Florida Funding & Insurance Help Guide for Parents

1 · Start here

Understanding how ABA is paid for

Paying for ABA can feel complicated, and most families start with the same question: *what will this cost us?*

The honest answer is that it depends on your specific health plan. Two families with the same insurance company can have very different benefits, because coverage is set by the individual plan — not by the company name on the card.

This guide explains how coverage generally works, what you may be responsible for, and what to do when something changes or goes wrong. It also explains what BRITE handles for you.

> *This guide covers Florida. Coverage rules, Medicaid programs, and funding options differ by state.*

2 · Insurance terms parents should know

These eleven terms come up constantly. Each example below is **hypothetical**. It explains the idea, and does not reflect BRITE's pricing, any particular plan's benefits, or what your family will owe.

Deductible — The amount you may need to pay toward covered services before your health plan begins paying for services that are subject to the deductible.

Example: If a plan has a $1,500 deductible, the family may have to pay toward covered healthcare services before the plan begins paying according to its benefits.

Copay — A fixed amount you pay for a covered service.

Example: A plan may require a fixed $25 payment for certain covered services.

Coinsurance — A percentage of the cost you pay after your deductible is met.

Example: If coinsurance is 20%, the family may be responsible for 20% of the plan's allowed amount after applicable deductible requirements are met.

Allowed amount — The amount your health plan recognizes for a covered service. Cost-sharing, such as coinsurance, is usually calculated from this amount rather than from the provider's full charge.

Example: If a plan's allowed amount for a service is $100, the family's coinsurance may be calculated from that $100 rather than from a higher billed charge.

Out-of-pocket maximum — The most you generally pay in deductible, copay, and coinsurance for covered, in-network services during a plan year. Premiums and certain other costs may not count toward this limit.

Example: After a family reaches the applicable in-network out-of-pocket maximum for covered services, the plan generally pays 100% of covered in-network costs for the remainder of the plan year.

In-network — A provider who has a contract with your health plan.

Example: A provider has a contract with the insurance plan, which can affect coverage and family cost-sharing.

Out-of-network — A provider who does not have a contract with your health plan.

Example: A provider does not have a contract with the plan, which may result in different benefits or higher family costs.

Prior authorization — Approval from your health plan before certain services can begin or continue.

Example: An insurer may require approval before certain ABA services can begin or continue.

Medical necessity — Your health plan's clinical criteria for determining whether a requested service qualifies for coverage based on clinical need.

Example: The insurer may review the assessment and treatment plan to determine whether the requested services meet its clinical coverage criteria.

Benefits verification — Checking with your health plan what benefits it reports for ABA.

Example: BRITE may confirm that the insurer reports ABA benefits, but that verification does not guarantee that every service or claim will ultimately be covered or paid.

Explanation of Benefits (EOB) — A statement from your health plan showing how it processed a claim and what it reports as your financial responsibility. **An EOB is not a bill.**

Example: After a claim is processed, a plan may send an EOB showing the amount billed, the allowed amount, what the plan paid, and what it reports as the family's responsibility.

3 · Three things people often confuse

This is the distinction that surprises families most often, so it is worth understanding early.

Having an ABA benefit ≠ meeting medical-necessity criteria ≠ receiving authorization

These are three separate steps, and clearing one does not clear the others.

A benefit means your health plan includes ABA as a covered service.

Medical necessity means the requested services meet your plan's clinical criteria for coverage.

Authorization means your plan has approved specific services before they begin.

Benefits verification is not a guarantee of coverage or payment

When BRITE verifies your benefits, we are asking your health plan what it reports about your coverage at that moment. That information is useful, and it is where every family should start, but it is an **estimate, not a promise**.

Plans may still review medical necessity, require authorization, apply plan limits, or determine that a service is not covered. Final coverage decisions are made by your health plan.

> *Example: A child may have ABA listed as a covered benefit, but the insurer may still require clinical documentation supporting medical necessity, and may require authorization before services begin.*

4 · How the process usually works

Contact BRITE → Benefits verification → Benefits reviewed with family → Required documents → Clinical assessment → Authorization (if required) → **Services begin**

The exact steps, and the order in which they happen, vary by payer and plan. Some plans require authorization before an assessment; others require it afterward. Some require a referral or prescription; others do not. BRITE will review the requirements reported by your health plan with you.

5 · Understanding your costs

What you pay depends on how your health plan is built: your deductible, your copay or coinsurance, whether your provider is in-network, and any limits your plan applies to ABA.

About the out-of-pocket maximum

Out-of-pocket maximums generally apply only to **covered, in-network services**. Services your plan does not cover, services received out-of-network, and services that are not authorized may not count toward your out-of-pocket maximum. This is one of the most common misunderstandings, and it matters when families are planning financially.

Before services begin, BRITE provides families with a written summary of the benefit and cost-sharing information available to us and reviews that information with the family by phone. We explain the coverage and estimated financial responsibility reported by the health plan and answer questions. This information is an estimate, not a guarantee of coverage or payment.

6 · Questions to ask your health plan

Call the member services number on the back of your insurance card. These questions are written so you can read them aloud, in order. It helps to write down the date, the name of the person you spoke with, and a reference number for the call.

> *"I would like to ask about coverage for ABA therapy — sometimes listed as applied behavior analysis or behavior analysis — for my child."*

1. **Is ABA or behavior analysis a covered benefit under my plan?**
2. **Does my plan require a specific diagnosis for ABA or behavior analysis coverage?**
3. **Are there specific diagnosis codes or diagnostic documentation requirements I should know about?**
4. **If my child does not have an autism spectrum disorder diagnosis, can ABA still be covered under my plan?**
5. **Is this provider in-network with my plan?** *(Have BRITE's information ready.)*
6. **What is my deductible, and how much of it have we met so far this year?**
7. **Is there a copay or coinsurance for these services, and how much is it?**
8. **Is prior authorization required before services begin?**
9. **Does my plan require a referral or a prescription, and if so, who does it need to come from?**
10. **Are there any limits on hours, visits, or age?**
11. **Is caregiver training covered?**
12. **If a request is denied, what is the appeal process, and what are the deadlines?**

> *"Could you give me a reference number for this call?"*

> *Answers to these questions describe what your plan reports. Coverage may still depend on medical necessity, authorization, network status, and other plan requirements.*

7 · What to do if your insurance changes

Tell BRITE as early as you can. A new health plan may require a new benefits verification, a review of network participation, new documentation, and a new authorization, even if your child's therapy has not changed at all.

Let us know if:

- You start a new plan, or your employer changes plans
- You lose coverage
- You receive a new insurance card
- Another insurance becomes primary, or your child gains a second policy

The earlier we know, the more time we have to address new requirements before they affect services.

8 · What if ABA is denied?

A denial is not necessarily the end of the process. Different denials have different causes, and the right response depends on the cause.

1. **Ask for the reason in writing.** You are entitled to a written explanation. Do not rely on a summary given over the phone.
2. **Identify what kind of issue it is.** Common reasons include:

   · Eligibility · Benefit or coverage limitations · Missing or incomplete documentation
   · Network status · Authorization · Medical necessity

   These have genuinely different solutions. A documentation problem is resolved very differently from a disagreement about medical necessity.
3. **Review your reconsideration and appeal rights**, including the deadlines. Deadlines are often short.
4. **Keep copies of everything** — letters, forms, and notes from calls, with dates and reference numbers.
5. **Contact BRITE if you receive a denial.** We can review the reason and may be able to provide information or documentation to support a reconsideration or appeal. Final coverage decisions are made by the health plan.

9 · Other funding pathways (not insurance)

These pathways are separate from insurance. Some families use one of them, and some combine them with insurance coverage.

Florida Medicaid

If your child has Florida Medicaid, behavior analysis services may be covered for recipients under 21 when they are medically necessary. Prior authorization is required.

For most families, authorization now goes through the child's **Medicaid managed care plan**, which means the plan, rather than the state, reviews the request.

If your child has Florida Medicaid, contact BRITE to confirm whether we participate with your child's specific Medicaid managed care plan.

Florida Medicaid requires a Comprehensive Diagnostic Evaluation before Behavior Analysis services can begin. If your child still needs an evaluation, BRITE can help you understand the requirement and direct you to evaluation resources.

Florida Medicaid requirements for behavior analysis are currently being reviewed at the state level. For the most current information, check with your child's plan or visit our website.

9 · Other funding pathways, continued

Family Empowerment Scholarship for Students with Unique Abilities (FES-UA / Step Up For Students)

FES-UA is **not insurance**. It is an education savings account: approved families receive funds that can be used for approved educational and specialized services, including ABA.

BRITE accepts FES-UA funding for eligible ABA services.

Eligibility, award amounts, and the rules governing how funds may be used are set by the scholarship program and change from year to year. Apply and check current rules through **Step Up For Students**.

HSA and FSA

Certain medically necessary therapy expenses may be eligible for payment or reimbursement through a Health Savings Account (HSA) or Flexible Spending Account (FSA). Eligibility depends on applicable tax rules and the terms of your account. Confirm with your account administrator or tax adviser. *BRITE cannot provide tax advice.*

Private pay

BRITE offers private-pay services in appropriate circumstances. Contact us for current options and pricing, or ask for our Private Pay guide.

If BRITE is not in-network with your health plan

Contact us. In some circumstances, an out-of-network option or a network-gap or single-case arrangement may be available, depending on your plan.

10 · What BRITE helps with

Benefits verification & review. For insurance-funded services, BRITE verifies available benefit and eligibility information, provides a written benefits summary, and reviews the information with the family by phone before services begin. We explain the coverage and estimated cost-sharing information reported by the health plan and answer questions. This information is not a guarantee of coverage or payment. For Medicaid managed care, verification includes checking the member's plan and the applicable network and authorization requirements.

Authorization. When prior authorization is required, BRITE submits the authorization request and supporting documentation to the health plan. We will let you know if additional documents are needed from you or another provider.

Reauthorization. BRITE coordinates authorization and reauthorization requests, including submission of required clinical documentation. We work with families in advance of authorization renewals when updated information or documents are needed.

Claims. We submit claims directly to your health plan and follow up on processing as needed.

Billing. After your health plan processes a claim and identifies any amount that is your financial responsibility, BRITE will notify you of the balance and provide applicable billing information.

Problems. If a billing or coverage issue occurs, BRITE reviews the issue and works with the health plan as appropriate to help determine the next steps.

On timelines. Authorization timelines vary by plan and request type. Once required documents are complete, BRITE submits the request and follows up as appropriate.

11 · When to contact BRITE

- New or changed insurance
- A new insurance card
- Loss of coverage
- Another insurance becoming primary
- A denial, or unexpected correspondence from your insurer
- Questions or concerns about an authorization
- An unexpected bill or a billing question

Billing and insurance questions

billing@briteaba.com

(561) 203-0779

Monday–Friday, 8:30 a.m.–6:30 p.m. ET

12 · Parent checklist before services begin

- ☐ Insurance card (front and back)
- ☐ Diagnostic or evaluation records
- ☐ Referral or prescription, if your health plan requires one
- ☐ Relevant prior treatment records *(optional, but helpful)*
- ☐ Guardian and consent information
- ☐ Any insurance correspondence about ABA

13 · Where to get independent help

Florida Department of Financial Services

Division of Consumer Services — free help with insurance questions and complaints.

Helpline **1-877-693-5236**
Out of state **(850) 413-3089**
Hours Monday–Friday, 8:00 a.m.–5:00 p.m. ET
Website **myfloridacfo.com/division/consumers**

Your health plan's appeal process — described in your plan documents and in any denial letter.

School-based services work differently from insurance. If you have questions about IEPs, evaluations, or services through your child's school, see our School District ESE Resources guide.

Looking for ABA services? We can help.
BRITE ABA · ABA therapy for children ages 18 months to 21 years
(772) 202-2494
briteaba.com

Disclaimer — References to external organizations, programs, or resources are provided for informational purposes and do not imply endorsement, partnership, or affiliation unless BRITE's participation is specifically stated. This guide provides general information. It is not insurance, legal, or tax advice. For insurance-funded services, final coverage and payment decisions are made by the health plan.

Information verified August 2026. Plans, programs, and requirements change.