Resources for Individuals with Pre-existing Conditions

California Health Care Reform

How California is Implementing the Federal Patient Protection and Affordable Care Act

DEPARTMENT OF Managed HealthCare

2012

The Affordable Care Act:
Resources for Individuals with Pre-existing Conditions Q&A

Q: What is the federal health care reform law?

A: The Patient Protection and Affordable Care Act creates more affordable health coverage options and puts in place strong protections to make sure health plans and insurance companies provide comprehensive health coverage to you and your family. The law requires plans and insurers to cover you and your family. It also requires everyone to have health coverage starting in 2014. Some changes have already begun, and most changes will take place by 2014.

Q: Will I have to give up my current coverage?

A: No. When your coverage is renewed, it might contain new benefits required under federal law, but if your plan was already in effect on March 23, 2010, you can keep your current coverage, as long as your health plan and/or employer continues to offer it. Plans that were in effect prior to March 23, 2010 are called "grandfathered" plans. Your health plan must explain in its written materials if it is a "grandfathered" plan.

Q: Why does the law require everyone to have health insurance coverage?

A: When people do not have health coverage, everyone pays. Hospitals are required to treat people who need emergency medical care, whether or not they have health coverage. When doctor and hospital bills go unpaid, these costs are passed on in increased insurance premiums for those who have coverage or to government programs funded by tax dollars. Right now, this "uncompensated care" is estimated at more than $50 billion per year in the U.S.

Q: Will I lose my current primary care provider because of the Affordable Care Act?

A: No. You will be able to remain with your current provider as long as s/he participates in your health care plan.

Q: What is cost-sharing?

A: Cost-sharing refers to the costs you pay "out of pocket" for medical services covered by your plan. This generally includes deductibles, co-insurance and co-payments or similar charges. It does not include extra costs for using non-emergency providers not in your plan.

Q: What is the Health Benefit Exchange?

A: The Health Benefit Exchange will help individuals and small groups research and buy more affordable health coverage. Starting in 2014, individuals and small businesses will be able to compare health plans, get answers to questions, find out if they are eligible for tax credits, and enroll in a health plan that meets their needs. To purchase coverage in the Exchange, you must live in California and be a U.S. citizen or national or be lawfully present in the U.S. For more information about the California Health Benefit Exchange, go to www.HealthExchange.ca.gov.

Q: Does the Affordable Care Act change how I get emergency care?

A: No. The new federal law, like current California law, requires that emergency services be covered without prior authorization from your health plan. You can go to the nearest hospital that provides emergency care, whether or not it is in your health plan's network.

Q: Will I have to pay a co-pay for preventive services?

A: Health plans cannot charge you for certain preventive services. Those services can be found at: www.healthcare.gov/law/provisions/preventive/index.html. Co-pays may be required if preventive services are received from an out-of-network provider or for non-preventive services that are provided during the same visit as preventive ones. If you think you have been wrongly charged for preventive services, first, contact your health plan to file a complaint. You can

do this over the phone, in writing or online. If your health problem is urgent, or if you already filed a complaint and are not satisfied with your health plan's response, contact the Consumer Assistance Program at 1-888-466-2219 or www.DMHC.ca.gov to get help with your complaint.

Q: I thought health care reform was going to lower premiums, but my premium recently increased. Is that legal?

A: Yes, health plans can raise their premium rates. But, the law requires your health plan or insurer to justify premium increases to state and/or federal regulators. The DMHC publicly posts rates filed by plans at wpso.dmhc.ca.gov/RateReview/. Rate increases of 10 percent or more will also be reported on the federal website at www.healthcare.gov. These sites will provide you with more information about factors contributing to premium increases and help you compare pricing.

Q: What is the Pre-Existing Condition Insurance Plan?

A: The Pre-Existing Condition Insurance Plan (PCIP) provides health coverage for people who have a pre-existing medical condition and have been uninsured for at least six months. You must also be a U.S. citizen or be lawfully present in the U.S. to be eligible to enroll. The PCIP is one of the first major expansions of health care coverage for people who are uninsured. For more information about enrolling in PCIP, go to www.PCIP.ca.gov.

Q: Who is eligible to participate in the PCIP?

A: There are three criteria that must be met:

- You must be a U.S. citizen, U.S. national or lawfully present in the United States.
- You must have been uninsured for at least six months.
- You must have a pre-existing condition.

Q: How do I enroll in PCIP?

A: To apply for PCIP, you must submit all of the following:

- A completed and signed application form;
- A copy of documentation of citizenship or legal presence in the United States; and
- Evidence that you were denied coverage due to your preexisting conditions or evidence of your pre-existing condition

For more information and to download an application, visit www.PCIP.ca.gov.

Q: What if I have not been without coverage for six months or if I am not eligible for PCIP?

A: There is a second plan in California, the Major Risk Medical Insurance Program (MRMIP) that you may qualify for. You can find out more information at www.PCIP.ca.gov or by calling 1-800-289-6574.

Q: Can health plans still limit or exclude coverage for pre-existing conditions?

In California, group health plans can limit or exclude coverage for pre-existing conditions for adults (age 19 and older) for up to six months from the date coverage begins.

If you are an adult enrolling in individual coverage, your plan can still exclude or limit coverage for a pre-existing condition for up to 12 months if your plan contract covers one or two people. If your plan contract covers a family of three or more, the limit can apply to you for only six months from the date your coverage begins.

If you are trying to enroll your adult child (19-25) as a dependent under your individual coverage, the health plan may deny enrollment to adult children based on pre-existing conditions or health history.

Special rules apply to pre-existing condition exclusions for children under the age of 19, explained below.

Q: What if my child has a pre-existing condition exclusion under his/her current coverage?

A: If your child (under the age of 19) is enrolled in a group health coverage plan, the health plan cannot exclude coverage for a child's pre-existing condition.

If your child was enrolled in an individual health coverage plan before Sept. 23, 2010, any pre-existing condition exclusion should have already expired.

If you purchased a new individual health coverage plan for your child on or after Sept. 23, 2010, the health plan cannot apply any pre-existing condition limitation to your child.

Q: Does a health plan have to enroll my child in individual coverage if we apply at any time of the year?

A: Yes, your child can apply for individual coverage at any time. Beginning Sept. 23, 2010, no child under age 19 can be denied coverage because of a pre-existing condition. Health plans must offer individual coverage to children under the age of 19 year-round.

While your child can apply for coverage at any time, the premium rates may be lower if you apply during "open enrollment." A child's open enrollment period occurs every year during his or her birth month. California law does not limit the premiums that health plans charge to a child if he or she applies for coverage outside of open or special enrollment periods.

If you enrolled in individual coverage and you are trying to add your adult child (age 19-25) as a dependent, the health plan can deny coverage to your adult child based on his or her pre-existing condition or health history. The health plan could also choose to enroll your adult child, but with a pre-existing condition exclusion (for up to 6-12 months).

Q: How much do I have to pay for preventive care?

A: Health plans cannot charge you for certain preventive services received within the plan's provider network. Those services can be found at: www.HealthCare.gov/prevention/index.html.

Q: What if I am charged for a preventive care item or service that I think should be free?

A: First, contact your health plan to file a complaint. You can do this over the phone, in writing or online. If your health problem is urgent, or if you already filed a complaint and are not satisfied with your health plan's response, contact the Consumer Assistance Program at 1-888-466-2219 or www.HealthHelp.ca.gov to get help.

Q: Can I be charged for preventive services received from out-of-network providers?

A: Yes. A health plan may charge you for preventive services you receive from out-of-network providers.

Q: I am pregnant. Are prenatal and preventive services covered?

A: The Affordable Care Act requires health plans to cover certain preventive services for pregnant women at no cost. To learn more about these free preventive services, visit www.HealthCare.gov/prevention/index.html.

Q: I am concerned about cancer. Does the Affordable Care Act provide for cancer prevention?

A: Health plans must cover a variety of important cancer prevention services at no cost. These include:

- Breast cancer screening: Mammograms every 1 to 2 years for women over 40, referrals for genetic counseling and chemo prevention discussion for women at increased risk
- Cervical cancer: Regular Pap smears and coverage for HPV vaccine coverage
- Colon cancer: Screening for adults over 50
- Tobacco cessation

Q: I think I may be HIV positive.

A: Health plans must cover HIV screening tests at no cost.

The Affordable Care Act:
Pre-Existing Condition Insurance Plan (PCIP) FACT SHEET

The Patient Protection and Affordable Care Act provides you and your family with new protections, programs and resources. One new program that began in October 2010 is called the Pre-Existing Condition Insurance Plan (PCIP), a health insurance program for people with pre-existing medical conditions.

What it Means for You

The PCIP offers health coverage to uninsured individuals with pre-existing health conditions. The monthly premiums for PCIP may be lower than premiums for similar individual coverage in the private market. The California PCIP is run by the Managed Risk Medical Insurance Board (MRMIB) under a contract with the federal government.

To qualify for PCIP, you must also meet the following eligibility requirements:

- Be a California resident.
- Have no health insurance coverage for the past six months. This means in the last six months you were not enrolled in any individual or job-based health plan, including COBRA or Cal-COBRA, Medicare Part A and/or Part B, or in Medicaid/Medi-Cal.
- Be a U.S. citizen, U.S. national, or lawfully present individual in the United States.
- Have a pre-existing condition, as shown by:
  - A denial letter from a health insurance company or health plan dated within the last 12 months, or
  - A letter from a licensed doctor, physician assistant, or nurse practitioner dated within the past 12 months, stating that the individual has or had a medical condition, disability or illness, or an offer of individual (not group) health coverage with higher premiums than the Major Risk Medical Insurance Program (MRMIP) preferred provider organization (PPO) rate in the area where you live. The offer letter must be dated within the last 12 months, or
  - A certificate of creditable coverage letter issued by another state or federally administered PCIP program showing previous enrollment within the past six months (see page 20 of the PCIP/MRMIP Handbook for more details).

It's easy to apply:

- Call 1-877-428-5060 to ask for an application
- Talk to an insurance agent or broker who can help you apply, or
- Visit www.PCIP.ca.gov

Key Dates

The program will last until Dec. 31, 2013, after that date, health plans will not be able to deny coverage to individuals with pre-existing conditions.

For More Information: For assistance, call the Help Center at **1-888-466-2219**, email us at **helpline@dmhc.ca.gov** or log onto **healthhelp.ca.gov**.

DEPARTMENT OF Managed HealthCare

The Affordable Care Act:
Curbing Insurance Rescissions and Cancellations FACT SHEET

The Patient Protection and Affordable Care Act provides you and your family with new protections, programs and resources. The Act prohibits a health insurer from cancelling coverage for honest mistakes on applications or medical history questionnaires.

What it Means for You

Under California and federal law, a health plan cannot rescind or cancel your coverage simply because you made an honest mistake on your application or about your health history.

A rescission means a health plan declares your health plan contract or policy invalid from the day it began.

California health care consumers have been protected from inappropriate rescissions for many years. The federal law provides similar protections to all Americans. The new law also limits the reasons for which a health plan can cancel your coverage going forward.

This provision applies to all health plans and types of coverage, including employer-based group health plans and individual health insurance coverage purchased for you and your family.

Your health plan can rescind your health coverage if you intentionally put false or incomplete information in your application. If the health plan rescinds your coverage, you may be required to pay back all of the money the health plan spent on your medical care.

If your health plan determines that you intentionally put false or incomplete information in your application, it must give you at least 30 days' notice before it can rescind your coverage. This allows you to appeal the decision or find new coverage without a lapse.

You can appeal a rescission of coverage by contacting the DMHC Help Center at 1-888-466-2219 or helpline@dmhc.ca.gov.

Key Dates

This provision applies to "plan years" or "policy years" that began on or after Sept. 23, 2010. A plan or policy year refers to a 12-month period of benefits coverage – which may not be the same as the calendar year. Check with your plan to find out when your plan or policy year begins.

For More Information: For assistance, call the Help Center at **1-888-466-2219**, email us at **helpline@dmhc.ca.gov** or log onto **healthhelp.ca.gov**.

DEPARTMENT OF Managed HealthCare

The Affordable Care Act:
Ensuring Your Right to Appeal Health Plan Decisions

FACT SHEET

The Patient Protection and Affordable Care Act provides you and your family with new protections, programs and resources. Under federal and California law, health plans must have an internal review process through which you can appeal a health plan's decision. If you are not satisfied with the outcome of the internal appeal, then you can get an external review by an independent reviewer who is not part of your health plan.

What it Means for You

Before the law, some health plans in California were not required to allow consumers to appeal health plan decisions to an independent reviewer.

If certain health plans denied a treatment you needed or refused to pay for a service you received, there was no standard process for an internal or external review of that denial. You had to accept the health plan's decision.

Now, most health plans that are not "grandfathered" will be required to follow new rules regarding appeals.

These rules allow you to have a health plan's denial of care or treatment reviewed by the health plan within 30 days (or within three days if your issue is urgent). This is called an "internal review."

Your health plan must inform you in writing of your right to appeal when it denies a service or treatment.

If you are not satisfied with the health plan's internal review decision, you have a right to have the denial reviewed by an independent physician who is not a part of your health plan. This is called an "external review."

The health plan must follow the independent external review decision.

Both the internal and external reviews are free to you.

The new law does not make any changes to the Medicare or Medi-Cal appeals processes.

Key Dates

For consumers in self-insured Employee Retirement Income Security Act (ERISA) group health plans, this protection starts with plan years that began on or after July 1, 2011.

For most other Californians in individual or employer-sponsored health plans, this protection has been in place for many years through California's Independent Medical Review (IMR) laws.

For More Information: For assistance, call the Help Center at **1-888-466-2219**, email us at **helpline@dmhc.ca.gov** or log onto **healthhelp.ca.gov**.

DEPARTMENT OF Managed HealthCare

The Affordable Care Act:
Grievance/Appeal Form

FORM GA1

1 Member information (Member complete this information)

Last name

First name

Middle initial

Member identification number

Street address

City

State

Zip Code

Daytime telephone number ( )

Evening telephone number ( )

Name of person filing grievance/appeal *(If other than member)*

Last name

First name

Middle initial

2 Patient information (Complete only if patient is NOT the member)

Last name

First name

Middle initial

Member identification number

Street address

City

State

Zip Code

Daytime telephone number ( )

Evening telephone number ( )

Name of person filing grievance/appeal *(If other than member)*

Last name

First name

Middle initial

3 Grievance/Appeal information

Please describe the specific details of the problem you are having with your health plan, medical group or provider. *(Use a separate sheet if needed and attach copies of supporting documents if available)*

4 Resolution

Please specifically describe how you would like your grievance resolved.

Expedited appeal

☐ If this situation is a serious or imminent threat to your health and you want an expedited appeal, check here.

(You may call your health plan and request an expedited appeal over the phone)

5 Medical Release

I am asking my health plan to review my grievance. I allow my providers, past and present to release my medical records to my plan. These records may include medical, mental health, substance abuse, HIV, diagnostic imaging reports, and other records related to my grievance. These records may also include non-medical records and any other information related to my grievance. I allow my plan to review these records and information. My permission will end one year from the date below, except as allowed by law.

Patient or Parent signature

Date

For More Information: For assistance, call the Help Center at **1-888-466-2219,** email us at **helpline@dmhc.ca.gov** or log onto **healthhelp.ca.gov**.

DEPARTMENT OF Managed Health Care

The Affordable Care Act:
Grievance/Appeal Form Notes

FORM GA1

Instructions

You may use this form to file a complaint or appeal with a health plan.

Don't wait long to file! Most plans require you to submit your complaint within 180 days of the denial of service.

Attach copies of documents related to the complaint, such as denial letters from the health plan or medical group, bills for health care services you think should be paid by the health plan, explanations of benefits describing how a claim was paid or denied by the health plan, and any medical records from non-contracted providers. Do not send original documents or letters.

Mail or fax this form and any supporting documents to the health plan's Grievance and Appeals department. You may be able to file a complaint on-line through your health plan's web site.

You may call the health plan if you want to file an expedited appeal. You have a right to an expedited appeal if the health plan denial poses a serious or imminent threat to your health.

In most circumstances, your appeal will be reviewed by your health plan within 30 days, or within 3 days if it is an expedited appeal.

Your health plan will inform you in writing of the outcome of your appeal.

If you are not satisfied with the outcome of your appeal with your health plan, you may request an external review. The letter your health plan sends you about the outcome of your appeal will have information on where and how to request an external review.

Call California's Consumer Assistance Program at 888-466-2219 for more information on your external appeal rights.

Tips for filing an appeal with your plan

You can find your health plan's contact information on your health plan membership card or by calling the member services phone number listed on your membership card.

Clearly describe the problem you are having with the health plan, include dates, who you talked to and what they told you. It is important to describe the facts about your problem. If you have been denied medical care, describe why you need the care. You can ask your doctor to send a letter to the plan describing why you need the care.

Remain professional in your tone and state how you would like your appeal resolved.

If you are requesting an expedited appeal, make sure to describe why this is an urgent situation. Describe why waiting longer to receive the service or care could impact your health.

Include new information. If you have information that your health plan has not previously reviewed, such as results of lab tests or referrals from a doctor for a treatment or service, make sure to include this information in your appeal.

The Affordable Care Act:
"Grandfathered" Health Plans

FACT SHEET

The Affordable Care Act exempts most plans that existed on March 23, 2010 – the day the law was enacted – from some of the law's consumer protections. These plans are called "grandfathered" health plans.

What it Means for You

If you have health coverage through a plan that existed on March 23, 2010, your plan may be considered a grandfathered plan.

This is true whether you are covered by an individual health insurance policy that you had on that date or a job-based health plan that your employer established before March 23, 2010.

A grandfathered health plan isn't required to comply with some of the consumer protections of the Affordable Care Act.

Grandfathered plans can lose this status if certain significant changes are made that reduce benefits or increase costs to consumers.

If your plan loses its grandfathered status, all of the Affordable Care Act consumer protections will apply to you when your plan begins a new "plan year" or "policy year."

To find out if your health plan is a grandfathered plan:

- Check your plan's materials. Beginning with the first plan or policy year starting on or after Sept. 23, 2010, health plans must disclose their grandfathered status in any plan materials describing the plan's benefits that are distributed to beneficiaries or primary subscribers. These materials must also contain contact information for questions and complaints.
- Check with your employer or your health plan's benefits administrator. If you are in a group health plan, the date you joined may not reflect the date the plan was created. New employees and new family members may be added to a grandfathered group plan after March 23, 2010.

The following ACA provisions DO apply to grandfathered plans:

- Prohibition of rescissions
- Extension of dependent coverage (exception until Jan. 1, 2014 if dependent is eligible for own group coverage)
- Prohibition of lifetime dollar limits
- Restriction of annual dollar limits and no pre-existing condition exclusions for children under 19 apply to grandfathered group plans only

The following DO NOT apply to grandfathered plans:

- Coverage for recommended preventive services at no cost
- Elimination of pre-existing condition exclusion for children under 19 in individual plans
- Protection of choice of health care providers and access to emergency care
- New internal and external appeals regulations
- Rate review does not apply to grandfathered plans

If you experience significant changes in the benefits you receive or the costs you pay and you have a grandfathered employer-based group health plan, contact The U.S. Department of Labor for more information at 1-866-444-3273 or visit www.dol.gov/ebsa/healthreform.

For More Information: For assistance, call the Help Center at **1-888-466-2219**, email us at **helpline@dmhc.ca.gov** or log onto **healthhelp.ca.gov** .

DEPARTMENT OF Managed HealthCare

The Affordable Care Act:
No Limits on Your Health Benefits

FACT SHEET

The Patient Protection and Affordable Care Act provides you and your family with new protections, programs and resources. This law eliminates lifetime dollar limits or annual dollar limits on the essential health care benefits you can receive under your plan.

What it Means for You

Essential health care benefits include, but are not limited to, doctor office visits, hospital care and prescriptions.

Before the Affordable Care Act, many health plans could limit how much they would spend to cover your essential health benefits each year ("annual dollar limit"). Many health plans could also set a "lifetime dollar limit" on how much they would spend to cover your health benefits for the entire time you were enrolled in their plan. Anyone who had health care costs higher than these limits had to pay the amount that was over the limit.

The Affordable Care Act prohibits health plans from putting a lifetime dollar limit on your coverage. A health plan cannot limit the total it will spend to cover your benefits during the entire time you are enrolled in the plan. The new law applies to all employer-based group health plans ("group coverage") and all individual insurance coverage you purchased for you and your family.

The Affordable Care Act limits then phases out annual dollar limits a health plan places on most of your benefits (see below). Annual limits will be eliminated entirely in 2014.

This law applies to all group coverage and individual coverage purchased after Sept. 23, 2010. However, this new law does not apply to individual coverage purchased on or before March 23, 2010, known as "grandfathered" individual coverage. Your health plan must state in its plan materials if it is a grandfathered plan.

The new law does not require your plan or policy to eliminate annual or lifetime dollar limits on spending for non-essential health benefits. Federal regulations will define essential and non-essential health benefits.

Key Dates

Protections under the new law are effective as soon as you begin a new "plan year" or "policy year" on or after Sept. 23, 2010. A plan or policy year refers to a 12-month period of benefits coverage which may not be the same as the calendar year. Check with your plan to find out when your plan or policy year begins.

The new law phases out annual dollar limits for all plans except individual health insurance coverage purchased on or before March 23, 2010.

For health plan contracts and policies purchased on or before March 23, 2010, your health plan cannot have annual dollar limits on most benefits lower than:

- $750,000—for a plan year or policy year starting on or after September 23, 2010, but before Sept. 23, 2011.
- $1.25 million—for a plan year or policy year starting on or after September 23, 2011, but before Sept. 23, 2012.
- $2 million—for plan years or policy years starting on or after Sept. 23, 2012, but before Jan. 1, 2014.

No annual dollar limits will be allowed on essential health care benefits in a plan year or policy year that begins on or after Jan. 1, 2014.

For More Information: For assistance, call the Help Center at **1-888-466-2219**, email us at **helpline@dmhc.ca.gov** or log onto **healthhelp.ca.gov**.

DEPARTMENT OF Managed HealthCare

The Affordable Care Act:
Getting the Most Out of Your Health Care Dollar FACT SHEET

The Patient Protection and Affordable Care Act provides you and your family with new protections, programs and resources. The Act requires that most of your health care premium – or the amount you pay to a health plan to purchase coverage – is spent on providing care and quality improvement, not administrative costs. It also requires health plans and insurers to justify health care premium increases.

What it Means for You

To make sure insurance premium dollars are spent primarily on health care and improve the quality of the care received, the new law limits how much of your premium dollar health plans and insurers can spend on administrative costs, marketing and other non-health care-related costs. These percentage limits are also known as "Medical Loss Ratios" or MLR. If your health plan or insurance company spends more on administrative costs than the law allows, it must provide you or your employer a rebate, starting in 2012.

Generally, the law requires health plans and insurers to spend at least 80 percent of premium dollars on direct medical care and efforts to improve the quality of care provided. This applies to health insurance coverage purchased by small employers and individual coverage purchased by you for you and your family.

If you work for a large employer, the health plan must spend at least 85 percent of premium dollars on medical care and improvements on the quality of care.

If you work for an employer that is self-insured, your plan is not required to follow this premium dollar requirement and is not required to provide rebates.

Since Jan. 1, 2011, all health plans are required to post their rates on the Department of Managed Health Care's (DMHC) Rate Review website at http://wpso.dmhc.ca.gov/RateReview. Rate increases of 10 percent or more will also be posted to the federal government's national consumer website at HealthCare.gov. These sites can help you compare pricing.

The law also requires your health plan or insurer to justify unreasonable premium increases to the DMHC and Secretary of the U.S. Department of Health and Human Services.

Key Dates

If this protection applies to your plan, it will take effect when you start a new "plan year" or "policy year" on or after Jan. 1, 2011. A plan or policy year refers to a 12-month period of benefits coverage – which may not be the same as the calendar year. Check with your plan to find out when your plan or policy year begins.

The rebate program began on Jan. 1, 2011. Any rebates must be paid beginning in 2012. More details on the rebate program will be available on the DMHC website in the near future.

For More Information: For assistance, call the Help Center at **1-888-466-2219**, email us at **helpline@dmhc.ca.gov** or log onto **healthhelp.ca.gov**.

DEPARTMENT OF Managed HealthCare

The Affordable Care Act:
Resources for You

RESOURCE LIST

The Patient Protection and Affordable Care Act provides you and your family more freedom and control over health care choices. This resource list provides contact information for organizations dedicated to helping you better understand and navigate your health care coverage.

California Department of Managed Health Care

The California Department of Managed Health Care (DMHC) is the state agency that oversees health plans and protects the rights of health plan members.

1-888-466-2219

www.HealthHelp.ca.gov

California Department of Insurance (CDI)

CDI regulates, investigates and audits insurance businesses in the State of California. In most cases PPO, EPO, POS, indemnity and association plans are regulated by the CDI.

CDI Consumer Hot Line: 1-800-927-4357

www.insurance.ca.gov

Health Consumer Alliance (HCA)

HCA provides one-on-one assistance to low-income consumers in many counties. HCA offers services in multiple languages.

www.HealthConsumer.org

Health Insurance Counseling and Advocacy Program (HICAP)

HICAP provides counseling and advocacy for people who have or will soon have Medicare.

1-800-434-0222

www.cahealthadvocates.org/HICAP

Medi-Cal Managed Care Ombudsman

The Medi-Cal Managed Care Office of the Ombudsman helps ensure people on Medi-Cal receive all medically necessary covered services through their health plans.

1-888-452-8609 (many languages)

California Health Benefit Exchange

Starting in 2014, the Exchange will help individuals and small businesses buy affordable health coverage.

www.HealthExchange.ca.gov

Healthcare.gov

Provides information about the Affordable Care Act, insurance options, prevention and wellness.

www.HealthCare.gov

U.S. Department of Labor COBRA

Provides information on the Federal COBRA program to help you keep group health insurance if you lose your job or your hours are cut.

1-866-444-3272

www.dol.gov/dol/topic/health-plans/cobra.htm

U.S. Department of Labor HIPAA

Provides information on your Federal HIPAA rights to buy or keep health insurance.

1-866-444-3272

www.dol.gov/dol/topic/health-plans/portability.htm

Health Services Advisory Group (HSAG)

HSAG assists Medicare members with certain problems and appeals.

1-800-841-1602

www.hsag.com

Office of the Patient Advocate (OPA)

The OPA educates health care consumers on their rights and responsibilities and promotes transparency and quality health care by publishing an annual Health Care Quality Report Card.

1-800-466-8900

www.opa.ca.gov

For More Information: For assistance, call the Help Center at **1-888-466-2219**, email us at **helpline@dmhc.ca.gov** or log onto **healthhelp.ca.gov**.

DEPARTMENT OF Managed HealthCare