How does the health care law protect me?

Part 1

Rights & Protections

Whether you need health coverage or have it already, the health care law offers new rights and protections that make coverage fairer and easier to understand.

Some rights and protections apply to plans in the Health Insurance Marketplace or other individual insurance, some apply to job-based plans, and some apply to all health coverage.

These rights and protections provide even more choice and control over your health coverage when key parts of the law take effect in 2014.

Use this guide to learn about your rights and protections today and in 2014.

How the health care law protects you

- Creates the Health Insurance Marketplace (/what-is-the-health-insurance-marketplace), a new way for individuals, families, and small businesses to get health coverage
- Requires insurance companies to cover people with pre-existing health conditions (/how-does-the-health-care-law-protect-me/#part=3)
- Helps you understand the coverage you're getting (/how-does-the-health-care-law-protect-me/#part=4)
- Holds insurance companies accountable for rate increases (/how-does-the-health-care-law-protect-me/#part=10)
- Makes it illegal for health insurance companies to arbitrarily cancel your health insurance (/how-does-the-health-care-law-protect-me/#part=5) just because you get sick
- Protects your choice of doctors (/how-does-the-health-care-law-protect-me/#part=6)
- Covers young adults under 26 (/how-does-the-health-care-law-protect-me/#part=7)
- Provides free preventive care (/how-does-the-health-care-law-protect-me/#part=8)

- Ends lifetime and yearly dollar limits (/how-does-the-health-care-law-protect-me/#part=9) on coverage of essential health benefits
- Guarantees your right to appeal (/how-does-the-health-care-law-protect-me/#part=11)

Questions? Call 1-800-318-2596, 24 hours a day, 7 days a week. (TTY: 1-855-889-4325)

Part 2

The Health Insurance Marketplace

There is a new way to get health coverage: the Health Insurance Marketplace (/marketplace/individual).

Plans in the new Marketplace are offered by private companies, and every health insurance plan will cover a core set of benefits called essential health benefits (/what-does-marketplace-health-insurance-cover/). You'll be able to compare your options based on price, benefits, quality, and other important features. More people than ever will qualify to save money (/how-can-i-save-money-on-marketplace-coverage) on private insurance coverage.

You'll also learn whether you qualify for free or low-cost coverage through Medicaid (/do-i-qualify-for-medicaid) or the Children's Health Insurance Program (CHIP) (/are-my-children-eligible-for-chip). Fill out one Marketplace application and you'll see all the programs you qualify for.

- You can apply any time during open enrollment, which began October 1 and continues through the end of March.
- Marketplace coverage starts as soon as January 1, 2014.
- Find out how you can get ready to enroll (/how-can-i-get-ready-to-enroll-in-the-marketplace).

Part 3

Coverage for Pre-Existing Conditions

For plan years beginning in 2014, health plans can't turn you down or charge you more because you're sick or have a health condition. They also can't charge women more than men. The only exception is for grandfathered (/what-if-i-have-a-grandfathered-health-plan) individual health insurance plans.

insurance plans.

Learn more about coverage for pre-existing conditions (/what-if-i-have-a-pre-existing-health-condition).

Part 4

Summary of Benefits and Coverage

You have the right to get an easy-to-understand summary about a health plan's benefits and coverage.

Insurance companies and group health plans must provide you with:

- A short, plain-language Summary of Benefits and Coverage (SBC)
- A Uniform Glossary of terms used in health coverage and medical care

This information allows you to make "apples-to-apples" comparisons when you're looking at different plans.

All individual and group health plans must use the same standard form to help you compare plans. The SBC also includes details, called coverage examples, which allow you to see what the plan would cover in 2 common medical situations: diabetes care and childbirth.

You'll find a link to each plan's SBC in the Marketplace when you're comparing plans.

Where can I get an example of the Summary of Benefits and Coverage and the Uniform Glossary?

- Sample SBC form (https://www.cms.gov/CCIIO/Resources/Files/Downloads/sbc-sample.pdf) (PDF - 601 KB)
- Uniform Glossary (https://www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf) (PDF - 140 KB)

When can I get a Summary of Benefits and Coverage?

You have the right to get this summary when shopping for or enrolling in coverage.

The SBC is available for every plan in the Marketplace. You'll find a link to it on each plan page when you enroll through the website.

You can also ask for a copy from your insurance company or group health plan at any time. All health plans must provide the SBC to you at important points in the enrollment process, like when you apply for or renew your policy. You can also ask for a copy of the Uniform Glossary to

help you understand words used in health coverage and medical care.

Does this apply to my plan?

Yes. You can get a Summary of Benefits and Coverage for most health plans, including grandfathered (/what-if-i-have-a-grandfathered-health-plan/) plans, whether you get coverage through your employer or buy it yourself.

How can I get a Summary of Benefits and Coverage in another language?

If you don't speak English, you may be able to get the SBC and Uniform Glossary in your native language upon request. Learn more about resources for people who don't speak English. (/language-resource)

Part 5

Cracking Down on Frivolous Cancellations

The health care law stops insurance companies from canceling your coverage just because you made a mistake on your insurance application.

In the past, if your insurance company found that you'd made a mistake on your insurance application, they could:

- Take away your coverage
- Declare your policy invalid from the day it started
- Ask you to pay back any money they've already spent for your medical care

It's now illegal for insurance companies to cancel your coverage simply because you made an honest mistake or left out information that has little bearing on your health.

Does this apply to my plan?

Yes. These protections apply to all health plans, including grandfathered plans (/what-if-i-have-a-grandfathered-health-plan/), whether you get coverage through your employer or buy it yourself.

Does this mean that my plan can't be canceled for any reason?

No. Your insurance company can still cancel your coverage if you put false or incomplete information on your insurance application on purpose. They can also cancel your coverage if you don't pay your premiums on time.

Will I be notified before my plan is cancelled?

Yes. Your insurance company must give you at least 30 days' notice before they can cancel your coverage for the reasons stated above. This gives you time to appeal the decision or find new coverage.

Part 6

Doctor Choice & Emergency Room Access

You have the right to choose the doctor you want from your health plan's provider network. You also can use an out-of-network emergency room without penalty.

- **You pick your doctor:** You can choose any available primary care provider in your insurance plan's network. You can choose any available network pediatrician as your child's primary care doctor.
- **No referrals needed for OB-GYN services:** You don't need to get a referral from a primary care provider before you can get obstetrical or gynecological (OB-GYN) care from a specialist.
- **Access to out-of-network emergency room services:** Insurance plans can't require higher copayments (/glossary/co-payment) or coinsurance (/glossary/co-insurance) if you get emergency care from an out-of-network (/glossary/network) hospital. They also can't require you to get prior approval before getting emergency room services from a provider or hospital outside your plan's network.

Does this apply to my plan?

It depends. These rights don't apply to health plans created or bought before March 23, 2010, which are known as grandfathered (/what-if-i-have-a-grandfathered-health-plan/) plans. Check your plan's materials or ask your employer or benefits administrator to find out if your health plan is grandfathered.

Part 7

Young Adult Coverage

If you're under 26 years old, you may be able to get insured under a parent's plan.

You can join, remain, or return to a parent's plan even if you're:

- married
- not living with your parents
- attending school
- financially independent
- eligible to enroll in your employer's plan (with one exception, below)

Learn more about covering young adults under 26. (/can-i-keep-my-child-on-my-insurance-until-age-26)

Does this apply to my plan?

Yes. These rights apply to all health plans that offer dependent coverage, including grandfathered (/what-if-i-have-a-grandfathered-health-plan/) plans, whether you get coverage through your employer or buy it yourself.

But there's one temporary exception: Until 2014, grandfathered group plans that offer dependent coverage don't have to offer it up to age 26 if a young adult is eligible for job-based coverage through their own employer.

Do young adults have other insurance options?

If you're under 30, you may buy an insurance policy that covers only very high medical costs. Learn more about these "catastrophic" plans. (/can-i-buy-a-catastrophic-plan)

Part 8

Free Preventive Care

Many health plans are required to cover certain preventive care services at no cost to you.

You may be eligible for free preventive screenings (/what-are-my-preventive-care-benefits), like blood pressure and cholesterol tests, mammograms, colonoscopies, and more. This includes coverage for vaccines and new preventive services for women (/what-are-my-preventive-care-benefits/#part=2).

Does this apply to my plan?

It depends. These rights don't apply to health plans created or bought before March 23, 2010, which are known as grandfathered (/what-if-i-have-a-grandfathered-health-plan/) plans. Check your plan's materials or ask your employer or benefits administrator to find out if your health plan is grandfathered.

Learn more about preventive benefits (/what-are-my-preventive-care-benefits).

Part 9

Ending Lifetime & Yearly Limits

The health care law stops insurance companies from limiting lifetime coverage for essential health benefits (/what-does-marketplace-health-insurance-cover/). In 2014 this applies to yearly limits too.

Lifetime Limits

Insurance companies can't set a dollar limit on what they spend on essential health benefits (/what-does-marketplace-health-insurance-cover/) for your care during the entire time you're enrolled in that plan.

Yearly Limits

Insurance companies can still set a yearly dollar limit of $2 million on what they spend for your coverage for plan years or policy years starting before January 1, 2014. No yearly dollar limits on essential health benefits (/what-does-marketplace-health-insurance-cover/) are allowed for plan years starting January 1, 2014.

Does this apply to my plan?

It depends. Protections against lifetime limits on coverage apply to all health plans, including grandfathered (/what-if-i-have-a-grandfathered-health-plan/) plans, whether you get coverage through your employer or buy it yourself.

Protections against annual limits apply to most health plans, but they don't apply to grandfathered (/what-if-i-have-a-grandfathered-health-plan/) individual health plans. Check your plan's materials to find out if your health plan is grandfathered.

Are there any exceptions I should know about?

Yes.

- Insurance companies can still put a yearly dollar limit and a lifetime dollar limit on spending for health care services that are not considered essential health benefits (/what-does-marketplace-health-insurance-cover/).
- Some health insurance plans may have received a temporary waiver from the rules on yearly dollar limits. Yearly limit waivers end with plan or policy years beginning in 2014.

Part 10

Rate Review & the 80/20 Rule

The health care law provides 2 new ways to hold insurance companies accountable and help keep your costs down: Rate Review and the 80/20 rule.

Rate Review

Rate Review helps protect you from unreasonable rate increases. Insurance companies must now publicly justify any rate increase of 10% or more before raising your premium. This does not apply to grandfathered (/what-if-i-have-a-grandfathered-health-plan) plans.

80/20 Rule

The 80/20 Rule generally requires insurance companies to spend at least 80% of the money they take in on premiums on your health care and quality improvement activities instead of administrative, overhead, and marketing costs.

The 80/20 rule is sometimes known as Medical Loss Ratio, or MLR. If an insurance company uses 80 cents out of every premium dollar to pay for your medical claims and activities that improve the quality of care, the company has a Medical Loss Ratio of 80%.

Insurance companies selling to large groups (usually more than 50 employees) must spend at least 85% of premiums on care and quality improvement.

If your insurance company doesn't meet these requirements, you'll get a rebate from your premiums.

Use this tool to learn more about your insurance company and 80/20 rebates (http://companyprofiles.healthcare.gov/) .

Will I get a rebate check from my insurance company?

If your insurance company doesn't meet its 80/20 targets for the year, you'll get back some of the premium that you paid. You may see the rebate in a number of ways:

- A rebate check in the mail
- A lump-sum deposit into the same account that was used to pay the premium, if you paid by credit card or debit card
- A direct reduction in your future premium
- Your employer may also use one of the above rebate methods, or apply the rebate in

a way that benefits employees

If you or your employer are going to get a rebate, your insurance company must notify you by August 1.

If you have an individual insurance policy, you'll get the rebate directly from your insurance company.

For small group and large group plans, the rebate is usually paid to the employer. It may use one of the above rebate methods, or apply the rebate in a way that benefits employees.

Note: The 80/20 rebate rules don't apply when an insurance company has fewer than 1000 enrollees in a particular state or market.

Does this apply to my plan?

It depends.

For Rate Review: These requirements don't apply to grandfathered (/what-if-i-have-a-grandfathered-health-plan) individual and small group health plans. Check your plan's materials or ask your employer or your benefits administrator to find out if your health plan is grandfathered.

For the 80/20 Rule: These rights apply to all individual, small group, and large group health plans, whether your plan is grandfathered or not.

Part 11

Your Right to Appeal Coverage Decisions

You have the right to appeal private health plan decisions.

Private Insurance plans have to tell you why a claim has been denied and they have to let you know how you can dispute their decision.

Internal Appeals: You can ask your insurance company to reconsider its decision to deny payment for a service or treatment. It must review its decision.

External Review: If your insurance company still denies payment, the law allows you to have an external review. The review will be done by an independent organization that will decide if the insurance company should pay or not.

Where you live matters

Depending on the state you live in and the type of plan you have, your rights may vary. In certain states, some group plans may require more than one level of internal appeal before you can get an external review.

For step-by-step instructions, see our guide to filing an appeal (/how-do-i-appeal-a-health-insurance-companys-decision).

When can I request an appeal?

You can request an appeal when a health plan denies payment for a treatment or service. When your plan gets your request it is required to review its own decision. When your plan denies a claim, it's required to notify you of:

- The reason your claim was denied
- Your right to file an internal appeal
- Your right to request an external review if your internal appeal was unsuccessful
- The availability of a Consumer Assistance Program (if your state has one)

How can I file an appeal if I don't speak English?

If you don't speak English, you may be entitled to get appeals information in your native language. Learn more about resources for people who don't speak English. (/language-resource)

Does this apply to my plan?

It depends. These rights don't apply to grandfathered (/what-if-i-have-a-grandfathered-health-plan) health plans. Check your plan's materials or ask your employer or benefits administrator to find out if your health plan is grandfathered.