

Know Your Rights in the Health Insurance Marketplace®



You have certain rights when you enroll in a Marketplace health plan. These rights include:

- Getting straightforward information about what your plan covers, what you pay for services, what prescription drugs it covers, and what providers are in its network.
- Getting coverage for emergency services
- Requesting coverage for a prescription drug that your plan doesn't normally cover
- Appealing a health plan's decision not to pay a claim

Depending on where you live, your state may offer other rights and protections. Contact your local Department of Insurance for more information.

Getting plan information

You have the right to get an easy-to-understand summary of what the plan covers when you're shopping for or enrolling in coverage. This is called a Summary of Benefits and Coverage.

You can get this summary and other up-to-date information about every Marketplace plan when previewing plans and prices or enrolling in a plan through [HealthCare.gov](https://www.healthcare.gov).

Here's how: Visit [HealthCare.gov/see-plans](https://www.healthcare.gov/see-plans) to find plans available in your area. When reviewing a Marketplace plan, go to plan details. Then choose the information you need.

- Select "Plan documents" to get the plan's
 - Summary of Benefits and Coverage
 - Provider Network Directory
 - List of covered drugs
- Select "Urgent care & hospital services" to learn about its emergency service coverage.
- Select "Prescription drug coverage" for a list of covered drugs.

What's in the Summary of Benefits and Coverage?

This health plan document outlines the health care items and services the plan covers and your share of the costs when you're enrolled in the plan. The Summary of Benefits and Coverage also includes coverage examples for maternity care, diabetes care, and a simple fracture, so you can learn how a particular plan's cost sharing might work for a medical situation.

Insurance companies must also give you a "Uniform Glossary" that defines certain health coverage and medical care terms. All plans must use the same standard form for the Summary of Benefits and Coverage and Uniform Glossary to help you compare plans.

You can ask your insurance company for a Uniform Glossary and Summary of Benefits and Coverage at any time. All health plans must give you the Summary of Benefits and Coverage during enrollment, like when you apply or renew your policy.

What's a provider network directory?

A health plan's provider network directory (also called a provider directory) lists the network of doctors, hospitals, and other health care providers that contract with that health plan to give you medical care. If you use a doctor or facility that's not in your plan's network, you may have to pay more for the services you get.

When you're shopping for a health plan, use the plan's provider network directory on [HealthCare.gov](https://www.healthcare.gov) to search for your current doctor(s). Every Marketplace plan must also have a current provider network directory link on its website. After you enroll, you can use this directory to help you find a new doctor if you ever need one.

How do I find out if a plan covers my prescription drugs?

When you view or compare plans on [HealthCare.gov](https://www.healthcare.gov), there are several ways to find out which drugs each Marketplace plan covers:

- Select "Add prescription drugs" on the "Plan details" page and enter the drugs that you or other household members take now. Each plan listing will include coverage information for these drugs.
- Select "Go to plan details," then "Plan documents" for a list of covered drugs. You can also check the Summary of Benefits and Coverage, which includes a link to more information about the plan's drug coverage.

Can I request coverage for a prescribed drug my plan doesn't cover?

Every Marketplace plan must have a prescription drug exceptions process that lets you request coverage of a prescribed drug your plan doesn't cover. This is different from appealing the denial of a drug your plan covers.

How do I request an exception for a non-covered drug my doctor prescribed?

To request coverage of a drug through the exceptions process, your doctor would generally submit the request to your plan (orally or in writing), and explain that the non-covered drug is appropriate for your medical condition. Contact your plan for detailed information about its prescription drug exceptions process.

Can I get the non-covered drug during the exceptions process?

While you're in the exceptions process, your plan may cover your drug until it makes a decision, but the plan doesn't have to do so.

What happens if I get the exception?

If you get the exception, you can generally get the non-covered drug for a certain period. Your health plan will treat the drug as covered, but your share of the cost (like your coinsurance) could apply to the most expensive drug tier on the list of covered drugs (formulary). If your plan covers the drug through the exception, your share of the cost will count towards your out-of-pocket maximum.

Will I get coverage for emergency services?

All Marketplace plans (except dental-only plans) must cover emergency services. Your plan can't require prior authorization for emergency services you get at a hospital or independent freestanding emergency department, even if you get the service out of network.

Generally, your plan must cover emergency services regardless of any other term or condition of coverage.

What if I get emergency care out of network?

Your Marketplace plan must cover out-of-network emergency care:

- Without limiting coverage in ways that are more restrictive than in-network limits
- Without charging you a copayment or coinsurance that's more than the cost-sharing requirement for in-network emergency care

You may have to pay other out-of-pocket costs, like a deductible.

Requesting an appeal

If your health insurer refuses to pay a claim (in part or in whole) or ends your coverage, you have the right to appeal the decision. You can ask that your insurance company reconsider its denial. If your insurer denies your appeal, you can have an independent third party review your claim. Insurers have to tell you why they've denied your claim or ended your coverage. And they have to let you know how you can dispute their decisions.

Here are some resources to help you with your appeal:

- **Understand the appeals process.** For more information on the coverage appeals process, go to [HealthCare.gov/appeal-insurance-company-decision/appeals](https://www.healthcare.gov/appeal-insurance-company-decision/appeals).

- **Contact your state's Consumer Assistance Program (CAP) or Department of Insurance.** They may be able to help you, along with other local organizations. To find help in your area, visit [LocalHelp.HealthCare.gov](https://www.localhelp.healthcare.gov).
- **Get help in your language.** If you don't speak English, you can get help and information about appeals and other Marketplace issues in your preferred language at no cost. To talk to an interpreter, call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

How can I learn more?

To learn more about coverage through the Marketplace or your benefits and protections, visit **HealthCare.gov** or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

You have the right to get your information in an accessible format, like large print, braille, or audio.

You also have the right to file a complaint if you feel you've been discriminated against.

Visit [CMS.gov/About-CMS/Agency-Information/Aboutwebsite/CMSNondiscriminationNotice](https://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/CMSNondiscriminationNotice)

or call 1-800-318-2596. TTY users can call 1-855-889-4325.

Health Insurance Marketplace

CMS Product No. 11759
September 2023

This product was produced at U.S. taxpayer expense.

Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.



HealthCare.gov