FAQ's - Use of Private Insurance

Copays, Coinsurance and Deductibles

Why am I being asked to utilize my child's health insurance?

California Early Intervention Services Act (CEISA) Section 95004 indicates that direct services shall be provided pursuant to the existing regional center system under the Lanterman Developmental Disabilities Services Act, contained within the Welfare and Institutions Code (WIC) and 95004(b)(1) private health insurance for medical services identified in the Individual Family Service Plan (IFSP), other than for evaluation and assessment, shall be used. Many required early intervention services are considered medically necessary by various private health insurances. Welfare and Institutions Code Section 4659(c) states that regional centers shall not purchase any service that would otherwise be available from private insurance.

When should I begin to access health services for my child?

Immediately. You will need to inquire and access health services while the regional center is completing evaluations and assessments to determine eligibility for Early Start. There may be duplication of assessments between the regional center and your health plan in order to determine your child's developmental needs. If your child is eligible for Early Start, your service coordinator will review your health plan benefits and coverage limitations at your initial Individual Family Service Plan (IFSP). The primary funding agency for each required service will be determined and included in your IFSP.

Does the regional center assist with co-payments, co-insurance and deductibles?

Yes, as of July 1, 2019, regardless of income, a family is eligible for co-payments, co-insurance and deductible reimbursement. For Behavioral Services after age 3 under the Lanterman Act, income requirements below must be met in order to qualify for reimbursement.

Prior to July 1, 2019 for Early Start Service **OR** for ongoing Behavioral Health Service after age 3 under the Lanterman Act:, families whose yearly gross income is below 400% of the federal poverty level (FPL) are eligible to receive reimbursement for co-payments/co-insurance and deductibles when the service is provided by an in network provider. Families whose yearly income is above 400% of FPL may be eligible for reimbursement if criteria for exceptional circumstances are met: 1-The existence of an extraordinary event that impacts the ability of the parent to meet the care and supervision needs of the child to help maintain the child at home or in the least restrictive setting or impacts the ability of parent with a health care service plan or health insurance policy, to pay the copay or coinsurance. 2-The existence of catastrophic loss that temporarily limits the parent ability to pay the health care service plan or health insurance policy and creates a direct economic impact on the family. Catastrophic loss may include, but not limited to, natural disasters and accidents involving major injuries to an immediate family member. 3-Significant unreimbursed medical costs associated with the care of the consumer or another child who is also a regional center consumer.

What information do I need to provide to my service coordinator?

1) Explanation of Coverage (EOC): This is required if your child has private insurance and will be receiving ongoing Occupational Therapy (OT), Physical Therapy (PT), or Speech Therapy (Speech). You can obtain

this from most insurance companies by calling your insurance company or by downloading it from their website. AKA: Summary of Benefits, Summary of Plan

2) Income information (Federal Tax form 1040) if applicable: The first page of your federal tax form is only needed if you are asking the regional center for deductible and/or copay/coinsurance funding or reimbursement. It is critical that you provide information as soon as possible to limit your costs. This document declares the number of dependents as well as the gross annual income, which is used to determine whether you meet eligible criteria. There may be circumstances when additional information is required.

3) Family Letter: Only needed if your family's income is over 400% of FPL and you feel that you meet one of the three exceptions in law. There is no financial hardship policy. There are only three exceptions in statute, when the regional center may pay for copays, coinsurance and deductibles.

What if I don't want to submit my health insurance documentation?

Your health insurance information is required. Regional center may fund for early intervention services (OT, PT and/or Speech) to offer your family the opportunity to provide the required information and access health services. A Notice of Action (NOA) will be sent within 30 days of service end date if family chooses to not pursue insurance coverage.

What is the difference between an Explanation of Coverage (EOC) and Explanation of Benefits (EOB)?

Explanation of Coverage (EOC) is a summary of all the benefits that are covered by your insurance company. It documents the deductible amounts, copay/coinsurance, categories of coverage, and what is not covered and it will show you the limits of coverage. This summary document will also show you what the family vs. individual deductible is (you only need to meet the individual deductible for the early start eligible child). This is not related to an actual visit to a doctor.

Explanation of Benefit (EOB) is a summary of the charges that have occurred from a visit to a doctor/health care provider. It states the cost of the visit and the patient responsibility for the visit. A copy is mailed to you and a copy to your doctor/health care provider. It may also be referred to as a Schedule of Benefits under some health plans.