Texas Department of Insurance

2026

Texas Health Coverage Guide

TDI | Texas Department of Insurance

2026 Texas Health Coverage Guide

by the

Texas Department of Insurance

2026-28 edition
First posting, December 2025
Publication ID: THCG | 1225
This document is available online at tdi.texas.gov/reports.

Contents

Overview

The 2025 Texas Legislature created Texas Insurance Code 524A, which requires the Texas Department of Insurance (TDI) to develop a biennial reference guide to educate the public about health coverage in Texas.

History of health insurance and access to care

Health care in Texas and much of the U.S. is a hybrid system that relies on private and public funding. While most health care providers are privately operated, they get reimbursements from a variety of sources, including self-pay patients, commercial health insurance plans, and government supported health plans.

In Texas, 48% of people get health care services through employer-based health insurance benefits. This arrangement lets an employer provide subsidized health insurance benefits to employees as non-taxable employee compensation.

People without access to an employer-provided health benefit arrangement can buy individual health coverage like how they buy home or auto insurance. About 8% of Texans get coverage through the individual market, while 17% remain uninsured.

Medicaid and Medicare are government funded programs available for people that meet disability, age, medical condition, and income-level eligibility.

ACA and HealthCare.gov

Congress enacted the Patient Protection and Affordable Care Act (ACA) on March 23, 2010. It was amended by the Health Care and Education Reconciliation Act on March 30, 2010. ACA refers to the final, amended version of the law.

The law provides rights and protections to make health coverage fairer and easier to understand, along with subsidies to make it more affordable.

HealthCare.gov launched in 2013 to help people shop for and enroll in ACA health plans.

Key terms

For more glossary terms, visit www.HealthCare.gov/glossary.

Coverage

Health coverage, health plan, or health insurance

Legal entitlement to receive health care directly or receive payment or reimbursement for your health care costs under a contract with a health insurance company or health maintenance organization (HMO), a group health plan offered in connection with employment, or a government program like Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).

Costs

Premium

The monthly amount you pay for a health plan. If you have coverage through work, it's usually deducted from your paycheck.

Out-of-pocket costs

Health care expenses your plan doesn't reimburse. These include deductibles, coinsurance, copays for covered services, and costs for services your plan doesn't cover.

Deductible
The amount you pay for covered services before your health plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself.

- Some plans have separate deductibles for certain services like prescription drugs.
- Family plans often have both an individual deductible, which applies to each person, and a family deductible, which applies to all family members.

Coinsurance
The percentage you pay for a covered service after you've met your deductible.

For example, your health plan might pay 80% of a covered service. If the service costs $1,000 and your coinsurance is 20%, you pay $200.

Copay
The fixed amount you pay for a covered health service. For example, $25 when you go to the doctor and $40 when you go to a specialist.

Let's say your doctor's office visit costs $100 and your copay is $20.

- If you've met your deductible: You pay $20
- If you haven't met your deductible: You pay $100, the full amount for the visit.

Out-of-pocket maximum

Once you've reached your out-of-pocket maximum or limit, your health plan usually pays 100% of your covered essential health benefits. You still must pay your monthly premium.

Out-of-pocket limits don't include:

- Monthly premiums.
- Money spent on non-covered services.
- Out-of-network care and services.
- Costs above the allowed amount for a service that a provider may charge.

The ACA caps out-of-pocket limits at a set amount each year.

Services

Network

The providers your health plan contracts with to provide health services. You may have different coinsurance percentages and copay amounts based on the provider's network status.

Providers

A person, facility, or organization licensed to provide health care services. Often used collectively to refer to people or facilities that provide health services.

In-network vs. out-of-network providers

In-network providers contract with a health plan and agree to treat people with the plan for a set amount. Out-of-network providers don't have a contract and can balance bill people if the health plan pays less than what the provider charged. Health plans typically have higher copay and coinsurance amounts for using out-of-network providers.

Preferred providers

If your plan has a tiered provider network, using preferred providers costs less as they typically agree to see patients for a lower rate.

Participating providers

Some health plans have "participating" providers. These providers contract with a health plan, but the discount may not be as great as an in-network provider, and you may have to pay more.

Primary care provider

A primary care provider (PCP) is a doctor who directly provides or coordinates a range of health care services for a patient. HMOs have you pick a PCP when you enroll and require a written referral from your PCP before visiting a specialist.

Referral

A written order from your primary care doctor to see a specialist or get certain medical services.

Consumer rights

These are the primary federal and state protections that govern individual and employer health coverage.

Preexisting conditions

A health plan can't deny you coverage or charge more on HealthCare.gov because of a preexisting health condition or disability.

When deciding how much to charge, plans can only use your age, where you live, whether you smoke or use tobacco, and whether you're buying coverage for yourself or your family.

Essential health benefits

Health plans must cover essential health benefits, including free preventive health services, at an in-network provider. Plans usually cover all medically necessary services or supplies that meet accepted standards of medicine needed to diagnose or treat an illness, injury, condition, disease, or its symptoms.

In Texas, fully insured major medical plans must include certain mandated benefits, most of which are essential health benefits. Learn about the essential health benefits required for ACA coverage in Texas at www.tdi.texas.gov/healthguide.

Essential health benefits include:

- Ambulatory patient services (care you get without a hospital admission).
- Birth control and breastfeeding coverage.
- Emergency services provided in a hospital emergency facility (or comparable facility) to evaluate and stabilize sudden and severe medical conditions for an illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm.
- Hospitalization, like surgery that requires hospital admission and usually an overnight stay.
- Lab services.
- Mental health and substance use disorder services (MH/SUD), including behavioral health treatment, counseling, and psychotherapy.
- Pediatric services, including oral and vision care (adult dental and vision coverage aren't essential health benefits).
- Pregnancy, maternity, and newborn care (both before and after birth).
- Prescription drugs.
- Preventive and wellness services and chronic disease management.
- Rehabilitative and habilitative services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills.

Financial protection

- **Cost-sharing limits:** Plans have an out-of-pocket limit that caps the amount you'll pay if you need a lot of health care services. These limits apply to in-network essential health benefits.
- **No lifetime or annual coverage limits:** Companies can't put annual or lifetime limits on the amount they'll pay for essential health benefits.
- **Minimum value:** Health plans must cover at least 60% of the share of health care expenses.

Medical loss ratio requirement

Federal law caps the amount of health plan premiums that insurers can spend on administrative expenses and profit. For individual and small employer plans, insurers need to spend at least 80% of premiums on paying for health care, and for large employer plans, insurers need to spend at least 85% on health care. If they don't meet these thresholds, they must pay rebates to consumers.

Affordability

If you get health insurance through work, the premium shouldn't cost more than about 10% of your income. If your premium is unaffordable, you can apply for a tax credit on HealthCare.gov.

If you get health insurance on HealthCare.gov, you can apply for a premium tax credit to help reduce your monthly payment. The tax credit amount depends on your estimated annual income, family size, and the cost of health insurance where you live.

If you qualify for a premium tax credit, you can use any amount of the credit in advance to lower your premium.

- If at the end of the year you've taken more premium tax credit than you're due based on your final income, you must pay back the excess when you file your federal tax return.
- If you've taken less than you qualify for, you get the difference back.

Network adequacy

Network adequacy rules make sure you have reasonable access to providers and facilities without unreasonable travel or wait times. If you can't find an in-network provider, contact your health plan so they can give you options to get the care you need at in-network prices.

Protection from surprise medical bills

State and federal law have surprise billing protections that prohibit balance billing in most situations where you might inadvertently get care from an out-of-network provider. In Texas, fully insured plans have protections for emergency care, care from an out-of-network provider within an in-network facility, and diagnostic imaging or lab work ordered in connection with in-network care.

Children stay covered until age 26

Children can stay on their parents' plans until they turn 26. They don't have to live at home, be in school, or claimed as a dependent on their parents' tax return. Children with disabilities can get coverage after age 26. Dependent grandchildren can get coverage up to age 25.

Right to appeal

If your health plan denies your claim or preauthorization request for medical reasons, you can file an appeal. If you're not happy with the outcome of your appeal, you can ask the health plan for an external review.

Mental health parity

Fully insured health plans sold to individuals, small employer groups, and large employer groups must include MH/SUD services. Self-funded health plans don't have to cover MH/SUD services.

If plans offer MH/SUD services (by requirement or choice), they must cover MH/SUD services at the same level as physical illness services. This is known as "parity." Plans may not cover all MH/SUD services or specific provider types.

Where to get health insurance

Finding a health plan depends a lot on your employment status, income, and age. There are three main market categories, each with their own rules, enrollment periods, and oversight.

Group insurance

Group insurance provides coverage through your employer. Most large employers offer health plans that cover employees and their dependents. Some also offer coverage for former employees or members, and, in some cases, their families. Group plans are either fully insured or self-funded.

Employer-based plans can't deny or restrict coverage or charge you more because of your health status but can restrict coverage based on factors not related to health status.

Fully insured plans

TDI regulates fully insured plans and handles consumer complaints, rate reviews, and state-mandated benefits compliance. Health ID cards for these plans include the letters "TDI" or "DOI."

Self-funded plans

The U.S. Department of Labor regulates self-funded plans and handles complaints under the 1974 Employee Retirement and Income Security Act (ERISA). State mandates usually don't apply to these plans.

Employers that offer ERISA plans pay their employees' claims themselves and can decide the types of services the plan provides. Employers may contract with an insurance company to administer the plan, contract with a provider network, and pay claims.

Individual insurance

Individual insurance covers you and your family. It's not connected to your employer, so you can keep your plan even if you switch jobs. Most people buy these plans through HealthCare.gov.

TDI regulates individual plans. Plan premiums are locked in for one year. Rates usually go up each year when the plan renews to reflect your age and market-wide health care costs. Federal law requires companies to justify rate increases of 10% or more. For more information, visit ratereview.HealthCare.gov.

Health reimbursement arrangements

Instead of providing a group health plan, some employers use a health reimbursement arrangement (HRA) to give employees funds on a pretax basis that the employee can use to buy individual insurance. This is called an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA).

If you receive this type of benefit through work, you can't also get ACA tax credits. But if the HRA doesn't meet affordability standards, you can reject the HRA and use ACA tax credits instead.

Government programs

You can apply for CHIP and Medicaid through YourTexasBenefits.com and Medicare at Medicare.gov.

See the Resources section for more information on federal, state, and local health care programs.

CHIP

Health coverage for children in families with too much income to qualify for Medicaid but who can't afford to buy private insurance.

Medicaid

Health coverage for low-income children, pregnant women, former foster care youth, people with disabilities, and people age 65 and older in Texas. States can provide different services or providers under the Medicaid State Plan. They can also have different eligibility rules Moving from one state to another as a Medicaid patient may change the services available.

Medicare

A federal health program for people 65 and older and certain younger people with disabilities. It also covers people with ALS or end-stage renal disease.

How does insurance operate?

Who decides what services are covered?

While most health plans cover similar services and include care that's usually considered medically necessary, coverage can vary depending on how the plan is regulated.

Self-funded plans

Self-funded plans are subject to federal laws but exempt from state regulation. Federal laws include some coverage requirements, like preventive services, but employers have significant discretion to decide what to cover. The Department of Labor regulates these plans.

Fully insured plans

The state regulates fully insured plans. These plans are subject to federal laws like the ACA, which requires individual and small employer plans to cover a broad set of essential health benefits. These laws don't allow much variation in coverage. State law also requires certain coverage benefits, which vary between individual, small employer, and large employer markets.

State Medicaid and CHIP plans

State Medicaid and CHIP plans must meet minimum federal standards, but each state decides coverage above the minimum standards.

Medicare coverage standards

The Centers for Medicare and Medicaid Services (CMS) runs the Medicare program and federal law defines coverage standards. CMS approves private health insurers to offer Medicare Advantage (part C) and Medicare drug (part D) plans.

Medicare Advantage plans must cover the same services as traditional Medicare plans, but might cover additional benefits, or have different cost-sharing requirements. States don't regulate traditional Medicare, Medicare Advantage, or Medicare drug plans.

Medicare supplement plans

States regulate Medicare supplement plans according to minimum federal standards. Medicare supplement plan benefits align with the underlying Medicare plan structure.

Why don't providers have to accept all insurance?

Most providers accept health insurance, but some don't. This is a business decision and state and federal laws don't compel private parties to enter contracts. Each provider can decide whether to accept a health insurance plan. Some providers decide not to accept health insurance because of the administrative effort to file claims, or because they're not satisfied with the reimbursement amount offered by the insurance plan. In some cases, a provider will decide to participate but limit the number of patients they serve for certain plans with low reimbursement amounts.

When can I get a health plan?

Open enrollment period

The yearly period when people can enroll in a health plan. Outside the open enrollment period, you may still be able to enroll in coverage if you have certain qualifying life events. Some health insurance enrollment dates include:

- HealthCare.gov, November 1 – January 15.
- Medicaid or CHIP, any time of year.
- Medicare, October 15 – December 7.
- Medicare Advantage, January 1 – March 31.
- For job-based plans, ask your employer about the annual open enrollment period.

Special enrollment period

A time outside the open enrollment period when you can sign up for a health plan. Usually, 60 days before or after a qualifying life event.

Qualifying life event

A change might let you sign up for a health plan during a special enrollment period. This includes:

- Losing existing health coverage.
- Losing eligibility for Medicare, Medicaid, or CHIP.
- Turning 26 and losing coverage through a parent's plan.
- Having a change in income that makes you newly eligible for the premium tax credit.
- Having an employer offer you an HRA, ICHRA, or a QSEHRA.
- Getting married or divorced (if at least one spouse already has coverage).
- Having a baby or adopting a child (if at least one parent already has coverage).
- Death in the family (if the death causes you to lose your current health plan).
- Moving to a different ZIP code or county (if you already have coverage).
- Gaining membership or status in a federally recognized tribe.
- Becoming a U.S. citizen.
- Leaving jail or prison.
- AmeriCorps members changing service status.

How to shop smart for health coverage

If you're looking for health care coverage, you're probably looking for traditional health insurance, also known as major medical, comprehensive, or ACA-compliant coverage.

Traditional health insurance gives you financial protection from unexpected health care costs and helps you manage preexisting conditions.

Make sure you know what you're buying. Some websites offer alternative health plans that have fewer benefits and more limits than traditional health insurance.

Buying a plan on HealthCare.gov

- All plans on HealthCare.gov are traditional health insurance.
- TDI approves these plans and can help if you have a problem.
- You can shop during open enrollment and special enrollment periods.
- Plans will cover your preexisting conditions and provide other protections.
- Be cautious shopping on other websites since they might be selling limited plans or products that aren't insurance. Those plans aren't subject to most state and federal regulations.

Using doctors, hospitals, and medications

- Each plan has its own list of doctors, hospitals, and prescription drugs.
- When you compare plans on HealthCare.gov, you can enter the names of your doctors and medications you use to see which plans cover them.
- If a plan doesn't cover your doctors or medications, ask yourself if the plan has doctors or medications that you'd be comfortable switching to.
- Some doctors' offices require a copay for your visit and coinsurance for a facility fee when using certain health plans. This can increase your out-of-pocket costs, so check with your provider before picking a plan.
- Keep in mind:
  - The list of medications should stay the same during the year but may change when the plan renews.
  - The list of covered doctors and hospitals can change throughout the year if health plans and health care providers can't agree on a contract.
  - TDI reviews health plan networks to make sure they meet state requirements and include enough doctors and hospitals. If you can't find a doctor or hospital, tell the plan so they can help you find one at in-network prices.

Health plan costs

- Many people who shop on HealthCare.gov qualify for a subsidy that lowers their monthly premium.
- To find the best plan for you, compare the cost-sharing for care you expect to need – like regular medications or visits to your doctor or specialist. Also consider if you have an unexpected event, like an emergency room visit.
- Check whether the plan covers anything before you've met the deductible.

Primary care and referral requirements

- Most HMOs require you to select a PCP and get a referral before seeing a specialist.
- Make sure you understand the plan's requirements for getting care.
  - **Networks:** Ask whether you have to use doctors, hospitals, and urgent care centers in the plan's network or if you can use any that you want.
  - **Referrals:** Ask if you need a referral from your PCP before you can see a specialist.
  - **PCP:** Ask if your copay is lower if you use your designated PCP.

Avoid scams

Here are some warning signs that you might want to move on to another company.

- The agent or salesperson can't answer basic questions about the plan.
- You feel pressured to decide right away or give personal financial information. There are no limited time deals or discounts on health insurance.
- The price is much lower than other companies you've checked. This usually means the plan has fewer benefits and more limits.
- You get a call or email from a company or person you didn't contact first.

Get help from a trusted source

If you need help shopping for a health plan or filling out a HealthCare.gov application, navigators and certified application counselors can help. They're certified by the federal government and don't get incentives or commissions from insurance companies.

Navigators

People or organizations trained to help consumers, small businesses, and their employees as they look for a HealthCare.gov plan.

Certified application counselor

A person (affiliated with a designated organization) trained to help consumers, small businesses, and their employees as they look for health coverage options on HealthCare.gov.

Agents and brokers

Licensed agents and brokers:

- Don't charge you anything extra to enroll in a plan.
- May work for a single health insurance company or for several companies.
- Can only sell plans from companies they represent.
- Are licensed by TDI and have signed agreements to sell HealthCare.gov health plans.
- May get a commission from an insurance company for selling a plan. Some also receive commissions for selling non-insurance products.

You can qualify for a premium tax credit and other savings if you enroll with an agent or broker. But to get the savings, they must enroll you through HealthCare.gov.

Network-based health plans

Health plans contract with health care providers to treat members at discounted rates. These providers make up the plan's network.

Different network-based plan types have different rules that you must follow when you get care. Keep this in mind when choosing a plan. Plans that give you more flexibility usually have higher premiums.

- **HMO plans** only cover in-network services (except for emergencies), make you pick a PCP, and require a PCP-referral to see a specialist.
- **Exclusive provider (EPO) plans** only cover in-network services (except for emergencies), but you don't have to pick a PCP or get a referral to see a specialist.
- **Point of service (POS) plans** are a type of HMO plan that includes an out-of-network benefit. To get in-network care, you still need to choose a PCP and get specialist referrals.
- **Preferred provider (PPO) plans** cover in-network and out-of-network providers but pay a higher percentage of costs for in-network care.

Before enrolling in a plan, review the provider's directory to confirm the specific doctors, hospitals, and specialists you want to use are in network. Networks can change contracted providers over time, including mid-year, but they must let you know of significant network changes.

What to know about out-of-network care

You usually must meet a higher deductible before a PPO or POS plan will cover out-of-network care. Once you meet your out-of-network deductible, the plan will begin sharing the cost, but you'll likely pay a higher coinsurance rate than for in-network care.

You'll also owe any amount the provider charges that is above the plan's allowed amount. The allowed amount is the most a plan will pay for a covered service. For out-of-network providers, health plans often set allowed amounts based on Medicare rates. If the provider charges more than this amount, you may have to pay the difference.

If you have a PPO or EPO and think you can find cheaper care out-of-network, ask your plan how you can get credit towards your deductible. This applies when you pay for care out-of-pocket and the rate is cheaper than the average in-network provider.

You should ask for a cost estimate for the service, so you're not surprised by the bill.

How health plans compare

Requirement	HMO	PPO	POS	PPO
Is a primary care doctor required?	Yes	No	Yes	No
Is a specialist referral needed?	Yes	No	Yes	No
Are out-of-network providers covered?*	No	No	Yes	Yes

* Excluding emergencies or when no in-network provider is available.

Network adequacy and network gap protections

Network adequacy rules make sure that you have reasonable access to providers and facilities without unreasonable travel or wait times.

Requirements

- PPO and EPO networks must meet minimum access standards for the number, type, and distribution of contracted providers. Distance requirements depend on how urban or rural a county is and how routine or specialized the care is.
- HealthCare.gov qualified health plans (QHPs) must meet federal network adequacy certification standards set by CMS. These standards make sure QHPs provide adequate access to covered services, often requiring plans to meet time-and-distance standards and offer specialty coverage. Most QHPs in Texas are HMOs.
- Self-funded employer plans aren't subject to specific network adequacy standards.
- Networks can change during the plan year, but plans must let you keep going to your doctor for at least 90 days if they leave your network and you have a terminal illness, disability, life threatening condition, or are pregnant. The doctor must agree to continue treating you at the contract rate.
- Plans must cover emergency care to stabilize you. If you get emergency care at an out-of-network facility, you may be transferred to an in-network hospital once you're stable.

Network gap protections

If a plan can't provide necessary, covered in-network services, the plan must:

- Allow the member to get services from an out-of-network provider.
- Treat the service as if it were in-network.
- Make sure the member has a choice to use an out-of-network provider that won't balance bill.

Network adequacy waivers

- Health plans can apply to TDI for a waiver if they can't meet network adequacy standards.
- TDI only approves a waiver if the health plan shows good cause, like there aren't providers available in a certain area to meet the network gap. If providers are available, the plan needs to show they've made good faith attempts to contract.

Visit www.tdi.texas.gov/healthguide for more information on network adequacy waivers.

Understanding health plan costs

Premiums

The cost depends on your circumstances. To decide your premium, companies can't consider your gender or health factors, but can consider:

- Your age.
- Where you live.
- If you smoke or use tobacco.
- If the coverage is for one person or a family.

If you get a health plan through work, the company will base premiums on the group, but you may have to pay more if you use tobacco. Your employer might pay all or some of your premiums, but you may have to pay for your spouse and children.

Out-of-pocket costs

When shopping, consider both the premium and potential out-of-pocket costs to find the plan that best fits your budget. Plans with lower premiums often have higher cost-sharing.

- Your premium is the fixed amount you pay to keep your coverage active.
- The deductible is what you pay for covered services before your health plan begins to pay.
- Under the ACA, all plans cover preventive services without cost-sharing, even if you haven't met your deductible. Some plans might cover primary care or virtual visits before you meet your deductible.

Copay vs. coinsurance

Copay is a fixed amount that varies based on the service. For instance, you might pay a $25 copay to visit your primary care doctor or $40 to see a specialist.

Coinsurance is the percentage you pay for a service after you pay your annual deductible. For example, if your plan's allowed amount for an X-ray is $100 and your coinsurance is 20%, you would pay $20, and the plan pays the remaining $80.

Out-of-pocket limit

After you reach the out-of-pocket limit for covered services in a plan year (including deductibles, copays, and coinsurance), the plan pays for all covered services for the rest of the plan year.

HealthCare.gov plan categories

There are four HealthCare.gov plan categories: bronze, silver, gold, and platinum. The categories describe the average percentage of health care costs the plan covers, not the quality of care.

If available in your area, catastrophic plans are a fifth category with low monthly premiums but high deductibles. These plans are available to people under age 30 or those over 30 who qualify for hardship or affordability exemptions. Visit HealthCare.gov for exemption information.

If you qualify for extra savings (based on your income) and enroll in a silver plan, the plan pays more and you pay less. While a silver plan normally covers 70% of costs, the extra savings increase the value of the plan, so it's closer to a gold- or platinum-level plan. Learn more about extra savings at www.HealthCare.gov/lower-costs/save-on-out-of-pocket-costs.

HealthCare.gov cost estimates based on metal level

Metal level	Bronze	Silver	Silver with extra savings	Gold	Platinum
You pay	40%	30%	6-27%	20%	10%
Plan pays	60%	70%	73-94%	80%	90%
Typical deductible	High	Moderate	Low	Low	Low

Health savings accounts

If you have a qualifying high-deductible health plan (HDHP), you can make pretax contributions to a health savings account (HSA). With an HSA, you deduct the money you set aside for qualifying health care expenses from your annual taxable income. It can also help you pay medical expenses, which helps if you have a high deductible. There's no deadline to spend the money, so you can build up the amount over time and even use it to help with Medicare cost-sharing in retirement.

In 2026:

- Federal tax laws will allow more people to use HSAs.
- All bronze and catastrophic plans on HealthCare.gov qualify to use HSAs. Other HDHPs must:
  - Have a minimum deductible (at least $1,700 for self-only or $3,400 for family coverage).
  - Limit maximum out-of-pocket costs ($8,500 for self-only or $17,000 for family coverage).
  - Not cover expenses before you meet your deductible, except for preventive services, telehealth, and primary care visits.
- The maximum yearly contribution amount depends on your coverage type:
  - $4,400 for self-only and $8,750 for family coverage.
  - People age 55 and up can contribute an additional $1,000 per year.
- You can spend HSA funds on qualifying health care expenses like:
  - Cost-sharing amounts, like your deductible, copays, and coinsurance.
  - Dental and vision expenses.
  - Prescriptions and over-the-counter pharmacy items like band-aids and thermometers.
  - Medical equipment like hearing aids, breast pumps, health monitors, and wheelchairs.
  - Primary care fees up to $150 per month per person or $300 per month for families.

Alternative health products

Alternative health plans

Alternative health plans may have a lower monthly cost, but don't assume they'll provide traditional major medical coverage.

Unlike major medical plans, these plans:

- May not cover all injuries or illnesses, including preexisting and chronic conditions.
- May have waiting periods to join, pay less for each service, and limit annual coverage.
- May require you to join an association and pay membership dues to buy a plan.
- Don't qualify for federal savings options like tax credits and cost-sharing reductions.
- Don't have to follow the calendar year. If they end mid-year, you won't qualify for a special enrollment period to buy a plan on HealthCare.gov.
- May use post-claims underwriting. This means if you file a claim for a high-cost service, like inpatient hospital stay for an asthma attack, the insurer can retroactively investigate your medical history. If they find you had a preexisting condition (like having seen a doctor for asthma in the last year), they can deny the claim and possibly cancel your plan.

Short-term health plans

Short-term or limited-duration health plans offer temporary coverage, limited to a three-month term. (The duration is based on federal rules, which might change in the future.) They don't cover preexisting conditions and have more exclusions and limits on what they cover compared to traditional health insurance. When the plan ends, you must buy a new plan. If you're sick, you might not be able to get another short-term plan. You might have to wait until open enrollment on HealthCare.gov.

Limited-benefit health plans

Limited-benefit health plans only pay some of your health care costs and don't typically cover general illness or routine care. Some examples are:

- Accident plans will only pay part of your bills for some injuries.
- Disease plans, such as cancer insurance, will only pay part of your bills for a specific illness.
- Fixed indemnity plans only pay a set amount (such as $100 per day if you're hospitalized) no matter the doctor or facility. These plans usually make you pay for the service when you get it and file a claim to be paid back.

Other health coverage arrangements

Texas law authorizes some health coverage arrangements that are exempt from state regulations, other than those specifically identified in law. These types of arrangements aren't insurance. Because they're exempt from regulation, TDI usually can't do anything to help if a consumer has a complaint – even if the plan is violating its contractual terms. These plans don't have federal ACA protections either.

Discount health care programs and cards

Discount health care programs aren't insurance. These programs typically sell cards that provide members with discounts for services from participating physicians and providers. The programs can provide value to people without a health plan by reducing out-of-pocket health care costs.

- Members pay the full discounted cost of the medical service.
- Discount health care programs must register with TDI to sell their programs in Texas.

Subscription plans

Subscription plan members typically pay a monthly or annual fee to use a doctor or service in the plan. This is sometimes called direct care or concierge care.

- You may have to pay visit, lab work, or other service fees.
- If you need care the plan doesn't cover, you will have to pay the full cost yourself.

Nonprofit agricultural organizations

Certain nonprofit agricultural organizations, like Farm Bureau organizations, can offer health benefit plans to their members. These plans:

- Can deny coverage or charge more based on health status.
- Can exclude coverage for preexisting conditions.
- May have annual or lifetime coverage limits.
- Aren't subject to state and federal coverage standards.
- Are exempt from state and federal insurance regulations, except that state balance billing laws apply.

Health care sharing ministries and other sharing programs

A health care sharing ministry (HCSM) is a nonprofit that limits membership to people of a similar faith. Members agree to make monthly payments to pay for the medical expenses of other members, but there's no guarantee the HCSM will pay a member's claim. An HCSM might not cover preexisting conditions or provide as many benefits as major medical plans. While Texas doesn't regulate HCSMs, they are specifically authorized by state law.

If you're considering an HCSM, here are some tips:

- Check consumer reviews to make sure the plan has a good payment and service record. Texas and other states have taken enforcement actions against some HCSMs who broke the law.
- Read the fine print and understand where your payments go. Some HCSMs spend a high percentage of member contributions on administrative expenses.

There might be other crowd funded programs available in the market. Some of these may operate on a for-profit basis. Like HCSMs, these programs aren't regulated and don't guarantee to cover your expenses. Follow the same tips above if you're considering a sharing or crowd funded program.

Health plan documents

Summary of benefits and coverage

The health plan must give you a summary of benefits and coverage when you apply. A copy is usually included with your insurance contract. This document uses a standardized template to provide a high-level summary of the plan's benefits, exclusions (services that your health plan doesn't cover), and cost-sharing requirements. This makes it easier to compare benefits from different plans. Review the summary to get a basic understanding of how your plan works and the insurance contract for a more detailed understanding.

Disclosures

Texas requires PPO, EPO, and HMO plans to provide disclosures about their network upon request. The disclosures tell you whether the network has any gaps that require them to get a waiver from state network adequacy requirements. Health plans must post plan disclosures on their websites.

Formulary prescription drug list

A list of generic, brand name, and specialty prescription drugs covered by your health plan. It shows which drugs your plan covers and the level of cost-sharing you'll pay.

Insurance contract

Health insurers issue a policy to the person or employer that applies for coverage as the policyholder. Employees receive a certificate of coverage for insurance or evidence of coverage for an HMO. No matter what the document is called, the contract is a legal agreement about what the health plan covers and what rights and responsibilities apply to enrollees.

Before you apply for a health plan, you can request the plan's terms and conditions. Upon request, health plans must give you a document that summarizes:

- Covered services and benefits, including prescription drug coverage.
- Emergency care benefits and information on access to after-hours care.
- Limitations or exclusions.
- Your premium, deductible, copay, coinsurance, and other out-of-pocket responsibilities.
- The distinction between preferred providers and nonpreferred providers and the difference in how the plan covers services from preferred versus nonpreferred providers.
- Preauthorization requirements and penalties if you don't get the authorizations.
- Complaint resolution procedures.
- Service area, the geographic area of which doctors and hospitals you may use. It's also generally the area where you can get routine (non-emergency) services. The plan may end your coverage if you move out of the plan's service area.
- Out-of-area services and benefits.
- How to find a current preferred provider directory.
- Network adequacy information.

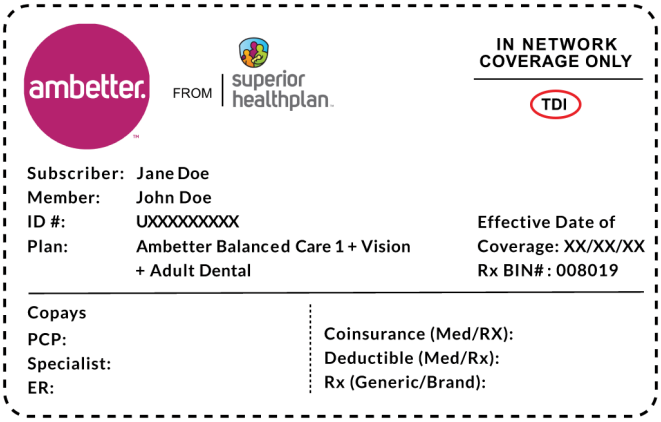
Health plan ID card

Your health plan ID card includes key details about your health plan including who regulates your plan.

Plans regulated by TDI have "TDI" or "DOI" somewhere on the card. The examples below show there isn't a standard designation spot on ID cards.

Self-funded employer plans that TDI doesn't regulate usually have the employer's name and will note that the plan is "administered by" an insurance company, or that the company is providing "administrative services only."

Health plan ID card samples


ambetter. FROM superior healthplan

IN NETWORK COVERAGE ONLY

TDI

Subscriber: Jane Doe
Member: John Doe
ID #: UXXXXXXXXX
Plan: Ambetter Balanced Care 1 + Vision + Adult Dental

Effective Date of Coverage: XX/XX/XX
Rx BIN# : 008019

Copays
PCP:
Specialist:
ER:

Coinsurance (Med/RX):
Deductible (Med/Rx):
Rx (Generic/Brand):


Amerigroup
An Anthem Company

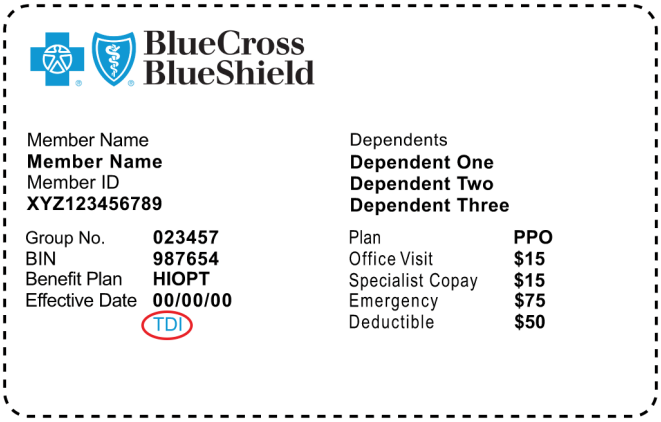
AMERIGROUP TEXAS, INC.

Effective Date:
Date of Birth:
Subscriber #:
Type of Coverage: CHIP

Member Name:
CHIP Perinate Number:
Pharmacy: 1-800-600-4441

Amerigroup Member Services and Behavioral Health
(24 hours a day, 7 days a week): 1-800-600-4441
24-Hour Nurse HelpLine: 1-800-600-4441

TDI


BlueCross BlueShield

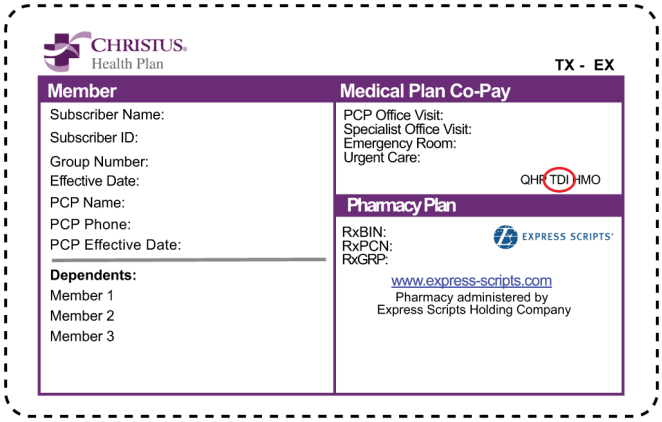
Member Name
Member Name
Member ID
XYZ123456789

Group No. 023457
BIN 987654
Benefit Plan HIOPT
Effective Date 00/00/00

TDI

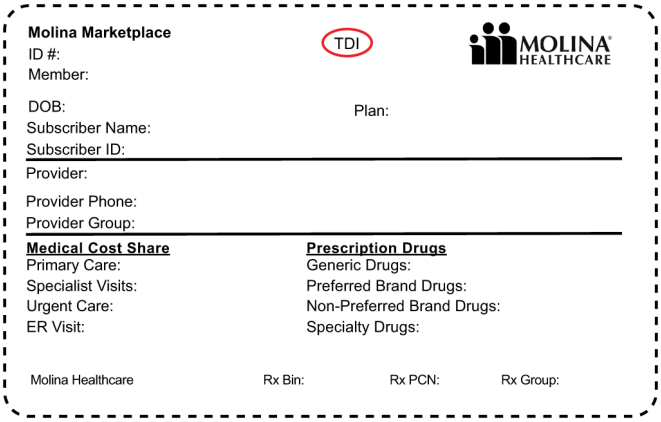
Dependents
Dependent One
Dependent Two
Dependent Three

Plan PPO
Office Visit $15
Specialist Copay $15
Emergency $75
Deductible $50


CHRISTUS Health Plan

TX - EX

Member	Medical Plan Co-Pay
Subscriber Name: Subscriber ID: Group Number: Effective Date: PCP Name: PCP Phone: PCP Effective Date: **Dependents:** Member 1 Member 2 Member 3	PCP Office Visit: Specialist Office Visit: Emergency Room: Urgent Care: QHP TDI HMO **Pharmacy Plan** RxBIN: RxPCN: RxGRP: EXPRESS SCRIPTS www.express-scripts.com Pharmacy administered by Express Scripts Holding Company


Molina Marketplace
ID #:
Member:

TDI

MOLINA HEALTHCARE

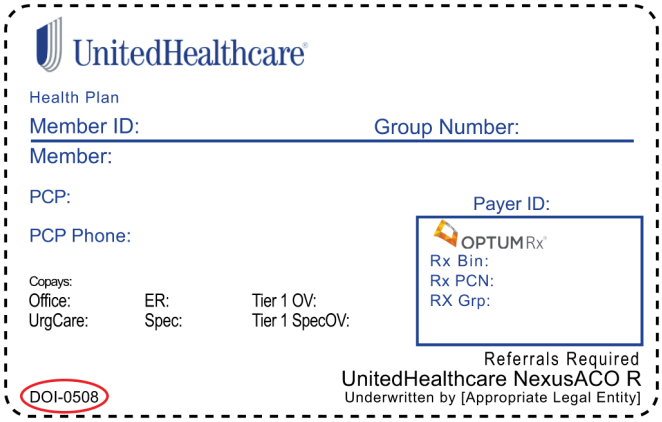
DOB:
Subscriber Name:
Subscriber ID:
Provider:
Provider Phone:
Provider Group:

Plan:

Medical Cost Share
Primary Care:
Specialist Visits:
Urgent Care:
ER Visit:

Prescription Drugs
Generic Drugs:
Preferred Brand Drugs:
Non-Preferred Brand Drugs:
Specialty Drugs:

Molina Healthcare Rx Bin: Rx PCN: Rx Group:


UnitedHealthcare

Health Plan

Member ID: Group Number:
Member:
PCP:
PCP Phone:

Payer ID:
OPTUMRx
Rx Bin:
Rx PCN:
RX Grp:

Copays:
Office: ER: Tier 1 OV:
UrgCare: Spec: Tier 1 SpecOV:

Referrals Required
UnitedHealthcare NexusACO R
Underwritten by [Appropriate Legal Entity]

DOI-0508

Explanation of benefits

Each health plan sends an explanation of benefits (EOB) to let you know it got a claim or bill from a health care provider. Depending on the service, the plan could get claims from multiple providers. The EOB will show you:

- Service date.
- Medical services used.
- The billed amount or what they charged the plan. This is what you'd owe without a health plan.
- The allowed amount or the contracted amount that the health plan and provider have agreed on. This is the amount used to calculate your cost-sharing.
- How much you might owe.

If the insurance company doesn't pay the whole amount, the doctor or provider might bill you for the rest. Wait until you get the doctor's bill before paying, and don't pay more than the amount the explanation of benefits says you may owe.

If the insurance company didn't pay anything, check the reason. Does it make sense to you? For example, your insurance might not pay anything if you haven't met your annual deductible.

If there's a problem

- Contact your health care provider if there's a mistake on the bill.
- Contact your health plan if you have a question about what was covered.
- If you got a bill you weren't expecting, visit the surprise billing section in the guide.

If you suspect fraud, call your health plan. You can also report it at www.tdi.texas.gov/fraud.

Preauthorization

When a health plan denies a service, either before treatment (preauthorization) or after treatment (claim denial) because the service isn't medically necessary or is considered experimental or investigational, it's called an adverse benefit determination.

You have clear rights to challenge these decisions under both Texas Utilization Review laws and federal appeals regulations.

Preauthorization for services

Preauthorization is a process where the health plan must approve a service before it's used to confirm it's medically necessary and covered. This process serves the benefit of confirming coverage and patient cost before treatment, which reduces the chance of denied claims. However, the primary cost is the potential for treatment delays, which is why strict regulatory timelines exist.

- **TDI-regulated plans** must respond to urgent care requests within 24 hours and routine requests within three business days.
- **ERISA-regulated plans** must usually respond to urgent requests within 72 hours and non-urgent requests within 15 days.

Texas Gold Card Law

The 2021 Texas Legislature passed House Bill 3459, the Texas Gold Card Law, to reduce treatment delays by exempting providers with high approval rates from the preauthorization requirements for certain services.

The law requires a health plan to give a preauthorization exemption ("Gold Card") to any provider who has a preauthorization approval rate of 90% or higher for a specific service (like a knee replacement). The 2025 Texas Legislature modified the Gold Card evaluation rules through House Bill 3812 to increase the number of providers who qualify by including more data. For example, evaluations now look at 12 months of data instead of six months. They also include preauthorization requests from plan types that aren't subject to the Insurance Code, including Medicaid, Medicare, and self-funded employer plans.

Surprise medical bills

Surprise medical bills or balance billing occur when you inadvertently get care from an out-of-network provider. For example, you picked an in-network surgeon, but you didn't get to pick the anesthesiologist. If the anesthesiologist is out-of-network, you'll get a surprise bill. When you get out-of-network care that is protected by the law, the EOB will say that you shouldn't get a surprise bill.

State and federal law protect consumers with fully insured or self-funded plans for:

- Emergencies.
- Air ambulance services.
- In-network hospital services.

If you have a state-regulated plan, Texas also bans surprise bills for:

- Labs and imaging ordered by an in-network doctor.
- Ground ambulance services received in an emergency.

You have a state-regulated plan if:

- Your insurance card has "DOI" or "TDI" on it.
- You have insurance with:
  - Employees Retirement System of Texas (ERS).
  - Teacher Retirement System of Texas (TRS).
  - Texas Farm Bureau, a self-funded school health plan, or an employer plan that's opted into Texas' surprise billing laws. The patient's insurance card will have "TXI" on it.

If you get a surprise bill, visit www.tdi.texas.gov/medical-billing/surprise-balance-billing.html.

Resolving a health plan dispute

If you disagree with a decision made by your health plan, you have options.

Tell your health plan you want to appeal its decision

You or your doctor can appeal treatment decisions if you disagree with them. For example, your plan might deny a preauthorization request if they think the care isn't medically necessary or appropriate.

To appeal, follow the procedures in the notice you got telling you the plan denied the treatment or service. If your condition is life-threatening or your health plan stops covering a prescription you're already taking, you can ask for an external review right away, without appealing to the health plan first.

Ask for an external review

If you're not happy with your appeal or were denied care for a life-threatening condition, you can ask for an external review. Someone who doesn't work at the insurance company or for your provider (an independent reviewer) will decide if the insurance company must pay for the service. External reviews are free to you.

While Texas has its own independent review process, the ACA requires plans to follow the federal external review standards process posted at maximusferp.my.site.com/FERP/s. Due to federal preemption, the U.S. Department of Labor or the U.S. Department of Health and Human Services (HHS)/CMS oversees the external review process for most plans in Texas, rather than TDI using the state process (though TDI still helps with fully insured plans). TDI bulletins direct most plans to follow federal requirements. TDI bulletins are available at www.tdi.texas.gov/bulletins.

How to get help

File a complaint with TDI if:

- Your insurance card has "TDI" or "DOI" on it.
- You have a Medicare supplement policy.
- You have a long-term care insurance or disability plan.
- You have short-term insurance or another limited benefit plan.

TDI doesn't regulate:

- Medicare, Medicaid.
- CHIP plans that aren't HMOs.
- Military plans.
- City, county, state, and federal employee plans.
- Teacher plans.

Not sure who regulates your health plan? Call our Help Line at 800-252-3439.

Contacts for health plans TDI doesn't regulate

Health plan	Regulating organization	Contact information
CHIP	Texas Health and Human Services	hhs.texas.gov
City and county employees	Cities and counties regulate their own insurance programs.	Send a written appeal or complaint to the address in your benefit booklet.
Federal employees, including postal workers	U.S. Office of Personnel Management	opm.gov
HCSMs	Texas Office of the Attorney General	texasattorneygeneral.gov
Medicaid	Texas Health and Human Services	hhs.texas.gov
Medicare	HHS and CMS	Medicare.gov
Medicare Advantage	Private health plans approved by CMS	Call your plan.
Military service members	TRICARE Standard	TRICARE.mil
Self-funded plans	U.S. Department of Labor	www.dol.gov/agencies/ebsa
State employees	ERS	ers.texas.gov
TRS-CARE	Teacher Retirement System	trs.texas.gov
University of Texas employees	The University of Texas System	utsystem.edu

Talk to an attorney about your legal options

If you're not satisfied with the outcome of your dispute, you may wish to consult an attorney. Visit www.tdi.texas.gov/consumer/legal-help.html to learn about resources that might help.

Losing your health plan

If a company stops offering your plan

Companies may decide to stop offering a plan. If your company drops your plan, it must offer you another plan it sells. If it doesn't sell any other plans, you'll have to shop for new coverage.

If you leave your job

Losing a job-based health plan is a qualifying event that triggers continued coverage and HealthCare.gov options. Your employer must tell you about coverage continuation within 30 days of the date your job ended.

Short-term limited-duration plans

A non-ACA-compliant plan is designed to bridge a short gap, like if you're starting a new job soon and need some limited protection for a short time. These plans:

- Can deny coverage based on your health status.
- Typically exclude coverage for preexisting conditions.
- Don't have to cover all essential health benefits.
- Need to give you a summary of what's covered and excluded.

HealthCare.gov

Losing employer coverage qualifies you for a special enrollment period on HealthCare.gov. If you've lost your job and don't know when you will find a new one, this might be the best option for affordable coverage that doesn't leave you exposed to big financial risks. You can also get a premium tax credit to help reduce your monthly premium. When you apply, do your best to estimate what your total income will be for the year, considering the time you spend looking for a new job.

COBRA

COBRA (Consolidated Omnibus Budget Reconciliation Act) lets you keep your health coverage after you leave your job, lose coverage as a dependent of the covered employee, or another qualifying event. It applies to employers with 20 or more employees. It doesn't apply to plans offered by the federal government or some church-related groups. If you pick COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

You can usually continue your coverage temporarily under COBRA. You can get coverage if:

- The company has 20 or more employees (on at least half business days in the prior calendar year).
- You leave your job for any reason other than gross misconduct. Gross misconduct usually means doing something harmful to others, reckless, or illegal.
- You lose your coverage at work because you switch from working full-time to part-time.

COBRA is often the most expensive option as you pay the full premium — not just the part of the premium you were paying as an employee, but also the part of the premium that the employer was paying on your behalf. This may be your preferred option if you need specialized care that could be complicated by switching plans.

- Provides the exact same coverage you had before.
- If your family was on your health plan, you can continue their coverage under COBRA. Your spouse and children can also continue their coverage if you go on Medicare, you and your spouse divorce, or you die. They must have been on your plan for one year or be younger than a year old. Their coverage will end if they get other coverage, don't pay the premiums, or your employer stops offering health plans.
- If you continue HMO coverage and move out of the service area, the HMO will pay only for emergency care. COBRA coverage will end if your employer stops offering health plans.
- You have 60 days after you leave your job to decide if you want COBRA.
- You must tell your employer in writing that you want it.

State continuation

State continuation lets you keep your coverage even if you can't get COBRA, though you usually can't get state continuation if you're fired. To qualify:

- You must have had coverage for the three months before your job ended.
- Your health plan must be subject to Texas insurance laws, so it doesn't apply to self-funded plans.

Texas state continuation (Mini-COBRA):

- Applies to employers with 2-19 employees.
- Up to 9 months for employees and dependents upon termination of coverage. The plan must be fully insured and subject to Texas law.

Texas state continuation extension:

- 20 or more employees (if the plan is fully insured).
- An extra 6 months of continuation coverage after federal COBRA is exhausted for a total of 24 months (employee) or 42 months (dependent).

Coverage under COBRA and state continuation

Person covered	Through COBRA	State continuation time	Total time
If you can get COBRA			
Employee	18 months	6 months	24 months
Spouse, ex-spouse, or dependent	36 months	6 months	42 months
If you can't get COBRA			
Primary or secondary plan member		9 months	9 months

Note: If you have a disability, you can get coverage for 11 months after COBRA coverage ends. The Social Security Administration determines disability.

Resources

Texas Department of Insurance

TDI can help check an agent or company's license status or complaint history. If you need help with a question, complaint, or appeal, call our Help Line at 800-252-3439 or visit tdi.texas.gov.

Other TDI resources include:

- TexasHealthCareCosts.org lets consumers see the average in-network and out-of-network costs for common medical procedures by ZIP code.
- TexasHealthPlanCompare.com offers online side-by-side comparisons of Texas health plans.
- TexasHealthOptions.com helps consumers find and understand coverage options.
- Health tips and resources at www.tdi.texas.gov/healthguide.

Local programs

2-1-1 Texas.org provides free information about services in your area.

Texas county health care districts in major metropolitan areas

Many counties use local property taxes to provide health care access to indigent residents, but eligibility and services vary widely.

Contacts for health care districts

Metro area	County	Website
Austin-Round Rock-San Marcos	Travis	CentralHealth.net
Dallas-Fort Worth-Arlington	Dallas	ParklandHealth.org
	Tarrant	JPSHealthNet.org
Houston-The Woodlands-Sugar Land	Harris	HarrisHealth.org
	Montgomery	MCHD-TX.org
San Antonio-New Braunfels	Bexar	UniversityHealth.com
El Paso	El Paso	UMCelpaso.org

State and federal programs

- **Office of Public Insurance Counsel** publishes HMO consumer satisfaction and quality-of-care reports at www.opic.texas.gov/hmo-report-card.
- **Texas Health and Human Services** helps more than 7.5 million Texans every month through state and federal programs, including Medicaid, CHIP, SNAP, Temporary Assistance for Needy Families, women's health, and support services for seniors or people with disabilities. Visit YourTexasBenefits.com to learn more.
- **Department of State Health Services** promotes and protects the health of people and their communities. Visit dshs.texas.gov to learn more.
- Visit Benefits.gov to find out more about federal government benefits and financial programs.

Program contact details

Program	Details	Website
Texas Health and Human Services		
CHIP	A federal-state program for children in families with too much income to qualify for Medicaid but can't afford to buy private insurance.	www.hhs.texas.gov/services/health/medicaid-chip
Medicaid	A federal-state program that pays for medical care for certain low-income groups.	www.hhs.texas.gov/services/health/medicaid-chip
Healthy Texas Women	Preventive health and family planning services for women ages 15 through 44 with low income and no insurance.	HealthyTexasWomen.org
Other health programs	Long-term services and support for seniors, people with disabilities, and caregivers.	www.hhs.texas.gov/services/health
Department of State Health Services		
Blood Lead Surveillance Branch	Monitors Texans with lead poisoning and runs prevention programs.	www.dshs.texas.gov/lead
Early Hearing Detection and Intervention	Services to prevent vocabulary, communication, and cognitive skills development delays.	www.dshs.texas.gov/tehdi
Newborn Screening	Newborn screening follow-up, case management, and outreach education.	www.dshs.texas.gov/newborn
Oral Health Improvement Program	Education, prevention services, and emergency dental treatment services.	www.dshs.texas.gov/dental
Regional and local health operations	Local health departments, public health districts, and health units in Texas.	www.dshs.texas.gov/regional-local-health-operations
School Health Program	School health leadership, support, and guidance to Texas school districts.	www.dshs.texas.gov/schoolhealth
Federal programs		
Black Lung Program	Treatment, service, and supply information for coal miners with miner's lung.	www.dol.gov/agencies/owcp/dcmwc
COBRA	Information about continuing employer health care coverage.	www.dol.gov/general/topic/health-plans/cobra
Hill-Burton Program	Contracts with local hospitals, clinics, and nursing homes to provide free or low-cost care income-eligible consumers.	www.hrsa.gov/get-health-care/affordable/hill-burton
Indian Health Services	Health services for American Indians and Alaska Natives.	IHS.gov
Medicare	Information about plans and lets consumers find and compare nearby services.	Medicare.gov
My Health Finder	Find a doctor or hospital in your area and get information about diseases and conditions.	HealthFinder.gov
TRICARE	For active-duty and retired service members and their families.	TRICARE.mil
Veterans Affairs	Health care for veterans.	VA.gov

Other programs

- BenefitsCheckUp.org helps seniors find benefit programs.
- CureMeso.org helps patients and family members diagnosed with mesothelioma.
- HealthwellFoundation.org helps cover coinsurance, copayments, healthcare premiums, and deductibles for certain treatments.
- KidneyFund.org helps with direct financial assistance for dialysis and kidney transplant patients with limited income.
- NCOA.org partners with nonprofit organizations, government, and business to provide community programs and services, online help, and advocacy to seniors.
- NavigateLifeTexas.org has resources for kids with disabilities and special health care needs.
- New-Eyes.org offers vouchers for U.S. residents in need of prescription eyeglasses.
- RareDiseases.org helps people who are uninsured or under insured buy lifesaving or life-sustaining medications.
- RxAssist.org offers access to pharmaceutical company patient assistance programs.
- RxOutreach.org provides more than 50 generic medications that treat a wide range of conditions to people who financially qualify.
- UniteForSight.org offers free or low-cost vision care services.

Texas Department of Insurance
2026 Texas Health Coverage Guide

THCG | 1225