

Your Health Care Coverage



Texas Department
of Insurance

Learn about insurance.
1-800-252-3439 | tdi.texas.gov

Updated October 2017

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Get Help from TDI

For insurance questions or for help with an insurance-related complaint, call the **Texas Department of Insurance (TDI) Consumer Help Line** at **1-800-252-3439** or visit our website at **tdi.texas.gov**.

Visit **HelpInsure.com** to shop for automobile, homeowners, condo, and renters insurance. Visit **TexasHealthOptions.com** to learn more about health insurance and your options for coverage.

Getting sick can be expensive. Even minor illnesses and injuries can cost thousands of dollars to diagnose and treat. Major illnesses can cost many times that. Health insurance helps you get the care you need and protects you and your family financially if you get sick or injured.

This publication provides information about health care coverage in Texas. You can also visit TexasHealthOptions.com to learn more about health coverage. Texas Health Options is a free service of TDI.

Overview

If you don't have health insurance through your job or a government program, you can buy it from an insurance company or agent. This type of insurance is called individual coverage because it's sold directly to individuals, not to members of a particular group. For lists of companies and health maintenance organizations (HMOs) selling individual coverage in Texas, visit **TDI's Lists of Companies and HMOs** at **www.texashealthoptions.com//cp2/index.html**. You can also buy coverage through the **federal health insurance marketplace** at **HealthCare.gov** or by calling **1-800-318-2596**.

Open enrollment. You usually must buy health insurance during the annual open enrollment period. The open enrollment period is from November 1 to January 31 each year. You may buy health insurance at other times of the year only if you have a qualifying life event, such as getting married or divorced, having a baby, moving, or losing your current coverage.

Preexisting conditions. Health insurance companies must sell a plan to anyone who applies during the open enrollment period. Companies may not deny you coverage or charge you more because of a preexisting condition or disability.

Premiums. Premiums are what you pay to have coverage. When deciding your premium, insurance companies may consider only your age, where you live, whether you smoke or use tobacco, and whether the coverage you're buying is for one person

or a family. They may not consider your health status, medical history, claims history, genetic information, gender, disability, or other health factors.

Premium Subsidies

You might qualify for a subsidy to help pay for coverage if your income is between 100 percent and 400 percent of the federal poverty level. In 2017, this means an income between \$11,880 and \$47,520 for a single person, or between \$24,300 and \$97,200 for a family of four. If your income is below the poverty level, you aren't eligible for a subsidy.

Subsidies are available only when you buy a health plan through the marketplace. You can't get a subsidy if you buy directly from an insurance company or if you can get affordable health insurance at work.

For more information about subsidies, visit the [HealthCare.gov subsidies page](http://www.healthcare.gov/lower-costs/save-on-monthly-premiums) at www.healthcare.gov/lower-costs/save-on-monthly-premiums.

Health Plan Basics

Health plans are legal contracts between you and an insurance company or HMO. State and federal laws require plans to cover specified benefits, but each plan works differently. Plans can also vary in how much they'll pay – and how much you'll have to pay – toward your health care. Plans that cover a broad range of doctor and hospital services and that meet all of the legal coverage requirements are called major medical health benefit plans.

It's important that you understand what your plan covers and how it works. Review the Summary of Benefits and Coverage that comes with your plan. Before buying a plan, ask the company to give you a written description of the plan's terms and conditions or a sample contract.

Types of Plans

There are four types of major medical health benefit plans in Texas:

- point-of-service plans,
- HMO plans,
- preferred provider (PPO) plans, and
- exclusive provider (EPO) plans.

The main differences between the four types are the extent to which you can choose your own doctors, whether you must have a doctor to oversee all of your health care, and how the plan covers out-of-network care.

Point-of-service Plans

Point-of-service plans negotiate agreements with doctors, hospitals, and other health care providers to treat the plan's members at a discounted rate. These providers make up the plan's network. You must choose a doctor from the plan's network to oversee all of your health care. This doctor is called your primary care physician. You must get a referral from your primary care physician to see a specialist. You can usually go to providers outside of the network, but you'll pay more out of pocket if you do.

HMO Plans

HMO plans are similar to point-of-service plans. They also negotiate agreements with doctors, hospitals, and other health care providers to treat their members at a discounted rate. You must use providers in the HMO's network, or you might have to pay the full cost of your care yourself. There are exceptions for medical emergencies and for medically necessary services that aren't available in the HMO's network.

HMOs operate within specific geographic service areas. To be in an HMO, you usually must live or work in its service area.

You must choose a primary care physician to oversee your health care, and you usually must get a referral to see a specialist. Women don't need a referral for routine OB/GYN appointments if the doctor is in the HMO's network.

Some HMOs offer a point-of-service option that gives you more flexibility to choose your doctors. You'll still have to choose a primary care physician, but you may go to out-of-network doctors without a referral. If you use out-of-network doctors, however, you'll have to pay more out of pocket. An HMO point-of-service plan may exclude the option for out-of-network care for some medical conditions. The point-of-service option is usually offered as an add-on – or rider – to the plan for an additional fee.

PPO Plans

PPOs have networks of providers that have agreed to treat the PPO's members at a discounted rate. The difference between an HMO and a PPO is that a PPO allows you to go to any doctor you choose. Your out-of-pocket costs will be lower if you use providers in the PPO's network, though. In addition, you'll probably have to pay a separate deductible and higher copayments and coinsurance for care you receive outside the network. You don't have to choose a primary care physician in a PPO.

EPO Plans

EPOs also negotiate agreements with doctors and hospitals to provide care to their members at a discounted rate. You must use doctors and hospitals in the EPO's network. An EPO won't pay for care you receive outside its network. There are exceptions for medical emergencies and for medically necessary care that isn't available in the EPO's network.

Other Types of Health Insurance

The following types of health insurance provide only limited coverage. In addition, these policies can still deny you coverage or charge you more if you have a preexisting condition, and they usually have dollar limits on coverage.

- **Specified disease policies** pay only if you are diagnosed with the illness or condition named in the policy. Policy provisions are very specific. For instance, a cancer policy will pay only for services medically necessary to treat cancer. It won't pay to treat other illnesses.
- **Hospital surgical policies** cover only expenses directly related to hospital and surgical services, such as daily room rates, surgery, and doctor charges.
- **Short-term policies** provide coverage for a limited time, usually six to 12 months. Most people who buy short-term policies do so to protect themselves while they're in between jobs or waiting for other health coverage to start.

Health Plan Costs

Regardless of the type of plan you have, you must pay some of the cost of your health care yourself. This is called cost sharing. The cost will vary by the type of plan you have. Here are some of the costs you usually have to pay:

- **Premiums.** A premium is a fee you pay to have health coverage. Most people pay premiums monthly. Employers who offer health insurance often pay some or all of their employees' premiums. They typically don't pay premiums for family members covered by an employee's plan, however. If you have health insurance through your job, your premium is usually deducted from your paycheck.
- **Deductibles.** A deductible is an amount you must pay for covered health care before your plan will pay. For example, if your deductible is \$1,000, your plan won't pay anything until you've paid \$1,000 out of pocket for your care. You'll usually have to meet a deductible each year. Some plans have more than one deductible. For instance, you might have one deductible for in-network care and a separate deductible for out-of-network care. If your plan covers your family, you'll usually have a separate deductible for each family member and a deductible for the family.
- **Copayments.** Copayments are amounts you pay each time you go to the doctor, fill a prescription, or get a covered health service. For example, your plan might charge you \$25 to go to the doctor, \$50 to see a specialist, \$150 to go to the emergency room, and \$15 to fill a prescription. The amount you pay in copayments varies by plan.
- **Coinsurance.** Coinsurance is the percentage of the cost of a covered service

that you pay after you've met your deductible. For example, your health plan might pay 80 percent of the cost of a service, leaving you to pay the remaining 20 percent in coinsurance. HMOs rarely have coinsurance.

Federal law sets maximum dollar limits on the amount you have to pay out of pocket in a plan year. In 2017, the out-of-pocket limit is \$7,150 for an individual and \$14,300 for a family. In 2018, the limit is \$7,350 for an individual and \$14,700 for a family. Some plans might have lower out-of-pocket limits. Once you reach the limit, you won't have to pay copayments or coinsurance for the rest of the plan year. You'll still have to pay premiums.

Health Plan Benefits

State law requires health plans sold in Texas to cover a set of benefits called state-mandated benefits or mandates. The mandated benefits are different for individual plans, small-group plans, and large-group plans. Learn more about what Texas law requires at TDI's Mandated Health Benefits page at www.tdi.texas.gov/hmo/hmmanben.html.

Federal law requires individual and small-group plans to cover a set of health care services called essential health benefits. The essential health benefits include:

- ambulatory patient services (outpatient care you get without being admitted to a hospital),
- emergency services,
- hospitalization (including surgery),
- maternity and newborn care,
- mental health and substance use disorder services, including behavioral health treatment (including counseling and psychotherapy),
- prescription drugs,
- rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
- laboratory services,
- preventive and wellness services and chronic disease management, and
- pediatric services, including oral and vision care.

Plans may cover more services than the law requires. You can compare plans side by side on HealthCare.gov to see the benefits they offer. Federal law requires health plans to cover many preventive services for free. Depending on your age and gender,

Plan Comparisons

	PPO	POS	HMO	EPO
Primary care physician	No	Yes, for in-network services	Yes	No
Geographic restrictions	Network coverage may be limited to a specific service area in the state	In-network coverage is limited to a specific service area in the state; limited benefits while traveling	Coverage is limited to a specific service area in the state; limited benefits while traveling	Coverage is limited to a specific service area in the state; limited benefits while traveling
Filing claims	You usually don't have to file in-network claims; you may have to pay out-of-network doctors and hospitals in full and file for reimbursement	You usually don't have to file in-network claims; you may have to pay out-of-network doctors and hospitals in full and file for reimbursement	You usually don't have to file claims	You usually don't have to file claims
Average annual premiums	Usually higher than HMO	Usually lower than PPO	Generally lowest of all options, but may depend on plan	Usually lower than PPO
Deductibles	Consider a higher deductible for a lower premium	Consider a higher deductible for a lower premium	Consider a higher deductible for a lower premium	Consider a higher deductible for a lower premium
Copayments	Consider a higher copayment for a lower premium	Consider a higher copayment for a lower premium	Consider a higher copayment for a lower premium	Consider a higher copayment for a lower premium

you may get free check-ups, blood pressure and diabetes testing, contraceptives, mammograms, cancer screenings, and flu shots.

Some plans require you to get approval from the plan before you receive a covered health service. Make sure you check with your plan before you receive nonemergency services to find out whether you need prior approval.

Covering Dependents

Adult children may stay on their parents' plans until age 26. They don't have to live at home, be enrolled in school, or be claimed as a dependent on their parents' tax return. A parents' policy may cover married children, but not a married child's spouse and children.

Children with mental or physical disabilities who can't financially support themselves may continue to get coverage after age 26.

Except for emergency care and authorized referrals, HMOs can require dependent students to return to the plan's service area for doctor appointments and other health care services.

If two spouses are covered by separate health plans, and both plans cover their dependents, the parent whose birthday occurs first during the calendar year is the child's primary coverage. This means that plan will pay first for the child's health care. If the spouses divorce, a court usually determines which parent's plan is a dependent's primary coverage.

Texas law requires insurance companies to provide coverage for dependent grandchildren up to age 25.

Group vs. Individual Health Plans

Individual and group plans have different legal requirements. The coverage, cost-sharing, and process for resolving disputes may be different.

Group Health Plans

If you have health insurance through your job, you have a group health plan. Employers often offer group health plans as part of an employee benefits package. Other organizations – such as church-related organizations, fraternal societies, and other membership organizations – may offer group health insurance to their members. In a group health plan, you can choose to cover only you, or you and your spouse and dependents.

State and federal laws for group plans differ depending on the size and nature of the group.

Small-employer Plans

Small employers aren't required to offer health plans to employees. If they do, they may offer coverage to only full-time employees (those who work 30 hours or more per week) or to both full-time and part-time employees. Employers may not discriminate when deciding whom to offer coverage. Employers with between two and 50 employees are considered small employers.

Small-employer plans must cover essential health benefits.

Large-employer Plans

Employers with more than 50 employees provide large-employer plans. Every 120 hours worked by part-time and seasonal employees in a month counts as a full-time equivalent to determine whether a business has more than 50 full-time employees. Large-employer plans don't have to cover all of the essential health benefits that individual and small-employer plans cover. They must provide free preventive services, however. They can't have dollar limits on coverage or deny coverage because of an employee's preexisting conditions or health history.

Large employers who offer only an HMO plan must make a point-of-service option

available. The point-of-service option allows plan members to use out-of-network doctors. Members who use out-of-network providers will pay more out of pocket, however.

Large-employer requirement. Large employers that don't offer a health plan that meets affordability criteria and pays at least 60 percent of the cost of covered services must pay a penalty if any of their full-time employees get a subsidy through the health insurance marketplace.

Self-funded Plans

Employers who self-fund their health plans pay the costs of their employees' health care themselves, rather than buying coverage from an insurance company or HMO. Coverage may vary by plan and employer. Self-funded plans may require employees to contribute to the cost of the plan.

Self-funded plans often use insurance companies to help administer the plan. For example, the plan may use an insurance company's provider network or claims processing system.



Note: Most people who have health insurance in Texas have a self-funded plan. The U.S. Department of Labor regulates self-funded plans, so TDI has limited authority over them. These plans have their own procedures for complaints and dispute resolution. Direct questions and complaints about self-funded plans to the **U.S. Department of Labor's Employee Benefits Security Administration** at **1-866-444-EBSA (3272)**.

To find out if your health plan is self-funded, look at your insurance card. If your card shows "TDI" or "DOI" your plan is regulated by TDI. If you don't see this, your plan is self-funded and regulated by the Department of Labor.

Multiple Employer Welfare Arrangement Plans

A Multiple Employer Welfare Arrangement (MEWA) is a plan offered by a group of employers that have joined to offer health coverage. Self-funded MEWAs are regulated by both the U.S. Department of Labor and TDI. MEWAs must have a TDI license unless a licensed insurance company has assumed all of the MEWA's liabilities.

Individual Health Plans

Individual health plans can cover only you, or you and your spouse and dependents. They're called individual plans because they're sold directly to individuals, not to members of a group. You can buy an individual plan from an insurance company, agent, or broker, or through the federal health insurance marketplace.

You can buy an individual plan only during the annual open enrollment period. You

won't be able to buy insurance year-round, so don't wait to buy coverage until you need it.

Health insurance companies must sell a plan to anyone who applies during the open enrollment period. Companies may not deny you coverage or charge you more because of a preexisting condition, disability, other health factor, or your gender. When deciding what to charge you, companies may consider only your age, where you live, whether you smoke or use tobacco, and whether the coverage you're buying is for one person or a family.

Individual plans must cover the essential health benefits.

Your Rights and Protections

Appealing a Claim Denial

If an insurance company denies your claim, it must explain why in writing. If you're not satisfied with the explanation:

- ask the company to show you the policy language it used to deny the claim, and
- ask the doctor or hospital to send a letter explaining anything unusual about the procedure or the amount charged.

You may appeal the denial. To appeal a claim denial, first call your plan. Health plans must have a process to resolve claim disputes. You can skip the appeal process if you or your doctor believes your condition is life-threatening. The appeal process may be different if your plan is self-funded. Self-funded plans must follow the federal appeal and review process.

If you're not satisfied after an appeal, you might be able to have an independent review organization (IRO) consider the denial. An IRO is an independent third party certified by TDI. The insurance company or HMO must pay for the review, and it must follow the IRO's decision.

You have a right to an independent review for denials of:

- treatments the plan doesn't consider medically necessary,
- treatments the plan considers experimental or investigational, and
- medications that your doctor says are medically necessary but aren't on the carrier's formulary. A formulary is a list of a health plan's approved prescription drugs. Formularies vary by plan. If a drug is not on a plan's formulary, the plan typically won't pay for it.

You may get an IRO review only if the denial was for services covered by your policy. Insurance companies and HMOs must give you an independent review request form

when they deny a treatment and again if they deny your appeal.

For questions or more information about IROs, call **TDI's Managed Care Quality Assurance Office** at **1-866-554-4926**.

Handling Other Complaints

If you're unable to resolve a complaint against an insurance company or HMO, file a complaint with TDI. For more information about filing a complaint, visit **TDI's Insurance Complaints Resource Page** at **www.tdi.texas.gov/consumer/complfrm.html** or call the TDI Consumer Help Line.

If you have a complaint against a plan sold on the health insurance marketplace, call the marketplace.

For complaints against doctors, physician's assistants, or acupuncturists, call the **Texas Medical Board** at **1-800-201-9353** (Complaint Hotline) or visit its website at **tmb.state.tx.us**.

For complaints about health care facilities, call the **Texas Department of State Health Services** at **1-888-973-0022** (Complaint Hotline) or visit its website at **dshs.texas.gov/facilities/complaints.aspx**.

For complaints against pharmacists and pharmacies, call the **Texas State Board of Pharmacy** at **1-800-821-3205** or visit its website at **pharmacy.texas.gov**.

Handling Surprise Bills (Balance Billing)

Health plans that have provider networks negotiate discounted rates with providers. Your health plan will usually pay only the discounted rate, even if you go to an out-of-network provider and the out-of-network provider's rates are higher than the discounted rate. An out-of-network provider may bill you for the difference between what the provider charges and what your health plan pays. This is called balance or surprise billing.

For instance, if you go to an out-of-network doctor that charges \$150 for an office visit, but the plan's negotiated rate with its in-network doctors is \$25, the plan will likely pay only \$25 for the visit. The out-of-network doctor may then bill you the remaining \$125.

Surprise billing happens most often when you're in the hospital and some of the providers who treat you are not in your plan's network. Even if the hospital is in your network, some of the hospital-based providers who treat you might not be. This can happen, for instance, if you have surgery. You might have an in-network surgeon but an out-of-network anesthesiologist.

To avoid being balance-billed, make sure in advance that your health care providers -- including hospitals, clinics, other facilities, and doctors who practice at the facilities

-- are in your plan's network. If you're in the hospital, ask that all of the providers assigned to treat you are in your network. This might not always be possible, however, so make sure you understand which providers are not in your network and how much they charge.

If you get a bill from an out-of-network provider, ask the provider to give you an itemized statement of the charges. Texas law requires most providers to give you an itemized statement if you ask for one. Review the charges carefully.

Ask the provider to negotiate the charges with the insurance company or HMO. You can compare your charges to the average cost of the procedure using our **Health Insurance Reimbursement Rates Consumer Information Guide** at wwwapps.tdi.state.tx.us/inter/asproot/life/reimbursement/index.asp. Websites like guroo.com, fairhealthconsumer.org, and txpricepoint.org can also help you estimate the prices of various procedures.

Also discuss the issue with your health plan. Your health plan contract must describe how the plan determines payments to out-of-network providers.

If you think your health plan didn't pay the appropriate amount, file a complaint with TDI. You can **file a complaint online** at www.tdi.texas.gov/consumer/complfrm.html.

For more information, visit **TDI's Surprise Medical Bills (Balance Billing) web page** at www.tdi.texas.gov/consumer/cpmbalancebilling.html.

Mediating Hospital-based Out-of-network Provider Claims

If you have a dispute about a bill from a hospital-based out-of-network provider or an emergency care provider, you might be able to reduce the amount you owe through TDI's mediation process. During mediation, the provider and your health plan discuss your bill. The goal is to agree on how much the provider will charge, how much your plan will pay, and how much you must pay.

Not all claims are eligible for mediation. You may request mediation if your claim meets the following criteria:

- You have a PPO plan or have coverage through the Employees Retirement System of Texas or the Teacher Retirement System. Mediation isn't available for self-funded plans, Medicare, and Medicaid.
- Your claim is for a health care service or supply provided by a hospital-based provider that's not in your network or by an out-of-network emergency care provider.
- Your claim is for nonemergency care in a facility that's a preferred provider under your PPO plan, or for emergency care from any emergency care provider.

- The amount you owe the out-of-network provider (not including copayments, deductibles, coinsurance, and amounts paid by the insurer directly to you), is more than \$500.

If you're eligible, request mediation by submitting the **Health Insurance Mediation and Authorization Request Form** at www.tdi.texas.gov/forms/consumer/mediationform.pdf.

Once your provider receives notice that you've requested mediation, the provider may not attempt to collect payment (other than for copayments, deductibles, and coinsurance) until the mediation ends or you withdraw your request for mediation.

For more information about mediation, visit **TDI's mediation web page** at www.tdi.texas.gov/consumer/cpmmediation.html.

Your Rights under the Affordable Care Act

Preventive services. You can get some preventive services free (with no copayments or deductibles). Depending on your age and gender, you may get check-ups, blood pressure and diabetes testing, contraceptives, mammograms, cancer screenings, and flu shots. See the full list of preventive services at www.healthcare.gov/preventive-care-benefits. Health plans that existed on or before March 23, 2010, don't have to provide free preventive services.

No dollar limits. Insurance companies may not put dollar limits on the amount they will pay for covered health services. Previously, insurance companies could set limits on the amount they would pay.

No rescissions. Insurance companies may not rescind your policy because you made a mistake on your application. Companies may rescind a policy only if you commit fraud or intentionally misrepresent a fact. Rescind means to cancel a policy back to the effective date as if it had never been issued.

Your Rights to an Adequate Network of Health Care Providers

Texas law requires HMOs, PPOs, and EPOs to make covered health care services available within a certain distance of your home or office. Health plans also must:

- have enough providers and facilities to meet the needs of their members,
- allow members to continue seeing providers that are no longer in the plan's network for a certain period under special circumstances -- such as a terminal illness, disability, life-threatening condition, or pregnancy -- as long as the provider agrees to continue treatment at the plan's contracted rate,
- pay for emergency care to stabilize medical conditions that are serious enough to seek immediate care. If you get emergency treatment at a facility outside your network, you may be transferred to a network hospital after your condition is stabilized, and

- allow the use of out-of-network doctors and hospitals when medically necessary covered services aren't available within the network.

Under some circumstances, HMOs must allow members with ongoing, disabling, or life-threatening illnesses to use specialists as their primary care physicians.

Your Rights in a Group Plan

Insurance companies and HMOs may not cancel or refuse to renew a plan based on the health of the group's members. In a large-group plan, they may use health factors to set premiums, however.

Insurance companies and HMOs may not offer or deny coverage only to select employees in a group. They must give employers at least 60 days' notice before raising premiums and 90 days' notice before discontinuing a plan.

Insurance companies and HMOs must allow new employees at least 31 days from the first day of employment to decide if they want to enroll in a plan. They must also offer a 31-day open enrollment period each year to allow existing employees to join the plan. Employees experiencing a major life event -- such as a birth, adoption, marriage, or divorce -- may enroll before the next annual enrollment period.

Shopping for Coverage

- **Decide what coverage you want and need.** Choose a plan based on your needs. Plans with higher deductibles, copayments, and coinsurance have lower premiums. But you'll have to pay more out of pocket if you need medical care.
- **Consider factors other than cost.** A company's financial rating, network of providers, and history of consumer complaints are other important considerations. You can learn a carrier's financial rating from an independent rating organization, its complaints history, and its license status by calling TDI's Consumer Help Line or by viewing company profiles on our website.
- **Make sure you buy only from federally regulated or Texas-licensed entities.** If you buy health insurance from the federal marketplace, you might use a person called a navigator, assister, or counselor to help you. Call the **federal health insurance marketplace** at **1-800-318-2596** for more information. If you buy from an insurance agent or broker, make sure the agent or broker is licensed by TDI. Make sure the insurance company is licensed too. If you buy from an unlicensed insurance company, your claim could go unpaid if the company becomes insolvent. You can learn an agent's or insurance company's license status by calling the Consumer Help Line.
- **Get several quotes and compare policies.** When comparing prices, understand what each policy covers. If you have doctors that you want to keep, make sure they're in the plan's network. Otherwise, you might have to change doctors.

Also make sure that any medications you take are on the plan's formulary.

- **Visit HealthCare.gov to buy a marketplace plan.** You may be able to get a subsidy to help you pay for insurance if you buy through the marketplace. If you buy health insurance from an agent or broker or directly from an insurance company, you're not eligible for a subsidy.
- **Fill out all applications accurately and completely.** If you knowingly provide incorrect, incomplete, or misleading information, an insurance company may cancel your coverage or deny benefits. Never sign a blank policy application. If someone else fills out the application, double-check that all of the information is correct. Make payments by check or money order payable directly to the insurance company or HMO, not the agent. Ask for a signed receipt on official letterhead.
- **Take your time.** Don't be pressured into buying a policy. Ethical agents will not pressure you into buying a policy before you know what you want and need.
- **Ask questions.** Ask the plans you're considering these questions deciding:
 - Will the plan allow you to visit your choice of doctors and hospitals?
 - Are your current doctors in the plan's network?
 - Will the plan cover the medications you're currently taking?
 - Are there limits on medications, referrals to specialists, or treatments and surgeries?
 - Are there benefit limits per person, family, illness, treatment, or hospital stay?
 - What are the rules for out-of-network care and emergency care?
- **Never pay more than two month's premiums until you've gotten a copy of your policy, HMO certificate, or group membership certificate.**

Important! If you change health insurance companies, be aware of the effective date of the new policy. Most companies don't begin coverage until they approve your application and deliver your policy. A lapse in coverage could leave you vulnerable if you're sick or injured.

Rate Increases

Premiums for individual plans are locked in for one year. Rates usually go up when the plan is renewed to reflect your age and any increase in the cost of medical care. If your premiums are increasing beyond your ability to pay, you might be able to save money by shopping for a different plan. Remember that you can usually only buy insurance during the open enrollment period.

Federal law requires companies to justify rate increases of 10 percent or more before the increase takes effect. For more information about rate increases, visit HealthCare.gov's Rate Review page at ratereview.healthcare.gov/.

Losing Your Insurance

Insolvency

If an insurance company becomes insolvent, or unable to pay its claims, a guaranty association may pay the company's claims. The guaranty association pays claims up to the maximum dollar limit specified by state law. There are separate guaranty associations for different lines of insurance. The Texas Life and Health Insurance Guaranty Association pays claims for life insurance, health insurance, and annuities.

The guaranty association doesn't cover HMOs, MEWAs, self-funded plans, or fraternal benefit societies. If an HMO can't pay its claims, state law authorizes the commissioner of insurance to assign the HMO's members to another licensed HMO in the area.

Cancellation

Individual health plans that cover hospital, medical, and surgical expenses are guaranteed renewable. This means your insurance company can't decline to renew your policy, even for health-related factors. A plan can legally cancel your coverage, however, if you:

- don't pay your premiums or pay late,
- intentionally misrepresented information in your policy application, or
- filed a false claim or commit fraud against the plan.

Insurance companies may discontinue a plan as long as it drops the plan for all policyholders. If an insurer drops your plan, it must offer you another plan it sells. If an insurer withdraws from the Texas market entirely, it may not reenter the market for five years.

Losing Employer Group Coverage

If you have group coverage, you may lose your coverage if you:

- quit or lose your job,
- reduce to part-time status, or
- end your membership in the association or group sponsoring the plan.

Group plans must continue to offer coverage for up to three years for dependents who lost coverage because of the primary policyholder's retirement, divorce, or death. To qualify, a dependent must have been covered by the group policy for one

year or be less than a year old. Dependent benefits are the same as those provided by the group health plan. Continuation of coverage will end early if the dependent gets new coverage, premiums aren't paid, or the group policy is terminated.

COBRA Protection

If you lose your group coverage, you can usually continue coverage under COBRA (the Consolidated Omnibus Budget Reconciliation Act). COBRA is a federal law that gives employees - and some retired employees - the right to continue group health coverage for a certain period.

COBRA applies to employers with 20 or more employees. It doesn't apply to plans sponsored by the federal government and some church-related organizations. Employees aren't eligible for COBRA coverage if they're fired. Employees who lose coverage because of a reduction in the number of hours they work are usually eligible. An employee's spouse qualifies for COBRA coverage when the employee becomes eligible for COBRA or Medicare, or when the employee divorces or dies. An employee's children qualify for COBRA if the employee is eligible or if the child loses dependent child status under the rules of the health plan.

An employee, spouse, or dependent child has 60 days after qualifying for COBRA coverage to decide whether to enroll. If they enroll, they must pay the full premium and a 2 percent administrative fee. Coverage can continue for at least 18 months and up to 42 months, depending on the situation. If you have a disability that meets the standards of the Social Security Administration, your coverage period may be extended by an additional 11 months. Your COBRA coverage will be the same as the coverage you had with your employer's plan. If you continue HMO coverage through COBRA and move out of the service area, you will be covered only for emergency services. COBRA coverage will end if the group sponsoring the coverage stops offering health insurance to its members. For more information about **COBRA**, call **EBSA** at **1-866-444-EBSA (3272)**.


State Continuation of Group Coverage

Texas law requires some group plans to continue coverage for an additional six months after your COBRA coverage ends. For state continuation to apply, your coverage must have been through an insurance company or HMO subject to Texas insurance laws and rules. You might not qualify for state continuation if you were fired.

In addition, you must have been covered under the group contract for at least three consecutive months immediately before the end of your employment.

If you're not eligible for COBRA coverage, you can continue your group coverage for nine months. The continuation period begins immediately after your employment ends.

If you are eligible for COBRA as a...	COBRA applies for...	Texas continuation applies for...	For a total continuation period of...
Primary plan member (direct employee)	18 months	6 months	24 months
Secondary plan member (spouse, ex-spouse or dependent child)	36 months	6 months	42 months
If you are not eligible for COBRA as a...			
Primary or secondary plan member	0 months	9 months	9 months

 **Note:** If your coverage is through a family member who is retiring, has passed away, or whose family relationship with you has ended, you may have a separate right under state law to continue coverage for 36 months. See your plan documents for details

State and federal law requires employers to tell you about continuation of coverage within 30 days from the end of your employment. If you want to continue your insurance coverage, you must notify your employer in writing by the 60th day after your coverage ended.

State continuation doesn't apply to self-funded plans.

Health Care Programs

The following federal, state, and local groups and agencies offer health coverage or provide low-cost care:

	Agency/Program	Description	Contact
Federal	Benefits.gov	Find government benefits that you might qualify for	Benefits.gov
	Federal health insurance marketplace	Access to private health insurance plans and federal tax credits	1-800-318-2596 healthcare.gov
	Medicare	Federal health insurance program for people 65 and older and certain people under age 65 with disabilities	1-800-MEDICARE (633-4227) medicare.gov
	TRICARE	Health plan for active duty and certain retired U.S. military personnel	1-800-403-3950 www.mytricare.com 1-800-444-5445 (Humana Military Tricare South) humanamilitary.com
	U.S. Department of Veterans Affairs	Offers health care for veterans	1-877-222-VETS (8387) va.gov
State	Children's Health Insurance Program (CHIP)	Provides health care to children of families who earn too much money for Medicaid but can't afford health insurance	1-877-KIDS-NOW (543-7669) chipmedicaid.org
	Medicaid (administered by Texas Health and Human Services)	State/federal health insurance program for low-income Texans	1-800-252-8263 hhs.texas.gov/services/health/medicaid-chip
	Texas Health and Human Services	Department of Aging and Disability, Department of Family and Protective Services, Department of State Health Services, Healthy Texas Women	512-424-6500
	Texas Health Steps	Provides medical and dental checkups and care to children from birth to age 21 who are on Medicaid	1-877-THSTEPS (847-8377) www.dshs.texas.gov/thsteps/default.shtm
	Your Texas Benefits	Learn about state benefit programs that help people with little or no money	yourtexasbenefits.com 2-1-1
Local	County Indigent Health Care Program	Provides health care services to eligible residents through the counties, hospital districts and public hospitals in Texas	512-776-6467 www.dshs.texas.gov/cihcp/default.shtm
	Hill-Burton Program	Federally funded program that contracts with local hospitals, clinics, and nursing homes to provide free or low-cost care to people with low incomes.	1-800-638-0742 www.hrsa.gov/gethealthcare/affordable/hillburton/
	2-1-1	Provides free information about services in your area	2-1-1 www.211texas.org/211/

Note: Find more health care coverage resources on our web page at www.texashealthoptions.com/resources/index.html.

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Your Health Care Coverage (cb005)
Updated October 2017