1-800-927-4357

www.insurance.ca.gov

Health Insurance

California Department of Insurance

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

How will health care reform affect me?

In California, consumers already have new rights under the health care reform law. For example:

- Most policies now let you keep your children on your insurance until age 26.
- As long as you fill out the application honestly, your health insurance cannot be cancelled because you get sick.
- Many policies provide preventive care, such as vaccines and certain cancer screenings, with no out-of-pocket cost to you.
- More changes are coming soon. To learn more, see page 26.

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.
- 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. Contact us at:
  1-800-927-4357
  www.insurance.ca.gov
- For a list of other agencies that help people with health insurance problems, see page 33.

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?

You do not need to buy insurance now. But beginning in 2014, most people must buy health insurance. Health insurers will also no longer be able to deny your application. The California Health Benefit Exchange will help people find affordable health insurance. The federal government will provide subsidies for those who qualify.

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:

- Hospital care
- Visits to a primary care doctor and specialists
- Outpatient procedures, like surgery
- Laboratory tests and diagnostic services, like x-rays and mammograms
- Pregnancy and newborn care
- Preventive and routine care, like vaccines 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

Some services must be covered.

The law says that policies must cover certain services. For example, many policies must cover diabetes supplies. Check out the list of benefit mandates at **www.chbrp.org.**

Beginning in 2014, many policies must cover "essential health benefits." These include the services listed above, as well as prescription drugs, substance abuse treatment, and oral and vision care for children. California is still deciding on the list of essential health care services.

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 screenings
- Routine vaccines
- Regular pediatrician visits
- Vision and hearing screening for children
- Counseling about obesity

Under federal health care reform, many policies 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 health care reform began (March 23, 2010) do not have to follow this rule. They are called "grandfathered" policies.

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

These are plans that do not cover all basic health care services. See page 21.

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.

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. And some 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)

Some policies have a limit on what they will pay for your health care in one year or in your lifetime. Under health care reform this is changing. Health policies can no longer put a lifetime limit on essential health benefits. Yearly limits end in 2014.

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.

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 more than the allowed amount. Learn about PPOs on page 16.
- However, a provider in your PPO's network should not balance bill you. They can only bill you for your deductible, co-pay, or co-insurance.

Getting Group Health Insurance Through Your Job

Most people in California get group health insurance through a job. This is also called employee coverage. Employers with 50 or more employees buy large-group policies, and those with fewer than 50 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.
- 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 4. 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. Health care reform says that children under age 19 cannot be denied group insurance because of a pre-existing condition.

If you are age 19 or older, group health insurance can delay services for your pre-existing condition for up to 6 months. If you had health insurance within the last 63 days, this period might be shorter.

Beginning in 2014, health care reform says that insurers cannot deny group insurance to anyone because they have a pre-existing condition.

Waiting periods: Some group policies have waiting periods for all new employees, instead of exclusion periods for pre-existing conditions. The waiting period can be up to 60 days. During this time, you do not pay premiums or get any health care services.

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 a 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.

- 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 plan through your town or religious organization and you have a problem with the plan, 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 12).
- Or you may qualify for a public program (see page 14).
- Or you may be able to get on your spouse's or partner's group insurance. Try to do this as soon as possible, to avoid a gap in coverage.

Continuation Health Coverage

You and your dependents may be able to continue your health coverage with continuation health coverage.

- You have to pay all the premium.
- You cannot be denied coverage because of a pre-existing condition.
- 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.

Kinds of Continuation Health Coverage

- **COBRA** and **Cal-COBRA** may allow you and your dependents to keep your group coverage for up to 18 or 36 months.
- **Conversion** coverage is an individual policy with the same insurance company that offered your group policy. You must first use up all of the COBRA and/or Cal-COBRA that you qualify for.
- **HIPAA** coverage is also an individual policy. But you can buy it from any company that sells individual policies. You must first use up all of the COBRA and/or Cal-COBRA that you qualify for.

Certificate of Creditable Coverage

When you leave any health plan, ask for a Certificate of Creditable Coverage. Keep it. You may need it when you sign up for new insurance.

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 or through a licensed health insurance agent. You can search for health plans at **www.healthcare.gov.**

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 22–23 for tips on choosing a policy.

Can I be denied coverage? If you are age 19 or older, an individual policy can refuse to cover you if you have a pre-existing condition. Or it can charge you more, or limit your benefits. If you are pregnant when you join a plan, it may not cover your pregnancy care.

Can children under 19 with pre-existing conditions be denied coverage? No. Under health reform, individual policies cannot deny coverage to children under 19 because of a pre-existing condition. However, the premium can be higher.

New Rules in 2014

Beginning in 2014, plans will not be able to reject anyone's application based on their health history or pre-existing condition.

Can a policy delay services for adults with pre-existing conditions? Yes. Your policy may delay coverage for pre-existing conditions for up to one year after your policy starts. This is called an "exclusion period." This period is shorter if your previous insurance ended within the last two months.

How will coverage for pre-existing conditions change in 2014? Under health care reform, in 2014, most policies cannot limit benefits, charge higher premiums, or deny coverage due to a person's pre-existing condition.

Waiting Periods

Some individual policies have a waiting period before any of your benefits start. The waiting period is 60 days or less. You do not pay a premium during this period.

Premiums

- Your premium for individual health insurance depends on the plan you choose, your age, your health, your family size, and where you live.
- Your premium can be increased yearly or more often. 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, or gender identity.

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

Healthy Families

Healthy Families is low-cost insurance for children and teens who do not qualify for no-cost Medi-Cal. It provides health, dental, and vision care.

www.healthyfamilies.ca.gov
1-800-880-5305

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

Programs for People with Pre-Existing Conditions

These are programs for people who have been denied insurance because they have pre-existing conditions. In 2014 it will become illegal for most plans to deny you insurance because you have a pre-existing condition.

Both websites below have a link to the PCIP/MRMIP Application and Handbook, which helps you compare the two programs.

PCIP (The California Pre-Existing Condition Insurance Plan)

PCIP is a federal program under health reform. To qualify, you must have been without any health insurance for the last 6 months. The premium is based on your age and where you live.

www.pcip.ca.gov
1-877-428-5060

MRMIP (Major Risk Medical Insurance Program)

MRMIP is a state-funded program. Sometimes there is a waiting list due to limited funding.

www.mrmib.ca.gov
1-800-289-6574

Types of Health Insurance
Preferred Provider Organizations (PPOs)

For more information on comparing PPOs and HMOs, see pages 18–19.

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. Call **1-800-927-4357.**

Types of Health Insurance
Health Maintenance Organizations (HMOs)

For more information on comparing PPOs and HMOs, see pages 18–19.

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 makes referrals to specialists.
- The doctors and other providers may be employees of the HMO or they may have contracts with the HMO.
- To join an HMO, you must live in the area the HMO serves. Outside 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. This 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 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 HMO?

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

	PPO	HMO
Network	You pay less to see providers in your policy's network. These are called preferred providers.	You get care from the doctors, labs, and other providers in your plan's network.
Out-of-network	You can go out of the network, but you pay more.	You cannot see providers outside the 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 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 need referrals to see specialists or get lab tests.
Pre-approval	You may be able to get many health services without pre-approval.	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 are less likely to have a yearly deductible. • You usually pay a co-pay or flat fee for most doctor visits.

Other Types of Health Coverage

Fee-for-Service

Fee-for-service insurance is also called traditional or indemnity insurance. It was widely available in the past, but it is a rare type of insurance these days. Most insurance companies now offer the preferred provider network type of insurance, such as a PPO or HMO.

Fee-for-service policies usually allow you the most choice of doctors and hospitals, with few geographic limits. However, you must make sure that your doctor or hospital takes your insurance.

How fee-for-service works:

- You give the doctor (or other provider) your insurance card at the time you get care.
- Usually, the doctor bills your insurance. You must send a claim to your insurance if the doctor does not do that for you.
- Usually, your insurance pays part (such as 80%) and you pay the rest. For example, if the bill is $300, your insurance might pay $240 and you pay $60.
- If you have not paid your deductible yet, you may have to pay the whole $300.

Fee-for-service is usually the most expensive kind of insurance. You usually have a deductible. You usually pay a co-insurance, or percent, of the cost of each service. You send in a claim form for care you receive.

If you have a problem, you can call the California Department of Insurance. Call **1-800-927-4357.**

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. 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 it 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. Read the policy very carefully. If you have a serious illness, you might run out of coverage quickly.

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 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?

Shopping for Health 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 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 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?
- Are prescription drugs 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?

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.

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.**

Applying for Health Insurance

When you buy individual insurance, you need to fill out an application. Fill out the application accurately and completely. If you knowingly provide incorrect, incomplete, or misleading information, especially about a pre-existing condition, your coverage can be cancelled later. If the plan can prove that you deliberately lied on your application, they can charge you for all the costs of the services you received.

What if my application is not approved?

If you are purchasing individual insurance and you are 19 years of age or older, your application can be denied because you have a health problem. This will change in 2014 under health reform.

If you cannot find insurance, look into the programs described on pages 14–15.

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.

Ask questions.

If you are not sure how to get a service, talk to your doctor or call your plan. Usually there is a membership or customer service number on your membership card.

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 29.
- 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 plans must cover some specific treatments (mandates). To see this list, visit **www.chbrp.org.**
- For more information about the rules for plans regulated by the California Department of Insurance (most PPOs and fee-for-service plans), visit **www.insurance.ca.gov.**
- For more information about the rules for plans regulated by the California Department of Managed Health Care (HMOs and Blue Cross/Blue Shield PPOs), go to **www.dmhc.ca.gov.**
- Self-insured plans follow different rules. For more information, see your policy or go to **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 health care reform in California, go to **www.insurance.ca.gov.**

These reforms are already in effect:

- No cancellation of your policy when you become sick.
- Children under age 19 cannot be denied coverage because of a pre-existing condition.
- No more lifetime limits on essential health benefits (see page 4). Annual limits on essential benefits are also ending. They rise from $750,000 to $2 million a year until they completely end in 2014.
- No charge for preventive care such as mammograms, vaccines, well-child care, and many other health screenings.*
- You do not 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.

More reforms are coming in 2014:

- A health insurance company cannot deny you coverage if you have a pre-existing condition.
- No annual limits on essential health benefits.
- Medi-Cal coverage will expand to include more low-income families.†
- Health insurance companies must sell and renew insurance policies to anyone.
- The California Health Benefit Exchange opens a one-stop shop where you will be able to shop for and buy insurance. For more information, visit **www.hbex.ca.gov.**

Do I have to buy health insurance?

Beginning in 2014, most people will be required to purchase health insurance. Health insurers will also no longer be able to deny your application beginning January 1, 2014. The California Health Benefit Exchange will help people find affordable health insurance, and the federal government will provide subsidies for those who qualify.

The California Health Benefit Exchange

Starting in 2014, the Exchange will help Californians and small employers buy health insurance. To learn more, go to **www.hbex.ca.gov.**

The Exchange will help you find out if you can qualify for tax credits to save costs on health insurance. If you do, the Exchange can help you get the credit ahead of time to help you buy your policy.

† California will expand Medi-Cal coverage to include all individuals under 133% of the federal poverty level. See current levels at **http://aspe.hhs.gov/poverty/12poverty.shtml.**

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 plan. 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 (such as a pre-existing condition exclusion or a provider network exclusion).

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 the 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.**

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.

Certificate of Creditable Coverage—A written statement from your last health plan that says how long you were covered.

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 5) until you have met your $1,000 deductible. You may choose a higher deductible to lower your premium.

Essential health benefits—These are the benefits that some policies must cover beginning January 1, 2014. Most individual and small group insurance policies will have to cover these benefits.

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

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 does not 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. See pages 8, 12, and 13.

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 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.

Find More Information

For information about the Department of Insurance, see page 34.

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

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 August 2012. Health insurance laws are changing. Check our website for the most current information.

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

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