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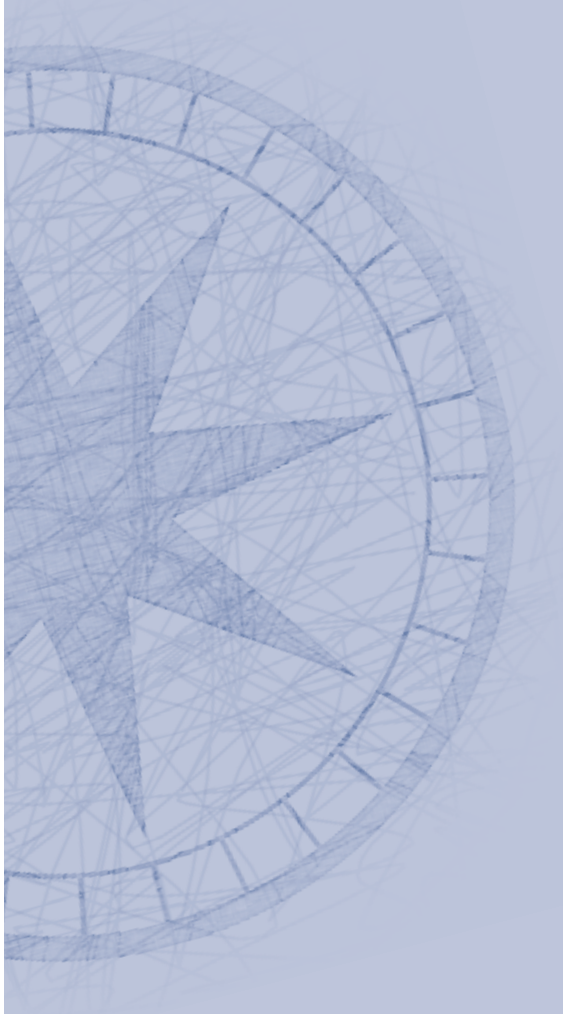
Your Child's Health Plan

In this chapter, you will find information about your child's health insurance plan, or health plan. Place a copy of the benefits handbook from your child's health plan in this chapter. If you do not have this information contact a Member Services Representative at the plan or your employer.



For more information about health insurance, paying for your child's health care, and public benefits see:

Infoline 2-1-1 or http://www.infoline.org
Look for the Health Care Resource Guide.

Office of the Healthcare Advocate
http://www.ct.gov/oha/site/default.asp
or call toll-free 1-866-HMO-4446.

Paying the Bills: Tips for Families on Financing Health Care for Children with Special Needs, available from New England SERVE. Order a free copy by calling 617-574-9493 or download it from www.neserve.org

Calling a Member Services Representative

A Member Services Representative at your child's health plan can help you by answering questions about:

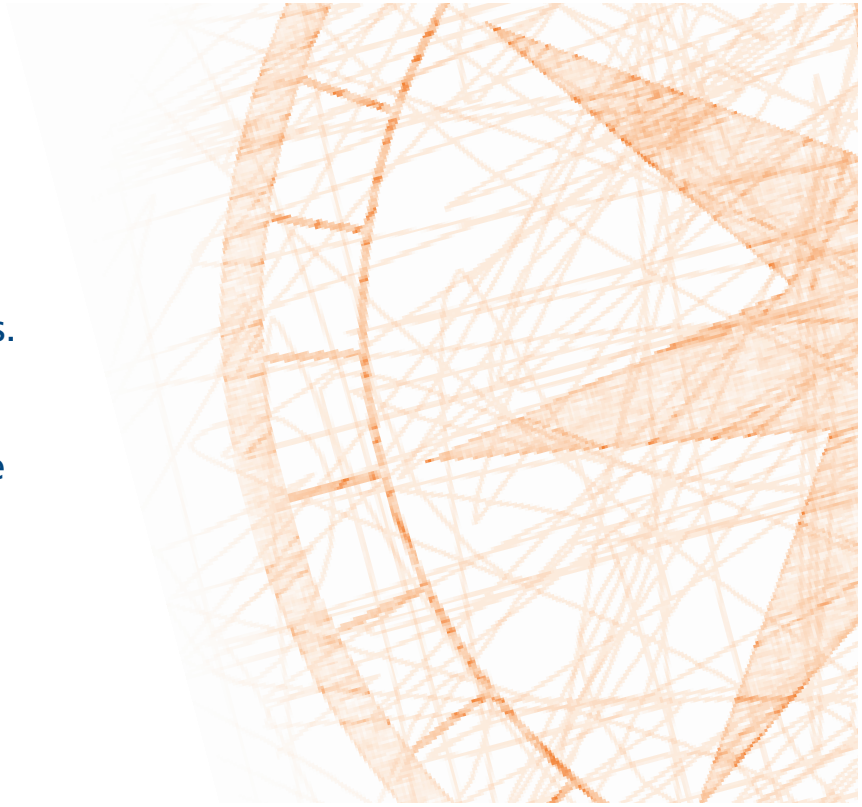
- Eligibility, benefit coverage, and enrollment in the health plan
- How to access other services, such as case management
- How to find a primary care provider (PCP) or specialty providers in the plan
- How to change your child's PCP
- How the prior authorization process works
- What to do if you have a complaint or grievance
- What to do if you disagree with a decision made by the health plan and you want to appeal the decision
- Coverage for services your child receives out-of-state
- Billing

Tip:

Have your child's insurance card with you when you call. You will find the plan's phone number and your child's membership number on the card. Also, write down your questions before you make the call.

Case Management

Case management, also called **care management**, is offered through many health plans to help families access and coordinate services and benefits.



A case manager (usually a nurse or social worker) works with you to:

- **Assess your child's health care needs**
- **Plan and coordinate your child's health care with your child's primary care provider (PCP)**
- **Communicate with health care providers**
- **Find resources and services**
- **Improve your child's overall care**

Call a Member Services Representative at your child's health plan to learn more about case management services.

Mental Health Services

Mental health and substance abuse services are sometimes called behavioral health services. Some mental health services are paid for by most health plans. Different plans may have different mental health and substance abuse service benefits. Some health plans work with another health insurance plan that specializes in mental health and substance abuse.

Check the benefits handbook or call a Member Services Representative at your child's health plan to learn more about mental health benefits.

Ask About:

- How to find a mental health provider in the plan
- The number of outpatient mental health visits the plan will pay for each year
- The number of inpatient mental health hospital days the plan will pay for each year
- How authorizations for inpatient and outpatient mental health services are arranged
- What to do in case of a mental health emergency

Mental Health Parity Law

In Connecticut, Mental Health Parity means a health plan that offers coverage for medical and surgical conditions must offer coverage for the diagnosis and treatment of mental and nervous conditions. Coverage for mental health services cannot be at a greater expense than the medical and surgical coverage.

For more information about the Mental Health Parity Law, contact:

The Office of the Healthcare Advocate http://www.ct.gov/oha/site/default.asp or call toll-free 1-866-HMO-4446.

The Prior Authorization Process

Prior authorization, also called prior approval, means getting permission from your child's health plan before your child uses a special service or kind of equipment. It is usually the responsibility of your child's primary care provider (PCP) or other treating provider to get prior authorization from the health plan.

Examples of services usually requiring prior authorization are:

- Most hospital admissions
- Medical procedures
- (Non-emergency) surgeries
- Some tests and consultations (such as a second opinion)
- Durable medical equipment (DME)
- Home health care
- Outpatient therapies (such as physical, occupational, and speech therapy)

Medical Necessity

In some cases, your child's PCP will need to write a letter of **medical necessity** to the health plan. This letter states the medical reasons why your child needs a special service or equipment.

*The Office of the Healthcare Advocate defines **MEDICAL NECESSITY** as the legal term used to determine what services will be provided and paid for. It describes services that are consistent with a diagnosis, meet standards of good medicinal practice, and are not primarily for the convenience of patient or provider. This definition and how it is used varies from plan to plan.*

Different plans have different prior authorization processes. Learn about the process at your child's health plan so you will know what to do if your child needs any services that require prior authorization.

Call a Member Services Representative or your child's case manager at the plan to learn more about the prior authorization process.

The Appeal Process

If you disagree with a decision made by your child's health plan, you or your child's primary care provider (PCP) may appeal to the plan. For example, you may request that a decision be reviewed if:

- The plan refuses to pay for treatment that you and your child's PCP believe your child needs
- The plan tells you that it will stop paying for treatment

Check the benefits handbook or contact a Member Services Representative at the plan for more information about how to appeal a decision. Ask for a copy of your plan's policy on prior approval and appeals. The Member Services Representative will work with you to help you find the best way to address the problem.

For more information contact
The Office of the Healthcare Advocate at
http://www.ct.gov/oha/site/default.asp
or call toll-free 1-866-HMO-4446.

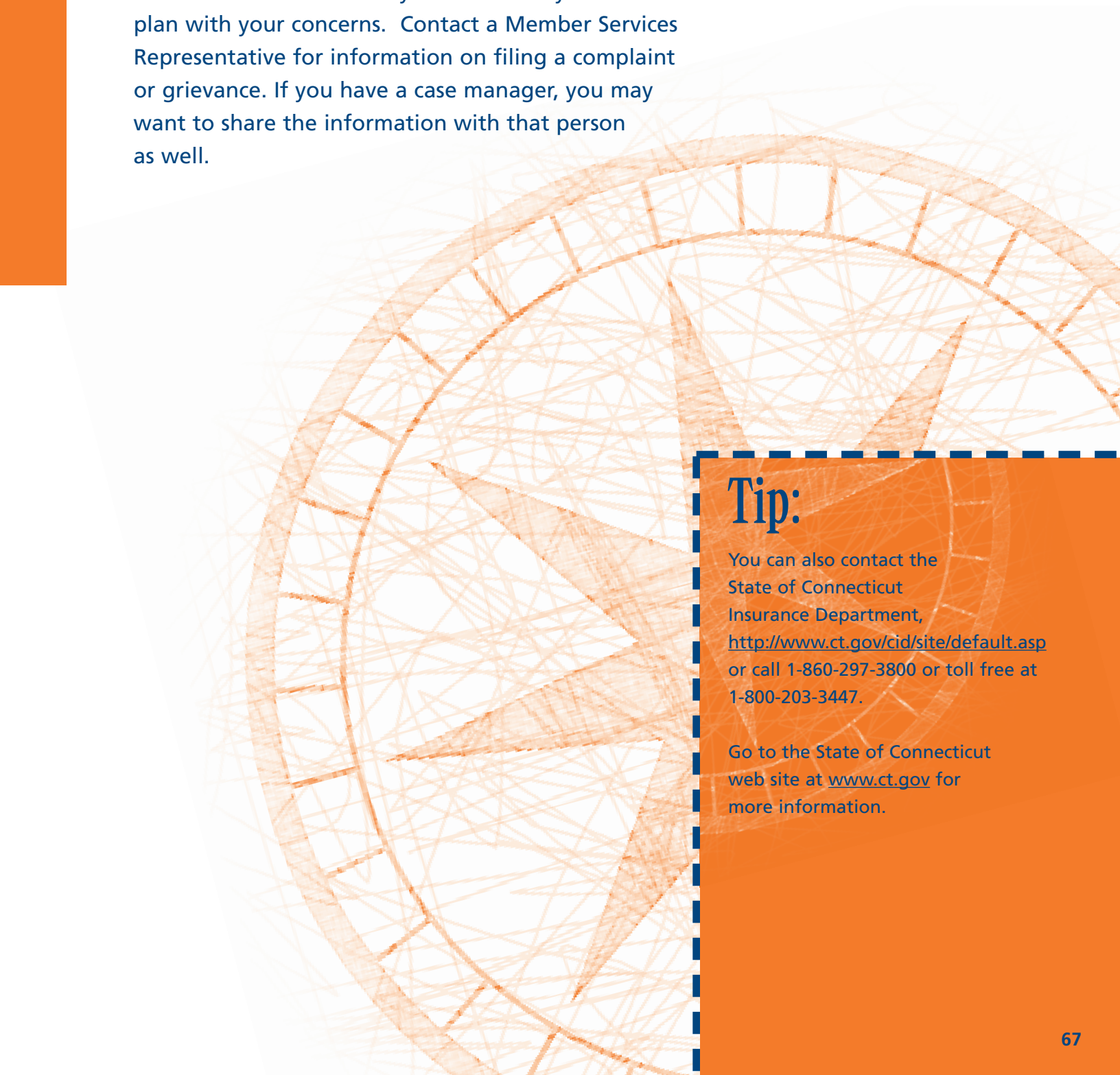
Connecticut Insurance Department,
http://www.ct.gov/cid/site/default.asp
or call 1-860-297-3800 or toll free at
1-800-203-3447.

Tip:

Federal law requires that a health plan allow you to appeal a decision up to 180 days from the service date. It is best to file an appeal as soon as you can. Remember to keep a written record of everything you do and everyone you speak to. Also, keep copies of any letters you send or forms you fill out.

What if I Have a Grievance or Complaint?

At times you may not be satisfied with the care your child has received and may want to notify the health plan with your concerns. Contact a Member Services Representative for information on filing a complaint or grievance. If you have a case manager, you may want to share the information with that person as well.



Tip:

You can also contact the State of Connecticut Insurance Department, http://www.ct.gov/cid/site/default.asp or call 1-860-297-3800 or toll free at 1-800-203-3447.

Go to the State of Connecticut web site at www.ct.gov for more information.

Changing Health Insurance Plans

If your child's health insurance plan changes:

- Learn as much as you can before the change.
- Go to informational workshops about different plan options, if available.
- As soon as you can, contact a Member Services Representative at the **new** health plan. Get a benefits handbook and a list of primary care and specialty providers in the network. Find out how the **new** plan will help you to transition your child's current services.
- Learn about the network of health care providers in the **new** health plan. Check if your child's primary care and specialty providers are in the network of the **new** health plan.
- Tell all of your child's providers and vendors about the insurance change. This includes home health care, durable medical equipment, and pharmacy. Be sure to have the name and subscriber information of the **new** health plan with you when you call.
- If any of your child's **current** health care providers are **not** covered by your **new** plan, speak with your **current** providers about the change and how to find **new** providers.
- If you work with a case manager at your **current** health plan, contact that person as soon as you know about the change. The case manager may be able to help with the transition.