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KNOW WHY YOU HAVE THE STRONGEST CLAIMS FOR HEALTH SERVICES, TREATMENTS AND REIMBURSEMENTS

Teachers, Police Officers, Firefighters, Department of Water & Power Employees and other City, County and Municipal Employees Have Stronger Rights

Big Sticks Help You Negotiate With Big Corporations

You've heard the phrase "Speak softly and carry a big stick." It's often used to describe President Theodore Roosevelt's foreign policy and it implies that you're more likely to get what you're negotiating for when you have a big stick.

Most Private Company Employees Don't Have The Big Stick

Private employer sponsored health plans are governed by a federal law known as the Employee Retirement Income Security Act ("ERISA"). Public employees like you are generally **not** subject to ERISA. This law limits what a covered insured can recover if illegally denied a treatment or a claim. Under ERISA, you cannot recover for anything other than the cost of the treatment and potentially some attorneys' fees. You cannot recover for emotional distress, loss of income, or punitive damages. Although this might sound like a lot, litigating against a large health insurance company can easily cost over $200,000. This limit generally eliminates the likelihood of a lawyer taking your case on contingency.

Public Employees Have More Rights

Teachers, police officers, firefighters, department of water and power employees and other city, county and municipal employees are not covered under ERISA and have the "Big Stick." They can sue. The simple reality of being able to hire an attorney to fight for your treatment rights means you can change the world: at lease that part of the world that get's health treatment from your insurance company or provider.

What Minimum Health Benefits Are Required Under California Law

Obamacare Sets A New Universal Minimum Standard of Care	Laws in California require health insurance providers to provide minimum policy benefits. Under the Patient Protection and Affordable Care Act (commonly referred to as "Obamacare"), these basic minimum benefits are referred to as "essential health benefits." These benefits are as follows: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
Check Your Evidence of Coverage Section for Detailed List of Your Benefits	If you have a health plan through your employment with a public entity, such as teachers, police officers and fireman, then the best place to look for your benefits is in your Evidence of Coverage. Also, if you are looking to understand your Medicare benefits than the best resource is Medicare.gov, to understand your Veterans Affairs' benefits than the best place to look is VA.gov, and to understand Medi-cal then the best place it look is http://www.dhcs.ca.gov/services/medi-cal/Pages/MediBen_Svcs.aspx.
California Law May Add Additional Benefits	There are many benefits to which you can be entitled under your health plan policy pursuant to California law but which the policy does not explicitly describe. Health insurance companies and managed health plan providers will often deny coverage for such benefits and merely hope that the subscriber or insured is too ignorant to know their rights. This most commonly happens when a consumer seeks mental health treatment coverage.
Behavioral Health Treatments In California	In 1999, the California legislature passed a law most commonly referred to as the Mental Health Parity Act. The act requires health care plans and health insurance companies to provide coverage for the diagnosis and treatment of people with severe mental illness under the same terms that they apply to other medical conditions. Such severe mental illnesses include: Schizophrenia; Schizoaffective disorder; Bipolar disorder (manic-depressive illness); Major depressive disorders; Panic disorder; Obsessive-compulsive disorder; Pervasive developmental disorder or autism; Anorexia nervosa; Bulimia nervosa. This law requires insurance companies and health plan providers to provide treatment for persons with severe mental illness, regardless of whether or not that person's policy explicitly states that the policy provides such coverage. Despite this law, many health plan providers and insurance companies have patterns and practices of informing members and insureds that certain treatments are not covered because those treatments are not explicitly mentioned in the evidence of coverage.

Million Entitled To Autism Behavioral Therapies

For example, our offices represented some parents of children with autism spectrum disorder who sought medically necessary behavioral therapy from a large managed health care provider. We learned during the course of these lawsuits that the health care provider had explicitly taught their benefits representatives to tell inquiring members that the important treatment was not covered by the members' policies. However, under the Mental Health Parity Act coverage for the treatment was a necessity. It is for this reason that it is important to know your rights and to not accept any coverage determination that a managed health plan manager or health insurance companies makes just on its face.

If you're a teacher, police officer, firefighter, department of water and power worker or other city, county or municipal employee and in or near Los Angeles, and you're having trouble getting medical treatments call our office.

Things To Know About Appealing Your Health Insurance Claim, Treatment or Procedure When It Is Denied

Step 1:

Determine what type of insurance you have.

Before seeking to enforce your rights, you must know your rights. If you have a health care coverage agreement from a third party then the odds are you receive that coverage from a health insurance company, a managed health care plan provider, a self-insured association, or the government. The most straightforward way to determine what type of policy or plan you entered into is to check your enrollment form. An enrollment form is a document that one signs to give notice of their desire to participate in the benefits of a plan.

Step 2:

Understand your coverage.

Most plans have a Certificate of Benefits (also known as an Evidence of Coverage) that specifically describes the health care benefits covered by your health plan, or something similar. Check you documents or call your health plan and ask them where you can find a list of your benefits. Some States, like California, have laws like the Patient Protection and Affordable Care Act (commonly referred to as "Obamacare"), that defined minimum benefits. Obmacare under California law requires coverage to include "essential health benefits" that include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Step 3: *Benefits you may be entitled to not explicit in your policy.*	Health insurance companies and managed health plan providers will often deny coverage for such benefits and merely hope that the subscriber or insured is too ignorant to know their rights. This most commonly happens when a consumer seeks mental health treatment coverage. Certain autism treatments are also generally not explicit in an insurance policy, but may be required treatments under the law (as they are in California). These are trickier to determine and you should check with a lawyer or a large advocacy group in your State that fights for the treatment or services you're seeking.
Step 4: *Gather all information and documents about your claim or treatment denial.*	Document all communications that you have or have had with the insurance company or health plan manager. This means collect copies of all letters that the insurance company or health plan manager sent to you and all letters that you sent to the insurance company or health plan manager. If you had any phone conversations with the insurance company or health plan manager then be sure to keep a log of the time and date of the conversation, the name, title, and/or employee identification number of the person with whom you talked, and a description of everything that was said during the conversation. It is also necessary for you to collect as much medical evidence concerning your need for the treatment at issue as possible. This means gather copies of your medical records and all referrals from health care professionals. It is important that you learn the complete basis for the denial and have the insurance company or health plan manager commit to their position and reasoning in writing.
Step 5: *Internal appeals process.*	Insurance companies and managed health care providers have internal appeal processes that are required by law. We recommend highly that before you begin to learn about the appeal process of your specific insurance or managed health plan company that you contact a lawyer who is knowledgeable and has experience with health care coverage issues. A lawyer can advise you as to how to best structure your appeal so that you get the results that you deserve. Each insurance company and health plan manager has a different internal appeal procedure. You need to determine their appeals process and if you choose to appeal, as opposed to hire a lawyer, you need to follow their appeals process. If you write an appeal letter then the things that are important to include are your name, contact information such as your address and phone number, and information about your policy including the policy number, the group number, and the claim number. You should also include as much written evidence as you have such as doctors letters and medical records but always keep a copy of anything that you send. It is important to keep in mind that many companies have time limits for their internal appeal process. When you receive a denial of your coverage claim, you should immediately look into the time requirements for the internal appeal process so that you can determine by when you will have to file an appeal, should you choose to do so. If you miss these deadlines than you can lose your opportunity to have the denial appealed at all.

Step 6:

External appeals process.

It is possible that after the internal appeal process that your health plan provider or insurance company might reverse their earlier denial. However, if that is not the case then in California you have a right to have your claim reviewed by an independent body. Such an independent review can be incredibly helpful in getting your coverage denial changed but it is not something that you should automatically consider since it is not a prerequisite for seeking court intervention because of the bad faith denial. In some circumstances, it can be more efficient and beneficial to a person with a denied coverage claim to skip the independent review stage and simply file a lawsuit to get the coverage that they deserve. It is for this reason that if you have completed the internal review process and your denial was not reversed then you should contact a lawyer that specializes in bad faith health insurance to get advice as to whether an external review is the right path to take for relief.

If after consultation with an attorney, you decide that the best move for you would be to seek an external review then you must determine the proper entity from which you should seek the review. In California, the proper entity is determined by the type of coverage that you have. If you are member of a managed health care plan then you will seek a review from the Department of Managed Health Care ("DMHC"). Whereas, if you are covered by a health insurance company then you can seek a review from the California Department of Insurance ("CDI"). Both the DOI and the DMHC have similar appeal procedures.

After you determine whether your claim is regulated by the DMHC or the CDI, then you should visit the website for the particular agency that governs your claims' external appeal. The DMHC website can be found at: http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_forms.aspx. You can also call the DMHC at 1-888-466-2219. The website for the CDI is http://www.insurance.ca.gov/0100-consumers/0020-health-related/0010-consumer-provider-complaints/. You can also reach the CDI by calling them at 800-927-HELP (4357). Both the DHMC and CDI have detailed information for how to file a complaint for an external appeal but generally the information that you provide to them will mirror the information and documents you provide to your insurance company or health plan provider when you seek an internal appeal.

Step 7: Seeking court intervention.	If the external appeal does not result in a reversal of the coverage denial or if you decide to skip the external appeal then you also have the choice of filing a lawsuit against your insurance company or managed health care provider. The upside to a lawsuit is that it puts immediate pressure on your insurance company or managed health care provider. Insurance companies or managed health care providers who might have ignored you in the past will usually pay a lot more attention when a member has initiated a legal action. Further, a lawsuit can result in complete coverage for the medical treatment that you seek, in addition to the possibility of additional monetary awards due to the insurance company's or managed health care provider's bad faith in denying your claim. Most lawyers who specialize in bad faith health insurance coverage law take such cases on a contingency basis, meaning that they do not charge any money to a client but instead take a percentage of any recovery. As a result there is very little risk to you in bringing a lawsuit.

About Scott Glovsky

You've been harmed, injured or abused: call, it's free, and it might just change your life.

I fight for the justice you deserve	We may live in a "David vs. Goliath" world, but my firm is here to hold major corporations accountable for putting their bottom line profits ahead of peoples' lives. I am a skilled trial lawyer on a mission to make a real difference in my clients' lives, and change the system so that others will not needlessly suffer similar fates. My practice emphasizes civil trial law, including insurance bad faith, catastrophic personal injury, and health-related cases. Our insurance cases include fighting a wide range of battles with health, life, disability, property and liability insurers. We get justice for our clients and hold the wrongdoers accountable.
Cases & People That Make A Difference By Helping Others	Scott Glovsky is a nationally recognized victim's rights advocate. His cases have been covered by Oprah Winfrey, People Magazine, The Los Angeles Times, CBS Evening News, Michael Moore (Sicko) and hundreds of other media outlets.
Awards, Recognition & Achievements	Multiple multimillion Dollar Settlements & Awards President's Award of Merit – Consumer Attorneys' Association of Los Angeles California's Street Fighter of the Year – Trial Lawyer's Award Graduate of Gerry Spence's Trial Lawyer's College Southern California SuperLawyer (2006 – Present) Board Member – Consumer Attorneys of California

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