RCeB
Regional Center of the East Bay

Early Start Program

A Guide to Health Insurance

For Parents of Children from Birth to 3 Years
with Developmental Delays

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INTRODUCTION

Why Did I Get This Booklet and Why is it Important?

This booklet will help you learn how to use your health plan in getting medical services for your infant or toddler (birth to three years) who has developmental delays.

This booklet will explain how the 2009 change to the California Early Intervention Services Act, the law that governs the Early Start program, of the Regional Centers of California, affect how your infant or toddler gets services.

The change requires parents to request medical services through their child's health plan. The Regional Center can provide for these services only if the child's health plan does not cover the services.

The law applies to medical services that are part of the Early Start program. Some of these services are speech and language therapy, physical therapy, occupational therapy and applied behavioral analysis.

You are getting this booklet because

- Your child has been determined by the Regional Center to be eligible for the Early Start Program.
- Your child may need speech and language therapy, physical therapy, occupational therapy or applied behavioral analysis.

How do I use this booklet?

Use this booklet to understand how to work with your child's doctors and providers, your health plan and the Regional Center to get services for your infant or toddler.

At the end of the booklet, there is a Glossary that explains the terms used in the booklet, and a section on Resources and Information for further help and contact information.

HELPFUL TIPS: Look for the "Helpful Tips" throughout the booklet. They give important information that can:

- Help you find the services and providers you are seeking, and
- Avoid delays in getting services.

Where do I start?

It may all seem overwhelming. But take it one step at a time. Here is what this booklet will cover:

Section 1 – The role of the Regional Center.
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1 The Role of the Regional Center

If you have received this booklet, your child has likely been evaluated by the Regional Center and determined eligible for the Early Start Program. The Regional Center assigns a case manager and will help with support services. However, since California state law changed in 2009, **families must use their health plan for medical services**, if their plan covers the services. Speech and language, physical and occupational therapies are included under "medical services."

The law changed when California amended The California Early Interventions Services Act (Section 95004 (b)(1) of the Government Code) through the 2009 budget trailer bill. The law now states, "a family's private insurance for medical services or a health care service plan identified in the individualized family service plan, other than for evaluation and assessment, shall be used in compliance with applicable federal and state law and regulation."

Helpful Tip!
Remember the Lanterman Act, which is the law that governs Regional Center services. Section 4659 of the Lanterman Act says that, before the Regional Center pays for a service, it must "identify and pursue all possible sources of funding…[for the service] including private entities" such as health plans.

The Regional Center is the "payor of last resort." This means that the Regional Center may pay for services only after the health plan and all other payors have met their legal obligations to pay. It may be helpful to mention this to your health plan, particularly if they try to refer you back to the Regional Center.

The Regional Center will provide speech and language therapy, occupational therapy or physical therapy services for children in the Early Start program who are determined to need these services:

- **If you can show that these services are not covered by your health plan:** Your health plan Member Handbook, Evidence of Coverage (EOC) or letter from the health plan should state your plan does not cover the services.
- **If you have exhausted your appeals through the health insurance system** (see Section 4, page 12: Getting Services through Your Child's Health Plan). Your documentation should show: the health plan has denied your appeals and you are not eligible for an Independent Medical Review (IMR), or a state agency has denied your appeal.
- **While you are waiting for a decision on your request for services or your appeal** and if your child qualifies for Early Start services, the Regional Center will provide services to your child while you wait. Services will start no more than 45 days after the Regional Center determines your child is eligible. You will need to show proof you have requested the services from your health plan or are appealing the health plan's denial of your request.

Helpful Tip!
Keep your Regional Center case manager informed about your progress with your health plan.

Must my child be evaluated by both the Regional Center and by my health plan?

The health care system and the Regional Center system are separate systems. Each uses its own set of criteria to decide if your child is eligible for services. Your child may be eligible under one system and not the other.

The Regional Center determines whether your child is eligible for the Early Start program, the Prevention Program, or neither. If your child is eligible for the Early Start program, the Regional Center will pay for certain medical services (for example speech, occupational or physical therapy) but only if your health insurance will not pay for them.

Your child's health plan will almost always require that health plan providers assess your child. The health plan may be able to use information from the Regional Center evaluation as part of its own evaluation. While some parts of the evaluation may be the same, some are different.

Expect that both the Regional Center and your health plan will periodically review your child's progress to decide whether changes to treatments are needed.

Helpful Tips!
- o Contact *both* the Regional Center and your child's health plan.
- o You do not need to wait to complete one evaluation before you start the other. In fact it may help your child get services faster to pursue both the Regional Center evaluation and the health plan evaluation at the same time.
- o If you get the results of one evaluation before the other is completed, you can share the results for possible review and consideration.

2 Meet with Your Child's Doctor

What is the role of my child's doctor or Primary Care Provider?

In order to make the best use of the health care system, and to get the services your child needs through your health plan, you should start with a visit to your child's doctor.

Your child's doctor (provider) can be a key partner in getting your child the services your child needs.

- Either your doctor or another health plan provider will evaluate and diagnose your child. This evaluation is independent of the Regional Center evaluation, and will help determine which services will be provided by your health plan.
- If you and the doctor decide your child needs services for developmental delays, your doctor will refer your child to therapists or other professionals.

The treating therapists or your doctor will recommend services and develop a treatment plan.

Helpful Tips!

o If you are still unsure about your child's diagnosis or the suggested treatment plan, you may ask for a second opinion from another doctor.

o If you know the therapist you want your child to see, let your doctor know, and make sure that person is in your health plan network. If the therapist is not in your health plan network, suggest that the therapist apply to the health plan to join the network.

o If the plan does not have an appropriate therapist, you or your doctor may request the health plan to approve services from the therapist outside the health plan network.

- Sometimes your child's doctor can refer you directly to a therapist or mental health provider; sometimes the doctor must get approval from the health plan or the medical group.
- Your health plan will usually need an evaluation to decide if your child is eligible for services and will often also require a treatment plan before approving specific covered services.
- Involvement of your child's doctor and your child's specialists is necessary for getting approval from your health plan. They must provide the clinical information about your child and your child's condition that the health insurer will use in its decision about whether to pay for requested services.
- Your child's doctor may also refer you to the Regional Center for help.

Helpful Tip!

o Your child's doctor can and should provide clinical information to the Regional Center for the Regional Center's evaluation process. However, before sharing any personal information about you or your child with the Regional Center, your doctor must have your consent.

3 Understand Your Child's Health Insurance

There are many words describing health insurance and the companies that provide it. In this booklet, we use "health plan" to mean any type of health insurance company or plan, public or private.

There are also many ways to refer to a person who has health insurance, such as enrollee, subscriber or customer. In this booklet, we use "member" to mean anyone who has health coverage.

What kind of health plan does my child have?

Whether your child has private health insurance paid for by you or your employer, or has public coverage such as Medi-Cal or Healthy Families, the purpose of your health insurance is to help pay for medical care by paying medical services providers for the care they give to members.

What your insurance covers, how much you will pay, and **how** you obtain services will depend on the type of insurance you have and your specific plan, no matter which insurance plan you have. Also, you may have a separate health plan for mental health services; this plan will have different requirements than your regular health plan.

Here are some of the important differences you will want to know about your specific plan:

- **Covered services** – What specific services will your health plan cover?
- **Deductibles** – Do you have to pay a minimum amount before your insurance starts to pay for services?
- **Co-pays and co-insurance** – How much will you pay each time you get health care?
- **Benefit limits** – How many times will the plan pay or covered services in a specified period of time? Are there limits to what the health plan will pay annually or during a lifetime?
- **Plan exclusions or limitations** – What services are NOT covered or are limited under your health plan?
- **Plan rules** – What are the rules about accessing services? How does the plan work? What are the processes for referrals and approvals?
- **Provider network** – Which providers (doctors and others who provide services) will the health plan cover?

Types of Health Insurance – What is the difference?

PLAN FEATURES	INDEMNITY OR FEE-FOR-SERVICE PLANS	MANAGED CARE PLANS
Provider Choice:	Choose any licensed provider	Use only network providers
Cost to You:	More than managed care; provider may charge more than plan pays; you also pay a percent of each bill.	Less than Indemnity.
Billing/Paperwork:	You pay, then bill your plan	Provider bills plan directly
Pre-approval for some services:	May require pre-approval for some services	Will require pre-approval for some services.

Types of Managed Care Plans

Most people under age 65 who have insurance in California have some kind of managed care plan. There are three main types of managed care plans.

- Health maintenance organizations (HMOs), including Medi-Cal Managed Care plans and Healthy Families plans, as well as Kaiser
- Preferred provider organizations (PPOs)
- Point-of-service plans (POS)

All three kinds of plan have contracts with doctors, hospitals and other heath care providers.

The providers agree to accept certain fees from the plan. Usually, you must get care from providers that are part of your plan; otherwise you will likely be responsible for paying for the full cost of care.

REGULATORY AGENCY*	TYPE OF PLAN
DMHC – Department of Managed Health Care	HMOs, Blue Shield PPOs, Anthem/Blue Cross PPOs, Medi-Cal Managed Care plans
CDI (also called DOI) – California Department of Insurance	PPOs (that are not Blue Shield or Anthem/Blue Cross) and all Indemnity plans.
DOL-EBSA – U.S. Department of Labor, Employee Benefits Security Administration. Most self-insured health plans are governed by ERISA, a federal law that is overseen by the DOL-EBSA. If you are a member of a self-insured health plan through your employer or union, then you can contact the DOL-EBSA for help.	Self-insured health plan governed by the Employee Retirement Income Security Act (ERISA): health plan is through an employer or a union.
You must file a complaint with the employer or plan directly or go through a court of law.	Self-insured plans not under ERISA: these can be self-insured health plan through a school district, local government, or religious organization

*See Resource Section for more information on what regulatory agencies can do for you and how to contact them.

Why do I need to know what type of health insurance my child has?

- The process you must follow to get covered services depends on the type of plan you have. The large insurance companies — such as Anthem/Blue Cross, Blue Shield, Aetna or Cigna — offer several different types of plans.
- Which state or federal agency oversees your plan also depends on the type of plan you have. This is important to know because this is the agency you may contact if you have a complaint about your plan.

Types of Health Plans

HMO – Health Maintenance Organizations

As an HMO member you will get a list of providers in the HMO's network. Generally the plan pays for your care only if you see network providers, except in emergencies. HMO members choose a primary care provider (PCP) from this network. You can also change PCPs if you want.

Your child's PCP is:

- usually a pediatrician, family practice doctor or clinic; can be part of a medical group
- the main provider of care
- the initial decision-maker for addressing your child's health care needs
- the first professional you will work with to determine next steps

A medical group consists of primary care providers (PCPs), specialists and other providers. It is usually the medical group or one of its doctors, not the HMO, which decides what care you receive and how you receive it. The medical group or your PCP will give approvals (if required) to see specialists, or to receive medical services such as speech therapy, lab tests, X-rays, and hospital care. Some services require only a referral from the PCP, some must be approved by the medical group, but some must be approved by the health plan.

When you choose a PCP, you are also selecting the specialists and other health professionals who work with that medical group. If your child needs covered services that cannot be provided by the medical group or network, your PCP can recommend a provider outside the network, and provide information to your health plan explaining why your child needs to use a non-network provider.

What you pay
For each visit or service, you usually pay a small co-pay or fee. Co-pays vary depending on your specific plan. Co-pays usually are between $5 and $40 each time you receive outpatient services. A few HMOs also have a yearly deductible, or an amount that you must pay before the HMO's payments to the provider start.

PPO – Preferred Provider Organizations

PPOs also have networks of providers. PPOs usually allow you to go directly to specialists within their provider network without first getting a referral or approval from your PCP. You may go to a provider that is not on the preferred provider list, but the plan will usually only pay a small percentage of your expenses or will pay none.

What you pay
You usually pay a yearly deductible before the PPO starts to pay some or all of your bills. You also usually pay a percent of the bill (called co-insurance) or a co-pay when you get a covered service. The PPO pays the rest. Co-insurance amounts, co-pays and deductibles vary depending on your specific plan

POS – Point of Service Plans

A POS is a mix between an HMO and a PPO. You choose a PCP and you get most of your health care from an HMO network. You also have a choice to see out-of-network providers when you need a specialist, like in a PPO plan. However, you will probably be required to do paperwork yourself and submit claims for reimbursement from the health plan.

What you pay
Most plans require you to go through your primary care physician before you see the out-of-network specialist. If you refer yourself to an out-of-network doctor, the POS plan often pays even less.

Health Savings Accounts (HSA) and High Deductible Plans

An HSA is a tax-free savings account. You or your employer may put tax-free funds into the account. Then you use these funds to pay for health care until your deductible is met. An HSA is usually combined with a plan that has a large deductible.

Self-Insured Health Plans (Single Employer Self-Insured Plans)

Some large employers, labor unions, school districts and municipalities create an insurance pool of money and then pay for the health care services of their members (employees) from this pool. It is common for self-insured plans to turn over the administration of their health plans to a Third Party Administrator (TPA). Often the employer will contract with a health plan to act as a TPA for all health care claims.

Self-insured plans can be managed care or indemnity plans. They are generally regulated by the U.S. Department of Labor, Employee Benefits Security Administration.

Medi-Cal

Medi-Cal is the state and federal program that provides health coverage for lower-income families, children, people with disabilities, and people over 65.

Most children on Medi-Cal are members of an HMO Medi-Cal Managed Care plan. In Alameda County, Medi-Cal members have a choice between the Alameda Alliance for Health and Anthem/Blue Cross. In Contra Costa County Medi-Cal members choose between Contra Costa Health Plan and Anthem/Blue Cross. Kaiser Medi-Cal Health Plan is available to a limited number of people with Medi-Cal. To be eligible, you must have had coverage through Kaiser in the past 6 months, must have it currently, or you must have an immediate family member currently enrolled in Kaiser. To get Kaiser, you must first enroll in Alameda Alliance for Health or Contra Costa Health Plan. Medi-Cal Managed Care plans receive payments from the state and pay providers for services that are given to Medi-Cal beneficiaries who are members of the plan.

Some children are not HMO members, and the state pays providers directly for services. This is called "fee-for-service" or regular Medi-Cal. Children on regular Medi-Cal may go to any provider who accepts Medi-Cal; the State must give prior approval for services that require an authorization

For people on Medi-Cal, all mental health services are provided through Alameda County Behavioral ACCESS or Contra Costa County Mental Health Division. These services may be provided by county, community-based organizations, or a network of private therapists.

What you pay
Unless you have "share-of-cost" Medi-Cal, covered services are free for children and families. However, because of California's state budget problems, Medi-Cal may

begin to charge small co-pays for some services. Families may be eligible for share-of-cost Medi-Cal if their incomes are higher than the Medi-Cal income guidelines. To receive share-of-cost Medi-Cal, beneficiaries must contribute to their health care expenses by paying a share of the cost of the services they receive each month. Once they meet the full share amount, they are "certified" and Medi-Cal will cover all other costs for that month.

Behavioral Health Plans or "Carve-Outs"

These plans specialize in mental or behavioral health care. They are generally set up by large insurers as separate companies (for example United Behavioral Health or Aetna Behavioral Health). These plans have different networks and, often, different rules than the medical plan. If you are in an HMO, the PCP is not always in charge of referrals and authorizations for the behavioral health plan services. Sometimes you will need to contact the behavioral health plan for approvals. (See Section 4, page 13: Are the Services Covered? — Mental Health Parity)

Healthy Families Program (HFP)

HFP is a state and federal program that covers children in lower- and middle-income families whose income is too high to qualify for Medi-Cal and do not have private insurance. All children in HFP are enrolled in Managed Care plans. Healthy Families enrollees in Alameda have a choice of two plans: Alameda Alliance for Health, or Kaiser. Enrollees in Contra Costa County can choose Contra Costa Health Plan or Kaiser.

What you pay
Healthy Families members pay a monthly premium based on income and co-pays for some services.

Kaiser Child Health Plan (CHP)

CHP is HMO health coverage for lower- and middle-income children who do not qualify for Medi-Cal or Healthy Families because their family income is too high or they do not meet state immigration requirements, and who do not have access to employer-provided insurance.

What you pay
CHP members pay a monthly premium based on income and co-pays for some services.

TRICARE

TRICARE is the health care program serving active-duty military service members, National Guard and Reserve members, retirees, their families, survivors and certain former spouses worldwide. TRICARE offers both managed care and fee-for service options.

TriWest is a contractor to the Department of Defense and administers the TRICARE program in the 21-state West Region. Call TriWest Customer Services for more information: **1.888.874.9378**

Non-insurance health programs:

CCS – California Children's Services

The California Children's Services (CCS) program provides coverage for essential health care to children with special health care needs, including cancer, diabetes, and conditions related to premature birth.

Children may be eligible for the CCS Medical Therapy Program (MTP). MTP operates Medical Therapy Units staffed by CCS physical and occupational therapists in some public schools. Children are eligible for services at no cost if they meet specific medical eligibility criteria or have Individual Education Plans that include MTP services. *There is no income requirement for this program.*

To receive any other CCS services children must qualify financially. Children are financially eligible for CCS if they are:

- enrolled in Medi-Cal or Healthy Families, or
- uninsured with an annual family income of less than $40,000, or the family must pay 20 percent or more of its annual adjusted gross income for treatment of the CCS eligible condition.

Find out more about CCS and the Medical Therapy Program at **http://www.dhcs.ca.gov/services/ccs**

CHDP – Child Health and Disability Program

The CHDP program makes preventive health care available to California's lower income children. Children and youth can receive regular preventive health assessments, as well as referrals for diagnosis and treatment when indicated.

CHDP works with a large number of organizations, services and care providers to help children get appropriate care. These include doctors, nurse practitioners, schools, local health departments, health agencies, and social and community service agencies. CHDP can also assist families with medical appointment scheduling, transportation and access to diagnostic and treatment services.

Find out more about CHDP at:
www.dhs.ca/gov/pcfh/cms/chdp/directory.htm.
or call your county health department.

How do I find out about my child's health plan?

Begin by looking at the information you got when you enrolled in your health plan. Generally, the most direct way to discover exactly what you are entitled to under your health plan is by reading all or a combination of the following:

- **Evidence of Coverage (EOC)**
- **Member Handbook**
- **Summary Plan Description**

Every plan must provide at least one of these documents to its members. It describes the services and benefits of your health plan. It also describes the obligations of the health plan, the health plan's rules, and your rights as a health plan member. Some health plans have more detailed descriptions of services than others. Be sure to check the covered services section and the Exclusions and Limitations Section. EOCs are revised every year. If you don't have a current EOC, call your health plan to request one.

- **Website.** Most health plans have detailed information on their websites. Often you must be a member of the health plan in order to access specific information for the type of plan you are enrolled in. Call your health plan's Customer Service department (sometimes called Member Services) to get help with the website.
- **Member ID Card.** Your member identification (ID) card has some benefit information as well as your plan's Member Services telephone number.
- **Member Services or Customer Services.** Every health plan has a member services department created for the purpose of answering members' questions, helping them understand their benefits or solve problems. If you speak to or exchange emails with several different member service representatives about the same problem, you may find the information can vary depending on the person you talk with. For this reason, make sure to always get the full name and the correct spelling of the name and job title of everyone you talk to, and record it along with the date, approximate time, and notes of the conversation.

4 Getting Services through Your Child's Health Plan

How do I request services through my child's health plan?

Your doctor (PCP) is responsible for arranging an evaluation for your child and for making a recommendation for services to your health plan. In most plans, your doctor will need to submit a request for services to the medical group or the health plan.

Your doctor may refer you to an appropriate professional — a physician specialist, neurologist, psychologist, developmental specialist, occupational or physical therapist, or a speech and language specialist — for further evaluation. Generally, if your doctor refers you to another provider, your health plan will cover these services. But be sure to ask your doctor.

Helpful Tips!

o You should immediately begin working with your health plan. Don't wait for a decision from the Regional Center. Make an appointment with your child's doctor; the doctor will make a referral for the services your child needs.

o You do not have to wait for your health plan to decide eligibility. You can begin the evaluation process with the Regional Center right away.

What should you do after evaluation? Depending on the results of your child's evaluation, your doctor will recommend treatments and services.

Health plans differ at this point:

- If you are a Kaiser member, your child's request for services must be reviewed by the Kaiser Regional Center Review Committee. (This is a Kaiser committee not affiliated with the Regional Center.)
- Some insurers, like Anthem/Blue Cross, allow your doctor to refer you directly for services with an Anthem/Blue Cross provider.
- With other insurers, your doctor's referral must be reviewed and approved by the medical group or by the health plan.

Your health plan or the medical group will notify you and your doctor about what services have been approved for your child as well as the number and frequency of approved services.

If the request is denied, you will receive an explanation of the reason for the denial, and information about how you can ask for reconsideration of (appealing) the decision. (See page 15: Denials)

What determines whether a health plan will approve services for my child?

The services should be listed in your health plan materials as "covered services" plan and must be determined to be medically necessary for your child.

Are the services covered?

Check your health plan materials for specific information about what your plan covers.

Speech and language therapy, occupational therapy, physical therapy

In California, HMOs and PPOs regulated by the Department of Managed HealthCare (DMHC) are required to cover "basic health care services." These include speech therapy (ST), occupational therapy (OT), and physical therapy (PT). Even though it is not required, more than 80% of the PPOs and indemnity plans regulated by the California Department of Insurance (CDI) also cover ST, OT, and PT. Self-insured plans are not subject to these rules but most cover ST, OT, and PT.

A few plans specify that PT, OT, and ST are covered for developmental delays, and a few specifically exclude services for developmental delay.

Services for autism, autism spectrum disorder, and pervasive developmental disorder

Evaluation

Health plans are required to cover evaluation for autism if indicated. Your child's doctor will make the referral.

Applied Behavioral Analysis (ABA)
ABA and other intensive behavioral therapies are still usually not covered by health plans. Health Plans take the position that ABA is not medically necessary for many children with autism or pervasive developmental disorder. Also health plans do not pay for services provided by unlicensed individuals. Lastly, health plans often regard ABA as an educational, not a medical service. There are some health plans that may cover ABA: TRICARE (for active military), a few self-insured plans, and others. Some parents have been successful in appealing a health plan denial for ABA services. (See page 16: Appealing a health plan decision)

Mental Health Parity law and autism diagnosis
In 2000, California passed Assembly Bill 88, the Mental Health Parity law. AB 88 requires private health plans to provide equal coverage for physical health and some serious mental health conditions. The serious mental health conditions include autism and pervasive developmental disorders.

What does this mean? The DMHC has clarified that plans may not deny a service or require that members are responsible for a higher portion of the cost simply because the diagnosis is autism. Also, plans cannot limit or deny covered services unless their decision is based on medical necessity. In addition to mental health services, some parents have been able to get health plan approval for PT, OT, and ST for their autistic children.

Medi-Cal-covered services
Medi-Cal covers speech therapy, physical therapy, occupational therapy, and behavior analysis therapy when ordered by a Medi-Cal provider. If your child has fee-for-service or regular Medi-Cal, the provider must submit a Treatment Authorization Request (TAR) to Medi-Cal.

Are the services medically necessary?

Your health plan covers treatments and equipment and supplies when they are "medically necessary." Your health plan will pay for a service only if it is a covered benefit and if it is medically necessary.

When you or your provider requests approval from the health plan or medical group for your child's services, the health plan/medical group will decide if the services are covered and if they are medically necessary.

Health plans may differ in how they define and interpret medical necessity. Generally, medical necessity means that the plan's medical directors agree that a treatment is needed and expected to be effective. To be medically necessary means:

- The treatment is expected to cause significant improvement within a specified timeframe.
- The improvement would not happen without the treatment.

In deciding whether the requested services are medically necessary, the health plan will look at:

- The unique clinical history and condition of your child,
- The proposed treatments and treatment plan,
- Any relevant laws or regulations, and
- Scientific studies, evidence and expert recommendations, including recommendations of any federal agencies, such as the National Institutes of Health, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

Limits on the number of treatments

If a service is medically necessary, an HMO health plan cannot place arbitrary restrictions on the number of sessions that will be covered. This means that the number of services authorized must be based solely on medical necessity.

Medi-Cal and medical necessity

Medi-Cal's definition of medical necessity is the federal definition: it is very broad. For children, it includes all services needed to "correct or ameliorate defects, physical and mental illnesses and conditions discovered by the screening services, whether or not such services were covered under the Medicaid State Plan." This means that Medi-Cal is intended to cover medical services, such as physical, occupational, and speech therapy that your child needs.

Is there a treatment plan for my child?

Before most health plans will approve services that are expected to continue over a longer period of time, the plan will first require your providers to submit a treatment plan.

The treatment plan should also help you — as the parent — determine if the proposed treatment is appropriate. The treatment plan must include:

- The exact behavior or function that is targeted
- The types of services that will be provided

- How often the service will be provided, and for how long
- The treatment goals: these should be specific and tied to dates. How will your child's progress be measured? How will you know if the treatment is working?

The health plan will review your child's progress to see if treatment goals are being met. The health plan may decide to stop paying for a treatment if goals have been met or if there is not sufficient progress toward the goals.

Standing Referrals

You may not have to get approval or a referral every time your child sees a specialist or therapy provider. Health plans must have a "standing referral procedure."

A standing referral allows your child to get "continuing care from a specialist… or specialty care center" without a referral or approval from the health plan or from your child's PCP for each appointment.

This rule applies to members with "life-threatening, degenerative or disabling" medical conditions that require "specialized medical care" over a long time. The plan may limit the number of visits and the period of time the visits are authorized, and may also require regular reports from the specialist.

Which providers will the health plan pay for?

Plans must meet your needs by having an adequate network. If your child needs a particular type of specialist and the plan does not have this type of provider in its network, the plan must help you find one and pay for medically necessary care.

How long do I have to wait for an appointment?

On January 17, 2011, the California DMHC established standards regarding the time a patient has to wait to see a plan provider. For example, health plans must ensure that there are enough providers in the network so that members can get an appointment for non-urgent specialty care within 15 days and appointments for non-urgent primary care or mental health care within 10 days. (See California Code of Regulations, Title 28, Section 1300.67.2.2)

How far should I have to go to see a provider?

All plans must have primary care providers and mental health professionals within 30 minutes or 15 miles, and specialists within 60 minutes or 30 miles of where you live or work. (See California Code of Regulations, Title 10, § 2240.1(c). and Title 28 § 1300.51 H (i))

If your child is covered by Medi-Cal, you may have a problem finding a provider who accepts Medi-Cal payment rates. The providers who do accept Medi-Cal rates are often booked months in advance. If your child belongs to a Medi-Cal Managed Care plan, call Member Services. Medi-Cal plans are regulated by DMHC and are required to provide non-urgent services within the time limits described above.

Will the health plan pay for services at home?

Most health plans will not approve services delivered to your child in the home. Health plans are required to provide services in the home only if it is not possible or not safe for the member to leave home.

How long should I wait for a decision from my health plan?

Generally, health plans are required to respond to your doctor's requests for services within five business days. A decision to approve, deny, delay or modify the doctor's request must be communicated to providers within 24 hours of the decision (by fax or email) and to the member within two days (in writing). If your child is already receiving approved care, and the health plan decides to deny continuation, the care to the child cannot be stopped until the treating provider agrees to an appropriate care plan. (See California Health & Safety Code § 1367.01 and Insurance Code §10123.135)

If your child has Medi-Cal coverage and is not a health plan member, you may have to wait much longer for a decision from Medi-Cal.

Denials

A health plan may deny, delay, or modify a request for a service or refuse to pay a provider's bill for services. A health plan may deny services based on several reasons, including:

- The service is not covered in your health plan contract, including services by non-licensed providers.
- The service was obtained from a non-network provider without prior authorization.
- The service is not medically necessary, meaning
  - It is considered experimental and/or unproven,
  - There is no medical indication for the service, or
  - There is not enough clinical data to prove it is effective.

The person at the health plan who denies the request must be a health care provider who is knowledgeable about the specific clinical issues involved.

The health plan or medical group will periodically assess your child's progress in the treatment plan. If a health plan decides that the treatments have not helped your child make significant progress, and the goals of the treatment plan are not being met, then the plan may deny additional treatments. If you or your provider believes differently, you may appeal the decision (See page 16: Appealing a health plan decision).

The health plan will send a denial letter to you and to your doctor. The letter must give:

- A clear concise explanation of the reasons for the decision,
- A description of the criteria or guidelines used,
- A reference to your EOC/Member handbook,
- The clinical reasons for the decisions regarding medical necessity, and
- Instructions for how you can file an appeal with the health plan, a state agency, or through the courts — and what the rules are.

The letter from the plan to your doctor or treating therapist must include the name and the direct telephone number of the health care professional responsible for the denial, delay, or modification.

If your child has Medi-Cal fee-for-service (is not in a Medi-Cal Managed Care plan), Medi-Cal must send you an approval or denial of the treatment authorization request (TAR). This is called a Notice of Action (NOA).

If the TAR is denied, Medi-Cal must:

- Explain the denial
- Tell you the regulation or law on which the denial is based
- Explain how you can file an appeal

If your child is already receiving services, Medi-Cal must give you 10 days' notice before it stops paying for those services. If you appeal this decision by requesting a state hearing with the Department of Social Services (DSS), your child's service must be continued at least until the hearing.

On the back of the NOA is a "Request for Fair Hearing." (See page 18: Requesting a state hearing)

Steps you can take if your health plan denies services for your child:

1

Talk with your child's doctor or other health care provider who requested the services. Ask your doctor's opinion and ask for your doctor's help. Ask your doctor to follow up with your health plan. Call your health plan Member Services and explain your problem.

2

(if first step does not help)
File an appeal (also called complaint, grievance, or reconsideration) with your health plan.

Call the Help Center or California Department of Insurance Consumer Help Line for help and advice.

3

Contact the HMO Help Center or the Department of Insurance, and ask for an Independent Medical Review (IMR). See page 17: Requesting an Independent Medical Review

4

For people with Medi-Cal: ask for a Medi-Cal state hearing.

IMPORTANT: If you file for a state hearing first, you cannot get an IMR later.(see page 18: Requesting a state hearing.)

Appealing a health plan decision

If you decide to appeal, follow the directions and timelines on the denial letter. Appeal to the health plan first. Then if you do not agree with the health plan's decision to deny, delay, or change the service you requested, you may appeal the decision to a regulatory agency.

Health plans have a formal process for plan members and providers to disagree with a decision and ask that the decision be changed. This process may be called an appeal, reconsideration, or grievance.

Helpful Tips!
Here are some things to remember as you go through the appeal process:

- o Don't wait. Appeal as soon as possible.
- o Be persistent. Be prepared for the possibility that the process may take a long time, and may be complex.
- o Speak up. Make sure your requests are clear.
- o Have someone with you for support during phone calls.
- o Keep notes on all your calls and interactions with the health plan. Include the correct, full name and job titles of everyone you speak with, in addition to your notes.
- o If you are told decisions over the phone, confirm these in a letter or email.

You can appeal through your health plan, to state agencies, or, if you have Medi-Cal, request a hearing through the California Department of Social Services (DSS). If your child has Medi-Cal and is not in a health plan, your only way to appeal is to request a hearing through DSS.

Start with your child's health plan

Generally, you have 90 days from the date on the denial letter to appeal to the health plan.

Most health plans must offer more than one level of appeal. If you appeal a decision and are denied again, you may appeal again. The health plan will send your second appeal to appropriate professionals who were not involved in the previous denials.

How to file an Appeal, Reconsideration, or Grievance

Very often, people do not appeal a health plan denial because the process is too hard to understand or because they think it will not work. However, it can be the only way to get the health plan to reverse its decision, especially if you can provide additional clinical information.

Call your health plan's Member Services or Customer Services department to start the process. Have this information ready when you call:

- Your health plan membership number
- A short description of your problem, explaining what service was denied
- What service your child needs and why
- The date of the denial
- If you feel the problem is urgent, explain why

You may be able to get the grievance and appeal form from the health plan's website or your PCP's office. HMOs also allow you to file a grievance over the phone. *However, your appeal will be much stronger if you, together with your providers, send the health plan a written document explaining in detail why you disagree with the health plan's decision*.

If you use the plan's grievance form, you can attach additional back-up information to the form. If you appeal over the phone, you can send additional information in later. Be sure to tell the Member Services representative that you or your doctor will be sending additional information.

Your appeal letter

If the health plan is denying services because the treatment or equipment is not covered under your particular plan, your appeal letter should refer to your plan materials (Evidence of Coverage, Member Handbook, information from plan website, etc.). Show that the services are listed as covered benefits, or, at least, are not listed as excluded services.

If the health plan says that the services are not covered, and you believe, by law, they should be, put that fact in your letter. For example, AB 88, (the Mental Health Parity law) states that if mental health services are a plan benefit, mental health services for autism must be covered, and may not be limited except if they are determined to be not medically necessary.

If the denial is due to lack of medical necessity, the appeal letter should describe the services your child needs and why. The most effective "letters of medical necessity" could include:

- Objective information about your child's medical history and current condition
- Documentation of medical need; how will a service benefit your child; what will happen if your child does not receive the requested treatments
- References to current medical literature and practice that support your request, and/or
- How providing this service could avoid future medical expenses.

Getting help with the appeal

It's best to work together with your doctor or other provider on your appeal. Your doctor or other provider should contact your health plan and write the letter of appeal. Your Regional Center case manager can also help. Also, see the Resources section of this booklet.

In addition to your doctor, the best sources of help are usually:

- The office of the Family Resource Network in your county
- The state Office of the Patient Advocate or HMO Help Center
- Legal Aid
- Community Health Advocacy Project in your area

The health plan must give you its decision within 30 days, or within three days if your request is urgent.

Where do I go next if my health plan turns down the appeal?

Requesting an Independent Medical Review

You have 180 days from the date of the health plan denial to appeal to the DMHC or CDI. The process is called requesting an Independent Medical Review or IMR. An IMR is a review of your case by one or more health care professionals who are not part of your health plan.

The reviewers should understand your child's condition and the recommended services. You do not pay anything.

If the IMR is decided in your favor, your plan must give you the service or treatment you asked for.

You may qualify for an IMR if your health plan:

- Denies, changes, or delays a service or treatment because the plan says it is not medically necessary
- Denies an experimental treatment for a serious condition. If this happens, apply for an IMR right away. You do not have to file a complaint with your plan first.
- Will not pay for emergency or urgent care that you already received.

If your plan is self-insured (see page 9: Self-Insured Plans, in Section 3 – Understand Your Child's Health Insurance), check your health plan materials, or contact your employer or union or your plan to find out how to appeal your health plan's denial.

If you have Medi-Cal, request an IMR *before* you request a state hearing.

May I go directly to the HMO Help Center or the Department of Insurance?

Generally, you must go through your health plan's process first.

If you are not satisfied with your plan's decision, or the plan does not meet the deadline for responding, contact the Help Center (DMHC) or the CDI.

- If your problem is urgent, contact the Help Center directly.
- If your plan denies a service because it is experimental or investigational, contact the Help Center directly.
- If your plan cancels your coverage, contact the Help Center directly.

Requesting a state hearing

If your child has Medi-Cal, either through a heath plan or directly from the state, you may also appeal by filing a request for a state hearing.

You have 90 days from the date on the denial letter to request a state fair hearing.

You can do this at any time, but be aware that you cannot request an IMR if you have already requested a state fair hearing. So, it is recommended that you request an IMR first (See above: Requesting an IMR).

If your child is in a Medi-Cal Managed Care plan, you or your child's provider may request an "Expedited State Hearing". An Expedited Hearing is granted if taking the time for a standard decision "could seriously jeopardize the enrollee's life, or health, or ability to attain, maintain or regain maximum function."

To request a state hearing:

- Complete the "Request for State Hearing" on the back of the Notice of Action (Keep a copy for yourself.)
- Submit your request one of these ways:

  (1) By mail to the county welfare department at the address shown on the Notice of Action.

  OR

  (2) By mail:
  California Department of Social Services
  State Hearings Division, P.O. Box 944243
  Mail Station 19-37
  Sacramento, California 94244-2430

  OR

  (3) By fax:
  State Hearings Division
  at fax number 916.229.4110

  OR

  (4) By telephone:
  1.800.952.5253 (Voice)
  1.800.952.8349 (TDD)

You have the right to have someone represent you or be with you at your hearing. This could be a relative, friend, a lawyer, or an advocate from a community organization.

For more information on state hearings go to:
http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx

State hearings are available only if you have Medi-Cal.

Where to Go For Help

IF YOUR CHILD HAS THIS TYPE OF PLAN	CONTACT THIS AGENCY	WHAT THIS AGENCY CAN DO FOR YOU	PHONE & WEBSITE
HMO, Blue Cross PPO, Blue Shield PPO	HMO Help Center (DMHC)	Help if you have a problem with your health plan. Process your complaint. Give you forms & instructions. Help you request an IMR.	www.hmohelp.ca.gov 1.888.466.2219 (voice) 1.877.688.9891 (TDD)
Other PPOs and Indemnity Plans	California Department of Insurance (CDI)	Process your complaint. Give you forms & instructions. Process your IMR.	www.insurance.ca.gov 1.800.927.4357 (voice) 1.800.482.4833 (TDD)
Medi-Cal Managed Care Plan	HMO Help Center (DMHC)	Help if you have a problem with your health plan. Help you file a complaint. Give you forms & instructions. Help you request an IMR.*	www.hmohelp.ca.gov 1.888.466.2219 (voice) 1.877.688.9891 (TDD)
	Medi-Cal Managed Care Ombudsman	Help if you have a problem with your Medi-Cal Managed Care plan	1.888.452.8609 (voice) 1.888.452.8609 (TDD)
	California Department of Social Services, State Hearing Division, P.O. Box 944243, MS19-37 Sacramento, CA 94244	*Help and process a State Hearing request.	1.800.952.5253 (voice) 1.800.952.8349 (TDD)
Medi-Cal: regular or fee-for-service	California Department of Social Services, State Hearing Division, P.O. Box 944243, MS19-37, Sacramento, CA 94244	Help and process a state hearing request.	1.800.952.5253 (voice) 1.800.952.8349 (TDD)
Medi-Cal mental health	Department of Mental Health Ombudsman	Help with Medi-Cal mental health care problems	1.800.896.4042 (voice)
Self-Insured Plan	Employer, union or the U.S. Department of Labor, Security Benefits Administration	Information & help with your self-insured health plan	www.dol.gov/ebsa 1.866.444.3272 (voice)

*If you have Medi-Cal, it is often better to request an IMR before you request a state hearing. If you get a State Hearing first, you cannot get an IMR later.

5 Be an Effective Advocate for Your Child

Know your rights

Most health insurance in California is regulated by the state. An important function of the state regulatory agencies is to make sure that consumer's rights are protected. This includes the right to receive covered services when needed and to file complaints when you have a problem, and to request an Independent Medical Review.

Your child's health information

Under federal law, you have the to right see and get copies of your child's medical records and also have the right to request changes to any errors in their files. Health plans and health providers must protect personal health information. People also have the right to receive notice of how their personal information can be used or shared with others.

Finally, you have the right to file a complaint if you feel these rights were denied.

Language assistance

If your first language is not English, your health plan usually must give you assistance in your language. This may include:

- Doctors and staff who speak your language. Ask your plan for a list of doctors who speak your language. This information is also in the health plan provider directory and often on the health plan website.
- Printed materials in your language, such as consent forms and directions for treatment, denial or approval letters for services, and plan rules
- Interpreters for you when your child needs care. When you make an appointment be sure you ask for an interpreter if you will need one. You do not have to pay for this. Do not depend on your family or friends to interpret. You need an interpreter who is trained in medical interpretation.

If you request a state hearing or you are appealing a health plan denial in person or over the phone, and you have trouble understanding English, be sure to request an interpreter.

Health plan member rights

By state regulation, you also have rights as a health plan member.

You have the right to:

- Be treated with courtesy and respect
- Get quality health care
- Get care from qualified medical personnel
- Choose a doctor you trust
- Get an appointment when you need one
- Understand your health problem and the risks and benefits of your treatment choices
- Get a second opinion about a diagnosis or treatment
- Choose or refuse treatment
- Get a copy of your medical records

If you are in a Medi-Cal Managed Care plan, you may change plans at any time. Just call **Health Care Options** at **1.800.430.4263**

Good Recordkeeping

Do not underestimate the value of good recordkeeping. Keep all your notes and letters in one place. Keep a log of all communications you have with your providers, the Regional Center and health plan.

Doctors' Offices:

- Ask the physician office to copy you on all correspondence.
- Ask where, how (letter, email, phone, other records) and to whom insurance information is sent.
- Ask for and keep copies of all referrals.

Regional Center

- Keep a copy of your child's Regional Center evaluation results.
- Keep a record of your child's case manager and contact information.

Health Plan
Your folder or binder should include all of your notes, and copies of all your correspondence, reviews and evaluations. Keep in mind the following:

- Track every phone call
  - – Date of conversation, name, number, title, of contact
  - – Make notes of every conversation, including
    - √ dates promised for action
    - √ requests for confirmation in writing
- Keep copies of all correspondence

Who should be copied on your correspondence?

- PCP offices
- Regional Center case manager
- Service providers or specialists, if involved

"If it isn't written, it never happened"

- If you are told something over the telephone, try to follow up with an email or a letter that you send to your health plan via Certified Mail.
- When requesting services ask for a claim number. This allows you to verify what has been offered or discussed with your health plan.

The 3 Ps: Be Prepared, Patient, and Persistent

Even when you have done everything right, you will find that sometimes you are required to re-do paperwork, re-contact your health insurer or renew your efforts. Here are some tips for coping with some of the worst delay tactics.

- Always write the number of days that you have been trying to get resolution to a problem at the top of all your correspondence.
- Let the health plan know you intend the contact the Office of the Patient Advocate of the Department of Insurance by a certain date, and THEN DO IT!
- Find a way to join a parent's forum or group, either online or at regular meetings. Your Regional Center case manager might be able to help you find others who can share information, resources, and at least a place to vent.
- When all else fails, if you repeatedly do not get a response from your health insurer, send a summary of the issue to the health plan with copies to the company's CEO, the health plan's Public Information Officer, the California Governor's office and a major daily newspaper editor.

You are in charge of getting the services your child needs,
but you are NOT alone. Here are some resources that can help:

Regional Centers and Early Start Program

Regional Center of the East Bay (RCEB) (Alameda and Contra Costa Counties)

For information on the Early Start Program and other services for children from birth to 3 years, or if you are concerned about your child's development: Call the **Early Intervention Referral Line** and follow the instructions: **510-618-6195** (Alameda and Contra Costa Counties)

www.rceb.org

RCEB, Alameda County
500 Davis Street, Suite 100
San Leandro, CA 94577
510-618-6100

RCEB, Contra Costa County
2151 Salvio St., Suite 365
Concord, CA 94520
925-798-3001

State Early Start Program:

For Early Start information:
800/515-BABY (2229)
Email: earlystart@dds.ca.gov
www.dds.ca.gov

Family Resource Centers (FRCs)

Support from other parents of children with disabilities or special health care needs, help on how to use the Early Start system, information, referrals, and advocacy.

Alameda County

Family Resource Network
510-547-7322
5232 Claremont Avenue (in the BANANAS Building), Oakland, CA 94618
Email: info@frnoakland.org
www.frnoakland.org

Contra Costa County

CARE Parent Network/ARC
1340 Arnold Drive, Martinez, CA 94553
925-313-0999 or 800-281-3023
Email: info@careparentnetwork.org or careofarc@aol.com
www.contracostaarc.com

State and Federal Agencies

California Department of Insurance (CDI)

If you have a "non-Blue" PPO, EPO, POS, indemnity, or association plan, contact CDI to:

- File a complaint or get information about your health insurance.
- Request an Independent Medical Review, or
- Get information about choosing an insurance plan

Consumer Hotline: 800-927-HELP (4357); TDD (800) 482-4TDD
If you call, be prepared to wait. The phone lines are often busy.
8:00 AM to 6:00 PM Monday to Friday except State holidays.
www.insurance.ca.gov

Department of Managed Health Care (DMHC), HMO Help Center

If you have an HMO, a Medi-Cal Managed Care Plan, or a Blue Cross or Blue Shield PPO, contact the HMO Help Center to:

- Resolve an urgent problem or a problem that you cannot resolve with your health plan,
- Request an Independent Medical Review (IMR)

1-888-466-2219 or TDD 1-877-688-9891, 7 days a week, 24 hours a day
Email: contactopa@opa.ca.gov
www.hmohelp.ca.gov/ or www.dmhc.ca.gov

Office of the Patient Advocate (OPA)

The OPA is an independent state office, working with the Department of Managed Care.
If you have an HMO, a Medi-Cal Managed Care Plan, or a Blue Cross or Blue Shield PPO, contact the OPA for

- Information on health consumers' rights and responsibilities.
- Health plan, medical group, and hospital "report cards".

Voice 1-866-466-8900 or TTY 1-866-499-0858
Email: contactopa@opa.ca.gov
www.opa.ca.gov
Read "How to Use your Health Plan".
opa.ca.gov/about/consumer_information/HMO_Guide.aspx

U.S. Department of Labor

If you have a self-insured or ERISA health insurance, for information on your health care rights:
(415) 625-2481 or (866) 444-3272
www.dol.gov/ebsa

Medi-Cal Managed Care Office of the Ombudsman

If you have a Medi-Cal Managed Care Plan, contact the Office of the Ombudsman to:

- Resolve a problem with your health plan,
- Get information or referrals, or
- Resolve an urgent enrollment or disenrollment issue.

1-888-452-8609 (many languages) Monday through Friday, 8am to 5pm; excluding holidays
Email: MMCDOmbudsmanOffice@dhcs.ca.gov

Medi-Cal Mental Health Care Ombudsman

For help with Medi-Cal mental health care services
Phone: 1-800-896-4042 (many languages)

California Department of Social Services (DSS), State Hearings Division

If you have Medi-Cal or Medi-Cal Managed Care, contact DSS to

- File a state hearing request (State Fair Hearing)**

**Be aware, that once you request a State Fair Hearing, you may not request an IMR. (See Department of Managed Health Care above). If you go through the IMR process first, and do not like the outcome, you may then request a State Fair Hearing.
1-800-952-5253 (English and Spanish)
TDD (800) 952-8349
www.dss.cahwnet.gov/shd/PG1094.htm

Medi-Cal Program: Eligibility, Benefits, Enrollment

Health Care Options

Help with enrolling in or leaving a Medi-Cal managed care plan
1-800-430-4263 (many languages)
1-800-430-7077 (TTY)

Alameda County Social Services

Social Services Agency
8477 Enterprise Way
Oakland, CA 94621
(510) 639-1090

Contra Costa County Social Services

Employment & Human Service Department
40 Douglas Drive
Martinez, CA 94553
1-800-709-8348.

State Medi-Cal Information:Department of Health Care Services

www.dhcs.ca.gov/services/medi-cal/Pages/MCIndividual.aspx
www.cuidadodesalud.gov/enes/ (Español)

Medi-Cal for Children

Find an Application Assistor in your area: (888) 747-1222
Apply online: www.healtheapp.net

Medi-Cal Mental Health Services (also serves uninsured children)

Contra Costa Mental Health Division

Information and help with mental health care and emergencies
24-Hour Hotline: 888-678-7277
www.cchealth.org/services/mental_health/
http://contracosta.networkofcare.org/mh/home/index.cfm

ACCESS Alameda County

Information and help with mental health care and emergencies
24-Hour Hotline: 800-491-9099
TTY 1-800-653-2373
www.acbhcs.org http://alameda.networkofcare.org/mh/home/index.cfm

Other Programs for Children

Healthy Families Program

Find out if your child qualifies, and how to apply: 800-880-5305 or
To apply online: www.healtheapp.net/
To find an Application Assistor in your area: 888-747-1222
If your child has Healthy Families coverage and you have questions about coverage:
1-866-848-9166, Monday to Friday, 8 a.m. to 8 p.m., or on Sat. 8 a.m. to 5 p.m.
HealthyFamilies@MAXIMUS.com

Kaiser Child Health Plan

If you want to apply for your child of if you have questions about coverage.
Phone: 800-464-4000 or TTY 800-777-1370

California Children's Services (CCS)

State website: www.dhcs.ca.gov/services/ccs

Alameda County CCS

510-208-5970
www.acphd.org/user/services/listing.asp

Contra Costa County CCS

925-313-6100
Email: ccs@hsd.cccounty.us
www.cchealth.org/services/ca_childrens_services/

Community Resources

Consumer & Family Support listings

Regional Center of the East Bay website http://www.rceb.org/resources/support.html
Alameda County Medical Home Project: 510-540-8293

First 5

Alameda County: www.ackids.org

Developmental Checklists on website

Contra Costa County: www.firstfivecc.org

(800) 644-2666 or TTY (800) 804-1616

Bay Area Legal Aid and Community Health Advocacy Project

Free civil legal services; help with health coverage, access, & service problems for lower income people.
www.healthconsumer.org

Alameda County

Monday through Friday 9:00am to 5:00pm.
1735 Telegraph Ave, Oakland, CA 94612
(510) 663-4744
Legal Assistance Line: (510) 250-5270; (800) 551-5554
California Relay Service: Dial 711 or from TTY dial 1-800-735-2929 or visit www.ddtp.org/california_relay_service/

Contra Costa County

Monday through Friday, 9:00am to 5:00pm.
1025 Macdonald Avenue Richmond, CA 94801
(510) 233-9954
Legal Assistance Line: (510) 250-5270 or (925) 219-3325
California Relay Service: Dial 711 or from TTY dial 1-800-735-2929 or visit www.ddtp.org/california_relay_service/
East Contra Costa County: call 510-233-9954.

Through the Looking Glass (TLG)

Research, training, and services for families with a child, parent or grandparent who has a disability or medical issue.
3075 Adeline Street, Suite 120
Berkeley, CA 94703
510.848.1112 or 1.800.644.2666 or (VOICE) or TTY: 510.848,1005
www.lookingglass.org

Disability Rights California – Bay Area Regional Office

Information and advocacy for people with disabilities, including developmental disabilities
800.649.0154 (TTY) or 510.267.1200 (Voice)
www.disabilityrightsca.org

Head Start (ages 2-1/2 to 5) and Early Head Start (ages 0-2-1/2)

Child care, education and other services to help meet the developmental, health and school readiness needs of low income children..

Contra Costa County Community Services:

East/Central County: (925) 427-8852
West County: (510) 374-7144
www.ccccsd.org/faq.html

Alameda County

CAPE – Dublin, Pleasanton, Livermore, Sunol
(925) 443-9380 x 104

City of Oakland – Oakland
(510) 238-3165

Berkeley-Albany YMCA – Albany, Berkeley, and Emeryville
(510) 848-9092 x302

Xanthos, Inc – City of Alameda
(510) 865-4500

Child, Family & Community Services –
San Leandro, San Lorenzo, Castro Valley, Fremont, Newark, Union City
(510) 796-9512

De Colores Head Start – Unity Council - Oakland
Fruitvale Village,
(510) 535-6107

Childcare Resource and Referral Agencies

Alameda County

BANANAS, Inc.
Northern Alameda County
(510) 658-0381
www.bananasinc.org

4C's of Alameda County
Southern Alameda County
(510) 582-2182
www.4c-alameda.org

Child Care Links
Eastern Alameda County
(925) 417-8733
www.childcarelinks.org

Contra Costa County

Central Contra Costa
925-676-5437
Central@cocokids.org

West Contra Costa
510-758-5439
West@cocoids.org

East Contra Costa
925-778- 5437
East@cocokids.org

Contra Costa Child Care Council
www.cocokids.org/ (English) or www.cocokids.org/es/ (Español)
www.cocokids.org/finding-care/special-needs.

State and National Organizations

TACA – Talk About Curing Autism:

Support and information for families affected by autism
www.tacanow.org

Insurance Help for Autism:

Helps parents obtain insurance coverage for autism related services.
www.insurancehelpforautism.com

Zero to Three, National Center for Infants, Toddlers, and Families:

Informs, trains, and supports professionals, policymakers, and parents in their efforts to improve the lives of infants and toddlers.
www.zerotothree.org

Early Intervention Family Alliance:

Works with families and others on federal policy to improve the Early Intervention program.
www.eifamilyalliance.org

Autism Speaks:

Provides information on autism; funds research on causes, prevention, treatments, and cure for autism; advocates for needs of families.
www.autismspeaks.org

GLOSSARY

Appeal — An appeal is a request to your health plan to review again a decision the plan has made in response to a Grievance, Complaint, or request to pay for a service. Normally, appeals involve deadlines, timelines, and paperwork and require persistence.

Allowed Amount — The amount considered the total payment to a provider. The health plan, the member, or a combination may pay this amount.

Annual Out-of-Pocket Maximum — See Out-of-Pocket Maximum.

Authorization or Approval — See Pre-Approval or Pre-Authorization

Behavioral Health Plan — A plan that covers the services of mental health providers.

Benefit — A service your health insurance covers. For example, emergency care and preventive care are common benefits.

California Children's Services (CCS) — State program that helps pay for treatment for children with certain chronic conditions or diseases or physical limitations.

CDI – California Department of Insurance — Regulates non-Blue Cross and non-Blue Shield PPOs and all Indemnity plans.

Child Health and Disability Prevention Program (CHDP) — State program that provides assessments and preventive care for children with low incomes. CHDP is funded by state and federal funds.

Claim/Claim Number — A claim is a bill for medical services typically submitted to the insurance company by a healthcare provider. The insurance company assigns each claim a unique number.

Co-insurance — Percentage of the charges that you must pay each time you see a doctor, get a prescription, or get other services. If your plan has a Deductible, the co-insurance is the amount you must pay for medical care after you have met your deductible.

Complaint — An expression of dissatisfaction about the way a health plan or health plan provider provides services; a request to your health plan to solve a problem about your care. Also called a Grievance.

Co-pay or co-payment — Flat fee (for example, $15) you pay for each time you receive a covered health care service. The amount can vary by type of service.

Covered Services — Medical services, supplies, or treatments for which your health plan will pay. Covered Services are listed in your EOC and must also be Medically Necessary to be payable.

Deductible — Amount you owe each year for health care services before your health plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you have paid $1000 for covered health care services. The deductible may not apply to all services.

DMHC — California Department of Managed Health Care — Regulates HMOs and some PPOs.

Evidence of Coverage (EOC) — A written guide from your health plan that explains what the plan does and does not cover and the rules you must follow for getting care. Also called a Member Handbook or Summary Plan Description (SPD)

Exclusions — Services that are not covered by a plan. Sometimes services have limitations. Exclusions and limitations must be clearly described in plan materials.

Fee-for-Service Plans — See Indemnity Insurance.

Flexible Spending Account or Arrangement — FSAs allow employees to use pretax dollars to pay for some health care expenses such as co-pays and non-covered medical care.

Grievance — See Complaint

Group Coverage — Health plans offered to a group of individuals by an employer, association, union or other entity.

Health Reimbursement Arrangement (HRA) — Funds an employer allocates that you may use for covered healthcare expenses.

Health Savings Account (HSA) — An account established by an employer or an individual to save money toward medical expenses on a tax-free basis. Any balance remaining at the end of the year "rolls over" to the next year.

Healthy Families Program — California's Children's Health Insurance Program, a state and federally funded program that covers health, dental, and vision care for children in lower and middle-income families.

Help Center — A program within the Department of Managed Health Care that provides assistance to people to help them understand their health care benefits and rights and solve problems with their HMO or Blue Cross/Blue Shield PPO.

High Deductible Health Plan — A plan that provides comprehensive coverage for high-cost medical events. It features a high deductible and a limit on annual out-of-pocket expenses. This type of plan is usually coupled with a health savings account or a flexible spending account.

HMO — A managed care plan in which you choose a Primary Care Provider, and you must get all your health care services from the doctors and other providers in the network. HMO stands for health maintenance organization.

Independent Medical Review (IMR) — If you disagree with your health plan's decision after an Appeal, you may request an IMR of your case by medical professionals who are not part of your health plan. If the IMR is decided in your favor, your health plan must provide the treatment or service. You can request an IMR through CDI or the DMHC depending upon what type of coverage you have.

Indemnity Insurance — Plans that normally allow you to use any licensed provider. Features include deductibles and co-insurance. Providers are paid a fee for each health care service.

Individual Coverage — Health insurance you buy for yourself and your family. Usually costs more than group coverage provided through an employer or another group such as a union or professional association.

Insurance Adjustment — The dollar amount difference between the "Allowed Amount" and the amount the you owe (Kaiser). Also can mean the difference between the full charges and the amount owed by the insurance plan or a combination of the insurance plan and the member. The adjustment code explains the reason for the adjustment.

Limitations: See Exclusions

Managed Care Plan — Managed care plans, most commonly an HMO or PPO, involve an arrangement between the insurer and a selected network of health care providers (doctors, hospitals, etc.). Plan members have significant financial incentives to use the providers in that network. There are specific standards for selecting providers and formal steps to ensure that quality care is delivered. Often Indemnity or Fee-for-Service plans have some type of managed care feature such as utilization review.

Medi-Cal — California's Medicaid program to help people with lower incomes get health care services. Services are free or low-cost, depending on income. Medi-Cal Fee-for-Service: Medi-Cal for enrollees who are not in a managed care plan.

Medical Group — A group of doctors who have a business together. Medical groups include primary care doctors, specialists, and other providers.

Medically Necessary — Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Network — The doctors, medical groups, labs, hospitals, and other providers that work for or have a contract with the HMO or PPO.

Non-Participating Provider or Non-Preferred Provider — A provider who does not have a contract with your health plan. In a PPO or POS plan, you will pay more to see a non-Participating Provider. In general, except for Emergency Services, HMOs will not pay for services from Non-Participating Providers.

Out of Network/Out of Plan — See Non-Participating Provider

Out-of-Pocket Maximum — The maximum amount you have to pay in a year for services. After you reach the Maximum, you won't have to pay any more for Deductibles, Co-Pays, or Co-Insurance for most services.

Participating Provider — A provider who has a contract with your health plan to provide services to you. Also called Network Provider.

Patient Name — Name of the person getting care.

Patient Responsibility — Amount you owe. This can be: a co-pay, coinsurance, or an amount applied toward your deductible.

PCP — See Primary Care Provider

POS — Point of Service Plan — An HMO option that allows you to choose at the time you get a service to use a non-HMO provider, but at a higher cost than you would pay for network providers.

PPO — A managed care plan in which you can choose to get your health care from the doctors and other providers in the network (Participating Providers) or go outside of the network (Non-Participating Providers) and pay a higher cost. PPO stands for Preferred Provider Organization.

Pre-Approval, Pre-authorization, or Authorization — A decision by your medical group or health plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Is required for certain services before you receive them, except in an emergency. Pre-Approval isn't a promise your health insurance or plan will cover the cost.

Preferred Provider. See Participating Provider

Primary Care Provider — Your main doctor who directly provides your care, coordinates your care and refers you for other services when you need them. Also called a primary care physician or PCP.

Referral — A written or electronic order you must have from your PCP before you can get care from a specialist, a screening test, or other care that your PCP cannot give you.

Second Opinion — Advice from a second doctor about your choice of treatments or the cause or nature of your illness. You have a right to a second opinion in California regulated health plans. A second opinion can be within your plan or outside the network if you have a referral from your doctor and approval from your plan.

Self-Insured Plan — Often offered by large employer or unions. Instead of buying coverage from an insurance company, the employer or union uses its funds to pay health care claims to providers.

Service Date — Date you received care from the provider.

Service Description — Health care service received.

Specialist — A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Standing Referral — A referral that allows you to see a specialist without getting a referral from your primary care doctor each time.

State Hearing or State Fair Hearing — A Medi-Cal State Hearing is a meeting where you explain your problem to a judge. Your health plan also explains its side. Ask for a Medi-Cal Hearing if you disagree with the health plan decision to deny, reduce or stop your care.

Urgent care — Care you need soon, usually within 24 hours, for a medical situation that is serious but is not an emergency.

Compiled and written by Janie Tyre, Health Policy and Communications Consultant, in consultation with the staff of the RCEB Infant and Young Children Services Department, May 2011

RCeB
Regional Center of the East Bay

MISSION

Regional Center of the East Bay supports persons with developmental disabilities and their families with the tools needed to achieve lives of quality and satisfaction, and builds partnerships that result in inclusive communities.

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