

Children Diagnosed With Cancer: Financial and Insurance Issues

When a child is diagnosed with cancer, families and parents will need to know about and cope with many problems. This document, which offers ideas for managing the costs of cancer diagnosis and treatment, is one in a series of documents for parents and caregivers of a child with cancer. The other documents have information on how to cope with the cancer diagnosis, understanding the health care system, returning to school, and the late effects of cancer treatment.

Covering the costs of cancer treatment

If your child has been diagnosed with cancer, how to pay for treatment is usually not the first thing that comes to mind. But having health insurance coverage for cancer treatment and all of the needed follow-up care is critical.

Some people must work out money issues before their child can even start treatment. For others, it can become a problem after treatment begins. Either way, it takes time and energy to manage medical bills, insurance, and finances when your child has cancer.

Here, we'll look at some of the new and existing resources that may be available to help families of children with cancer afford the care the child needs. Some of these resources can be especially helpful if your child isn't covered by health insurance. They include government programs that help low income families, disability benefits, and aid from voluntary organizations.

Even if your child has health insurance, you'll find that it doesn't cover all the costs involved. There are many extra expenses that come with illness. For instance, transportation, a place to stay while your child is being treated, food, and child care for other children in your family are not part of your health plan. A parent may have to take unpaid time off work or give up a job because of treatment schedules. (See our document, *Family and Medical Leave Act* for more about taking time off but keeping your job.) One or both parents missing time at work may cause a serious loss of income. Even if your child is well-insured, cancer can cause financial problems.

It's important to have accurate, up-to-date information and a good understanding of your financial situation and your child's insurance coverage. And, if health insurance costs are not deducted from your paycheck, it's important to pay the monthly insurance premiums on time to keep the coverage your child has. Having no health insurance can be scary, but there are still options.

Here, we'll cover:

• Private health plans or health insurance

- Government programs
- Options if your child is uninsured
- Getting help with living expenses
- Other resources

Private health insurance options

The new health care law known as the Affordable Care Act (ACA) is intended to make private health insurance more affordable for people with cancer in the family. The law also ensures that most insurance plans cover the health care needed by cancer patients and survivors. This section looks at the law's impact on different types of private health insurance.

For an overview of the new law, please read our brochure called *The Health Care Law: How It Helps People With Cancer and Their Families*. You can also call us anytime at 1-800-227-2345 for the most up-to-date information.

Group health plans

Many people get health insurance coverage for their dependent children by listing them as beneficiaries on their own employee plan, so that they are covered by insurance through a group plan offered by their employers. Under the new health care law employers with more than 50 full-time workers must offer health insurance or pay a penalty. Employees whose health insurance is too expensive (more than 9.5% of their household income for just the employee's coverage) can look into buying an individual plan in their state's marketplace. Some of these people will qualify for financial help to pay for a marketplace insurance plan. (See "Where to get private individual coverage: the health insurance marketplace" in this section.)

Group health plans cover a group of people, usually employees of the same company, and many plans cover their dependents, including children. Generally, employers must offer health coverage to full-time employees. Some employers pay part of employee health care *premiums*, which are the monthly payments for coverage.

Most people who get health insurance through their jobs will continue to do so under the new health care law. If your employer charges less than 9.5% of your household income for single coverage (insurance that covers just you), it's likely you won't qualify for financial help to buy an individual plan to cover you and your family in the marketplace.

If you find it hard to afford the amount your employer charges for a plan that covers your children, you may want to contact your state marketplace to find out if your children might get coverage there at a lower cost (see "Individual health plans" below). You can also find out if your children qualify for any special programs such as CHIP or Medicaid. For more on these programs, see "State-sponsored children's health insurance programs (CHIP)" and "What is Medicaid" in the section called "Government-funded health plans."

Some group plans are grandfathered

If you are still in a group plan that your employer had in March 2010, certain limits on health insurance might be allowed because the plan is "grandfathered." Check with your insurance administrator at work or look at your Summary of Plan Benefits to learn when your plan started and find out if it's grandfathered. Grandfathered group plans don't have to meet all the requirements of the new law, even if your employer is still enrolling new people in them.

Individual health plans

Individual health plans are sold by insurance companies directly to a person, not through an employer. Some individual plans also cover family members or dependents. It's important to know that even though it's called an individual plan, it can still cover your family. The name refers to how you buy it rather than how many people it covers.

For many years, individual health plans could vary a lot by the types of health care services they covered, the amount of care they would pay for, how much they charged, and the types of people they covered. For example, insurance companies could look at your personal and family health history, and require physical exams or lab tests before deciding whether to insure you or your family. Based on the results, they could decide not to offer you a health plan, or they could charge you higher monthly premiums than they did to younger, healthier people. They could require people who were sick or injured to pay more for their care or turn them down for coverage altogether. They also offered different levels of coverage, with many plans not covering the care needed by someone with a serious illness like cancer.

Parts of the new health care law call for major changes in individual health plans. The law is designed to improve the coverage these plans offer and make these plans more affordable for people with cancer or other serious illnesses. For instance, the law:

- Requires health plans to cover children and adults with a pre-existing condition such as cancer (Pre-existing conditions are illnesses that a person has before getting health insurance.)
- Prohibits insurance plans from canceling coverage if the patient gets sick
- Requires that most individual health plans cover 10 categories of essential health benefits
- Prohibits annual and lifetime dollar limits on the amount of a patient's care the plan will pay for, in plans that started on or after January of 2014
- Requires insurers to provide current policyholders and people shopping for coverage with a short and simple summary of their coverage
- Allows young adults to stay on their parents' health insurance until age 26
- Makes sure that patients who take part in clinical trials are covered for their other health needs
- Provides financial help to low- and middle-income people when health coverage through their employer is unavailable or unaffordable, so that they can buy individual insurance in the health insurance marketplace. (It's important to know that affordability is calculated by the cost of an individual policy rather than a family policy.)

• Requires most Americans, even children, to have health insurance unless the family income is very low or there are special exemptions for each family member. (If a child is uninsured and doesn't have an exemption, parents pay a penalty with their income taxes.)

Grandfathered individual health plans and cancellations

Individual health plans that do not meet the requirements of the new law, including those listed above, can continue <u>only</u> if they existed before the law was signed in March 2010. (These are called "grandfathered" plans.) If you bought a new individual policy in or after January 2014, it must meet all the new law's requirements. If you bought one between those dates, it must meet most of the new health care law requirements but there are a few limits it might have.

Unless a health plan stayed essentially the same after March of 2010 and became grandfathered, it must adapt to the law or be discontinued. This is one reason that many people across the country have received notices from insurers that their individual plan has been or will be canceled. State insurance commissioners now have the option of allowing health plans that were slated to be cancelled at the end of 2013 to be extended for another year. In states where insurance commissioners approve, insurers will have the option to continue these plans for current policyholders. Keep in mind that these plans can still discriminate based on health status or history by charging more or denying coverage, because they are not required to comply with all of the patient protections included in the health care law. If your child is covered under one of these plans, you may want to look at how well it meets your child's needs before you decide whether to keep it. Also be aware that these plans cannot continue to offer coverage beyond the end of 2015.

People facing the cancelation of their family coverage may have other options from their insurer, or they can look at plans sold in one of the new marketplaces.

Where to get private individual coverage: the health insurance marketplaces

You can buy health insurance coverage (online, by phone, by mail, or in person) through the health insurance marketplaces. All plans sold in the marketplaces must meet the requirements of the new law that make sure plans cover certain benefits. Costs are controlled, and patients get clear information about the coverage offered. Individual health plans can still be sold outside the marketplaces, but the financial help that the law provides to help low- and middle-income families pay for coverage is only available with marketplace plans.

If you are under 65 and can't get your child covered through your employer, you may be able to buy a health plan for your child through your state's health insurance marketplace. If you can't get coverage for yourself at work, there are plans on the marketplace that cover entire families. Lowand middle-income people and families may be able to get financial help through the marketplace to help them afford a plan. People with health coverage through work whose health care premiums are too high compared to their income may also be able to buy coverage through the marketplace.

The health care law requires that all health plans sold in a marketplace cover essential health benefits, such as cancer screenings, treatment, and follow-up care. Each state's marketplace puts the health plans into groups, or "tiers," based on the level of coverage they offer and their cost to consumers. The highest tier is platinum, followed by gold, silver, and bronze. The platinum level is more costly up front, but tends to pay higher percentages of your medical costs and has lower deductibles. The bronze level costs less, but the out-of-pocket costs are higher in case of an illness.

After you give your information, the marketplace will tell you if you qualify for financial help to buy a plan. Individuals who make up to \$45,960 per year and families of 4 with a combined income of up to \$94,200 a year should qualify for help buying a health plan through the marketplace. The marketplace will also tell you if your child qualifies for Children's Health Insurance Program or for Medicaid. See "State-sponsored children's health insurance programs (CHIP)" and "What is Medicaid" in the section "Government-funded health plans" for more on this. The law gives states the choice to enroll more people in Medicaid coverage than ever before, but not all states have decided to do so. For details on whether your child might qualify, visit www.healthcare.gov, or find your state marketplace by calling 1-800-318-2596.

Enrolling in a marketplace plan

Enrollment in the marketplaces for private, individual health plans began October 1, 2013. People who enrolled by Dec. 24 had coverage as of January 1, 2014. The first marketplace open enrollment period ends March 31, 2014. Another open enrollment period will begin in November 2014, though people with a life-changing event such as job loss, divorce, moving out of their plan's service area, or the birth of a child can enroll in a marketplace plan at times outside of the open enrollment period. You have up to 60 days after the event to enroll in a marketplace plan. There are a few ways to enroll:

- Visit www.healthcare.gov, the federal government's official marketplace website. Whether your state offers the federally run marketplace or is operating its own marketplace, you'll be directed to the right website through www.healthcare.gov.
- Call the federal toll-free number, 1-800-318-2596, to enroll over the phone (TTY: 1-855-889-4325). Information about your state's marketplace and the plans sold on it is offered 24 hours a day, 7 days a week in more than 150 languages.
- Apply in person with the help of a trained counselor in your community. Find help in your area online at https://localhelp.healthcare.gov.
- Complete a paper application and mail it in. You can download the paper application form and instructions from www.healthcare.gov.

When the state marketplaces opened in October 2013, some had technical problems that made it difficult to use their websites to enroll in a plan. Most of these problems have since been fixed. If you have problems with online enrollment for any reason, it might be best to choose one of the other options, such as phone, mail, and in-person enrollment.

Private individual plans that aren't part of the marketplace

People will not have to buy health insurance from the marketplace, but it will be the place to go if you're looking for cost reductions and tax credits to help pay for insurance to cover you and your family. If you go to a private broker or some other non-marketplace source, you can't qualify for financial assistance buying your plan. Be sure that the plan you buy meets the minimum essential coverage requirements, otherwise you could end up paying a penalty at tax time.

Types of private health plans for children

There are many different types of health insurance and health service plans. Most insurers work to contain costs by requiring that hospital admissions, tests, treatment, and specialized care be

approved ahead of time (pre-approved, pre-authorized, or pre-certified). Insurers often limit benefits and pass along some of the costs to their enrollees and beneficiaries. Families must be ready to deal with many phone calls, lots of paperwork, ongoing follow-up, and careful record keeping. This is a lot to add to your schedule. And it's even harder when you are worried about your sick child and all the other problems illness can cause.

Here are very brief descriptions of plans that are used most often:

Managed care plans

These types of plans typically coordinate or "manage" the health care of enrollees. There are different types of managed health care plans. Some plans – like health maintenance organizations or HMOs – have a more limited network of providers and hospitals while other models like Preferred Provider Organizations (PPOs) have a wider provider network.

Most managed care plans have lower premiums and co-payments (co-pays) than traditional feefor-service insurance. Co-insurance may also be less.

Co-payments or **co-pays** may also be called *co-insurance*. This is the amount you must pay at the time of service, usually a flat fee for office visits or other services.

Co-insurance may be a percentage of the bill you must pay even after you've paid the yearly deductible amount.

Premiums, co-pays, and co-insurance amounts can differ between managed care companies and even between services within the same company. There's usually no need to file claim forms.

Some managed care plans require members to use a primary care provider who coordinates all of the patient's care and serves as a "gatekeeper" for care from specialists. The gatekeeper is usually a primary care doctor who's responsible for the overall medical care of the patient. This doctor organizes and approves medical treatments, tests, specialty referrals, and hospitalizations. For example, if your child needs to see an expert like a lung specialist, you would need a referral from the primary care doctor before a specialist sees the child. Otherwise your plan may not pay.

Under most managed care plans, members must use only the services of certain providers and institutions that have contracts with the plan. Some plans do not require prior approval (also called *pre-authorization*), but do require that members choose to get their care from a list or network of providers. When parents choose to go outside the network for their child's care, they generally have to pay more, or even pay for the full service with no help from their health insurance plan.

Many different types of institutions and agencies sponsor managed care plans, not just insurance companies. These include employers, hospitals, labor unions, consumer groups, the government, and others. It helps to know all the ins and outs of the plan and how it will affect your child's care.

These are the most common types of managed care plans:

• **Health maintenance organizations (HMOs):** An HMO will usually cover most expenses after a modest co-pay. HMOs often limit your choice of providers to those in their *approved*

provider network. This means you have to check their listing to be sure the doctor you want your child to see is one of their doctors. If not, the bill may not be covered in full, and you may have to change to a different type of health plan to get that doctor's services covered. Or you might have to switch to one of the approved doctors on their list.

- Point of service plans: A point-of-service plan (POS) is a type of HMO. The primary care doctors in a POS plan usually refer you to other doctors in the plan or network. If your child's doctor refers you to a doctor who isn't in the plan (he's out of network), the plan will still pay all or most of the bill. But if you choose to take your child to a doctor outside the network, you will have to pay co-insurance, even if the service is covered by the plan. Co-insurance is usually a certain percentage of the cost for each service. For example, the insurance company may pay 80% of the bill and you have to pay the other 20%.
- **Preferred provider organizations:** The preferred provider organization (PPO) is a hybrid of fee-for-service and an HMO. Like an HMO, there are only a certain number of doctors and hospitals your child can use to get the most coverage. When your child uses those doctors (sometimes called *preferred* or *network* providers), most of the medical bills are covered. When you don't use these providers, the PPO makes you pay more of the bill out of your own pocket. So you pay more to choose providers that are not in the network.

Getting the most from your managed care plan: Sometimes you must go out of network for your child's care. You may be able to reduce your costs if you discuss and negotiate costs up front with doctors, clinics, and hospitals when surgery, procedures, or other treatments are planned. You can start with the billing department to find out the usual costs of the treatment your child needs. You may want to contact your insurer to find out what the company will pay and how much you'll have to pay. You can use this information to find out if the medical facility or clinic will be willing to accept the amount paid by insurance as full payment. If not, ask if they're willing to discount the portion you have to pay.

Fee-for-service plans

Fee-for-service plans are the least restrictive plans that offer the most choice in medical providers. They are also called *indemnity* or *traditional* health plans. If you have this type of health insurance, you can choose any doctor who accepts your particular health insurance plan, change doctors any time, and go to any hospital anywhere in the United States.

You pay a monthly fee, called a *premium*. Each year, you also have to pay a certain dollar amount of the medical costs (known as the *deductible*) for each family member before your insurance will start to pay. After you have met your child's deductible, your insurance will pay a set percentage of the medical bills for the rest of the year.

You might have to pay your medical bills yourself and then fill out forms and send them to your insurer to get reimbursed (paid back) for what you've already paid. If your doctor "accepts" your insurance, their office will often bill the insurance company for you, and then send you a bill for the amount your insurance didn't cover. Keep receipts of your child's drugs and other medical costs, and any payments made by you and your insurance company. This paperwork can help you greatly if there's a dispute about payments or other problems in the future.

After your stated deductible is met, the insurance company pays a percentage (70% to 80% is common) of the covered costs submitted to them. The percentage they pay is based on what they consider to be "usual, customary, and reasonable" charges (called *UCR charges*). The insurance

company decides what the UCR charge is. If your child's doctor charges more than the UCR, you may get a bill for the balance in addition to your usual co-pay percentage. This is called "balance billing."

Things to consider when shopping for health insurance

For children living with cancer it's especially important to choose the health insurance plan that best meets their needs. When comparing plans, consider a number of factors, including:

- What are the total benefits covered by the plan?
- What are all of the costs associated with the plan, including premiums, deductibles and copays?
- Are your child's providers included in the network of doctors and hospitals covered by the plan?
- Does the plan cover the prescription drugs your child takes?.

For more on selecting an insurance plan, see the section called "Options for uninsured children."

Other things to know about finding health insurance for children

Fake health insurance and other deceptions

There have always been people looking to profit from the needs and hardships of others. Now they're exploiting health care reform in many different ways. They may advertise on hand-lettered signs, post ads online, or go door to door. They may be completely fly-by-night or they may have a legitimate-sounding 800 number. But here are some basic approaches to watch for:

A common tactic is to offer a **stripped-down insurance policy** that doesn't meet the law's requirements for covering major illness.. These policies are cheap because they make you pay for most of your child's care. By the time you find out your child has a serious illness it may be too late to get real coverage.

Another way is to offer a **medical discount card** that gives you minor discounts but leaves the big payments up to you. Sellers might call this "coverage" or "protection," but it's neither. Discount cards can be helpful, but they don't take the place of health insurance.

Some offer completely **fake health insurance**. The seller takes your money and gives you a worthless piece of paper. They may promise lower rates if you buy now. The seller might say that they're "required" to offer this great, low-cost coverage by the Affordable Care Act. Sometimes scammers say that it's government-sponsored insurance or that they work for the government. Or they'll use a well-known insurance company's name, even though they don't work for the company.

Some fraudsters have gone to great lengths to create **websites that mimic official marketplace websites.** These sites are designed to fool people into thinking they are on an official marketplace site. They may offer anything from fake health insurance to a policy that doesn't cover serious illnesses. Be sure you are on www.healthcare.gov, your state's official website, or a site they refer you to before entering any personal information.

Identity theft scams

A final way that scammers exploit the ACA is a ruse to try to get your personal and financial information for identity theft. Some might even call and pose as government workers looking to "update" your information, asking for your date of birth, Social Security number, or bank account numbers. If you get such a call, notify the FTC online at www.ftccomplaintassistant.gov or call 1-877-FTC-HELP (1-877-382-4357).

How to spot scammers

Watch out for aggressive sales people, very low premiums, and a push for you to sign up right away. They may try to evade your questions, and often don't have the full policy details in writing. Some offer you coverage only if you join an association, union, or other group. You may not get an insurance card or policy for some time after you sign up, if ever. And when you file a claim, there's no response or a very slow response; when you call they explain it's a glitch or processing error – if they answer at all. Here are some tips to help you protect yourself.

- Don't give them money, but especially don't give them credit card information, birth dates, Social Security numbers, or bank account numbers unless you're sure of who they are and what you're getting.
- Read the policy line by line or have someone read it for you.
- Check out any association you have to join go online, be sure they have a street address, and find out if they have legitimate activity besides selling insurance.
- Call your state insurance department to be sure the plan is licensed in your state; also ask if the plan has had complaints made against it. (See the "To learn more" section to find your state insurance department.)
- Finally, check with your child's doctor and pharmacist to be sure they accept the plan.

Catastrophic coverage

Treating and managing most cancers costs a lot of money. Some insurance plans offer supplemental coverage called *catastrophic coverage* with high deductibles and fairly low premiums.

Catastrophic illness insurance is sometimes called a *hospital-only* or *short-term plan*. These plans often won't cover doctor visits, medicines, or routine care, but kick in when your child is hospitalized and has very high expenses. Depending on the policy, expect to pay a few thousand dollars for the deductible alone, some percentage of co-insurance on the rest of the bill, plus the total cost for any items and services not covered by the plan.

Even though they are called "hospital-only" the plans won't necessarily cover all or even most of your child's hospital bill. It's important to understand exactly what the plan will cover and not rely on a catastrophic plan for your child's primary coverage. These plans will not provide the coverage needed to treat a disease like cancer and do not meet the requirements of the health care law. If this is your child's only form of coverage, you will likely face a penalty at tax time unless the child is exempt from the requirement to have health insurance. (You can find out about exemptions at www.healthcare.gov/exemptions/.)

Catastrophic coverage plans may be offered in the health care marketplace for people with very low incomes or other hardships that exempt them from having to get standard health coverage. The marketplace plans have some advantages over the usual catastrophic coverage plans, in that they cover some preventive care. But a person who gets an exemption from buying a regular health plan can't get help paying the premiums for catastrophic coverage. And when there's a serious illness, the out-of-pocket costs with catastrophic plans can run very high. This is not a good option for a child with cancer.

Health Savings Accounts

If you have enrolled or plan to enroll in an insurance plan with a high deductible, you may be able to set up a Health Savings Account (HSA). You don't have to pay federal income taxes on the contributions you make to the HSA as long as the money is used to pay for qualified medical expenses. If you use it for anything else, you will be required to pay the tax and a penalty.

Note that an HSA is different from a Flexible Spending Account (FSA); for instance, you can have an FSA even if you don't have a high-deductible health plan. FSA funds are set up to be used for both medical and child care expenses. But the FSA money you don't use goes away at the end of each year, while the HSA money is yours until you take it out. For more information about setting up an HSA you can contact your employer, bank, or credit union.

Pre-existing condition exclusions

A *pre-existing condition* is a health problem that a person had **before** joining the health plan. Before the new health care law went into effect, health plans could impose a *pre-existing condition exclusion period* on patients, meaning that the patient would have to wait a certain amount of time before the plan would pay any health care costs related to the pre-existing medical problem. The wait could be as long as a year for employer plans, and some individual plans refused to cover certain pre-existing conditions such as cancer at all.

The current health law prohibits most health plans from imposing pre-existing condition exclusion periods, or from refusing to cover people with a pre-existing condition. But some health plans, including grandfathered plans that were in existence when the law was signed in March 2010, can still have exclusion periods for pre-existing conditions.

Grandfathered employer plans: Federal law has long prevented employers from applying exclusion periods for a pre-existing condition in certain situations, and this law still applies to grandfathered employer plans. You may be able to avoid the exclusion period in a grandfathered plan if you have had health insurance with a previous employer and have not been without health insurance coverage for more than 63 days. Some states require employer plans to cover pre-existing conditions even for people who were without insurance for more than 63 days. You can call the US Department of Labor at 1-866-444-3272 to find out more about your specific situation. (See the section called "The Health Insurance Portability and Accountability Act of 1996" for more information.) Note that employers can sign up new employees for grandfathered plans if the employer has had the plan since 2010, so you may need to ask if your plan is grandfathered.

Grandfathered individual policies: If you have a grandfathered individual plan, the pre-existing condition exclusion period could still be many years or even unlimited. Such plans can also continue to impose an *elimination rider* that keep that disease, body part, or body system from ever being covered by that policy. Grandfathered individual policies can't sign up new people, so this

only applies if you had an older policy that you were able to keep. (See "High-risk pools and Pre-Existing Condition Insurance Plans" in the section "Health insurance options for the uninsured.")

Grandfathered plans will be going away: The health care law defines grandfathered plans as those that were being sold when the law began to go into effect in March 2010. A plan can keep its grandfathered status only if it does not make a significant change to the coverage it offers or the prices it charges. Because health plans often change their coverage and/or price from year to year, many lose their grandfathered status over time. The total number of grandfathered plans is shrinking, and, with time, there will be few, if any, grandfathered plans left. If you've had your insurance plan since at least 2010, it's important to find out if it's a grandfathered plan.

National law prohibits discrimination based on genetic testing or test results

The Genetic Information Nondiscrimination Act (GINA) does not allow health insurers to turn down people or charge higher premiums for health insurance based on genetic information or the use of genetic services, such as genetic counseling. GINA defines genetic information as any of these:

- A person's own genetic tests
- The genetic tests of family members
- One or more family members with a genetic disease or disorder

GINA bars group health plans, individual plans, and Medicare supplemental plans from using genetic information to limit enrollment or change premiums. It also forbids these insurers to request or require genetic tests. GINA applies to all health insurance plans (including federally regulated plans, state-regulated plans, and private individual plans).

The law also forbids discrimination by employers based on genetic test results or genetic information. GINA states that employers must not discriminate on the basis of genetic information (no matter how they got the information) in hiring, firing, layoffs, pay, or other personnel actions such as promotions, classifications, or assignments.

You can learn more about GINA in our document called *Genetic Testing: Patient Privacy and Discrimination Considerations*.

Hospital indemnity policies and other supplemental insurance

Hospital indemnity policies, sometimes called *supplemental medical policies*, pay a fixed amount for each day a person is in the hospital. Not all indemnity policies cover children, and some that do pay a lower rate for days that children are in the hospital than they do for adults. There may also be a limit on the total number of hospital inpatient days a policy will pay in a calendar year or a cap on the total number of days it will ever pay. The money received from such policies can be used as the insured needs or wishes. It's often used for medical costs not paid by the insurance company, or the other expenses that families face when one member is ill.

These supplemental plans don't provide comprehensive coverage to treat a disease like cancer and they don't meet the health care law's requirement to have insurance. So, if this is your child's only form of coverage, you will likely face a penalty at tax time. You could also have to pay huge out-of-pocket costs if your child has a serious illness. This is not a good option as the only coverage for a child with cancer.

How to manage your child's health insurance

- **DON'T** let your child's health insurance expire.
- Pay premiums in full and on time. New insurance can be hard to get and can cost a lot.
- If you are changing insurance plans, don't let one policy lapse until the new one goes into effect
- Know the details of your child's health insurance plan and its coverage. Ask for a Summary of Benefits and Coverage (SBC), an easy-to-understand description of a plan's benefits and the costs you will have to pay. If you think your child might need more coverage than a plan offers, ask your insurance carrier if better coverage is available.
- When possible, call the insurer to make sure that any planned medical service (such as surgery, procedures, or treatments) does not require prior authorization.
- If a bill looks odd or wrong, make sure to call or email your insurer to avoid being mistakenly charged more than you should.
- Submit claims for all medical expenses even when you aren't sure they're covered.
- Keep accurate and complete records of claims submitted, pending (waiting), and paid.
- Keep copies of all paperwork related to your claims, such as letters of medical necessity, explanations of benefits (EOBs), bills, receipts, requests for sick leave or family medical (FMLA) leave, and any communication with insurance companies.
- Get a caseworker, a hospital financial counselor, or a social worker to help you if your finances are limited. Often, companies or hospitals can work with you to make special payment arrangements if you let them know about your situation.
- Send in your child's bills for reimbursement as you get them. If you become overwhelmed with bills or tracking your medical expenses, get help. Contact local support organizations, such as your American Cancer Society (ACS) or your state's government agencies, for extra help in finding resources.

Getting answers to insurance-related questions

Questions about health insurance coverage often come up during treatment. Here are some tips for dealing with insurance-related questions:

- Speak with the insurer or managed care provider's customer service department.
- Ask the cancer care team social worker for help.
- Hospitals, clinics, and doctors' offices often have someone who can help you fill out claims for insurance coverage or reimbursement. A case manager or a financial assistance counselor may be able to help guide you through what can be a complicated process.
- Talk with the consumer advocacy office of the government agency that oversees your insurance plan. (See the section called "Who regulates insurance plans?")

• Learn about the insurance laws that protect the public. Call your American Cancer Society National Cancer Information Center at 1-800-227-2345 and ask for the Health Insurance Assistance Service. You might also visit www.healthcare.gov/using-insurance/understanding/rights/index.html for more information.

Keeping records of your child's insurance and medical costs

It can be hard to keep track of the bills, letters, claim forms, and other papers that start flowing into your home after a child is diagnosed with cancer. But keeping careful records of medical bills, insurance claims, and payments helps families better manage their money and lower their stress levels. Some families already have a system for tracking their finances and records and only need to expand it and create new files. Others may have to come up with a plan to handle all of the paperwork. One method is to keep a simple notebook with tabs for each month. It's an easy way to track bills, insurance, Explanation of Benefits forms, and payments.

Record-keeping is also important for those who wish to take advantage of the deductions available in filing itemized tax returns. The Internal Revenue Service (IRS) has information and free publications about tax exemptions for cancer treatment expenses (see "To learn more"). The rules change from time to time, so the IRS is the best source of current information.

Records to keep

- Medical bills from all health care providers write the date you got the bill on each one
- Claims filed, including the date of service, the doctor, and date filed
- Reimbursements (payments from insurance companies) received and Explanation of Benefits (EOB) forms
- Dates, names, and outcomes of calls, letters, or emails to insurers and others
- Medical costs that were not reimbursed, those waiting for the insurance company's response, and other costs related to treatment
- Meals and lodging expenses
- Travel to and from doctor's appointments and treatments or the hospital (including gas, mileage, and parking for a personal car; and taxi, bus, medical transportation, or ambulance fees)
- Admissions, clinic visits, lab work, diagnostic tests, procedures, and treatment dates
- Drugs given and prescriptions filled

Tips for record-keeping

• Decide who will be the family record-keeper or how the task will be shared.

- Get the help of a relative or friend, if needed. This may be especially important for parents who are single or live alone.
- Set up a file system using a file cabinet, drawer, box, binders, or loose-leaf notebooks.
- Review bills soon after getting them and note any questions about charges.
- Check all bills and forms paid to be sure they are correct.
- Some people prefer to pay bills by check so they have a clear record of payment. If you pay bills online, you can save electronic copies of payment documents on your computer, or print out proof of payment.
- Save and file all bills, payment receipts, and Explanations of Benefits forms. If you use checks, your bank or credit union can tell you how to get copies of canceled checks if needed. If you have to get canceled checks or proof of online payments from banks or credit card companies, you may be charged a fee.
- Keep a daily log of events and expenses; a calendar with space for writing is useful.
- Keep a list of cancer care team members and all other contacts with their phone and fax numbers and e-mail addresses.
- Find out what's tax deductible and be sure to keep the originals of those records. (See the "To learn more" section for the IRS phone number.)

When you have problems paying a medical bill

Many families go through times when they find it hard to pay their bills on time. Most hospitals and agencies are willing to discuss and work with you to resolve these problems. To help keep a good credit rating, pay attention to notices that say the bill will soon be turned over to a collection agency. You want to avoid this if at all possible.

When a medical bill comes that can't be paid right away, families can:

- Explain the problem to the hospital or clinic financial counselor or the doctor's office secretary.
- Work out a payment delay or an extended payment plan.
- Talk with the team social worker about sources of short-term help.
- Think about asking relatives or friends to help out with money on a short-term basis.

Handling a health insurance claim denial

It's not unusual for insurers to deny some claims or say they won't cover a test, procedure, or service that doctors order. The new health care law gives consumers more information and the right to appeal a claim denial. For example, an insurer must notify you in writing of a claim denial within 30 days after a claim is filed for medical services you've already had, and within 72 hours for urgent care cases.

Under the new rules, health plans that are not grandfathered (those that began on or after September 23, 2010) must have an internal appeals process that:

- Allows consumers to appeal when a health plan denies a claim for a covered service or rescinds (takes back) coverage;
- Gives consumers details about the reasons for the denial of claims or coverage;
- Requires plans to notify consumers about their right to appeal and how to begin the appeals process;
- Offers consumers a way to speed up the appeal in urgent cases

If the insurer denies a claim, it must explain your right to appeal the decision. If you ask for it, they must give you all the information about the decision. Plans that were started before September 23, 2010 are still appealed under the old rules of coverage (grandfathered).

Before you appeal, you may want to take these steps:

- Ask your insurance company's customer service representative for a full explanation of why the claim was denied.
- Review your health insurance plan's benefits. You may need to look at the more detailed Summary of Benefits notice.
- If your child's plan is through an employer, contact the health plan administrator at work to find out more about the refusal.
- Ask the child's doctor to write a letter explaining or justifying what has been done or has been requested. Keep a copy of this letter in case an appeal is needed later.
- Ask your insurer if your employer's health plan is self-insured, and on what date the plan started. (This is to learn if the new law's requirements apply or if the plan is grandfathered.) This will help you figure out which rules apply and which appeals process to follow.
- Talk to your state insurance department or the agency that regulates your insurance company to verify that the insurance company has acted properly and that the denial has not been made in error. (See the section "Who regulates insurance plans?")

You can then re-submit the claim with a copy of the denial letter and your child's doctor's explanation, along with any other written information that supports using the test or treatment that's been denied. Sometimes the test or service will only need to be "coded" differently. If questioning or challenging the denial with these methods doesn't work, you may need to:

- Put off payment until the matter is resolved. Keep the originals of all the letters you get; your child's cancer care team may be able to help you make copies if you need them.
- Keep a record of dates, names, and conversations you have about the denial.
- Formally request an *internal appeal* (or *internal review*) by the insurance company. Complete any forms the insurer requires, or write them a letter explaining that you're appealing the insurer's denial. Include your name, claim number, and health insurance ID number, along with any extra information such as a letter from your child's doctor. Your child's cancer care team members may be able to help with this.

- You have 6 months (180 days) from receiving a claim denial to file an internal appeal.
- Find out if you live in one of the US states that also have a special Consumer Assistance Program (CAP) that can help you file an appeal. (You find out online at http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.)
- If you don't live in a CAP state, get help from the consumer services division of your state insurance department or commission. Check the blue pages of your phone book or contact the National Association of Insurance Commissioners online at http://naic.org/state_web_map.htm, or you can call them at 1-866-470-6242.
- Do not back down when trying to resolve the matter.
- Find out about getting an external review. (See "The external appeals process" below.)

The external appeals process

If your internal appeal is denied, you may be entitled to an independent *external review* by people outside of your health plan. Note that if your child has employer-sponsored coverage, you may have to file a second internal review before you can file for an external one. Check with your insurance company about the process. For urgent health situations, the timelines are shorter, and you may be able to ask for an external review at the same time you ask for an internal one.

Outside or commercial health plans: Most commercial health plans (those offered by insurance companies) take part in the federal external review process. Find out if your child's plan does, and if so, call the US Department of Health and Human Services at 1-877-549-8152 for an external review request form, or go to www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/csg-ext-appeals-facts.html to learn more about appeals.

Self-insured health plans: If your plan is self-insured (see section "Who regulates insurance plans?"), you can ask your insurer how to start an independent external review. Or you can contact the Employee Benefits Security Administration at the US Department of Labor. You can find contact information in the "To learn more" section.

If all the internal and external appeals are exhausted, and the claim is still denied, ask the health care provider if the cost of the bill can be reduced. Many providers are willing to reduce the bill to get paid faster.

Keeping employer-sponsored health insurance coverage

There are federal laws which give people the chance to continue employer-sponsored medical insurance coverage (including for their children) when a person has a *qualifying event* (defined below in the COBRA section). For many people COBRA can be a good option, but for others it may cost less to buy an individual plan to cover yourself and your family on the state health insurance marketplace. You may also qualify for financial help in buying a marketplace plan, especially if your family income has dropped with the job loss.

COBRA (Consolidated Omnibus Budget and Reconciliation Act of 1986)

COBRA gives you, your spouse, and/or your dependents the right to keep your health insurance coverage at the employer's group rates. But because the employer usually covers a portion of the plan cost when you're employed, you usually pay much more than you did while employed. You must now pay the portion that your employer paid plus a small administrative fee. In most cases, you can keep the insurance for up to 18 months. Some people may be able keep it for their child a few months longer.

The new health care law now offers another option besides COBRA. You have the option to purchase new coverage through the state health insurance marketplaces. The marketplace plans may offer more affordable coverage options for you and your family than an employer plan through COBRA. Even if you lose your job at a time the marketplace does not have open enrollment, you have 60 days in which you can buy a marketplace plan. See "Enrolling in a marketplace plan" in the "Private health insurance options" section for details.

For those who don't want to use a health insurance marketplace plan, COBRA is still available when coverage would normally be lost because of *qualifying events*, such as

- Stopping work
- Reducing work hours
- Divorce or legal separation
- The covered person becomes eligible for Medicare
- A dependent child is no longer considered a dependent according to the terms of the plan
- Death of the employee

How long COBRA allows people to keep their group medical insurance depends on the qualifying event. For example:

- Up to 18 months of continued coverage is allowed if you stop working or reduce the number of hours you work.
- 29 months of coverage is possible if a beneficiary is considered disabled. (This determination of disability is made by the Social Security Administration.)
- 36 months of coverage is available for the spouse or child in cases of divorce or legal separation, the covered person becoming eligible for Medicare, death of the employee, or when a dependent child is no longer considered to be a dependent.

If a person is fired for gross misconduct, he or she is not eligible for COBRA – and neither are their children or spouse.

COBRA is not given automatically but must be chosen by the former employee or beneficiary within 60 days of getting the written COBRA "election notice." (This is not always within 60 days of when you stopped working.) The employer must notify an employee in writing that COBRA is available after work is stopped or hours are reduced. If you elect to keep your and your

dependents' insurance through COBRA during that 60 days, it will retroactively cover back to the date the insurance ended.

But there's also a deadline for notifying the plan administrator of qualifying events that don't directly involve the employer, which varies according to the qualifying event. Whose responsibility it is to notify the plan administrator also depends on the qualifying event. In cases of family changes, the beneficiary must do it, for instance, in these situations:

- Divorce
- Legal separation
- An employee's child reaches the status of non-dependent (which can be up to age 26)
- The employee becomes eligible for Medicare

This means it may be the employee, the employee's spouse, or the employee's adult child who needs to notify the plan administrator of a qualifying event. If this notice is not given within the deadline, the spouse or child may lose their COBRA rights.

If coverage for dependent(s) is ending for any of these reasons or because of the employee's death, their coverage may be continued for up to 36 months. Contact the employer's human resources person, the insurance company, or check the policy to find out what must be done and who should do it.

You can keep your health insurance 1) if the premium is paid, 2) until you, your child, or your spouse becomes covered under another group policy, but 3) only up to a certain time limit.

Premiums cannot be more than 102% of the cost of the plan for employees in similar situations who have not had a "qualifying event."

COBRA coverage may be lost if your former employer stops offering all health insurance coverage.

COBRA is overseen by the US Department of Labor and they can give you more detailed information on how it works. (See the "To learn more" section.) Families often are concerned about being able to pay the premium for COBRA. If this is the case, talk to your health care team social worker who may have suggestions about how to get help with these costs.

For more details, read our document called What Is COBRA?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This is a federal (US) law with many clauses that can help parents of children with cancer. The 2010 health care law no longer allows pre-existing condition exclusion waiting periods in most plans. The HIPAA rules about pre-existing conditions now only apply to grandfathered health plans that already existed when the new health law went into effect in March 2010.

Here are the ways HIPAA may help you:

• It allows a parent who has had a grandfathered health plan for at least 12 months with no long loss of coverage (usually more than 63 days) to change jobs and be guaranteed other coverage

with a new employer (as long as that employer offers group insurance). In this case there may be no waiting period and the pre-existing condition exclusion may be reduced or not applied.

- It requires insurers to renew coverage for all employers and individuals as long as premiums are paid on time.
- It guarantees that group insurance coverage is available to employers with 2 to 50 employees. (Note: It doesn't require these small employers to buy and offer the insurance to their employees.)

The new health care law now governs some of the issues and limitations that were covered by HIPAA before. For more information about HIPAA visit our website or call and ask for *What Is HIPAA*? You can also contact your state department or commission of insurance. Go the "To learn more" section for contact information.

The Family and Medical Leave Act of 1993

The Family and Medical Leave Act (FMLA) requires employers with at least 50 employees to provide up to 12 weeks of unpaid, job-protected leave for eligible employees with certain family and medical needs. Having a child with cancer is certainly a reason to take family leave.

Employees are eligible if they have worked for a covered employer for at least 1,250 hours in the previous 12 months. For the time period of the FMLA leave, the employer must maintain the employee's health coverage, including coverage for dependents.

Your child's pediatric oncologist and the team social worker can help with the paperwork your employer needs for FMLA leave.

This act is regulated by the US Department of Labor's Wage and Hour Division. They can give you more information. Check your local phone book under US Government, Department of Labor for contact information or find it in the "To learn more" section. Also, our document called *Family and Medical Leave Act (FMLA)* can give you more details on this option.

The Americans With Disabilities Act of 1990

The Americans With Disabilities Act (ADA) helps to protect anyone who has, or has had, certain disabilities, including cancer, against discrimination in the workplace. Parents of dependent children with cancer are also protected under this law.

The ADA requires private employers who employ 15 or more people, labor unions, employment agencies, and government agencies to treat employees equally, including the benefits offered them, without regard to their disabling condition or medical history. It also does not allow employers to screen out potential employees who have children with disabilities.

This Act, along with the Health Insurance Portability and Accountability Act (HIPAA), makes it easier for a parent to change jobs and move from one group insurance plan to another. This law is overseen by the US Equal Employment Opportunity Commission (EEOC). They can answer questions and give you more information by phone at 1-800-514-0301. You can also get more details in our document called *Americans With Disabilities Act: Information for People Facing Cancer*.

Government-funded health plans

What is Medicaid?

Medicaid is a state and federal government program that covers much of the cost of medical care for people with income below a certain level – the level varies from state to state. Not all health providers accept Medicaid.

In past years, Medicaid covered specific groups of people, including:

- Low-income families with children
- Supplemental Security Income (SSI) recipients
- Children under age 6 from low-income families may be eligible in some states (even if other family members are not)
- Pregnant women whose income is below certain federal poverty guidelines
- Infants born to Medicaid-eligible pregnant women

Several states still limit Medicaid to the above groups of people, but the health care law now gives states the choice to cover more low-income people through Medicaid. States that take this option (see the Kaiser Family Foundation website for updates) have extended Medicaid coverage to everyone earning up to a certain amount, whether or not they fall into one of the specific categories listed above. The law offers federal money to pay all of a state's costs to increase Medicaid coverage at the start, with the federal share slowly going down to 90%.

Medicaid pays only a percentage of the direct cost of medical care to hospitals and doctors, but families are not billed for the rest.

Children that Social Security determines to be disabled are usually eligible for Medicaid.

Having insurance coverage does not make a person ineligible for Medicaid.

Some children who are not eligible for Medicaid when they are diagnosed become eligible after the family's medical debt affects their income and assets.

In some situations, being eligible for Medicaid can help a child or family, even if it's not used to pay direct medical costs. For example, most medical centers make their own determination of a family's ability to pay medical bills. A family with an income low enough to qualify for Medicaid may get special consideration that could result in a discounted hospital bill. Medicaid funds may also be used in some states to help pay the cost of transportation to hospitals and clinics and for food and lodging if a family has to travel for treatment or follow-up care.

In the states that have decided not to cover more people through Medicaid, many low-income people still won't qualify for Medicaid. Some very low-income people who don't qualify in these states won't qualify for help paying for a private insurance plan in the marketplace either. But you may want to keep checking, because states can decide at any time to extend Medicaid coverage as allowed under the health law.

For details on whether you or your children qualify and for how much, visit www.healthcare.gov, or find your state marketplace by calling 1-800-318-2596. Your team social worker can also give

you more information on applying for Medicaid, or you can contact your county social service or health department. These numbers can be found in the blue pages of your local phone book, or you can get them from your state Medicaid office (see the "To learn more" section).

If you live in a state that has broadened its Medicaid coverage, it's a good idea to re-apply in 2014, even if you or your children have been turned down before.

State-sponsored children's health insurance programs (CHIP)

There's a special state and federal partnership that pays for medical services for children called the Children's Health Insurance Program (CHIP). CHIP offers some type of low-cost health insurance for uninsured children and pregnant women in families with incomes too high to qualify for state Medicaid programs, but too low to pay for private coverage.

Within federal guidelines, each state sets up its own CHIP program, including eligibility guidelines, benefits offered, and cost. The program covers doctor visits, medicines, hospitalizations, dental care, eye care, and medical equipment. It's funded by state tax dollars. People enrolled in Medicaid usually are not eligible for state-sponsored health insurance programs.

To find out more about CHIP, call 1-877-543-7669 (1-877-KIDS NOW). You can also go to the CHIP website, www.insurekidsnow.gov, to learn more about the program in your state.

Can Medicare help with medical care costs for children?

Medicare is a federal program funded through the Social Security system. It offers insurance for US citizens and qualified legal immigrants who meet certain criteria. Young people with cancer who are disabled may get Medicare benefits after collecting Social Security benefits under the Supplemental Security Income (SSI) program for 2 years.

For your child to get SSI, you must apply for it on behalf of the child, complete with household income and the child's medical and school information. Social Security will then determine if the child is disabled. A lot of confusing information and rumors about how Medicare benefits change (or don't change) under the new health care law have been going around. But don't let this keep you from exploring this possibility if your child has been getting Social Security. You can get upto-date information on SSI and Medicare from the Social Security website (www.ssa.gov); click on "Disability." If you have Medicare questions, talk with your team social worker, call Medicare directly at 1-800-633-4227, or contact your local Social Security office.

Medicare plus Medicaid: People on Medicare who have a low income and limited resources may get help paying for their out-of-pocket medical expenses from their state Medicaid program. For more information, contact your state or county Medicaid office (see the "To learn more" section).

What other public assistance programs might help pay for my child's medical care?

Children's Special Health (Care) Services (CSHS or CSHCS)

This is a state-run program, financed by state and federal money. It may help pay some health care costs for children, usually those 21 and younger with certain chronic conditions, including cancer.

In many states these programs have different names. To find out if such programs can help you, talk to a hospital or clinic financial counselor or talk with the team social worker. Or you can try calling your state health department.

Hill-Burton Funds

A few hospitals and other non-profit medical facilities get Hill-Burton funds from the federal government so they can offer free or low-cost services to those who can't pay. Each facility chooses which services it will provide at no or lowered cost. Medicare and Medicaid services aren't eligible for Hill-Burton coverage. But Hill-Burton may cover services that other government programs don't.

Eligibility for Hill-Burton is based on family size and income. First you'll need to find out if there's a facility in your area that has any Hill-Burton obligation for which you may qualify. If your child is cared for at such a facility, you may apply for Hill-Burton help at any time, either before or after care is received. Call the Hill-Burton Program for more information at 1-800-638-0742 and leave your address to request a packet of information. You can also visit their website, www.hrsa.gov/gethealthcare/affordable/hillburton/facilities.html, for a listing of Hill-Burton-obligated facilities, eligibility criteria, and frequently asked questions about the program.

Can children who are not US citizens get Medicaid or Children's Special Health Services?

There are situations in which children who are not citizens of the United States, but are legal immigrants, may be able to get Medicaid, CHIP, or Children's Special Health Services (CSHS) to pay for some of their treatment. All questions about Medicaid eligibility rules and regulations should be discussed with your county Medicaid specialists. Talk to the hospital or clinic financial counselor about CHIP or CSHS coverage. The services of an interpreter can usually be arranged if speaking or understanding English is a problem.

Will children covered by Medicaid, CHIP, or Children's Special Health Services be treated the same as children covered by private health plans?

Children and teens should get the same quality of care, the same state-of-the-art treatment, and any other services available – no matter who pays for it. If parents have any questions or concerns about this, they should speak with the pediatric oncologist in charge of their child's care or with another member of their child's cancer care team.

Veterans' and military benefits may help children

What if the child's parent has TRICARE?

TRICARE is the Department of Defense's health insurance program for those in the military, as well as some family members, survivors, and retirees. It offers a number of different plan options to cover people in the US and overseas, and includes family plans as well as plans for certain reservists. Pharmacy plans, dental plans, and other special services are available for some

beneficiaries. If the parent is a veteran who retired from the military, their child, teen, or young adult may be eligible for TRICARE.

Unlike insurance plans that are governed by the new health care law, TRICARE has its own set of rules about young adults. It only covers children as dependents on their parent's plans up to age 21, or age 23 if they are full-time students who are financially supported by their families.

If the sponsor-parent is on active duty, in reserves, or is retired from the military, individual coverage may be available through TRICARE for unmarried adults up to age 26 if they don't qualify for coverage at work. However, this is a separate policy with its own premium. Check with your TRICARE office about signing up.

The service member must register eligible family members, including children, in the Defense Enrollment Eligibility Reporting System (DEERS) to get health coverage for them. Records can be kept up to date by the service member or the family members through the nearest military personnel office or ID card-issuing facility, or online at www.military.com/benefits/tricare/tricare-eligibility.html.

Each TRICARE plan has its own limits and requirements. Choose your plan carefully and know how it works. You can find more on TRICARE at www.tricare.mil, including a way to compare different plans to find one that best suits your family and children.

What if a parent is a military reservist who has been called to active duty?

Members of the military reserve units who are called up for active duty from private employment have certain rights about the health care coverage they get from their employers. They are allowed to pay the full cost of their health plan, very much like COBRA, during their time away. When they return to work, their health coverage must be re-instated without any waiting period. See "To learn more" for US Department of Labor contact information to find out more about this.

What if the child's parent died in the military or became permanently disabled due to military service?

A program called the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is available for certain spouses, widows, or widowers and their children who are not eligible for TRICARE. CHAMPVA can cover the spouse or widow(er) and the children of a veteran who:

- Is permanently and totally disabled due to a service-connected disability as determined by a VA regional office
- Was rated permanently and totally disabled due to a service-connected condition at the time of death
- Died of a service-connected disability
- Died on active duty and the family members are not eligible for TRICARE benefits

CHAMPVA is a comprehensive health care program in which the VA shares the cost of covered health care services and supplies with eligible beneficiaries. The program is administered by the VA Health Administration Center. You can find out more about CHAMPVA, including things like

eligibility, benefits, finding a provider, and filing claims by calling 1-800-733-8387, or visiting their website, www.va.gov/hac/hacmain.asp (select CHAMPVA under "Special Programs").

Who regulates insurance plans?

It helps to know who regulates a health plan if you have a problem that you can't resolve directly with the plan. You have the option of contacting the government group that regulates the health plan to find out if they can give you more information or extra help:

- The private group plans (or fully insured plans) that employers purchase from insurance carriers as a benefit for employees are usually overseen by your state's insurance commission or department of insurance. You can find this department in the blue pages of your phone book, search for it online on your state government website, or contact the National Association of Insurance Commissioners (see the "To learn more" section for contact information).
- Self-funded plans (or self-insured plans) are health plans that employers or unions create just for their employees and their families. They're overseen by the US Department of Labor's Employee Benefits Security Administration. You can ask your employer if your group health plan at work is self-insured.
- Individual plans sold through the health insurance marketplaces are regulated by a marketplace board in every state. This state board oversees the function of the marketplace and the plans sold within it.
- Managed care plans are regulated by several state and federal agencies. Your state insurance commissioner or department of insurance can give you information about a specific plan.
- Medicaid is a joint program that's controlled by your state health department and the federal Centers for Medicare and Medicaid Services.
- Medicare is run by the federal Centers for Medicare and Medicaid Services.
- TRICARE is overseen by the US Department of Defense.
- The Veteran's Health Care system (including CHAMPVA) is regulated by the US Department of Veteran's Affairs.

Options for uninsured children

What if my child is not listed as a beneficiary under either parent's health insurance?

Sometimes even if a parent has group health insurance through an employer, family members are not covered. If the problem is that the premiums cost too much, talk about this with your team social worker, who should know more about financial resources that may offer help.

If possible, the insured parent should talk with their employer (or their employee benefits person at work) about how to enroll their child. Look closely and compare plans if you're trying to decide

among several insurance or managed care options. Sometimes there's a chance to look at and consider different types of coverage during open enrollment periods. (During open enrollment you are able to make changes in your health coverage. This usually happens once a year.)

Another option is the health insurance marketplace. You can buy insurance here if the marketplace is in an open enrolment period. Your child can't be turned down because of a pre-existing condition, and you'll find out if your child qualifies for Medicaid or CHIP when you apply.

Sometimes it's possible to add yourself, your spouse, or a child to a work health insurance policy or the health insurance marketplace outside the open enrollment period if you've had a major change in situation; for instance, if you've married, divorced, adopted a child, or a parent left their job. Check with your health insurance administrator at work about your group health plan, and contact your health care marketplace about enrolling your child in a private individual plan there.

Some workplace plans may be grandfathered, which can mean coverage is limited (with things like annual caps and pre-existing condition exclusions). Check before you sign up. (See "Grandfathered employer plans" in the section "Other things to know about health insurance.")

If you get insurance through your job (or your spouse/partner's job), you may want to keep the administrator's phone number and email address handy. Group insurance is better for most people than individual insurance. But in some cases, you may find a better deal for your child in your state's marketplace. (See "Where to get private individual coverage: the health insurance marketplace" in the section "Private health insurance options.")

Cancer treatment can go on for long time and cost a lot. Insurance issues can be very complex and many families need help not only in finding answers, but even in knowing the right questions to ask.

What if my child is a young adult?

The new health care law provides coverage for young adults up to the age of 26 under their parent's health insurance (if the plan has dependent or family coverage). This means that adult children ages 18 through 25 can join or stay on a parent's plan whether or not they are:

- Married
- Living with a parent
- In school
- Financially dependent on a parent (the young adult does not have to be listed as a dependent on the parent's tax return)

The only exception is if the young adult can get their own job-based coverage, then they cannot be covered by the parent's plan.

The cost of the insurance for young adults cannot be any higher than for dependent children under the age of 18.

What can I do if work does not offer group health insurance?

Families that don't have health insurance through an employer can explore a number of options:

- Under the new health care law, people looking for health coverage will be able to compare plans and select the best one for their family on health insurance marketplaces in each state. Your state's marketplace will collect information from you to find out if you or your child qualifies for Medicaid. Low or middle-income families may qualify for financial help to pay for coverage. For a list of state marketplaces, visit www.healthcare.gov or call 1-800-318-2596. Open enrollment for the marketplace ends March 31, 2014. The next open enrollment period is planned to start November 15, 2014.
- You can also buy individual insurance outside the marketplace to cover children or families. Most plans will meet the requirements for sufficient coverage so that you avoid the penalty at tax time, but some don't. Be sure to ask whether it meets the minimum requirements of the new law.
- Some states have health insurance options for low-income residents, in which the state pays for part of the coverage.
- Decide if one parent should look for a job with a large company or government agency that offers health insurance.
- Find out if there are health maintenance organizations (HMOs) or health care service plans in your community. You can sometimes get very good coverage through these plans. Many offer a period of open enrollment each year during which applicants are accepted regardless of past or current health problems.
- If a parent and child have recently been covered under an employer-sponsored plan for at least one day, and the employer still offers insurance coverage, the parent should be able to keep their medical insurance (or just the child's, if the parent went part time, lost or left the job, died, got divorced, or became eligible for Medicare) through COBRA. The employer should tell you, in writing, about your COBRA option. For more information, please see "COBRA (Consolidated Omnibus Budget and Reconciliation Act of 1986)" in the section called "Keeping employer-sponsored health insurance coverage."
- Look into your child's eligibility for Medicare, which covers people who are permanently disabled and have been getting Social Security (SSI) for 2 years.
- If your family income is low, find out if your child is eligible for state or local benefits such as Medicaid or CHIP.
- If you have insurance at work and want to leave the job, ask if you can convert your group insurance to an individual plan for your family. Some group plans have a clause that allows people to convert, but premiums may be much higher. You usually must apply for individual plans within 30 days of leaving a job. (This is different from COBRA, which allows you to stay with the group insurance but only for a limited time.)

When looking into insurance options, find out about differences in coverage. The health care law requires plans to provide a Summary of Benefits and Coverage (SBC). The SBC is an easy-to-understand document with details on the benefits and the costs you will be responsible for. It includes specific disease examples to help compare plans and find the one that's right for you. Look into these things:

• Choice of doctors

- Protection against cancellations
- Increases in premiums
- What the plan really covers, especially in the event of catastrophic illness (a serious illness, like cancer, that can add up bills quickly)
- How much deductibles and co-pays will cost you

Be wary of ads or agents offering what they might call "government-issued insurance" or other low-cost health insurance. See "Fake health insurance and other deceptions" in the "Types of private health plans for children" section for more on this.

If you think an insurance company has treated you unfairly, contact your state insurance commission for more information. See the "To learn more" section to find your state insurance department.

What sources are available to help with treatment costs if my child doesn't have insurance and there's no public assistance available?

No child is denied treatment in a non-profit hospital if a family is unable to pay. If insurance coverage can't be arranged, and if a child cannot be covered under Medicaid or another program, a family may have to look at other options to meet some of the costs of treatment. These options could include programs through the Salvation Army; church-related organizations, such as Lutheran Social Services, Jewish Social Services, and Catholic charities; or the Lions Clubs. The Patient Advocate Foundation may also be helpful. Here are some other things you can try:

- Talk with hospital or clinic financial counselors or the patient accounts office to see if you can arrange to pay bills over an extended time.
- Seek financial assistance from special funds or from organizations like the National Children's Cancer Society (NCCS). The NCCS provides direct assistance with medical care and other costs of a child's cancer. Other groups may be able to help with specific costs in some parts of the country or help you find other sources of support. Some drug companies help with drug costs for patients in financial need. And special medical center and community funds often exist to help families with the costs of medical care. The team social worker should have information on these and other potential resources.
- Fundraising can be done to help with medical bills and related expenses. Families often need help from relatives, friends, church members, schools, or community groups to carry out successful fundraising efforts. Parents should give permission for others to raise funds for their child. Caring for their ill child and managing the needs of family and work usually takes all their time and energy. In any fundraising effort, parents should consider their child's and their own need for privacy.
- Often it's best to set up a simple trust fund into which donations can be placed. A trustee is then named to approve spending from the fund. This way parents can avoid even a hint of any improper use of the fund. Parents may find it most helpful to check with an accountant,

attorney, or bank officer about setting up such a trust. Ask whether money in a trust fund will affect eligibility for public assistance programs.

• Explore the possibility of free treatment through the Pediatric Branch of the National Cancer Institute or St. Jude's Children's Research Hospital in Memphis, Tennessee. Patients accepted for treatment at these institutions must meet specific criteria. Ask your child's oncologist for more information.

Though it's not available in all areas, the United Way of America and the Alliance of Information and Referral Systems have set up a 211 service in many parts of the country. You can call 211 to find out what help might be available in your area, or visit them online at www.211.org.

Financial issues for families: Getting help with living expenses

The major costs of a cancer diagnosis and treatment are for things like time in the hospital, clinic visits, medicines, tests and procedures, home health services, and services of doctors and other professionals. Insurance, managed care, or public health care programs pay most of these costs if you're covered in such a plan.

But families also have many indirect costs or other expenses when a child has cancer, along with their usual bills. These costs can be for things like:

- Travel (gas and parking) to doctor visits, clinics, hospitals, and treatment appointments
- Lodging (a place for the patient and/or family to stay) during treatments away from home
- Meals during travel or clinic visits
- Extra child care costs
- Communication (phone calls, faxes, copies of medical records, etc.) with doctors, friends and relatives
- Special foods and nutritional supplements
- Special equipment or clothing

Also, a child's treatment plan can cause parents and family members to lose time at work and, in some cases, all or part of their salary. Even more money is lost if one parent has to quit a job or take an extended leave of absence. Of course, costs increase as treatment is extended, if there are treatment complications, or if the cancer comes back. This section offers just a few ideas of where you might be able to get some help dealing with the costs of cancer. See the "To learn more" section for other resources that may be useful to you.

What help is available with short-term housing near the treatment center?

Sometimes cancer treatment for kids requires travel. Most major pediatric treatment centers have a Ronald McDonald House nearby. These houses provide low-cost or free housing for patients and

their immediate families. They're designed to offer a nice break for any family with a seriously ill child, not just those with limited funds.

Although partly funded by McDonald's Children's Charities, each House has its own management, sets its own admissions standards, and operates according to its own rules. Check with your health care team's social worker or nurse to learn more, or contact Ronald McDonald House Charities at 630-623-7048 or www.rmhc.org. Families must be referred by medical staff and/or social workers at the treatment facility.

Another possible option is the Healthcare Hospitality Network. This group of nearly 200 non-profit organizations throughout the US provides free or low-cost family-centered lodging to families getting medical treatment far from home. You can call 1-800-542-9730 or check online at www.nahhh.org to see if there's a location that works for you.

Many treatment centers also have other short-term housing possibilities or discount arrangements with nearby motels and hotels. The clinic social worker or oncology nurse may have ideas for low-cost housing during hospital or clinic treatment.

Where can families find help with housing needs or mortgage payments?

The extra costs of a child's treatment or major loss of family income may make it hard for families to pay their mortgage or rent on time. To keep a good credit rating and stay in your home, talk with your creditor or landlord about your situation and try to make special arrangements. Family, friends, or church members may be able to give you short-term help if they are told about the problem. Talk about your situation with the team social worker who may know of special resources.

Families who need to move out of their homes after a child's cancer diagnosis should talk with their county department of social services to find out if they can get into low-cost or government-supported housing programs.

Where can families get help with driving and ground transportation costs?

People who have Medicaid may qualify for help with travel to medical centers and doctors' offices for treatment. This can take the form of payment or being reimbursed (paid back) for gas, payment of bus fare, or it may mean using a van pool. County departments of social services in each state arrange for help with transportation, but families must ask for it by talking with their Medicaid case worker.

The American Cancer Society Road To Recovery program is available in some areas. Trained volunteers drive patients and families to hospitals and clinics for treatment. Contact your local American Cancer Society office for more information on what's available in your area.

The Leukemia & Lymphoma Society, through its Patient Aid program, can help some families with the cost of gas and parking for outpatient treatment. This aid is only for those with blood cancers (leukemia, lymphoma, and myeloma). There's a limit on the amount of financial help to each patient and family for each year. Check with your team social worker about this program or contact the Leukemia & Lymphoma Society at 1-800-955-4572 or www.lls.org.

Community and church groups may be sources of help with travel or its costs, too. Also, talk to your team social worker about getting help with hospital or clinic parking fees.

Where can families get help with air travel?

The National Patient Travel Center (NPTC) is a central clearinghouse that refers callers to over 3 dozen charitable or special discounted patient air transport service groups. NPTC can help patients find a program to assist with the costs of air travel for illness-related reasons, including air ambulance services. The National Patient Travel Helpline screens callers, verifies the illness and need for transport, and determines if the caller is eligible for help through one of the air travel programs. You can call them at 1-800-296-1217, or visit them online at www.patienttravel.org.

Is there any help available for the cost of telephone service?

Help with the cost of basic charges for phone service may be available from Temporary Assistance for Needy Families (TANF; see "To learn more" for contact information). Speak with the eligibility worker in your county department of social services for more information. Families that have problems controlling phone charges may want to think about buying pre-paid calling cards, pre-paid cell phones, or plans with pre-paid minutes. If you have limited mobile phone minutes and call your company before you go over your limit, sometimes they can help you keep from going over your minutes for the month.

The Universal Service Administrative Company (USAC) is another resource that may help if your income is very low. Visit their website at www.usac.org/li/getting-service/benefits.aspx to learn more about phone service help that's available in your state. Or you can call 1-866-873-4727 and follow the low income/lifeline prompts.

You may also want to call the American Cancer Society to find out about other local sources of help with telephone service.

What help is available for food and food costs?

Some government programs help with food costs. The programs listed below are run by the US Department of Agriculture for different groups of people, and offer food help in different ways. Some families may qualify for more than one type of help. These programs include:

Supplemental Nutrition Assistance Program or SNAP (formerly the Food Stamp Program). It allows people to shop for food in grocery stores using a special Electronic Benefits Transfer card, much like a bank card.

Food Distribution Programs (these programs distribute food directly to needy families):

- Commodity Supplemental Food Program (CSFP)
- The Emergency Food Assistance Program (TEFAP)

Women, Infants and Children (offers vouchers; some health departments give food or formula):

- Farmer's Market Nutrition Program
- Senior Farmers' Market Nutrition Program

School meals (served to children only in schools):

- National School Lunch Program
- Fresh Fruit & Vegetable Program
- School Breakfast Program
- Special Milk Program
- Team Nutrition

Summer Food Service Program (meals for kids at community sites when school's out)

Keep in mind that some individuals and families can qualify for more than one type of help. You can learn more about all of these programs and others by visiting www.whyhunger.org/findfood. To ask about SNAP by phone, call your local health department or social services department. See your phone book's blue pages or call 1-800-221-5689 to get the local number. For the other programs, call the National Hunger Hotline at 1-866-348-6479 (1-866-3-HUNGRY).

How about Internet access?

You may notice that many groups and organizations now have a lot of information on the Internet, and it may be harder to call or reach a real person to ask questions. When you do call you might find that their answering messages encourage you to find the information you need on their website. For many groups, this is a way to save money and focus more funds on services for those in need. But it doesn't work for everyone who needs help.

Many people, especially families who are having financial troubles, don't have Internet access at home. This can make it harder for them to find what they need. You may want to see if your local public library offers use of their computers and Internet access at no cost to the user. An added benefit is that volunteers or staff there may be able to help if you're having trouble finding things.

Still, you don't always need Internet access to find help. Many organizations also provide toll-free phone numbers so that people without Internet access can learn about and ask for services. Don't be embarrassed to tell people that you don't have Internet access and you can't check their website.

And you can always call us, day or night, to find out about getting the help you need.

Where else can families get financial help?

Most families find it hard to turn to others or to agencies and outside groups for financial help. The extra expenses of a child's cancer may be the first time a family has had problems with money. Families should remember that their problems in such a situation are often short-lived and not unique. And in the future, they could be the ones who offer help to others.

Here are some possible sources of help for families who need extra financial support at this time:

- Income assistance for low-income families through Supplemental Security Income (SSI) benefits (see below)
- Income assistance from the Temporary Assistance for Needy Families (TANF) program (see below)

- Help with treatment-related travel, meals and lodging from public and private programs
- Help with basic living costs (like rent, mortgage, insurance premiums, utilities, and telephone) from public and private programs
- Help from church, civic, social, and fraternal groups in the community
- General help from special funds in the medical center or community
- Help from targeted fundraising for an individual patient or family

The team social worker may be able to give you more information about resources that might help your family. There are also organizations and written materials that can help you learn more about fundraising strategies (see "To learn more").

What are Supplemental Security Income (SSI) benefits?

Supplemental Security Income (SSI) is designed to supplement the income of eligible families with low incomes and limited assets in which there's a disabled individual. Children qualify if they meet Social Security's definition of disability. To get SSI, your income and assets must fall below a certain level.

Children can qualify if they meet Social Security's definition of disability. Income criteria are checked by the local Social Security Administration office. Disability evaluation specialists at the state Social Security office decide if the child is disabled. Not every child with a cancer diagnosis is considered disabled. Note that SSI is different from SSDI (Social Security Disability Income), which is only available to those who contributed to Social Security during their working years.

In many states, Medicaid is given to children getting SSI, but you may need to apply for it separately. You can get more information about SSI from the team social worker or from the nearest Social Security Administration office listed in the US Government section of your local phone book. See the "To learn more" section for more information.

Temporary Assistance for Needy Families (TANF)

Temporary Assistance for Needy Families (TANF) is a grant program that provides monthly cash to help pay for food, clothing, housing, utilities, transportation, phone, medical supplies, and other basic needs not paid for by Medicaid. TANF also helps states provide training and jobs for the people in welfare programs. A social worker can tell you about your state's plan or see the "To learn more" section for TANF contact information.

To learn more

More information from your American Cancer Society

Here's more information you might find helpful. You can order free copies of our documents from our toll-free number, 1-800-227-2345, or read them on our website, www.cancer.org.

Coping with childhood cancer

Children Diagnosed With Cancer: Dealing With Diagnosis (also in Spanish)

Children Diagnosed With Cancer: Understanding the Health Care System (also in Spanish)

Children Diagnosed With Cancer: Returning to School

Children Diagnosed With Cancer: Late Effects of Cancer Treatment

Treatment help

Prescription Drug Assistance (also in Spanish)

Clinical Trials: State Laws Regarding Insurance Coverage

Clinical Trials: What You Need to Know (also in Spanish)

Federal laws that can help with family employment and health insurance

What Is COBRA? (also in Spanish)

What Is HIPAA? (also in Spanish)

Family and Medical Leave Act (FMLA) (also in Spanish)

Americans With Disabilities Act: Information for People Facing Cancer (also in Spanish)

The Health Care Law: How It Can Help People With Cancer and Their Families (also in Spanish)

National organizations and websites*

Along with the American Cancer Society, other sources of information and support are listed below. Because there are so many sources, some have their full contact information listed in the text rather than here.

Possible sources of health coverage

Medicaid – US Department of Health and Human Services

Toll-free number: 1-877-696-6775 Website: www.medicaid.gov

For details on Medicaid coverage and CHIP eligibility. Your state social service or human service agency can give you the best answers to questions about your benefits, eligibility, and fraud. To get contact information for your state go to www.cms.gov/apps/contacts/ or call the number above

Department of Veterans Affairs

Toll-free number: 1-800-827-1000

Website: www.va.gov

For information on Veteran's medical benefits and whether your child qualifies for them:

Toll-free number: 1-800-733-8387 Website: www.va.gov/healtheligibility

US Department of Health & Human Services

Toll-free number: 1-800-318-2596 (to find your state's marketplace)

Website: www.healthcare.gov

Information and sign-up for the health insurance marketplace (open enrollment until March 31, 2014; re-opening in November 2014). Learn about your family's eligibility for tax credits, subsidies, and other kinds of help with insurance coverage

Getting help with insurance issues

US Department of Health & Human Services

Website: www.healthcare.gov

For the most current information on health care and insurance laws and how they might affect you and your child

National Association of Insurance Commissioners (NAIC)

Toll-free number: 1-866-470-6242

Website: http://naic.org/state_web_map.htm

To find your state's Insurance Commissioner or Department of Insurance

Cancer Legal Resource Center (CLRC)

Toll-free number: 1-866-843-2572 (may need to leave a number for a call back)

Website: www.cancerlegalresourcecenter.org

Provides free, confidential legal information about laws and resources for many cancerrelated issues including health insurance issues, denial of benefits, and government benefits

Patient Advocate Foundation (PAF)

Toll-free number: 1-888-879-4210 Website: www.patientadvocate.org

Case managers, doctors, and attorneys work with the patient's parents and their insurers, employers, and/or creditors to resolve insurance, job retention, and/or debt problems related to their child's diagnosis. Also has co-pay relief programs for some types of cancer, a scholarship fund for young survivors, and educational materials on many cancer-related topics.

Childhood Cancer Ombudsman Program

Toll-free number: 1-877-217-4166 (may need to leave message for return call)

Website: www.childhoodbraintumor.org

Provides resources to help families better exercise their rights to make decisions about medical treatment, school, rehabilitation, employment, and insurance reimbursement/coverage. This program is offered by the Childhood Brain Tumor Foundation, but services are provided for children and adult survivors of any type cancer.

Your rights at work

US Department of Labor, Employee Benefits, Security Administration (EBSA)

Toll-free number: 1-866-444-3272

Website: www.dol.gov/ebsa

Has information on employee benefit laws, including COBRA, FMLA, and HIPAA requirements of employer-based health coverage and self-insured health plans. Also has information on recent changes in health care laws. Information for military reservists who must leave their private employer for active duty can be found at:

www.dol.gov/elaws/vets/userra/mainmenu.asp

US Equal Employment Opportunity Commission (EEOC)

Toll-free number: 1-800-669-4000

TTY: 1-800-669-6820 Website: www.eeoc.gov

For information on all federal equal employment opportunity regulations, practices, and policies; publications; how to file charges of workplace discrimination; and how to find

EEOC offices in your area

Potential income sources and money management

Social Security Administration

Toll-free number: 1-800-772-1213

TTY: 1-800-325-0778 Website: www.ssa.gov

For general information, qualification criteria, and details on how to apply for program benefits (such as Supplemental Security Income). Makes referrals to local SSA and Medicare/Medicaid offices

TANF and State Health Departments – US Department of Health and Human Services

Toll-free number: 1-877-696-6775

Website: www.cms.gov/home/medicaid.asp

Provides contact information for each state's health department, including Temporary Assistance for Needy Families (TANF), food aid, and Medicaid in your state

National Association of Personal Financial Advisors

Toll-free number: 1-800-366-2732

Website: www.napfa.org

Offers objective financial advice on a "fee-only" basis (neither the advisor nor any related party gets paid based on the purchase or sale of a financial product). Also has a listing of fee-only planners in the person's area.

National Foundation for Credit Counseling (NFCC)

Toll-free number: 1-800-388-2227

Toll-free Spanish number: 1-800-682-9832

Website: www.nfcc.org

For referrals to local Consumer Credit Counseling Services and answers to questions about bankruptcy, credit, and debt collection practices

HelpHOPELive (formerly **National Transplant Assistance Fund** or **NTAF**)

Toll-free number: 1-800-642-8399 Website: www.transplantfund.org

Offers patients' families and supporters free guidance and support in setting up community fundraisers to help pay for cancer treatment

Internal Revenue Service

Toll-free number: 1-800-829-1040

TTY: 1-800-829-4059 Website: www.irs.gov

Has answers to tax questions, tax forms, and referrals to free tax help for those who qualify

Childhood cancer information and resources

American Childhood Cancer Organization (ACCO)

Phone number: 855-858-2226 Website: www.acco.org

Offers information for children and teens with cancer, their siblings, and adults dealing with children with cancer; also offers books and a special kit for children newly diagnosed with cancer, as well as some local support groups

CureSearch National Childhood Cancer Foundation (NCCF)

Toll-free number: 1-800-458-6223 Website: www.curesearch.org

Provides up-to-date information about childhood cancer from the world's top pediatric cancer experts. Has online information for patients and families, and a section for friends and the community to help them ease the burden of cancer and show support

National Children's Cancer Society, Inc. (NCCS)

Toll-free number: 1-800-532-6459 Website: www.children-cancer.org

Services include an online support network for parents of children with cancer, educational materials, and financial assistance for treatment-related expenses.

St. Jude Children's Research Hospital

Toll-free number: 1-866-278-5833 (doctor referral number)

Website: www.stjude.org

Covers all costs of care beyond those that are reimbursed by insurance. Total costs are covered when the child or teen doesn't have insurance. After an initial evaluation, assistance with transportation and local living expenses may also be provided. Website has information for patients seeking treatment, such as the admission policy, a guide for parents, and directions to the hospital. Patients are accepted by doctor referral only.

Other sources of help

2-1-1 Program Information and Referral Search

Toll-free number: 211 Website: www.211us.org

May be able to find help and resources in your local area

Other resources*

*Cancer Survival Toolbox*TM By the National Coalition for Cancer Survivorship. Available at http://canceradvocacy.org/toolbox or by calling 1-877-NCCS-YES (1-800-622-7937).

Mapping the Maze: A Personal Insurance and Financial Guide to Marrow and Cord Blood Transplant. Available from Be The Match at:

http://bethematch.org/WorkArea/DownloadAsset.aspx?id=1281.

Surviving Childhood Cancer: A Guide for Families by Margot Joan Fromer. Published by New Harbinger Publications, 1998.

United States Department of Health and Human Services: Families & Children website. Covers many topics, including sources of financial assistance and information on Medicaid and other health insurance. Available at www.hhs.gov/children/.

*Inclusion on this list does not imply endorsement by the American Cancer Society.

No matter who you are, we can help. Contact us anytime, day or night, for information and support. Call us at **1-800-227-2345** or visit www.cancer.org.

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For additional assistance please contact your American Cancer Society
1-800-227-2345 or www.cancer.org