

The Healthy Families Program

The Healthy Families Program provides low-cost health insurance for children. With Healthy Families, families pay small amounts each month to receive comprehensive healthcare coverage, which includes health, dental, and vision care services for their children.

Who is eligible?

- Children from birth up to their 19th birthday who are not eligible for no-cost Medi-Cal
- Children whose families' incomes are within the Healthy Families Program income limits, which are not over 250% of the Federal Income Guidelines (FIG)
- Children who have not had employer sponsored insurance coverage within the three months before applying to the Healthy Families Program, with some exceptions. These exceptions include: loss of a job, job status change, moved and insurance not available, death, divorce or legal separation, or COBRA ended. Please note that there is no three month wait if applicants cancel their COBRA coverage and want to apply to the Healthy Families Program
- Children stay eligible for a continuous 12 month period once they are determined eligible, regardless of changes in the family's income, as long as premiums are paid

How does immigration status affect eligibility?

- Children must be U.S. citizens or U.S. Nationals or Qualified Aliens residing in California
- Qualified Alien Status verification must be provided for children within two months after they are enrolled in the Healthy Families Program
- The immigration statuses of parents or individuals applying for the children are not required

What are the income limits?

- The Healthy Families Program uses the Federal Income Guidelines (FIG) to determine eligibility
- Children from birth through age 1 are eligible if their family income is between 200% and 250% of the FIG. (Children in this age group with family income at or below 200% of the FIG are eligible for no-cost Medi-Cal)
- Children ages 1 through 5 are eligible if their family income is between 133% and 250% of the FIG. (Children in this age group with family income at or below 133% of the FIG are eligible for no-cost Medi-Cal)
- Children ages 6 through 18 are eligible if their family income is between 100% and 250% of the FIG. (Children in this age group with net family income at or below 100% of the FIG are eligible for no-cost Medi-Cal)
- The Healthy Families Program uses certain program deductions. See page 2-8 for more information.

(Use until March 31, 2010)

Number of People in Family	Children Birth to Age 1		Children Age 1 through 5		Children Age 6 through 18	
	Monthly Income At Least	Monthly Income But Not Over	Monthly Income At Least	Monthly Income But Not Over	Monthly Income At Least	Monthly Income But Not Over
1	\$1,806	\$2,257	\$1,202	\$2,257	\$904	\$2,257
2	\$2,430	\$3,036	\$1,616	\$3,036	\$1,216	\$3,036
3	\$3,053	\$3,815	\$2,031	\$3,815	\$1,527	\$3,815
4	\$3,676	\$4,594	\$2,445	\$4,594	\$1,839	\$4,594
5	\$4,300	\$5,373	\$2,860	\$5,373	\$2,151	\$5,373
6	\$4,923	\$6,153	\$3,274	\$6,153	\$2,462	\$6,153

For example, in a family of three, a child age 3 is eligible for the Healthy Families Program if the family income is at least \$2,031.

Are there resource limits?

The Healthy Families Program does not take resources into consideration. Resources are items that families may own, such as cars, houses, jewelry, savings and checking accounts.

What does it cost?

- There are two costs with this program:
 - A monthly premium per child of \$4-\$17, depending on the family's income and the selected health plan. The maximum cost is \$51 per family per month.
 - A \$5 co-payment is charged for most outpatient services, such as doctor office visits. There is no charge for preventive services, such as immunizations and dental check-ups.

Insurance Premiums	Category A		Category B			Category C		
Health Plans Available	Number of Children		Number of Children			Number of Children		
	1	2 or more	1	2	3 or more	1	2	3 or more
Community Provider Health Plan	\$4	\$8	\$9	\$18	\$27	\$14	\$28	\$42
Other Health Plans	\$7	\$14	\$12	\$24	\$36	\$17	\$34	\$51

- There are no costs, premiums and co-payments for Native American Indian or Alaskan Native children, provided that acceptable documentation of proof of heritage is submitted within two months from the date of enrollment. Applicants must indicate on the application that they are requesting waivers of the family contributions.
- There is a \$250 annual limit on the total amount of health only co-payments the family must pay per benefit year, which is July 1 to June 30.
- Effective July 1, 2009, there will be an annual cap of \$1500 for dental services.
- First month premium payments do not need to be sent with the application; however, it is strongly recommended. The applicant will be billed after the children are enrolled. If the premium is not paid within two months, the children will be disenrolled.
- Families have the following premium payment options:
 - Personal check
 - Cashier's check
 - Money order
 - Credit card
 - Electronic Fund Transfer (EFT)
 - Cash, at participating Western Unions

- Children will get the fourth month of coverage free if premiums for three months of coverage are paid in advance and by the 20th of the month in which it is due.
- Families making payments via Electronic Fund Transfer (EFT) will receive a 25% discount on their monthly premium payments.
- Families can choose the Community Provider Health Plan in their counties which offers the Healthy Families Program coverage at a discounted rate.
- If family income goes down during the year, families may submit the Premium Reevaluation form at any time to lower their premium. The family must submit the form along with new income verification and will be notified whether their change in income lowers their premium.

NOTE: If families do not pay their monthly premiums within two calendar months after the payment is due, their children will be disenrolled.

What benefits are covered?

- This program offers health, dental, and vision services
- Enrolled children are eligible for all covered services that are medically necessary. Children are not excluded from coverage due to pre-existing medical conditions

How do children receive services?

Services are provided through private health, dental, and vision plans. Parents choose health, dental, and vision plans for their children when they apply. If a family forgets or chooses not to select a health plan when filling out the application, the children will be defaulted into the Community Provider Health Plan in their county, and dental and vision plans will be assigned. A family can change health, dental or vision plans within 90 days of their initial enrollment or during Open Enrollment (April 15-May 31) each year.

What if children have other health insurance?

- Children may be eligible for the Healthy Families Program even if they receive Share of Cost Medi-Cal.
- Children receiving California Children Services (CCS) who do not have no-cost Medi-Cal may be eligible for the Healthy Families Program. Children in the Healthy Families Program are eligible for CCS services
- Children will not qualify for the Healthy Families Program if they currently have, or have had, employer-sponsored health insurance within the previous three months.
- If children receive only health coverage through employer-sponsored health insurance, they CANNOT enroll in Healthy Families for dental and vision coverage only. However, if the employer-sponsored insurance provides only dental or vision coverage, the children can be enrolled in Healthy Families for health coverage.

What is the Annual Eligibility Review?

- The Annual Eligibility Review (AER) is required every year to determine if the children are still eligible for the Healthy Families Program.
- Families receive packets in the mail 60 days before their anniversary date. The anniversary date is the date the children were enrolled in the Healthy Families Program. The completed packet, with new income information and documentation, must be returned to the Healthy

Families Program before the end of the family's anniversary month or the children will be disenrolled.

- At the AER, children who are no longer eligible for the Healthy Families Program due to decreased family income are eligible for temporary Presumptive Eligibility Medi-Cal while their Medi-Cal applications are processed. See page 4-6 for more information.

What is the Open Enrollment?

- Each year, between April 15th and May 31st, families with children in the Healthy Families Program have an opportunity to choose new health, dental, and vision plans for their children.
- The Healthy Families Program will notify families about the Open Enrollment period and if families decide to change their plan(s), the changes will take effect July 1st.
- Families may also need to choose new health, dental, and/or vision plans if their current plans change their coverage areas or no longer participate in the Healthy Families Program.

How do families apply for their children or get more information?

- Call the Healthy Families Program: 1-800-880-5305 (this is a free call) to request an application.
- Visit the Healthy Families Program website, www.healthyfamilies.ca.gov, to download an application or to locate Certified Application Assistants (CAAs) in the area to help complete an application.
- CAAs in some organizations can help families submit on-line applications using Health-e-App or One-E-App. To obtain more information call the EE/CAA Helpdesk at 1-800-279-5012, Health-e-App at 1-866-861-3443 or One-E-App at info@oneeapp.org.
- Families can complete their application over the phone by calling 1-800-880-5305. The completed application will be mailed to the applicant for signatures and documentation.

What do families do if they have problems getting services?

- If families are unhappy with their health, dental, or vision plan, they must resolve the problems with the specific plan according to their policies and procedures.
- Under the Healthy Families Program, most plans will allow families to change their children's Primary Care Provider at least 12 times per year. They should call their health plan to initiate this change.
- Families may exercise their rights to change health, dental, and/or vision plans within 90 days of their initial enrollments or during Open Enrollment (April 15-May 31) each year. Families can call 1-866-848-9166 for further assistance.

How can a family transfer from one plan to another?

- Families may request a transfer from one health, dental or vision plan to another under certain circumstances. Transfers are allowed if any of the following occur:
 - Request for transfer is made one time for any reason within the first three months from the original start date; or
 - Families move out of the area served by the chosen insurance plan
 - Families request a transfer one time for any reason, within the first 30 days of the start date of coverage in a new plan following open enrollment; or
 - Managed Risk Medical Insurance Board (MRMIB) does not renew the contract with the participating insurance plan in which the child is enrolled, or the contract is cancelled

- Families cannot establish a good relationship with the plan and the Executive Director of MRMIB determines a transfer is in the best interest of the child. This request must be made in writing to MRMIB at PO Box 2769, Sacramento, CA 95812-2769.
- Families can send the transfer request by phone, mail or fax. Transfer requests may be mailed to the Healthy Families Program:

Healthy Families Program
P.O. Box 138005
Sacramento, CA 95813-8005

By phone: 1-888-848-9166

By fax: 1-866-848-4974

Where can information about the Healthy Families Program be found online?

The Healthy Families Program website is www.healthyfamilies.ca.gov.

Presumptive Eligibility (PE)

Formerly known as the Healthy Families Program Bridging

If a family's income decreases, and the children are no longer eligible for the Healthy Families Program, the family may continue their children's healthcare coverage through Medi-Cal Presumptive Eligibility (PE) at AER. Children may enroll into PE which will provide them with no-cost "fee for service" full-scope temporary Medi-Cal. Once the county determines the child is eligible for full-scope no-cost Medi-Cal, families will receive a packet to enroll their children into a Managed Care Medi-Cal plan (if they live in a county where Medi-Cal Managed Care is available).

Who is eligible?

Only certain children will qualify for PE. They must meet BOTH of the following requirements:

- Children currently enrolled in the Healthy Families Program who are found to no longer qualify at their Annual Eligibility Review because their family's income is too low;

AND

- Not currently enrolled in no-cost Medi-Cal

Children who are found to already have no-cost Medi-Cal at the time of the AER are NOT eligible for PE.

How do families apply?

- There is no separate application for PE; eligibility is determined based on the Healthy Families Program AER eligibility determination.
- Families will receive a notice from the Healthy Families Program that their children are no longer eligible because the family income is too low. Their applications will be forwarded to Medi-Cal and Medi-Cal will contact the family and the children will then receive PE coverage.
- Families may also qualify for PE if their income goes down and they submit a Premium Reevaluation form and new proof of income. If their income is below the Healthy Families Program income guidelines they can elect to be disenrolled, granted PE and have their information forwarded to Medi-Cal to be screened for eligibility for no-cost full scope Medi-Cal coverage. If the family does not elect to do so, they will remain in the Healthy Families Program until AER at the end of their anniversary month.

How long does PE last?

PE provides coverage beginning on the first day of the month after the end of the Healthy Families Program coverage and lasts until the Medi-Cal application process is complete. (PE generally lasts for up to 2 months)

What services do children with PE coverage receive?

Children receive full scope no-cost Medi-Cal coverage on a fee-for-service basis.

What does PE cost?

PE services are provided at no cost for temporary Medi-Cal.

How are children enrolled in Medi-Cal when they have PE coverage?

- Families who are determined to be below the HFP guidelines at AER or when submitting a Premium Evaluation Form will be automatically forwarded to Medi-Cal.
- The date that the Healthy Families Program forwards their information to Medi-Cal is used as the date of the application to Medi-Cal.

Can families appeal disenrollments while their children receive PE Coverage?

- Families can appeal their children's disenrollment from the Healthy Families Program during PE coverage under the Administrative Review Process (see page 4-8 for more information). Appeals can be made if children do not qualify to continue participation.
- Families have 60 days from the date on their disenrollment notices in which to appeal decisions.
- The Healthy Families Program Review is used for all appeals not covered under the Administrative Review Process as well as those appeals received past the deadlines required for the Administrative Review Process.
- If families' appeals are successful before the end of PE Coverage:
 - The children's Healthy Families Program coverage will be reinstated starting the first day of the month after their PE coverage ends.
 - There is no interruption in coverage.

The Healthy Families Program Appeals Process

The **Healthy Families Program Appeals Process** allows families to appeal decisions made by the Healthy Families Program, such as application denials or disenrollments. There are two types of appeal processes, the Administrative Appeals Process and the Program Review Process. Some families can request Continued Enrollment during the appeals process to continue their children's Healthy Families Program coverage (see page 4-10).

What is the Administrative Review Process?

The Administrative Review Process is used to appeal in the following situations:

- When families disagree with the Healthy Families Program application denials
- When families disagree with the effective dates of coverage
- When families disagree with the Healthy Families Program disenrollments

Appeals for other reasons use the Program Review Process.

How many levels does the Administrative Review Process have?

- The Administrative Review Process has three levels:
 - First Level Appeals
 - Second Level Appeals
 - Administrative Hearing

First Level Appeals

- First Level Appeals are reviewed by the Healthy Families Program.
- Appeals must be sent to Healthy Families Program within 60 days of the denial or disenrollment notices (the date of the denial decisions, NOT the date applicants receive their notices).
- Appeals can be made by completing the Program review forms included with the denial or disenrollment notices or by sending letters which include the following specific information:
 - A copy of the denial or disenrollment notice
 - The reason why the applicant thinks that the denial or disenrollment was wrong
 - The rule(s) that the applicant believes Healthy Families violated
 - A statement of how the applicant wants the appeal resolved
- The Healthy Families Program has 30 days to review an appeal.
- If appeals are granted, the Healthy Families Program takes appropriate actions and notifies the applicants.
- If appeals are denied, the Healthy Families Program notifies applicants that their appeals were denied and provides them the information necessary to make a Second Level Appeal.

Second Level Appeals

- Second Level Appeals are reviewed by the Managed Risk Medical Insurance Board (MRMIB).
- Applicants' requests for Second Level Appeals must be in writing and received within 30 days of the Healthy Families Program First Level Appeal decisions.
- These appeals must include the following information:
 - The reason why the applicant thinks that the denial is wrong

- The rule(s) that the applicant believes the Healthy Families Program violated or overlooked
- A statement as to how the applicant wants the appeal resolved

Second Level Appeals (Continued)

- MRMIB will determine whether or not appeals are valid and take appropriate actions.
- If appeals are granted, MRMIB will take the appropriate actions and notify the applicants in writing, including paying for medical expenses during a break in coverage.
- If appeals are denied, MRMIB will notify applicants that their appeals were denied and provide them the information necessary to request an Administrative Hearing (third level review).

Administrative Hearing (Third Level Review)

- Administrative Hearings (third level review appeals) are decided by an Administrative Law Judge.
- Requests for an Administrative Hearing must be received within 30 days of MRMIB's Second Level Appeal decisions.
- Requests must include statements of what actions are being appealed and why MRMIB's Second Level Appeal decisions were incorrect.
- The Administrative Law Judge prepares proposed decisions for MRMIB.
- MRMIB can accept or reject the proposed decisions.
- Decisions MRMIB accepts are final, and there are no further appeals.

What is the Program Review Process?

- The Program Review Process is used to appeal all decisions except those covered under the Administrative Review Process (questions about qualifying, eligibility, and effective date of coverage).
- The Program Review Process is used for late Administrative Review appeals (appeals submitted after the 60-day deadline).
- Program Reviews do not have any further appeals, unlike the three levels of the Administrative Review Process.
- To appeal, families can use the pre-printed forms attached to their denial letters. They can also send the Healthy Families Program the following information:
 - A copy of the denial notice
 - The reason why the applicant thinks the denial is wrong
 - The rule(s) that the applicant believes the Healthy Families violated or overlooked
 - A statement of how the applicant wants the appeal resolved
 - Any other relevant information
 - The Family Member Number (FMN) assigned by Single Point of Entry (SPE)
- Decisions will be made within 30 days of the date the appeal is received.
- All Program Review decisions are final.

The Healthy Families Program Continued Enrollment

Continued Enrollment (CE) provides coverage through the Healthy Families Program to families who request it while they appeal their children's disenrollment from the Healthy Families Program. If families' appeals are successful, there is no break in the children's coverage.

Who is eligible?

Families whose children are going to be disenrolled from the Healthy Families Program and want to appeal are potentially eligible for CE. If their appeal falls under the Administrative Review Process, children may be able to receive CE services.

How do families request Continued Enrollment (CE)?

Families are given information about appeals and CE in their disenrollment notices. The disenrollment notice with CE requirements will be sent to the family 15 days before the disenrollment date.

- Families receive forms with their disenrollment notices that they can send back to the Healthy Families Program to request CE and appeal their children's disenrollments.
- Requests must be in writing; consent via phone is NOT accepted.
- The Healthy Families Program must receive the CE form before the child's disenrollment date.

NOTE: Appeals received after the disenrollment date, but within 60 days of the disenrollment date, will be processed, but the children will not receive any CE coverage.

How long does Continued Enrollment (CE) last?

- CE extends the Healthy Families Program coverage for one month or until the appeal is resolved. The appeal must be received during the CE eligibility period.
- If families' appeals are successful, the children will remain enrolled in the Healthy Families Program.
- If families' appeals are not granted, the children will be disenrolled from the Healthy Families Program. CE ends at the end of the month when their appeals were decided.
 - There are no extra costs for CE coverage if families' appeals are not granted. Families do not have to repay any benefits their children received while enrolled in CE.
 - Families can file a second appeal (Second Level Review), but the children will not receive additional CE coverage during this appeal.

What services do children with Continued Enrollment receive?

- Children continue to receive full coverage under the Healthy Families Program.
- They continue to see their assigned Healthy Families Program providers.

What does Continued Enrollment cost?

- CE coverage costs are the same as regular Healthy Families Program coverage:
 - Monthly premiums
 - Co-payments (except for preventive services)
- Families will continue to receive their monthly invoices and must continue to pay their Healthy Families Program premiums even while covered under CE.

Health-e-App Online Application for Healthy Families and Medi-Cal



What is Health-e-App?

Health-e-App is the easy-to-use, streamlined way to submit the Joint Healthy Families and Medi-Cal for Families and Pregnant Women application online. Using this electronic alternative to the traditional paper Joint Medi-Cal and Healthy Families application, Certified Application Assistants (CAAs) can submit applications for these programs quickly and easily over the Internet. Built-in error checking helps CAAs to ensure that all required fields are filled out, which increases the completeness of the information on the application.

How does Health-e-App improve the application process?

Health-e-App is simple to use and reduces the time spent to mail an application so children can obtain needed health insurance as quickly as possible. It also provides a complete data entry process for information and helps to reduce application errors caused by illegible handwriting or incomplete information. The online application process offers the following enhanced features:

- Disposition tracking for each application
- Preliminary eligibility screening in just seconds
- Instantaneous error checking to improve quality of application information
- Online selection of health care providers and health, dental, and vision plans (for Healthy Families applicants)
- Electronic payment of Healthy Families initial monthly premium
- Automated computing of income and deductions
- Electronic signatures
- Interactive web-based training for CAAs
- ADA-compliant English and Spanish versions

Is Health-e-App faster than the paper application?

Yes. Filling out an application on Health-e-App takes approximately 20-30 minutes. Filling out a paper application can take up to 45 minutes. Health-e-App also enables you to provide the applicant with a preliminary eligibility screening as you complete the application.

When you submit an application, the information you entered is sent electronically to Single Point of Entry (SPE). Supporting documentation can be faxed to SPE, completely eliminating mail time from the application process. Faxed documents should be sent within 24 hours of submitting the online application.

How do I access Health-e-App?

To learn more about Health-e-App, please visit http://www.healthyfamilies.ca.gov/EEs_CAAs/Health-e-App.aspx or e-mail HFHeA@MAXIMUS.com.

If you are an Enrollment Entity that would like to sign up for Health-e-App, please call the Health-e-App Help Desk at 866-861-3443. Enrollment Entities registered to use Health-e-App can create Health-e-App accounts for their CAAs. CAAs with Health-e-App accounts can login to the website at: www.healthapp.net.