

If you decide to see a doctor outside the PPO network, you pay much more. Before you see out-of-network providers check with your PPO to find out what is covered.

Where can I go if I have a problem?

If you have a PPO, call the California Department of Insurance for assistance at **1-800-927-4357.**

Types of Health Insurance
Exclusive Provider Organizations (EPOs)

For more information on comparing PPOs, HMOs and EPO's, see pages 21–22.

Which doctors, hospitals, and other providers can I use?

You must use providers in the EPO network.

- Generally, you do not have to use a primary care doctor.
- You must use providers in the EPO network.
- Most of the time, you do not need to get referrals to see specialists who are in-network.
- EPOs can have many limits on the doctors or hospitals you can use.
- With an EPO, you can use the doctors and hospitals within the EPO's network. However, you cannot go outside the network for covered care.
- If you do go out-of-network, your EPO will not pay for any services. The only exception is if you have an emergency or urgent care situation.

What are my costs if I have an EPO?

Costs can vary. It depends on the providers you see. If you stay in the EPO's preferred provider network, your costs are less because you will be reimbursed for the health care you get. Like PPOs, you pay a co-pay or percentage of every medical bill up to a certain amount. If you decide to see a doctor outside the EPO network, you must pay for the full medical bill.

Where can I go if I have a problem?

If you have an EPO, or are not sure who to call, contact the Department of Insurance at **800-927-4357** for help. In some cases, the Department of Managed Health Care (DMHC) handles EPOs. For those, you will need to contact DMHC for help at **888-466-2219**.

Types of Health Insurance
Health Maintenance Organizations (HMOs)

For more information on comparing PPOs, HMOs, and EPOs see pages 21-22.

Which doctors, hospitals, and other providers can I use?

You must use providers in the HMO network.

- Usually, you must have a primary care doctor. This doctor provides your basic care and coordinates referrals to specialists.
- To enroll in an HMO, you must live in the area the HMO serves. Outside of this area you can only get emergency or urgent care.

What are my costs if I have an HMO?

Usually you pay a flat co-pay each time you see a doctor or fill a prescription. But you may pay a co-insurance for some services. Co-insurance is a part or percent of the cost, such as 20%.

Where can I go if I have a problem?

If you have an HMO, contact the California Department of Managed Health Care (DMHC) for assistance. Call the DMHC Help Center at **1-888-466-2219.**

Compare PPOs, EPOs and HMOs

Why would I choose a PPO?

You have a doctor you like and want to keep your doctor. You want the freedom to see providers out of your network even if you have to pay more. You want to see specialists and other providers without having to get referrals or pre-approvals.

Why would I choose an EPO?

You do not want to use a primary care physician and do not want to get referrals to see specialists. You also don't mind staying within the policy's network of physicians.

Why would I choose a HMO?

You want to have a primary care doctor who can help you decide what care you need and how to get it. Often HMOs have fixed co-pays for certain services, so you don't have to worry about getting a bill for a percentage of the cost of care.

	PPO	EPO	HMO
Network	You pay less to see providers in your plan's network. These are called preferred providers.	You get covered care from the doctor, hospitals, and other providers in you plan's network.	You get care from the doctors, labs, and other providers in your plan's network.
Out-of-network	You can go out-of-network, but you pay more.	You cannot see providers out-of-network except in an emergency or if your plan gives you pre-approval.	You cannot see providers out-of-network except in an emergency or if your plan gives you pre-approval.
Primary care doctor	You can choose whether or not to have a primary care doctor.	You may not have to use a primary care doctor.	You must have a primary care doctor. This is the doctor you usually see first when you need care.
Referrals	You may be able to get many health services without a referral.	You do not need to get referrals to see specialists if they are in the EPO's network.	You need referrals to see specialists or get lab tests.
Pre-approval	You may be able to get many health services without pre-approval.	You may need pre-approval from your health plan before you can get any services.	You will need pre-approval from your health plan before you can get many health services.
Costs	You may have a yearly deductible. You may also have deductibles for hospital care and prescription drugs. Care in the network costs a lot less than care outside the network.	You usually pay a co-pay or a flat fee for most services.	You usually pay a co-pay or a flat fee for most services.

Other Types of Health Coverage

Other types of health coverage are sold in California, but if it will be your main source of coverage, you should make sure that it meets minimum essential coverage requirements. If your policy does not meet these requirements, you might have to pay a tax penalty to the IRS as if you did not have coverage at all.

High-Deductible Plans

These plans have lower premiums but high deductibles. The deductible each year can be over $5,000 for an individual and over $10,000 for a family. This means that you must pay a lot of money each year before your plan covers anything except preventive care.

Usually a high-deductible plan is combined with a Health Savings Account (HSA). You or your employer can put tax-free money into a savings account and use this money to pay your deductible.

Limited Benefit Plans

Limited benefit plans are also called mini-meds. They provide very limited benefits. They are advertised on TV as low-cost health insurance. You should read the policy very carefully. If you have a serious illness, you might run out of coverage quickly. These plans do not count as full health coverage and you may end up paying a penalty at the end of the year if you don't have other coverage.

Discount Plans

Discount plans are not health insurance. They simply offer discounts from certain doctors, pharmacists, and other providers. They are often advertised on the Internet and late-night TV. You should read the plan contract very carefully. Before you buy, contact the California Department of Insurance at **1-800-927-4357.**

Supplemental Health Insurance Policies

These policies are for people who already have health insurance. They pay some of the costs that your main insurance does not cover. They can pay limited benefits such as a daily dollar amount if you are hospitalized, or a set sum dollar amount if you are diagnosed with cancer. Make sure you understand the supplemental policy:

- What are the limitations and exclusions?
- How does the policy coordinate benefits with your main health insurance?

Why is Minimum Essential Coverage Important

Any health insurance that includes California's essential health benefits has minimum essential coverage. If you have minimum essential coverage, you don't have to pay a tax penalty for being uninsured. See page 6 for more information on health benefits.

Some coverage, like limited benefit and discount plans and supplemental health insurance policies do not meet that requirement. If you are shopping for coverage that will be your main source of health coverage, make sure that it meets the minimum essential coverage standard before you buy it. If not, you may pay a penalty.

Shopping for Individual Insurance

Shopping for health insurance can seem overwhelming. Think about what is important to you. Start by asking these questions:

What are the costs?

- How much are the monthly premiums?
- Is there a deductible?
- How much are the co-pays and/or co-insurance?
- What is the plan's out-of-pocket maximum (the most you would have to pay in one year)?

Which doctors and other providers can I see?

- Is there a network? How large is it?
- Can I see any provider in the network?
- Is my current doctor in the network?
- If I need to choose a new doctor, are there doctors in my area accepting new patients?
- Will I need a referral from my doctor to see a specialist?
- Does the plan have hospitals and pharmacies near me?
- Do I need pre-approval (pre-authorization) from the plan for certain services?
- If I travel often, what kind of care can I get away from home?

What are the covered benefits?

- What services does the plan pay for? What is not covered? Are the services that I need covered?
- How much will I need to pay for my prescriptions?
- Are there any limits on the number of visits for some kinds of care?

What is the quality?

- The California Department of Insurance can tell you how a company ranks in complaints. You can find out how long it takes to reach a real person when you call the company and how many complaints the company gets. We have a PPO Report Card with quality information about PPOs. Call **1-800-927-4357** or go to **www.insurance.ca.gov.**
- The California Office of the Patient Advocate (OPA) has information on health insurance and provider quality, at **www.opa.ca.gov.**

Look at cost, benefits, and quality.

The most expensive plan may not offer the best quality of care. And the cheapest plan may not cover the benefits you need.

Applying for Health Insurance

Applying for health insurance is easier than ever thanks to the Affordable Care Act. You can contact an insurer directly, speak with a licensed insurance agent, or use California's health insurance marketplace - Covered California.

What if my application is not approved?

Health insurers that serve your area cannot deny your application.

Know Your Rights and Responsibilities

You have a right to:

- Be treated with courtesy and respect.
- Get quality health care.
- Get care from qualified medical personnel.
- Choose a primary care doctor or pediatrician you trust, and change doctors if you are not satisfied.
- Get an interpreter when English is not your first language.
- Get an appointment when you need one.
- Understand your health problem.
- Understand the risks and benefits of your treatment choices.
- Get a second opinion about a diagnosis or treatment.
- Choose or refuse treatment.
- Have your health information protected.
- Get a copy of your medical records.

Learn the rules for your policy.

- Read your health plan's Summary of Benefits to learn what is covered and what is not covered (excluded).
- Your insurance only pays for care that is medically necessary. This is defined in your insurance policy.
- Your plan may not pay for care that is experimental or investigational. But if you have a serious illness and feel that you need an experimental or investigational treatment, you can ask for an independent medical review. See page 31.
- You may need to get pre-approval from your health plan for some kinds of care.
- You do NOT need pre-approval for emergency care.
- Health insurers must cover Essential Health Benefits. See page 6.
- For more information about the rules for plans regulated by the California Department of Insurance visit **www.insurance.ca.gov.**
- For more information about the rules for plans regulated by the California Department of Managed Health Care, go to **www.dmhc.ca.gov.**
- Self-insured plans follow different rules. For more information, go to your human resources department or visit **www.dol.gov/ebsa.**

Health Care Reform

National health reform was passed by Congress and signed into law by President Obama in 2010. The name of the new law is the Patient Protection and Affordable Care Act (ACA).

Health reform offers many benefits to Californians looking for health insurance. For more information on healthcare reform in California, go to **www.insurance.ca.gov.**

Some reforms include:

- A health insurance company cannot deny your coverage if you have a pre-exisiting condition.
- No annual limits on essential health benefits.
- Health insurance companies must sell and renew insurance policies for everyone.
- No cancellation of your policy when you become sick.
- No more lifetime limits on essential health benefits.
- No charge for preventive care such as mammograms, vaccinations, well-child care, and many other health screenings.*
- You don't need to get a referral for pregnancy and other gynecological care, as long as the provider is in your network.*
- Generally, children can stay on their parents' policy until age 26, as long as the policy offers dependent coverage.*

* There are certain exceptions for "grandfathered" plans—plans that existed before passage of the Affordable Care Act.

What to Do if You Have a Problem with Your Policy

Contact your health plan to resolve your problem.

- Talk to your doctor and call your health insurer. Sometimes talking solves the problem.
- You can file a complaint with your health plan. A complaint is also called a grievance or appeal.
- Generally, your insurance company must make a decision within 30 days.
- If your health problem is urgent, your health insurance must do an Expedited Review. It must be done as soon as possible, in 72 hours or less.

If you are not satisfied with your health plan's review process or decision, call the California Department of Insurance (CDI). You may be able to file a complaint with CDI or another government agency.

If your policy is regulated by CDI, you can file a complaint at any time. The CDI reviews cases that involve:

- Disagreements about the services your health plan must cover.
- Termination or cancellation/rescission of your insurance policy.
- Exclusions and limits on services that are usually covered.
- Timely access to medical care.

My claim was denied. Now what?

Your health insurance policy tells you how to appeal if your plan denies your claim or pays less than you think it should.

You have a right:

- To receive an explanation of your plan's grievance and appeal procedures.
- To file a complaint, also called a grievance or appeal, with your plan.
- To receive an easy-to-understand written decision on your appeal.
- To file a complaint with CDI, Call **1-800-927-4357** or visit **www.insurance.ca.gov.**

Independent Medical Reviews (IMR)

In an IMR, independent medical professionals review a medical decision made by your insurance company. You can ask for an IMR if your health plan:

- Denies, changes, or delays a service or treatment, based on a decision that it is not medically necessary.
- Will not cover an experimental or investigational treatment for a serious medical condition.
- Will not pay for emergency or urgent medical services that you have already received.

  For more information about IMR:

  - Go to **www.insurance.ca.gov**
  - Call CDI at **1-800-927-4357**

Resumen en Español

Seguros de salud

Este folleto proporciona información valiosa sobre los siguientes temas:

- Conceptos básicos del seguro de salud
- Beneficios del seguro de salud
- Costos de seguro de salud
- Formas de obtener seguro de salud en California
- Grupo de seguro de salud
- Si usted pierde sus beneficios de salud de grupo
- Compras para su propio seguro de salud Individual
- Programas para personas de bajos ingresos
- Tipos de seguro de salud
- Organizaciones de Proveedores Preferentes (PPO)
- Organizaciones de Proveedores Exclusivos (EPO)
- Organizaciones de Mantenimiento de la Salud (HMO)
- Otros tipos de cobertura de salud
- Compras para seguro Individual
- Saber sus derechos y responsabilidades
- Reforma de la atención de salud
- Qué hacer si usted tiene un problema con su póliza
- Términos comunes
- Para más información
- Hable con el Departamento de seguros

Este folleto está disponible en español en nuestro sitio web en insurance.ca.gov. Seleccione traduce español en el lado derecho de la pantalla. Seleccione la ficha los consumidores elegir tipos de seguro, luego seleccione salud.

Common Terms

Allowed amount or negotiated rate—The most that your insurance will pay for a service. If your provider charges more than the allowed amount, you may have to pay the difference.

Balance billing—When a provider bills you for the difference between their usual charge and your insurance company's allowed amount. For example, if the usual charge is $100 and the allowed amount is $70, your provider might send you a bill for $30. In California, a provider in your preferred provider network may not balance bill you.

Claim—A claim is a request to your insurance company to pay for a health care service you received.

Co-insurance—This is your share of cost for a health care service. It is a percent (for example, 20%) of the allowed amount for the service. For example, if the charge for an office visit is $150 and your co-insurance is 20%, you pay $30 and your plan pays $120.

Co-pay—This is a fixed amount (such as $15) that you pay for a service. You usually pay the co-pay when you get the service.

Deductible—The amount you pay before your insurance company covers any costs. For example, if your deductible is $1,000, your plan will not pay anything (except preventive care—see page 6) until you've met your $1,000 deductible. You may choose a higher deductible to lower your premium.

Essential health benefits(EHBs)—These are the benefits that all individual and small group insurance policies have to cover. Grandfathered policies may not have to cover EHBs. EHBs are defined by the State of California and meet the Affordable Care Act's minimum essential coverage standard.

Exclusions, excluded services—Services that your health plan does not pay for.

Grandfathered Insurance Policies—Health insurance policies that were in place before March 23, 2010 (when the Affordable Care Act was signed into law) are called grandfathered policies. These policies are allowed to offer the coverage they did before the Affordable Care Act. Plans or policies may lose their grandfathered status if they make certain significant changes that reduce benefits or increase costs to consumers.

Minimum Essential Coverage—The least amount of coverage you can have so that you do not have to pay a tax penalty. Any insurance policy that covers California's Essential Health Benefits qualifies as minimum essential coverage.

Network—The facilities, providers, labs, hospitals, and pharmacies that your health plan has contracts with to provide health care.

Out-of-pocket limit—The most you pay during a year before your health insurance company begins to pay 100% of the allowed amount. This limit does not include your premium, balance-billed charges, or the costs for health care your plan doesn't cover.

Policy—The written contract between an individual or group policyholder and an insurance company. A policy outlines the responsibilities of both parties.

Pre-authorization, pre-approval, or **prior approval**—This is a form from your health plan that says the service your doctor or you requested is approved. Your health plan can require pre-approval for some services before you receive them, except in an emergency.

Pre-existing condition—A health condition you had before you joined a group plan or applied for individual insurance. Most policies are prohibited from denying coverage because you have a pre-existing condition. See pages 8, 11, 16 and 29.

Premium—The fee you pay to have insurance. Your employer may pay part of your premium. The premium is usually paid monthly.

Provider—A health professional or organization that provides health care services, such as a doctor, physical therapist, hospital, lab, or clinic. A preferred provider is a provider in your plan's network.

Tiered network—A kind of medical provider network with several cost levels. You pay different amounts to see providers in different tiers.

UCR (usual, customary, and reasonable)—The amount that providers in an area usually charge for the same or similar service. The allowed amount may be based on the UCR amount.

For More Information

California Department of Managed Health Care Help Center

Information and assistance for members of HMOs and some other health plans.

www.dmhc.ca.gov
1-888-466-2219

California Office of the Patient Advocate (OPA)

Information on health insurance and provider quality.

www.opa.ca.gov

HICAP (Health Insurance Counseling and Advocacy Program)

Free counseling and information on Medicare throughout California.

www.aging.ca.gov/hicap
1-800-434-0222

Medicare

Information and assistance with Medicare. This is the official federal Medicare website.

www.medicare.gov
1-800-MEDICARE

NAIC

Provides an online tool for individuals who may be life insurance beneficiaries by offering an easy-to-use tool to help find lost or forgotten policies.

www.naic.org

U.S. Department of Labor, Employee Benefits Security Administration (DOL-EBSA)

Information on COBRA and on some kinds of self-funded plans.

www.dol.gov/ebsa
1-866-444-3272

Talk to the Department of Insurance

We are the state agency that regulates the insurance industry. We also work to protect the rights of insurance consumers.

Contact the California Department of Insurance (CDI):

- If you feel that an insurance agent, broker, or company has treated you unfairly.
- If you have questions or concerns about health insurance.
- If you want to order CDI brochures.
- If you want to file a request for assistance against your agent, broker, or insurance company.
- If you are having difficulty opening a claim with your insurance company.
- To check the license of an agent, broker, or insurance company.

Call:
Consumer Hotline **1-800-927-4357**
TDD **1-800-482-4833**
8:00 AM to 5:00 PM, Monday to Friday, except holidays

Visit us on the Web at:
www.insurance.ca.gov

Write:
California Department of Insurance
300 South Spring St., South Tower, Los Angeles, CA 90013

Visit us in person:
300 South Spring St., South Tower, 9th Floor, Los Angeles, CA 90013
8:00 AM to 5:00 PM, Monday to Friday, except holidays

This brochure was printed in July 2016. Health insurance laws change regularly, so please check our website for the most current information.

Notes

Notes

Notes

The California Department of Insurance

Consumer Education and Outreach Bureau
300 South Spring Street, South Tower, Los Angeles, CA 90013

1-800-927-4357
1-800-482-4833 (TDD)
www.insurance.ca.gov

This brochure is a project of the California Department of Insurance.

Form 254 / Health Insurance
December 2016 - OSP