Insurance Frequently Asked Questions Table

GEORGIA SYSTEM of CARE

FAMILY | COMMUNITY | PARTNERS

	What kind of insurance is it?	Who is eligible?	What is the approval process and required documentation?	What is the timeline for service delivery?	What may be the challenges/denials?	What services are covered?
Medicaid: Medicaid Program	Medicaid is a medical assistance program that helps many people who can't afford medical care pay for some or all of their medical bills. Autism Spectrum Disorder (ASD) Program for disabled children provides assessment and treatment services according to the severity and is based on medical necessity. More details can be found here.	1. You think you are pregnant. 2. You are a child or teenager(0 - 18 years). 3. You are over 65 years. 4. You are legally blind. 5. You have a disability. 6. You have been diagnosed with breast or cervical cancer. 7. If a child is in foster care or adopted. 8. You need nursing home care. Eligibility FAQ's can be accessed here.	You need to speak with a representative at your local DFCS office to get started with the approval and the documents required during the approval process are 1. A copy of your birth certificate or other proof of identity and citizenship or immigration status 2. ID cards issued by federal, state or local government agencies or entities either containing a picture or identifying information 4.Social Security numbers, for each person requesting Medical Assistance 5. Paycheck stubs, payroll records or recent W-2 forms covering at least the past four weeks 6. Letters or forms that show your income from Social Security, SSI, Veterans Administration, retirement, pensions, unemployment, worker's compensation or all sources of income. 7. Health insurance information 8. Life insurance policies 9. Recent bank statements or bank books, and/or most recent tax return	Typically 1-2 weeks but determination varies.	If no communication is made with your doctor about your Medicaid application while you are waiting for your Medicaid card, you are responsible for paying any bills. The medical provider can use the approval notice to confirm your Medicaid eligibility and it is under the doctor's discretion to accept you as a Medicaid patient and file your claim(s) retroactively.	Medicaid in Georgia offers a variety of programs to assist children with behavioral health issues. Services may include Counseling Services, Psychological and Therapy Services, Autism Services, Occupational Therapy Services. Services and eligibility vary and can be found here.

			10. Information about the property you own (such as land, or stocks and bonds)			
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TEFRA/Katie Beckett: Medicaid Program	1. It provides benefits to certain children 18 years of age or less who qualify as disabled individuals under §1614 of the Social Security Act disabled and who live at home rather than in an institution. 2. These children must meet specific criteria to be covered. Qualification is not based on medical diagnosis; instead it is based on the institutional level of care the child requires. Title 42 Code of Federal Regulations outlines the criteria used to determine eligibility.	You are eligible: 1. If a child doesn't receive SSI or doesn't have Medicaid based on the family income (MAGI - modified adjusted gross income). 2. He or she is not already covered by Medicaid. 3. If your child is not enrolled in Medicaid Managed Care with UnitedHealthcare, Neighbourhood Health Plan or Tufts Health Plan, or Medicaid fee-for-service. 4. There are no additional benefits given to a child who qualifies for Medicaid through Katie Beckett than those given to a child who qualifies for Medicaid based on income.	**Step 1:** The child's provider must complete the Clinical Evaluation form. In addition, the parent or guardian is encouraged to provide copies of recent evaluations by medical and behavioral specialists, the Early Intervention Program (Individualized Family Service Plan-IFSP), Special Education (Individual Education Program-IEP), or other providers who have evaluated their child. **Step 2:** Current medical, psychological, educational and other professional evaluations, treatment plans, and progress notes are used to determine if a child is disabled and meets an institutional level of care and should be included with your child's clinical packet. The review team may also request additional information from families.	1. EOHHS (Executive Office of Health and Human Services) is required to make an eligibility decision within 90 days. Eligibility decisions can often be made more quickly when clinical information is received with the application or soon after.	Application may be denied if the applicant does not meet the criteria of: 1. Nursing Facility LOC 2. ICF/ID LOC 3. Rehabilitative services are not required five (5) days per week or skilled nursing services seven (7) days per week per the documentation submitted 4. This child has a diagnosis of intellectual disability or a condition that is closely related to intellectual disability, but the psychological/developmental evaluation scores do not meet the Level of Care criteria 5. You failed to submit all the required documents for review 6. The physician failed to certify the applicant requires the level of care	1. All Medicaid recipients must be reviewed annually for financial eligibility and periodically reviewed for clinical eligibility. Families must report any changes to financial, residency and insurance coverage within 10 days of the change.

					provided by a nursing facility or ICF/ID facility.	
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Georgia Families 360°: Medicaid Program (Amerigroup Community Care of Georgia)	1. Georgia Families 360° is the name of the Medicaid program covering children and youth in Foster Care, Adoption Assistance, and select youth in the custody of the Department of Juvenile Justice for healthcare benefits. This program is administered by Amerigroup, a managed care company. 2. All eligible members in Foster Care and the Department of Juvenile Justice must be enrolled in the Georgia Families 360° program with Amerigroup health plan. Because Georgia Families 360° is designed to serve a specific population of children and youth, a parent cannot	Georgia Families 360° members get coordinated care and services such as 1. Various evaluations were determined necessary for this special population such as clinical screening for the effects of trauma 2. Developmental milestone screening and ongoing care from a primary care pediatrician enrolled in the network 3. Wellness visits and shots to help keep your child healthy 4. Vision and dental care 5. Necessary prescription medication 6. Specialty medical services and hospital stays 7. Behavioral health services	There are several key items to be done when a youth enters foster care – 1. A Medicaid application must be submitted as soon as possible to determine eligibility 2. An initial E-Form should be sent to Amerigroup coinciding with the 72-hour hearing. 3. Amerigroup immediately assigns staff to the youth and begins outreach efforts to the identified placements, state agency staff, and providers 5.	Typically 3 to 5 days	The member could be disenrolled immediately from Amerigroup if he or she is: • No longer eligible for Medicaid • Disenrolled by the Georgia Department of Community Health (DCH) • Let someone else use his or her Amerigroup ID card • Moves out of state • Sent to jail or prison • Placed in a long-term nursing facility, state institution or intermediate care facility for the mentally disabled	Services include: Services requiring pre-authorization are: 1. Inpatient mental health 2. Partial Hospitalization program 3. Intensive Outpatient program 4. Chemical dependency services 5. Residential treatment Facility 6. Psychological and neuropsychological testing Services without requiring pre-authorization are: 1. Individual therapy 2. Group therapy 3. Family therapy 4. Trauma Assessments 5. Psychiatrist Appointments 6. Evaluation and Monitoring

	enroll their child in this program.					
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TRICARE: (Government-sponsored health insurance program)	TRICARE is for Unmarried biological, step-children and adopted children are eligible for TRICARE until age 21 (or 23 if in college, see "College Students" below). 1. Eligibility may extend beyond these age limits if he or she is severely disabled. 2. At age 21 or 23, he or she may qualify to purchase TRICARE Young Adult.	1. Uniformed Service members and their families, 2. National Guard/Reserve members Include members of the Army National Guard, Army Reserve, Navy Reserve, Marine Corps Reserve, Air National Guard, Air Force Reserve, U.S. Coast Guard Reserve, and their families, 3. Medal of Honor recipients and their families, and 4. Others registered in the Defense Enrollment Eligibility Reporting System (DEERS).	Step 1: Register your newborn or adopted child in the Defense Enrollment Eligibility Reporting System (DEERS). Step 2: Choose a TRICARE health plan and enroll your child if necessary and You need to register your child in DEERS within one year (365 days) of his or her birth or adoption. On day 366, your child won't be able to receive benefits until you register them in DEERS. **Documents required are:** 1. An original or certified-copy of the birth certificate or certificate of live birth signed by the attending physician or other hospital representative, if born in the US. 2. A Consular Report of Birth Abroad of a Citizen of the United States of America, if born overseas. 3. A record of adoption or a letter of placement of the child into the home by a recognized	Routine requests are processed within 2–5 business days Urgent requests are processed in an expedited manner for care that needs to be delivered within 72 hours	You loose eligibility 1. When a service member "separates" from active duty, it means they "get out" before retiring. 2. When dependent Child Reaches Age Limit. 3. One way you can temporarily lose coverage is to let your information in DEERS lapse. If you lose eligibility due to inaccurate DEERS information, simply update your information and your coverage is restored.	1. Your child is enrolled in a full course of study at an approved institution of higher learning 2. You (the sponsor) is still providing more than half of their financial support 3. You'll need a letter from the school's registrar's office stating that your child is enrolled full-time in an accredited college in pursuit of an Associate's Degree or higher. 4. Step-children are eligible for TRICARE as long as the parent of the child and sponsor are married. 5. If the marriage ends in divorce, the step-children lose eligibility on the date the divorce decree is final.

			placement/adoption agency or the court before the final adoption, if child is adopted.			
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PeachCare for Kids®: (Georgia's State Children's Health Insurance Program)	PeachCare for Kids® is a comprehensive health-care program for Georgia's uninsured kids. Primary, preventative, specialized, dental, and vision care are among the health advantages. Hospitalization, emergency department visits, prescription drugs, and mental health treatment are all covered under PeachCare for Kids®. A Georgia Families Care Management Organization (CMO) is assigned to each kid in the program and is in charge of managing their care.	1. children age 18 and under (eligible until 19th birthday) in families who meet the below-mentioned criteria 2. Income amounts are based on 247 percent of the Federal Poverty Guidelines and are updated annually. 3. Eligibility is dependent on the successful completion of required verification of income at application and annual renewal. 4. Your child(ren) must be a U.S. Citizen or fall within an eligible legal immigrant category. 5. Your child(ren) must not have current coverage or be eligible for Medicaid.	1. When you apply for medical assistance, children who fall under the Medicaid income limits will be placed on the appropriate type of Medicaid. Children who fall within the PeachCare for Kids income limits will be placed on Peachcare for Kids. No separate application is needed. 2. Application processing time can take up to 45 days. Once all documentation is provided, you will receive a notice advising you of what program your child(ren) are eligible for. You will also be notified if you will need to make a payment, the amount of the payment and the date that your payment is due.	PeachCare for Kids coverage begins on the first day of the month that proof of income and citizenship has been verified, all data matches have been completed and all applicable premiums have been paid for an eligible child.	1. Depending on your Medical Assistance category, you may have to make a small co-payment when you receive medical care, but Medical Assistance will pay most or all of the bill. 2. There may be any limits on the services, you can receive. 3. Premiums are due the first day of the month, 30 days before the month of coverage. 4. If your child's coverage is canceled because the payment was short or not received on time, your child will be locked out of PCK for a period of one month.	PeachCare for Kids® provide services like Complete Medical Care, Dental and Vision Benefits. Care for your teeth and eyes with exams and other services, Get Fit Rewards Focus on your health and get a free membership to a participating gym, Special Family Care Programs and receive up to $125 per year to pay for childcare, nontraditional supports and resources.

PeachCare for Kids® Eligibility income limit criteria:

Family Size	1	2	3	4	5	6	7	8	Over 8
Monthly Income	$2,652	$3,586	$4,521	$5,455	$6,390	$7,324	$8,259	$9,193	+ $9350
Annual Income	$31,814	$43,028	$54,242	$65,455	$76,669	$87,883	$99,097	$110,311	+ $4,540

PRIVATE INSURANCES:

	What kind of insurance is it?	What is the Bronze HRA plan?	What is the Silver HRA plan?	What is the Gold HRA plan?	What is the timeline for service delivery?	What may be the challenges?
Anthem Blue Cross and Blue Shield: (Private Insurance)	Anthem Blue Cross and Blue Shield of Georgia offers: Through Anthem, SHBP(State Health Benefit Plan) offers three Health Reimbursement Arrangement (HRA) Plan Options: • Gold HRA • Silver HRA • Bronze HRA	Bronze health insurance plans typically have low premiums and higher deductibles. Individuals and couples who rarely visit a doctor and only want or need coverage for medical emergencies should choose these plans. For knowing the premium and deductible amounts of the Bronze plan, refer Bronzeplandetails	Silver-level health insurance plans offer average premiums, but lower deductibles than bronze-level coverage. They are best suited to individuals and small families with average healthcare needs. Those who qualify can also receive cost-reductions with silver plans. For knowing the premium and deductible amounts of the Silver plan, refer Silverplandetails	Gold health insurance plans have higher monthly premiums but even lower deductibles than silver plans. They are best for individuals or families with regular, ongoing healthcare needs. Gold plans cover most routine healthcare costs. For knowing the premium and deductible amounts of the Silver plan, refer Goldplandetails	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For knowing the services refer preventive-care-benefits	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

1. Premium: The amount you pay each year before your plan starts to pay for covered services. This does not include costs for preventive services, which are covered regardless of the deductible

when provided by a doctor in your plan network.

2. Deductible: The amount you pay each year before your plan starts to pay for covered services. This does not include costs for preventive services, which are covered regardless of the deductible when provided by a doctor in your plan network.

	What kind of insurance is it?	What is the Humana simple and affordable plan ?	What is the Humana plan with support for dealing with a chronic condition?	What are the Humana plan prescription drug plans?	What may be the challenges?	Is there any additional information?
Humana: Private insurance with government-sponsored health insurance programs	Humana provides Medicare Advantage (MA) plans with a wide variety of options to choose by filtering using the zip code. With Medicare Advantage plans, rather than pay your medical bills directly, the federal government contracts with private insurance companies to administer your plan. You still have all the rights and benefits that come with Original Medicare, but private insurers—like Humana—compete for your business with low premiums and added benefits.	This all in one plan is simple; an all-inclusive plan where you would get everything as Original Medicare and prescription drug coverage. You can expect extra services like 1. Dental care 2. Vision care 3. Hearing care 4. Gym membership In many areas, they offer $0 monthly premium plans with all the benefits of Original Medicare Part A and Part B and so much more. You can find the plans based on the zipcode you are located in.	A Special Needs Plan (SNP) is a type of Medicare Advantage plan that combines all the benefits of Original Medicare with prescription drug coverage. Medicare C-SNPs - Chronic Condition Special Needs Plans are for those who have: • Diabetes mellitus • Cardiovascular disorders • Chronic heart failure • Chronic lung disorders Medicare D-SNPs - Dual-Eligible Special Needs Plans: Dual-Eligible SNPs are for individuals who are entitled to Medicare and who are also eligible for assistance from a state Medicaid program. With a D-SNP, all of your Medicare and Medicaid benefits are	This plan is for individuals who would like to add a separate prescription drug plan because Original Medicare doesn't cover prescription drugs. Types of plans: Humana Walmart Value Rx Plan® (PDP) Humana Premier Rx Plan (PDP) Humana Basic Rx Plan® (PDP) For the premium amount and deductible amounts of the above type of plans refer https://www.humana.c	To help manage costs, Medicare Advantage plans usually enter into contracts with a network of doctors and hospitals. That means you may have to pay more money out of pocket if you see a doctor outside the plan's network. And There are certain drugs that are covered by Humana. You can use the search tool to look up a specific drug you need. It will tell you whether the drug is covered by Humana and provide alternatives and generics. For the search tool according to zip code refer https://drug-list-search.apps.external.pioneer.humana.com/medicare	You need Humana plan with support for dealing with chronic condition if: 1. If you have specific needs as a result of a chronic medical condition. 2. If you are a resident of a long-term care facility. 3. If you are eligible for both Medicare and Medicaid.

			combined into one easy-to-manage plan.	om/medicare/part-d-2022		

	What kind of insurance is it?	Who is eligible?	What services are covered?	What are the common services one can expect for Individual and family plans?	What may be the challenges?	Is there any additional information?

Kaiser Permanente: Private Insurance associated with medicaid	In Georgia, Medicaid is run by the Georgia Department of Community Health (DCH). Medicaid's managed care program is called Georgia Families®, and PeachCare for Kids® is another program serving uninsured children in Georgia. Children who are eligible for either of these — and are enrolled with a Care Management Organization — can see a Kaiser Permanente pediatrician. With Kaiser Permanente, your children have access to participating doctors at their medical offices throughout metro Atlanta and in Athens.	To be eligible for Kaiser Permanente with medicaid, they should be an eligible member of Medicaid. Otherwise there are some separate plans for family and individuals in Kaiser Permanente in which applicants' ages must be 18 through 113 to qualify for this type of coverage. If this is a child-only plan, you should select Dependent.	If your child is eligible for Medicaid, Kaiser Permanente covers health services like: 1. Your child can get care from a pediatrician or nurse. 2. Your child's regular check-ups to stay healthy are covered. 3. Your child's shots and vaccines are covered. 4. Your child's lab tests and radiology services are covered. 5. Urgent & Advanced care	Common services may include: • Routine Physical Exam, • Primary Care Office Visit • Mental Health Visit • Lab Tests • Medications Charges for these type of services may vary based on the insurance type	1. If you fail to pay the premium 2. If you get services after your membership ends 3. If a service or procedure is not covered under the policy 4. Some services may require preauthorization	Kaiser Permanente has a Medical Financial Assistance Program which covers emergency and medically necessary health care services, pharmacy services and products, and medical supplies provided at Kaiser Permanente facilities. More information can be found here.

	What is Aetna's ACA individual and family plans? Platinum and Gold plans	What is Aetna's ACA individual and family plans? Silver and Bronze plans	What is the length of service delivery?	What are Aetna's ACA individual and family plan common services?	How long will it take to receive my member ID card after I make my initial payment?	What may be the challenges or denials?

# Aetna: Private Insurance	All ACA plans are divided into **Platinum plan:** The main goal is to achieve the lowest costs for care, even if it means the highest premium. • Highest monthly premiums • Lowest out-of-pocket costs • Lowest deductibles • Can apply for premium discounts **Gold plan:** The main goal is to pay a higher premium to keep your care costs in check. • Higher monthly premium • Lower out-of-pocket costs • Lower deductibles • Can apply for premium discounts	**Silver plan:** The main goal is to balance your premium costs with your out-of-pocket costs. • Moderate monthly premium Moderate out-of-pocket costs • Lower deductibles than Bronze plans • Can apply for premium discounts and extra plan savings **Bronze plan:** The main goal is to protect yourself from worst-case scenarios. • Lowest monthly premium • Highest out-of-pocket costs • Highest deductibles • Can apply for premium discounts	You can get the plan details by entering your zip code in https://aetnacvshealth.softheon.com/qhp/shopping/zip-code Choose a plan that you like, and then apply for it. **Length of service delivery:** An urgent request can receive a prior authorization determination within 24 hours and a non-urgent request can receive a prior authorization determination within 72 hours	All ACA plans cover these 10 essential benefits categories: 1. Prescription drugs (including brand name and specialty drugs) 2. Pregnancy, maternity and newborn care 3. Pediatric services, including dental and vision care 4. Mental health and addiction services 5. Preventive, wellness and disease management services 6. Lab tests 7. Emergency services 8. Hospitalization 9.Ambulatory services 10. Rehabilitative and habilitative services and devices	Following your initial payment, your member ID card will be mailed to you the next business day if you purchase coverage during the Open Enrollment Period after December 15, 2021. The Open Enrollment Period ends on January 15, 2022.	1. January 15 is the last day to enroll in Open Enrollment. To still enroll, you must qualify for any of the following: Losing your job could have resulted in you no longer having health care coverage, Perhaps you're getting married, Moving to a new state, having a baby. 2. The majority of the time, health care providers and facilities that aren't part of your plan aren't covered, with the exception of emergency medical care. Your plan name includes the name of the network you belong to. It's on your member ID card.

	What is Cigna?	What is Bronze plan eligibility?	What is Silver plan eligibility?	What is Gold plan eligibility?	What are the common services you will get in all the plans?	What may be the challenges or denials?

Cigna: Private Insurance	Cigna, a global health service company, offers health, pharmacy, dental, supplemental insurance and Medicare plans to individuals, families, and businesses. There are several health insurance plans based on the county you are living in and you can get detailed information of them by referring to CignaPlans	The plan is for those who would like to keep their premiums low or do not intend to see a doctor frequently. • Premium costs are low • Out-of-pocket expenses is high You can get information about the deductibles, out of pocket limits and the services they offer under this plan by referring to the plan specific document. A sample bronze plan details can be accessed by SampleBronzePlan	The plan is for those who have families and/or see doctors regularly for illnesses and accidents. • Premium costs are low compared to the gold plan but greater than the Bronze plan • Out-of-pocket expenses are low compared to the bronze plan but greater than gold plan You can get information about the deductibles, out of pocket limits and the services they offer under this plan by referring to the plan specific document. A sample silver plan details can be accessed by SampleSilverPlan	The plan is for those who have families and/or see doctors regularly for illnesses and accidents. • Premium costs are high for gold plan • Out-of-pocket expenses are lowest of all plans You can get information about the deductibles, out of pocket limits and the services they offer under this plan by referring to the plan specific document. A sample gold plan details can be accessed by SampleGoldPlan	All ACA plans cover these 10 essential benefits categories: 1. Prescription drugs (including brand name and specialty drugs) 2. Pregnancy, maternity and newborn care 3. Pediatric services, including dental and vision care 4. Mental health and addiction services 5. Preventive, wellness and disease management services 6. Lab tests 7. Emergency services 8. Hospitalization 9.Ambulatory services 10. Rehabilitative and habilitative services and devices	Most of the time, Cigna claims would cite inadequate medical evidence as the reason for denial and Many issues include denials related to timely filing, incomplete claim submissions, and contract and fee schedule disputes.