



Member Handbook

WellCare
means better
care.



Choices for a Healthy Life



NEW ENROLLEE HEALTH ASSESSMENT FORM (CONTINUED)

8. Have you received treatment or received an authorization for treatment within the last 30 days for any of the following conditions?

- Diagnosed with significant medical condition (If yes, what medical condition? Please provide name, address, and phone number of provider.) _____

- Organ or tissue replacement (If yes, organ or tissue? Please provide name, address, and phone number of provider.)

- Chemotherapy or radiation therapy (If yes, chemotherapy or radiation therapy? Please provide name, address, and phone number of provider.) _____

9. Have you received a prior authorization for services, such as scheduled surgeries or out-of-area services, from another plan, state, or its agent? Yes No

If **Yes**, please answer the following questions:

- What service was approved? (Consult, treatment, procedure, DME equipment—rental, etc.)

- Who provided the authorization? (Provider, state, etc.)

- What provider was authorized to render service? (Please provide the name, address, and phone number of the provider.)

- If approved by the State of Georgia, please provide the date requested by DCH. _____

10. Are you pregnant? Yes No Not Applicable

- If you answered **Yes**, are you receiving prenatal care? _____
- If you answered **Yes**, please have your doctor contact us via our toll-free number at 1-866-231-1821 as soon as possible, as you may be eligible for a free stroller through the Prenatal Rewards Program.
- If you would like us to help you find a doctor or help you set up an appointment, please call Customer Service. The number is 1-866-231-1821 (TTY/TDD: 1-877-247-6272). A visit to a doctor for pregnancy care should happen within 14 days of either becoming a WellCare member or finding out that you are pregnant after you join WellCare.



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WELCOME TO WELLCARE

We are glad you joined our family! It is a smart move. WellCare is the health care plan that really puts you in control. You can choose from a large network of great doctors and hospitals. And you will get caring health care, plus extras like these:

- Adult dental
- Adult vision
- Free monthly Personal Care Items
- Member voice mail
- 24-hour Health Advisor line

This handbook will tell you more about your benefits. We hope it will answer most of your questions. Visit the Web at georgia.wellcare.com if you need more help. The Web provides an easy way for you to learn more about us and your benefits and to manage your care with our plan. You can also call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272). We have friendly staff trained to answer all your questions.

WellCare is the largest Medicare- and Medicaid-only health care company in the United States. We have over 20 years of health care experience. Unlike other large companies, we really understand your needs. We are here to make sure your family gets great health care. So you can live happier and healthier.

As you work with everyone at WellCare, you will see that we put you and your family first, so you get better health care. Again, welcome to WellCare. We wish you good health!

Sincerely,

WellCare of Georgia, Inc.



GEOGRAPHIC OVERVIEW

Georgia Medicaid

Georgia Service Regions

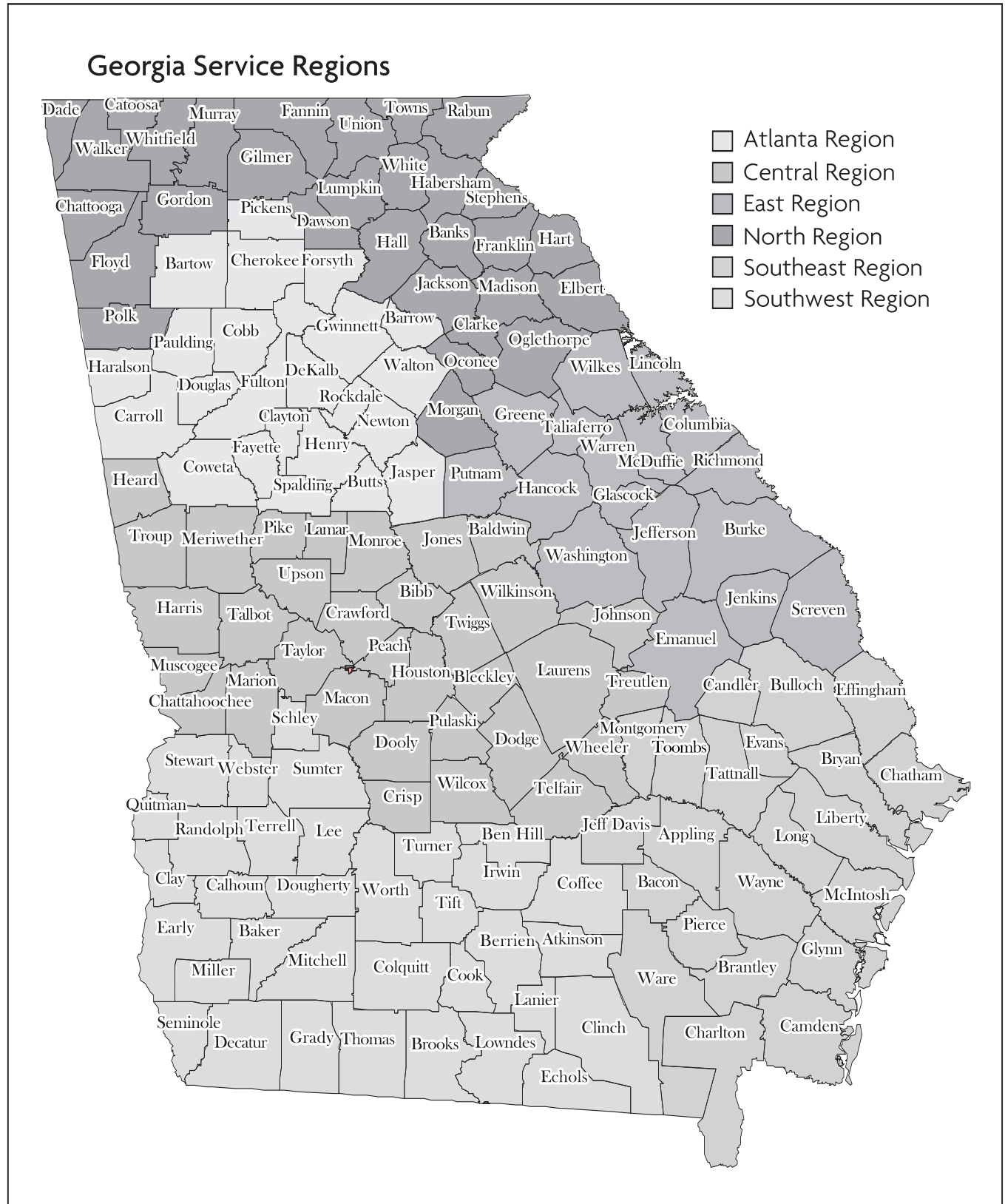


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WELCOME TO WELLCARE

This is your member handbook. It tells you how your WellCare of Georgia, PeachCare for Kids, and Medicaid health plans work. Please read it. Keep it in a safe place so you can find it when you need it.

NECESITA ESTA INFORMACION EN ESPAÑOL. Este libro contiene información que usted necesita saber. Para obtener este libro en español, llame al Servicio al Cliente al 1-866-231-1821 (TTY/TDD: 1-877-247-6272). También puede llamar para que le lean el libro en español.

GETTING STARTED

It's easy to get started. Follow these steps. You will be on your way to getting the care you need.

1st—Check your ID card. Put it in a safe place.

You should have received your WellCare member ID card in the mail. If not, call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

When you need care, you will give this card to your doctor. Your card has important information about your health plan. Keep this card and your Medicaid card with you at all times. Do not let anyone else use your card. If you do, you may lose your benefits.

Please take the time to look at the information on your ID card. Check the primary care physician (PCP) name on it. If you want to change your PCP, call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

Your member start date is on your ID card.

What if I lose my ID card?

If you lose your ID card, call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272). They will mail you a new card. If you lose your Medicaid card, call your caseworker at the Georgia Department of Family and Children Services. If you lose your PeachCare for Kids card, call Georgia Health Partnership at 1-866-211-0950.

2nd—Choosing your primary care physician (PCP).

If you have not selected a PCP or one is not listed on your ID card, please visit the Web at georgia.wellcare.com or call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

You can choose a PCP from among our network of doctors. As your personal doctor, he or she will help you arrange for all of the medical care you and your family need. You will find a listing of doctors to choose from in your provider directory. Changes are made to the provider directory on a continuing basis. To get an updated version of the directory, call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

Remember, you can change your PCP any time. Just visit the Web at georgia.wellcare.com or call Customer Service. Your family members enrolled in WellCare can each choose different doctors.

If you would like to learn more about your PCP, specialist, or another participating provider, such as his/her schooling or residency, qualifications, or whether or not he/she is accepting new patients, contact Customer Service at 1-866-231-1821. You can also find this information in your provider directory.

3rd—Visit your primary care physician (PCP).

Your PCP will take care of all routine medical care for you. They can arrange specialists or hospital care if needed. If it is not an emergency, call your PCP. The number is on your ID card.

Please get to know your PCP. Call their office to schedule a checkup. As a new member, you **MUST** see your PCP within 90 days of the start date on your ID card. If you are pregnant, you **MUST** see your PCP within 14 days.

Your PCP will get your records from doctors you have seen.

4th—Learn how to use your benefits.

It's easy to use your plan benefits. For non-emergency health needs, call your PCP. The number is on your ID card. Your PCP will handle all routine care. They can also send you to a specialist or the hospital.

5th—Get to know your Personal Health Advisor.

WellCare has a Personal Health Advisor who can answer your health questions. Call them when you are not sure what kind of care you need. It is a free service. Call any time, 24 hours a day, 7 days a week. Call 1-800-919-8807.

6th—Complete your New Enrollee Health Assessment Form.

A New Enrollee Health Assessment Form is included in the front of your member handbook. This form lets us know the type of health care you may need. This will allow us to serve you better. Please complete the form and return in the enclosed envelope.

7th—Ask for help in an emergency.

Go to the hospital or call 911 for a real emergency. This book tells you about your health plan. It also tells you how you can get care. See the *How to Get Your Medical Services* section for more information.

8th—Call with your monthly Personal Care Items order.

This book also has details about the products you can get with the Personal Care Items benefit. Each month, you pick \$10 in items. They will be mailed to you. Call 1-866-231-1821 (TTY/TDD: 1-877-247-6272) to order.

9th—Call WellCare Customer Service if you need any help.

Call us if you have any questions. Language services for all foreign languages are available. You can also call to request your member materials in a different format. This includes different languages, large print, and audio tapes. This is free of charge.

Customer Service is open on weekdays from 7am to 7pm Eastern. Call toll-free at 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

10th—Your enrollment in WellCare is your choice.

You can stop being a plan member during Open Enrollment or for good cause. Call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272) with questions.

11th—Understand your rights and responsibilities.

The law requires that your doctor knows what your rights are. It also asks that you respect your doctor's rights too. This book talks about this. You may also see these rights in your doctor's office.

12th—Read this book to learn more. Find out about your dental, vision, and mental health benefits.

You are now ready to use your WellCare benefits. We look forward to serving you!

MEMBER INFORMATION

ENROLLMENT IN WELLCARE OF GEORGIA

Medicaid

WellCare serves kids and adults that can be a part of Georgia's Medicaid program. This program provides health plans for select groups of kids and adults with low incomes. A person must meet certain requirements for Medicaid. The Georgia Department of Family and Children Services will make this decision.

PeachCare For Kids

WellCare also serves kids 18 and younger that are a part of Georgia's State Children's Health Insurance Program, PeachCare for Kids. It is for children who are not eligible for Medicaid or any other health insurance programs.

How is PeachCare for Kids different from Medicaid?

- There is a small monthly payment.
- The child must not be a dependent of a state employee.
- The child must not be 19 or older.
- PeachCare for Kids may not have Medicaid Fair Hearing rights.
- There is no co-payment for any service given to plan participants.

Call 1-877-427-3224 for details or to sign your child up for PeachCare for Kids.

HOW TO GET YOUR MEDICAL SERVICES

Members are cared for by doctors, hospitals, and others who contract with your plan. A doctor with the plan or the plan must approve your care.

The plan will pay for approved care. If it is not approved, you may have to pay for it.

Care that your doctor and plan approves must be medically needed. Your health at the time you see your doctor will be checked with medical practices. Services that are medically needed:

- Are for an illness that would place your health in danger.
- Follow accepted medical practices.
- Are given in a safe, proper, and cost-effective place, depending on what is wrong with you and how sick you are.
- Are not for convenience only.
- Are not custodial.
- Are needed when there is no better or less costly care, service, or place available.

COST SHARING

Medicaid

You may have to make a small co-payment when you get care. This depends on your Medicaid category. If you can't pay, you will still get service. Kids under 21, moms-to-be, nursing home residents, and hospice care members do not have a co-pay.

PeachCare for Kids

There is no co-payment for any service given by WellCare for a PeachCare for Kids participant. Members do pay a small monthly premium required by the Georgia Department of Medical Assistance. The premiums are:

- Age 5 and under—\$0 per month/per child
- Ages 6 and older—\$10–\$35 per month/per child (depends on monthly income)
- 2 or more children, ages 6–18—\$15–\$70 per month (depends on monthly income)

This book talks about the services your plan pays for. It also has the co-pay for each benefit. If you are not sure whether the plan pays for a service, call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

MEDICAID AND PEACHCARE FOR KIDS COVERED SERVICES

Benefits	Limits	Co-Pays
Ambulatory surgical services		\$3
Childbirth education services		\$0
Dental services (preventive and diagnostic)		\$10 for ages greater than 21
Dental emergency services	Ages 21 and older	\$0
Durable medical equipment		\$0
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services		\$0
Emergency transportation services		\$0
Emergency services		\$6 (if condition is not an emergency)
Family planning services and supplies		\$0
Federally qualified health center services		\$2
Health check services	Medicaid—ages 0 to 21 PeachCare for Kids—ages 0 to 19	\$0
Hearing services	Ages less than 21	\$0
Home health services		\$0
Hospice services		\$0
IDEA (Individual Disability Education Act)	Ages 0 to 3, as medically necessary	\$0
Inpatient hospital services		\$12.50 (unless admitted from an emergency room or transferred from another health facility)
Laboratory and radiological services		\$0
Mental health services	Ages less than 21—days greater than 30 are not covered. Services in a state operated mental hospital or institution for mental disease are not covered. Ages greater than 21—as medically necessary	\$0
Nurse midwife services		\$0
Nursing facility services	Days greater than 30 are not covered	\$0
Obstetrical services		\$0
Occupational therapy services	Ages less than 21—available under EPSDT as part of a written service plan Ages greater than 21—as medically necessary	\$0

Continued on next page.

MEDICAID AND PEACHCARE FOR KIDS COVERED SERVICES (CONTINUED)

Benefits	Limits	Co-Pays	
Orthopedic and prosthetic services	Braces, artificial limbs, artificial eyes, custom molded shoes, and diabetic shoes only	\$0	
Oral surgery		\$2	
Outpatient hospital services		\$3 (non-emergency hospital visits)	
Pharmacy services		\$0	
Physical therapy services	Ages less than 21—available under EPSDT as part of a written service plan Ages greater than 21—as medically necessary	\$0	
Physician services (PCP visits and specialists)		\$0	
Podiatry services		\$0	
Pregnancy related services		\$0	
Prescription drugs		Drug Cost	Co-pay
		<\$10.01	\$.50
		\$10.01–\$25.00	\$1.00
		\$25.01–\$50.00	\$2.00
		>\$50.01	\$3.00
Private duty nursing services		\$0	
Rural health clinic services		\$2	
Speech therapy services	Ages less than 21—available under EPSDT as part of a written service plan Ages greater than 21—as medically necessary	\$0	
Substance abuse treatment services	Inpatient and rehabilitative services covered as part of a written service plan	\$12.50	
Swing bed services		\$0	
Targeted case management	Covered for pregnant women under age 21 and other pregnant women at risk for adverse outcomes; infants and toddlers with established risk for developmental delay	\$0	
Transplants (heart and lung)	Ages less than 21; kidney, liver, bone marrow, and cornea are only covered transplants for ages greater than 21	\$0	
Vision services		\$10 for ages greater than 21	

Kids under age 21, pregnant women, nursing facility residents, hospice care members, and PeachCare for Kids members have no co-payments.

MEDICAID AND PEACHCARE FOR KIDS SERVICES NOT COVERED

- Social services
- Chore services
- Meals-on-Wheels
- Portable X-rays
- Long term nursing facility stays over 30 days
- Services for flatfoot
- Subluxation
- Routine foot care
- Vitamin B-12 injections

HOW TO GET APPROVED SERVICES

Call your doctor when you need regular care. They can send you to see a specialist for tests, specialty care, and other covered services not performed by your primary care doctor. Your plan pays for this care. If your PCP does not provide an approved service, ask your PCP how to get that service.

If your doctor or the plan does not arrange or approve your care, you will have to pay for it. Be sure your doctor approves for you to see a specialist. If you need care by a doctor that is not a plan doctor, call your doctor for help.

SECOND MEDICAL OPINION

If you want a second opinion about your care, call your doctor. They will ask you to pick a participating doctor in your service area. If you can't find a participating doctor, you will be asked to pick a doctor that is out of the plan network. You do not pay for these services. If the doctor that is giving the second opinion asks for tests, they must be done by a participating provider.

Your doctor will review the second opinion. They will then decide the best way to treat you. If you see a doctor out of the plan without approval, you may have to pay for it.

PRIOR AUTHORIZATION TIMEFRAMES

The plan will approve regular service in 14 days. Your doctor or the plan may need more time. The plan will then take 14 more days.

You or your doctor can ask the plan for a fast decision (decision made within 24 hours). You may ask for this if waiting for approval could put your life or health in danger. Sometimes, the plan will need more time. This can mean up to 5 days for approval.

Call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272) Monday through Friday, 7am to 7pm Eastern, to ask for a fast service decision. You can also mail a request to the plan or fax it to 1-813-262-2907. Be sure to ask for a fast review.

Authorizations for services delivered are made within 30 days of the plan getting all needed information.

SERVICES AVAILABLE WITHOUT AUTHORIZATION

You do not need approval from your doctor or your plan for these services:

- Visits to your PCP
- Routine dental care (but not surgery)
- Yearly eye exams and glasses
- Family planning (any plan provider)
- One women's health visit to an OB/GYN doctor a year

Even though you do not need approval for these services, you will need to pick a specialist from the plan's provider directory. Call to set up an appointment. Tell them you are a WellCare member. Show them your ID card.

You should have received a copy of the provider directory. If you need a copy, call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272). We will mail one to you.

HOW TO GET AFTER HOURS MEDICAL CARE

If you get sick or hurt when your doctor's office isn't open, and it is not an emergency, call your doctor. The number is on your ID card. If you cannot reach your doctor's office, call Customer Service at the number listed on your ID card. We will help you get the care you need.

WHAT TO DO IN AN EMERGENCY

In the case of an emergency, call 911. Call an ambulance if no 911 service is available in your area, or go immediately to the nearest hospital emergency room. The choice is yours. If you don't know if it is an emergency, call your doctor. Some examples of emergencies are:

- Heavy blood loss
- Cuts requiring stitches
- Poisoning
- Loss of breath
- Heart attack
- Broken bones
- Severe chest pains
- Loss of consciousness

An emergency is when the condition could cause:

- Harm to your health (this includes a mom-to-be and her unborn baby)
- Body injury
- Damage to a body part
- Organ damage
- Harm to self or others due to alcohol or drug abuse
- Injury to self or others

For moms-to-be, it may be an emergency:

- If you think there is no time to go to your doctor's regular hospital
- If you think that going to another hospital may cause harm to you and your baby
- If you think that you are in labor

You will need to show both your plan and Medicaid ID cards at the emergency room (ER). Ask the staff in the ER to call WellCare.

Let your doctor know as soon as you can when you are in the hospital. Let them know if you get care in an ER.

The ER doctor will decide if your visit is an emergency. If it is not, you get the choice to stay. If you stay, you must pay for the care.

Your plan will pay for follow-up care. Your doctor must say it is needed.

WHAT TO DO IF YOU NEED URGENT CARE

Your doctor should see you first for all care. Go to an urgent care center for a condition that needs treatment in 24 hours, but will not cause serious harm to your health. Such conditions include:

- Injury
- Illness
- Severe pain

If you are not sure if it requires urgent care, call your doctor. Urgent care center services do not need prior approval. You will need to show your plan and Medicaid cards at the urgent care center. Ask the staff to call WellCare. Let your doctor know if you receive care in an urgent care center so they can provide follow-up care.

OUT OF AREA EMERGENCY CARE

It is important to get care when you are sick or hurt. If you get sick while traveling, call Customer Service toll-free at 1-866-231-1821 (TTY/TDD: 1-877-247-6272). If you have an emergency while traveling, go to a hospital. It doesn't matter if you are not in the plan's service area. Show your ID card. Call your doctor as soon as you can. Ask the hospital staff to call WellCare.

If you have to pay for these services when you get them, write to our Claims Department. They will need copies of your medical reports. Send copies of bills and include proof of payment.

If you need care or are injured while away from the WellCare service area (the county you live in), call us toll-free at 1-866-231-1821 (TTY/TDD: 1-877-247-6272). We can help you.

PREGNANCY AND NEWBORN CARE

If you have a baby while a plan member, your baby will be covered by the plan from birth.

Moms-to-be should set a time for a prenatal visit with a plan doctor. See the doctor within 14 days of your effective date with the plan or finding out you are pregnant. Call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272) for help.

Moms-to-be should also call the plan to receive information about having and caring for a baby. The plan can also enroll them in the prenatal and stroller rewards programs. Moms will also need to choose a doctor for their baby. If they do not choose a doctor for their baby by the time their baby is born, the plan will assign one.

WHAT TO DO WHEN YOUR FAMILY SIZE CHANGES

Call your caseworker at the Division of Family and Children Services (DFCS) if your family size changes. You can also call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

DISEASE AND CASE MANAGEMENT PROGRAMS

Your plan has programs that help members with certain diseases and conditions get care. They include:

- Asthma
- HIV/AIDS
- Pregnancy
- Diabetes
- High lead levels
- Other complex conditions

Call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272) for more information or to enroll.

Guides are available for people with asthma, diabetes, and kidney disease. Call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

UTILIZATION MANAGEMENT PROGRAM

WellCare also has a utilization management program. The program has different parts. They include:

- Prior authorization
- Prospective reviews
- Concurrent reviews
- Retrospective reviews

We do these reviews to measure the health care and services that our members receive. We measure this based on the members' coverage. We check to see if the care and services are right. Then we determine how much coverage we can provide. And we decide on how to pay those who provide the care.

Sometimes, we have to deny coverage for services or care. These decisions may be made by our employees. Or, they may be made by a doctor or other reviewer. When this happens, we don't give a reward to anyone who makes these decisions. Also, if there are any financial rewards, they do not encourage using less services. For more information, call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

TRANSPORTATION SERVICES

For non-emergency transportation, please call a transportation broker listed in the table below. In most cases, you must call 3 days before you need the service. Each broker has a toll-free telephone number to schedule transportation services and is available weekdays (Monday-Friday) from 7am to 6pm. **In an emergency**, call 911 for a ride to the hospital. You must pay for the ride to the hospital if it was not an emergency.

Region	Broker/Phone Number	Counties Served
North	Southeastrans Toll-free: 1-866-388-9844 Local: 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Clarke, Cobb, Dade, Dawson, Douglas, Elbert, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Greene, Gwinnett, Habersham, Hall, Haralson, Hart, Jackson, Lumpkin, Madison, Morgan, Murray, Newton, Oglethorpe, Oconee, Paulding, Pickins, Polk, Rabun, Rockdale, Stephens, Towns, Union, Walker, Walton, White, and Whitfield
Atlanta	Southeastrans 404-209-4000	Fulton and DeKalb
Central	Southeastrans Toll-free: 1-866-991-6701 Local: 404-305-3535	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Crawford, Dodge, Fayette, Hancock, Heard, Henry, Houston, Jasper, Johnson, Jones, Lamar, Laurens, Meriwether, Monroe, Montgomery, Peach, Pike, Pulaski, Putnam, Spalding, Telfair, Treutlen, Troup, Twiggs, Upson, Washington, Wheeler, Wilcox, and Wilkinson
East	LogistiCare Toll-free: 1-888-224-7988	Appling, Atkinson, Bacon, Brantley, Bryan, Burke, Bulloch, Camden, Candler, Charlton, Chatham, Clinch, Coffee, Columbia, Effingham, Emanuel, Evans, Glascock, Glynn, Jeff Davis, Jefferson, Jenkins, Liberty, Lincoln, Long, McDuffie, McIntosh, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Ware, Warren, Wayne, and Wilkes
Southwest	Southeastrans Georgia Regional Development Center Toll-free: 1-866-443-0761	Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Colquitt, Cook, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Webster, and Worth

OTHER PROGRAMS

Your plan also offers the services listed below in your area. Call your doctor or Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272) to learn more.

- Stop smoking programs
- Domestic abuse support
- Programs for kids
- Drug and alcohol programs
- Programs for moms-to-be and their babies

HOW TO GET OTHER WELLCARE SERVICES

PRESCRIPTION DRUG SERVICES

Prescriptions and Pharmacy Access

Q. How do I get a prescription?

A. Prescriptions must be written by a plan doctor. A prescription by a doctor who is not with the plan must be approved by your plan doctor.

Q. Which drug stores will fill my prescription?

A. Prescriptions must be filled at a drug store in the plan network. A list of these drug stores is on the WellCare Web site, or you can call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272) for help.

Q. What is the process for getting a prescription filled?

A. Show your ID card when you give your prescription. Some drugs and over-the-counter drugs covered by the plan may have a co-pay. The co-pay is based on the cost of the drug. Call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272) to find out if you have a co-pay. Here's a co-pay guide:

Drug Cost	Member Cost
Less than \$10.01	\$.50
Between \$10.01 and \$25.00	\$1.00
Between \$25.01 and \$50.00	\$2.00
Greater than \$50.01	\$3.00

You can keep your co-pay low with generic drugs. These can cost less and work the same as a brand drug. Ask your doctor or pharmacist to give you the generic drug option.

Preferred Drug List

Q. What medicine does the plan pay for?

A. Medicines the plan pays for are on the Preferred Drug List (PDL). Doctors, pharmacists, and nurses make the list. Your doctor will go by the list when prescribing you medicine. The list will also have medicines that may have limits due to your age or gender. The list is on the WellCare Web site. The plan does not pay for these medicines:

- Those used for eating problems or weight gain
- Those used to help you get pregnant
- Those that are cosmetic or help you grow hair
- Those that help you stop smoking
- Barbiturates, except Seconal, Phenobarbital, and Mebaral
- Vitamins (some prenatal vitamins and fluoride preparations are covered)
- Some over-the-counter drugs (see next page)

Q. Can I get any medicine I want?

A. No. The plan made a list to show you the medicines that it will pay for. Call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272) with questions.

Q. What is the difference between brand name and generic drugs?

A. Generic drugs work the same as brand drugs. They have the same ingredients as brand drugs.

Over-the-Counter (OTC) Drugs

Q. Does the plan pay for OTC drugs?

A. You can get some over-the-counter medications at the pharmacy with a prescription. Some of the OTC drugs the plan pays for include:

- Coated aspirin
- Diphenhydramine
- H2 receptor antagonists
- Ibuprofen suspension for members under 21 years of age
- Insulin
- Insulin syringes
- Iron
- Lice B Gone
- Meclizine
- Multi-vitamins and vitamins with iron—chewable or liquid drops for members under 21 years of age
- Non-sedating antihistamines
- Proton pump inhibitors
- Topical anti-fungals
- Urine test strips

Q. Does the plan pay for Personal Care Items?

A. Yes. See the section below. Your family can choose up to \$10 worth of approved Personal Care Items each month. Make your selection and then call 1-866-231-1821 to order. Your order will be mailed to your home.

Helpful Pharmacy Terms

These terms will help you get to know your plan pharmacy benefits.

Co-pay—a fee a member should pay when he or she fills a prescription.

Generic drugs—medicines that work the same as brand drugs but cost less. The U.S. Food and Drug Administration approved them and made sure they work the same.

Over-the-counter (OTC) drugs—drugs you can buy that are not behind the drug store counter.

Pharmacy network—a group of drug stores that plan members can use.

Preferred Drug List (PDL)—medicines approved by plan doctors and pharmacists. These medicines work best, are safe, and cost less. The plan also has medicines it does not approve. The PDL shows doctors which drugs are best to use.

Call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272) with any pharmacy-related questions.

PERSONAL CARE ITEMS

Your family can get up to \$10 in over-the-counter items each month. This includes vitamins, medicines, and health supplies. The list you can choose from begins on the next page. Make your selection and then call, toll-free, 1-866-231-1821 (TTY/TDD: 1-877-247-6272) to place your order. Your items will be mailed to your home.

ITEM	BRAND DESCRIPTION	GENERIC COMPARABLE	SIZE	PRICE
ANALGESICS				
1	ADVIL TABS	IBUPROFEN 200MG FC TABS	50	\$5.00
2	ALEVE CAPLETS	NAPROXEN SODIUM 220MG CAPLETS	50	\$7.00
3	BAYER ASPIRIN	ASPIRIN 325MG CT TABS	100	\$3.00
4	BAYER EC ASPIRIN (ADULT REGIMEN)	ASPIRIN EC 81MG TABS	120	\$4.00
5	ECOTRIN MAX-STRENGTH TABS	EC ASPIRIN MAX ST TABS	60	\$6.00
6	TYLENOL EX-STRENGTH CAPLETS	ACETAMINOPHEN EX-ST CAPLETS	60	\$5.00
7	BENGAY	MUSCLE RUB	85GM	\$5.00
ANTACIDS				
10	MYLANTA GAS 80MG	ANTI-GAS 80MG	100	\$5.00
11	TUMS TABS	ANTACID CHW TABS	150	\$4.00
12	ZANTAC TABS	RANITIDINE HCL 75MG TABS	30	\$8.00
ANTI-DIARRHEALS				
13	IMODIUM CAPLETS	ANTI-DIARRHEAL 2MG CAPLETS	12	\$4.00
14	PEPTO-BISMOL LIQUID	PINK BISMUTH LIQ	8OZ	\$4.00
ANTI-FUNGALS				
15	GYNE-LOTRIMIN CREAM	CLOTRIMAZOLE VAG 1% CRM 1 APP	45GM	\$8.00
16	TINACTIN CREAM	TOLNAFTATE 1% CRM	1OZ	\$5.00
ANTI-HEMORRHOIDALS				
17	ANUSOL OINTMENT	ANUSERT HC-1 OINTMENT	1OZ	\$6.00
18	PREPARATION H OINTMENT	PROMPT RELIEF HEM OINTMENT	2OZ	\$7.00
CHILDREN'S PRODUCTS				
19	ORAJEL BABY	ORAJEL BABY	.33OZ	\$7.00
20	BALMEX OINTMENT	DIAPER RASH OINTMENT	1OZ	\$4.00
21	MYLICON DROPS	GAS RELIEF DROPS	30ML	\$7.00
23	POLY-VI-SOL DROPS	BABY VIT DROPS	50ML	\$7.00
24	MOTRIN SUSPENSION FOR CHILDREN	IBUPROFEN SUSPENSION CHILDREN	4OZ	\$7.00
25	TYLENOL CHILDREN'S GRAPE ELIXIR	ACETAMINOPHEN CHILD'S GRAPE ELX	4OZ	\$5.00
26	TYLENOL CHILD'S CHEW GRAPE TABS	ACETAMINOPHEN CHW GRAPE TAB	24	\$4.00
27	TYLENOL INFANT DROPS	ACETAMINOPHEN CHILD'S GRAPE ELX	.5OZ	\$5.00
COUGH/COLD				
28	BENADRYL TABLETS	DIPHENHYDRAMINE 25MG CAPLETS	24	\$4.00
29	BENADRYL ELIXIR	DIPHENHYDRAMINE LIQ ALC FREE	4OZ	\$4.00
30	CHLORASEPTIC	THROAT LOZENGES—CHERRY	18	\$3.00
31	VICKS VAPORUB	MEDICATED CHEST RUB	90GM	\$4.00
32	ROBITUSSIN SYRUP	GUIATUSS SYR	4OZ	\$4.00
35	AFRIN NASAL SPRAY	NASAL DECONGESTANT SPR	30ML	\$5.00
66	CLARITIN	LORATADINE 10 MG TABS	10	\$7.00
EYE CARE				
36	VISINE DROPS	STERILE EYE DROPS IRRITATION RELIEF	½OZ	\$3.00
FIRST AID CREAMS, OINTMENTS, & ANTISEPTICS				
39	CALAMINE LOTION	CALAMINE LOTION	4OZ	\$3.00

ITEM	BRAND DESCRIPTION	GENERIC COMPARABLE	SIZE	PRICE
FIRST AID CREAMS, OINTMENTS, & ANTISEPTICS (CONTINUED)				
40	CORTAID CREAM	HYDROCORTISONE 1% MAX-ST CRM	1OZ	\$4.00
42	NEOSPORIN OINTMENT	TRIPLE ANTIBIOTIC OINTMENT	1OZ	\$5.00
FIRST AID SUPPLIES				
43	COTTON BALLS	COTTON BALLS	100	\$3.00
44	ACE BANDAGE	ATHLETIC BANDAGE	1	\$5.00
45	ADHESIVE TAPE	ADHESIVE TAPE 1" X 5 YARDS	1	\$3.00
46	BAND-AIDS	BAND-AIDS ASSORTED	50	\$3.00
47	BUTTERFLY CLOSURES MED	BUTTERFLY CLOSURES MED	10	\$3.00
48	EAR WAX REMOVAL	EAR WAX REMOVAL	15ML	\$4.00
49	J & J GAUZE	STRETCH GAUZE BANDAGE 2" X 5 YDS	1	\$3.00
50	COTTON SWABS	COTTON SWABS	170	\$4.00
51	ORAL THERMOMETER	ORAL THERMOMETER	1	\$4.00
52	ALCOHOL SWABS	ALCOHOL SWABS	100	\$3.00
75	ICE BAG 9"	ICE BAG	1	\$8.00
LAXATIVES				
53	COLACE SOFTGELS	DOS 100MG SG CAPLETS	100	\$6.00
54	DULCOLAX SUPP	RELIABLE GENTLE LAX SUPP	12	\$4.00
55	DULCOLAX TABS	RELIABLE GENTLE LAX TABS	25	\$4.00
56	GLYCERIN SUPPOSITORIES CHILDREN	GLYCERIN CHILDS SUPP	25	\$3.00
PEDICULICIDES				
58	RID EXTRA STRENGTH SHAMPOO	LICE TREAT MAX STR SHAMPOO	4OZ	\$7.00
VITAMINS & MINERALS				
59	B-COMPLEX W/ B12 TABS	B-COMPLEX/B-12 TABS	100	\$6.00
60	CALTRATE 600 TABS	CALCARB 600 TABS	90	\$5.00
61	CENTRUM TABS	CERTAGEN TABS	100	\$7.00
62	FLINTSTONES	FRUITY CHW TABS (NF)	100	\$6.00
63	STUART PRENATAL TABS	PRENATAL-S TABS	100	\$6.00
64	VITAMIN C TABS	C CHW 500MG TABS	100	\$4.00
65	VITAMIN E SOFTGELS	E DL ALPHA 400IU SG CAPLETS	100	\$5.00
67	VITAMIN A 10,000 IU	VITAMIN A 10,000 IU	100	\$4.00
HERBALS				
68	COQ-10	COQ-10	30	\$10.00
69	GINKGO BILOBA	GINKGO BILOBA	90	\$7.00
70	GLUCOSAMINE/CHONDROITIN	GLUCOSAMINE/CHONDROITIN	60	\$10.00
71	SAW PALMETTO	SAW PALMETTO	60	\$8.00
FAMILY PLANNING				
72	CONDOMS	CONDOMS	QTY-3	\$3.00
MISC ITEMS				
73	PILL BOX	PILL BOX	1	\$2.00
74	TOOTHBRUSH	TOOTHBRUSH	1	\$2.00
76	TOOTHPASTE	TOOTHPASTE	6.4OZ	\$4.00
77	WAXED DENTAL FLOSS	WAXED DENTAL FLOSS	100YD	\$4.00
78	ANBESOL	ANBESOL	.33OZ	\$8.00

MEDICAID DENTAL SERVICES

Kids who need dental services can get their care through a plan dentist. Services include:

- 2 exams per benefit year
- 2 cleanings per benefit year
- 2 fluoride treatments per benefit year
- 1 filling per tooth
- Dentures—1 pair, every 3 years
- Denture repairs—2 adjustments per benefit year
- Oral surgery
- Orthodontic treatment

WellCare is pleased to offer expanded dental benefits to adults (age 21 and over) in the health plan. Dental services for adults include:

- 2 exams per benefit year
- 2 cleanings per benefit year
- X-rays once a year
- Prescriptions for dental services

**Pregnant members also receive 1 filling per tooth, fluoride treatments, and periodontal treatment.

PeachCare for Kids dental services include:

- 2 exams per benefit year
- 2 cleanings per benefit year
- 2 fluoride treatments per benefit year
- 1 filling per tooth
- Dentures—1 pair, every 3 years
- Denture repairs—2 adjustments per benefit year
- Oral surgery
- Orthodontic treatment

Doral Dental provides these services. Call them at 1-800-516-9615 to choose a dentist. They can also answer your questions about dental care.

MEDICAID VISION SERVICES

The plan pays for:

- Glasses for members under 21 years of age; the glasses must be approved by a doctor
- 1 pair of eyeglasses per person each year

Adults are also covered for some vision services. These additional benefits include:

- 1 adult eye exam each year
- Prescription eyewear with a \$40 allowance toward the cost (except for contact lenses)
- Prescriptions for vision services

PeachCare for Kids vision services include:

- 1 eye exam each year
- 1 pair of glasses per year
- 1 pair of lenses per year

Avesis provides these services. Call them at 1-800-828-9341 to choose a doctor. They can also answer your questions about vision care.

MEDICAID AND PEACHCARE FOR KIDS HEARING SERVICES

The plan pays for hearing care for members under 21 years of age. Benefits include:

- Inner ear implants
- Tests
- Hearing aids (1 every 3 years)
- Hearing aid fitting and dispensing
- Hearing aid repairs and parts
- Newborn hearing tests

GETTING BEHAVIORAL HEALTH SERVICE

If you need help, call Magellan Behavioral Health at 1-800-424-5412. They will help you find a doctor in your area and give you choices. You can also get names of doctors at www.magellanhealth.com.

What to Do if You Are Having a Problem

If you have any of the feelings below, call Magellan. They will give you names of doctors.

- Always feeling sad
- Feeling hopeless and/or helpless
- Feelings of guilt or worthlessness
- Problems sleeping
- No appetite
- Weight loss or gain
- Loss of interest in things you like
- Problems paying attention
- Being upset

- Your head, stomach, or back hurts, and your doctor hasn't found a cause
- Drug or alcohol problems

Behavioral Health Services

You can get other mental health services at the hospital. This includes substance abuse and other care. To learn more, call Magellan at 1-800-424-5412. Magellan will be happy to help you.

Limitations and Exclusions

The plan pays for 30 days of hospital stay a year. This is for short term mental health and help with drug problems. The plan also covers short hospital stays and therapy out of the hospital.

What to Do in an Emergency or if You Are Out of the Plan's Service Area

First, make sure you are in a real mental health emergency. This is if you are a danger to yourself or someone else. If you think you are, call 911 or go to the hospital. The hospital can be out of WellCare's service area. If you need help, call Magellan at 1-800-424-5412.

Call your doctor if you had an emergency. (Follow up with them within 24 to 48 hours.) If you get care out of the plan area, you will be taken to a plan facility when you are well enough.

ACCESS TO MEDICAL SERVICES

The plan has a medical team to offer quick service to members.

Travel time to medical services:

Location	Urban	Rural
PCPs	Within 8 miles	Within 15 miles
SPECIALISTS	Within 30 minutes or 30 miles	Within 45 minutes or 45 miles
HOSPITALS	Within 30 minutes or 30 miles	Within 45 minutes or 45 miles

Timely care:

- Emergency care right away; this is both in and out of the plan area
- Urgent care within 24 hours; urgent care is for a problem that's not a life threat; it could cause sickness or harm with no care
- Care for adults within 72 hours of request
- Care for children within 24 hours of request
- Physical exams within 21 days of request
- Follow-up care as needed

MEDICAID AND PEACHCARE FOR KIDS COVERED HEALTH SERVICES

Call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272) for help with benefits. They can tell you what your plan does not pay for.

MEDICAID AND PEACHCARE FOR KIDS SERVICE REGIONS

Each county in Georgia is separated by service regions. A list of the counties and each service region is located in the front of this handbook. Members must access care within the approved service areas that are listed. Members must also receive all medically necessary covered health care services from WellCare facilities or providers. Members will be responsible for services received outside of the service area, except for emergencies. In the case of an emergency, you do NOT have to be in the plan's service area to receive care. Please call 911 or visit the nearest hospital to receive the care that you need.

Please call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272) for any questions you may have.

IMPORTANT INFORMATION YOU SHOULD KNOW ABOUT WELLCARE OF GEORGIA

ENROLLMENT

Voluntary Enrollment

You can join the plan by calling 1-888-423-6765 (TTY/TDD: 1-877-889-4424). For extra help, call 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

Mandated Enrollment

If you do not choose a health plan, the State will choose one for you. Before they pick a plan for you, they will try to reach you several times by phone, mail, and in person. If you do not respond, they will choose a plan for you. Call 1-888-423-6765 (TTY/TDD: 1-877-889-4424) for information.

Open Enrollment

You start a 12-month membership after you enroll or the State enrolls you in a plan. You have 90 days to try the plan and change plans, if you want. At the end of 90 days, you will stay in your plan for the next 9 months before you can change plans again. If after 9 months in the plan you are still Medicaid eligible, you will be able to change plans. This is called your Open Enrollment period. Outside your Open Enrollment period, you will only be able to change plans if there is a fair reason to do so. This is called having a “good cause” to change plans. A good cause could include:

- Moving out of the plan’s service region
- Moral or religious reasons
- Request to be on the same CMO plan as family members
- Poor quality of care
- Change of eligibility

If you have any questions, call 1-888-423-6765 (TTY/TDD: 1-877-889-4424).

Reinstatement

If you lose your Medicaid eligibility and get it back within 60 days, the State will put you back in your plan. We will send you a letter in 10 days after you are a member again. You can get your doctor back or pick another.

Moving Out of the WellCare Service Area

Your plan is offered in many Georgia counties. If you move, call Customer Service. You will want to pick a doctor near your new home. You must call 1-888-423-6765 (TTY/TDD: 1-877-889-4424) to choose another plan if you move out of your plan area. You will continue to use plan doctors until you are disenrolled.

Voluntary Disenrollment

You may ask to cancel your membership during the first 90 days. You may ask to disenroll without cause. This means you do not need a valid reason for doing so. Call 1-888-423-6765 (TTY/TDD: 1-877-889-4424).

Disenrollment will not affect your Medicaid eligibility. You will get Medicaid’s benefits instead of plan services.

You may still file an appeal or grievance even if you have quit the plan.

Involuntary Disenrollment

You may lose your WellCare membership if you:

- Go into a nursing home or state institution or into a place for the mentally handicapped for more than 30 days
- Use care services in a bad manner
- Impair the plan's ability to give you or others service
- Act in a disruptive way and this attitude/behavior is not caused by a known illness
- Lose your Medicaid eligibility or can no longer be a member

You cannot be taken out of the plan for these reasons:

- Medical problems from before you were a member
- Change in your health
- Not being able to think well any more
- Poor actions from your special needs
- Amount of services you use

APPEALS AND GRIEVANCES COORDINATORS AND ASSISTANCE

To learn more about appeals and grievances, call 1-866-231-1821 (TTY/TDD: 1-877-247-6272). Customer Service can help you weekdays from 7am to 7pm Eastern. Send letters to:

WellCare of Georgia

Attn: Appeals Department

P.O. Box 31368

Tampa, FL 33631-3368

WellCare of Georgia

Attn: Grievances Department

P.O. Box 31384

Tampa, FL 33631-3384

QUALITY AND MEMBER SATISFACTION INFORMATION

You can ask about the plan's performance and member satisfaction. Call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

HOW DOCTORS ARE PAID

WellCare works hard to give you the care you need. We work with many doctors. You may ask how they are paid. You can also ask if how they are paid will affect your doctor's use of referrals. You may ask if it will affect other services you may need. Call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272) for details.

AUTHORIZATION AND REFERRAL PROCESS

To learn more about the plan's authorization and referral process, call 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

PRESCRIPTION DRUG PROGRAM

To learn more about the plan's prescription drug program, call 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

GRIEVANCE INFORMATION

To learn more about grievances filed with the plan in the past 3 years, call 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

FRAUD AND ABUSE

Fraud happens when your health care plan gets billed for a service that costs more than the service received. Fraud also happens when your health care plan pays for a service that someone never used. If you know that fraud happened, tell us. Call our 24-hour hotline at 1-866-678-8355.

To learn more, call 1-866-231-1821 (TTY/TDD: 1-877-247-6272). You can also contact the Georgia Department of Community Health's Program Integrity Hotline at 1-800-533-0686.

EVALUATION OF NEW TECHNOLOGY

New technology and applications of existing technology are evaluated every year. The findings are reviewed to:

- Determine how new advancements can be included in the benefits that members receive
- Ensure that members have equitable access to safe and effective care
- Ensure awareness of changes in the industry

The review of new technology occurs in the following areas:

- Medical procedures
- Behavioral health procedures
- Pharmaceuticals
- Medical devices

To learn more, call 1-866-231-8821 (TTY/TDD: 1-877-247-6272).

WEB SITE

Manage your health care by using the Web. Log onto **georgia.wellcare.com** and sign up today. Features of the Web include:

- Provider search by county or zip code
- Member Message Center
- Online member handbook and provider directory
- Benefit information

Did you know you can update your member information online? Just go to **georgia.wellcare.com** and select the "Members" page on the left side. Then, select "Register" to set up an account.

The information on our Web site is either “secured” or “unsecured.” With secured access, your Personal Health Information (PHI) is kept confidential.

In our secured section, you can:

- Change your primary care physician (PCP)
- Change your address
- Check your eligibility, your co-pays, and the PCP assigned to you
- Check your authorization status (if your PCP has submitted the request to us)
- Read your member handbook
- Check messages we send you through the Message Center

In our unsecured section, you can:

- Contact us about a question or concern that does not involve your PHI
- Find important phone numbers
- Read frequently asked questions (FAQs) from members
- Learn more about Medicaid and PeachCare for Kids
- Find a doctor
- Find a pharmacy
- Look up a medication on our Preferred Drug List
- Report a case of fraud and abuse

If you have any questions, please call our Customer Service Department. Call 1-866-231-1821 Monday through Friday, from 7am to 7pm Eastern. TTY/TDD users, please call 1-877-247-6272.

HEALTH CHECK SERVICES

The plan offers checkups to all Medicaid members ages 0 to 21. The plan also offers PeachCare for Kids member checkups for those ages 0 to 19.

Because it is important for a child's health later in life, WellCare wants to make sure kids visit their primary care doctor for checkups at early ages.

What is a health checkup?

A checkup is a time when your child's primary care doctor will make sure that your child is growing up healthy. The doctor will:

- Do an unclothed physical and mental health exam
- Give any needed shots
- Do any needed blood tests
- Measure height, weight, and how well your child sees and hears
- Look into your child's mouth and check teeth
- Screen your child for tuberculosis and lead
- Give you health tips and education according to your child's age
- Talk to you about your child's growth, development, and eating habits

The specific preventive care services that your child should receive at each age can be found in the *Preventive Health Care Guidelines* on the following pages.

Why is a health checkup important?

Checkups are needed. The visits help find any health concerns before they become a problem. Also, your child can get needed shots during visits.

When should a health checkup happen?

Children should visit their doctor for checkups, even when they are well, at the following times:

- At birth in the hospital
- 2–4 days or 1 week
- 1 month old
- 2 months old
- 4 months old
- 6 months old
- 9 months old
- 12 months old
- 15 months old

- 18 months old
- Every year from age 2 to age 5
- Every other year from age 6 to age 10
- Every year from age 11
 - To age 21 (Medicaid members)
 - To age 19 (PeachCare for Kids members)

How much does a health checkup cost me?

Nothing. Checkups are provided by your child's primary care doctor at no cost to you.

What if I need help making a doctor's appointment?

WellCare can help you get an appointment. Just call 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

What if I need help getting to a doctor's appointment?

The plan can help you get a ride to the doctor. Just call 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

PREVENTIVE HEALTH GUIDELINES—ADULTS 21 AND OLDER

FREQUENCY OF PHYSICAL EXAMINATION

All new members should get a baseline physical exam in the first 90 days of enrollment. Pregnant members should be seen in the first 30 days. The Cleveland Clinic's recommendations for periodic health exam visits for asymptomatic adults are:

- **Age 19 to 39**—every 1 to 3 years (women should get an annual Pap smear; if 3 normal smears in a row, then 1 every 3 years)
- **Age 40 to 64**—every 1 to 2 years based on risk factors
- **Age 65 and older**—every year

Age	Screening	Frequency
18 years of age and older	Blood pressure, height, body mass index (BMI), alcohol use	Each year from age 18 to 21; then, every 1 to 2 years or at PCP's recommendation
Men 35 to 65 years of age	Cholesterol (non-fasting TC/HDL)	Every 5 years (more often if elevated)
Women 45 to 65 years of age	Cholesterol (non-fasting TC/HDL)	Every 5 years (more often if elevated)
High risk men and women 20 years of age and older	Cholesterol (non-fasting TC/HDL)	Every 5 years (more often if elevated)
Women 18 to 25 years of age who are sexually active (consider at age 12 if sexually active)	Chlamydia	Each year and at PCP's recommendation
Women 18 to 65 years of age (or 3 years after onset of sexual activity, whichever comes first)	Pap smear	Every 1 to 3 years
Women 40 years of age and older	Mammography	Every 1 to 2 years
50 years of age and older	Colorectal	Periodically, depending upon test
Women 65 years of age and older (60 and older if at risk for fractures)	Osteoporosis	Routinely
65 years of age and older	Vision, hearing	Periodically

IMMUNIZATION

Tetanus-Diphtheria and acellular pertussis (Td/Tdap)	Td: Every 10 years, 18 years and older Tdap: Substitute 1 dose of Tdap for Td (one time administration)
Varicella (VZV)	Susceptible adults only, 18 years of age and older – 2 doses
Measles, Mumps, Rubella (MMR)	Women of childbearing age, if not already immune
Pneumococcal	65 years of age and older – 1 dose
Influenza	Every year, 50 years of age and older
Hepatitis B vaccine	Adults at risk, 18 years of age and older – 3 doses
Meningococcal conjugate vaccine	College freshmen living in dormitories and others at risk, 18 years of age and older – 1 dose

PREVENTION

- Aspirin to prevent cardiovascular events
 - Men: 40 years of age and older
 - Women: 50 years of age and older
- Breast cancer (for women at high risk)
- Prostate specific antigen (PSA) test and rectal exam (for men after 40 years of age per PCP's discretion)

COUNSELING

- Calcium—1,000 mg a day for women 18 to 50 years of age; 1,200 to 1,500 mg a day for women 50 years of age and older
- Folic acid—0.4 mg a day for women of childbearing age; 4 mg a day for women who have had children with Neural Tube Defects (NTDs)
- Breast feeding—women after giving birth
- Quitting tobacco; drug and alcohol use; STDs and HIV; nutrition; physical activity; sun exposure; oral health; injury prevention; polypharmacy

References:

- Guide to Clinical Preventive Services, 2005: Recommendations of the U.S. Preventive Services Task Force, June 2005.
- Recommended Adult Immunization Schedule – United States, October 2006-September 2007. MMWR October 13, 2006, Vol. 55, No. 40.
- Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) May 2001.
- Bone Health and Osteoporosis: A Report of the Surgeon General (2004).
- Cleveland Clinic [www.cchs.net/health/health-info/Periodic Health Exams and Cancer Screening](http://www.cchs.net/health/health-info/Periodic%20Health%20Exams%20and%20Cancer%20Screening).

Legal Disclaimer: These clinical practice guidelines were developed to assist practitioners in making decisions about appropriate health care for specific clinical circumstances. These guidelines are not fixed protocols that must be followed, but are intended for health care professionals and providers to consider. While they identify and describe generally recommended courses of intervention, they are not presented as a substitute for the advice of the physician or other knowledgeable health care professional or provider treating the patient. Individual patients may require different treatments from those specified in a given guideline. Guidelines are not entirely inclusive or exclusive of all methods of reasonable care that can obtain/produce the same results. While guidelines can be written that take into account variations in clinical settings, resources, or common patient characteristics, they cannot address the unique needs of each patient nor the combination of resources available to a particular community or health care professional or provider. Deviations from clinical practice guidelines may be justified by individual circumstances. Thus, these guidelines must be applied based on individual patient needs and are not a substitute for the professional medical judgment of the provider of care.

PREVENTIVE HEALTH GUIDELINES—NEWBORN UP TO 21 YEARS OLD

Age	Well-baby Checkups and Shot Guide
Newborn	Well-baby checkup* at birth; hearing test; newborn screening blood tests; Hepatitis B (HepB) shot
2–4 days	Well-baby checkup*, as recommended; newborn screening blood tests; Hepatitis B (HepB) shot, if not done at birth This visit is especially important if your baby was sent home within 48 hours of birth.
1 month	Well-baby checkup*; second HepB; newborn screening blood test, if not already done
2 months	Well-baby checkup*; Diphtheria, Tetanus, and Pertussis (DTaP) shot; Polio (IPV) shot; Pneumococcal (PCV) shot; Haemophilus influenzae type b (Hib) shot
4 months	Well-baby checkup*; DTaP, Hib, IPV, PCV shots
6 months	Well-baby checkup*; DTaP, HepB, Hib, IPV, PCV shots
9 months	Well-baby checkup*; blood lead test; hemoglobin or hematocrit
12 months	Well-baby checkup*; blood lead test, hemoglobin or hematocrit, if not done at 9 months; Hib shot; Measles, Mumps, Rubella (MMR) shot; Hepatitis A (HepA) shot; Varicella (chicken pox) shot; PCV shot; dental visit, as need identified
15 months	Well-baby checkup*; DTaP, Hib shots; urine test and blood lead test, if not done at 9 or 12 months
18 months	Well-baby checkup*; second HepA (6 months after the first dose)
24 months	Well-baby checkup*; blood lead test
Flu shots	Each year for kids age 6 months or older who have certain high risk diseases like asthma and diabetes

Age	Well-child Checkups and Shot Guide
3 years	Well-child checkup*; eye screening; annual dental visit**
4–5 years	Well-child checkup* each year; eye screening; MMR, DTaP and IPV shots sometime between ages 4 and 6; annual dental visit; urine test at age 5 years
6–10 years	Well-child checkup* every other year; annual dental visit; urine test at age 6 years, if not done at age 5 years
11–12 years	Well-child checkup* once; Meningococcal shot; Tetanus, diphtheria, and pertussis (Tdap) shot
13–21 years	Well-adolescent checkup* each year; hemoglobin or hematocrit by age 14; annual dental visit; urine test by age 16; females should have a pelvic exam and Pap smear between ages 18 and 21

This is just a guide. It does not replace your doctor’s advice. Talk with your doctor to make sure you and your family get the right tests and care.

*Well-baby, -child, and -adolescent checkups/exams—infant unclothed, older child undressed and covered; health history; developmental and behavioral assessment; sleep position counseling from 0 to 9 months; injury and violence prevention; nutrition counseling; height and weight test; test for obesity (known as BMI); vision and hearing screening; head circumference at 0 to 24 months; blood pressure, at least every year beginning at age 3.

As needed:

- Hemoglobin or hematocrit between age 15 months and age 6 years; also between age 11 and age 21
- Urine testing from age 11 through age 21
- Lead risk assessments and/or testing from age 3 to age 6
- Tuberculosis risk assessments and/or testing from age 12 months through age 21
- Cardiovascular disease risk assessments and cholesterol screening from age 2 through age 21
- Sexually transmitted disease testing from age 11 through age 21
- “Catch up” on any shots that were missed at an earlier age

**A dental visit may be recommended starting at age 1.

References:

- Committee on Practice and Ambulatory Medicine Recommendations for Preventive Pediatric Health Care, PEDIATRICS, Vol. 105 (3), March 2000, pages 645-646, Copyright © 2000 by the AAP.
- Recommended Childhood and Adolescent Immunization Schedule United States-2006, approved by the Advisory Committee on Immunization Practices (www.cdc.gov/nip/acip/), the American Academy of Pediatrics (www.aap.org), and the American Academy of Family Physicians (www.aafp.org).
- Recommended Immunization Schedule for Child and Adolescents Who Start Late or Who Are More Than 1 Month Behind, United States-2006, approved by the Advisory Committee on Immunization Practices (www.cdc.gov/nip/acip/), the American Academy of Pediatrics (www.aap.org), and the American Academy of Family Physicians (www.aafp.org).
- American Dental Association (<http://www.ada.org/>).

ADVANCE DIRECTIVES

Your care is your decision.

The law says you have a right to refuse care. This includes care that keeps you living. The law says that the plan must tell members about advance directives.

Advance directives help you make your wishes known.

An advance directive is a legal paper. It tells doctors what type of care you want to get (or not get) if you are not able to tell them. There are two types—a Living Will and a Durable Power of Attorney for Health Care Decisions.

LIVING WILLS

A Living Will shows the type of care you want if you are not awake and will not wake up. It can be used if you have a condition that will lead to death. It tells your doctor when to keep up or stop care to keep you alive.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

A Durable Power of Attorney for Health Care Decisions names the person you want to make choices for you. It will be used if you are not able to make choices. It will also be used if you can't tell your doctor about the care you want.

A Living Will or Durable Power of Attorney for Health Care Decisions is used when you can't decide for yourself. It's also used if you can't tell your doctor your wishes.

You can change or cancel your wishes at any time. If you make changes, you should tell your doctor and family.

How can I get an advance directive?

You can call a lawyer or your local legal aid office. You can also ask your doctor or call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272). Your health care is your choice.

MEMBER ADMINISTRATIVE REVIEW AND GRIEVANCE PROCEDURE

FILING A COMPLAINT WITH WELLCARE

We want you to tell us if you have any problems with the care you get. Call us at 1-866-231-1821 (TTY/TDD: 1-877-247-6272). We can help you if you speak another language.

This section tells you how to make a complaint. There are also rules for what the plan must do when we get a complaint. If you make a complaint, we must be fair. We can't drop you from the plan or treat you differently.

ADMINISTRATIVE REVIEWS AND GRIEVANCES

You can make a complaint if you have problems with the care you get. "Administrative reviews" and "grievances" are the two types of complaints you can make.

An administrative review is when you want us to change a decision we made about your care. It could be:

- If we refuse to pay for services you think we should cover
- If a doctor didn't give you care you think you should have gotten
- When a doctor cuts back services you had been getting
- If you think we stopped your care too soon

A representative can file one of these for a member who died.

A grievance is when you have any other type of problem with the plan or a doctor. It could be for:

- Quality of care
- Wait times during doctor visits
- The way your doctor or others behave
- Not being able to reach someone by phone
- Not getting information you need
- An unclean or poorly kept doctor's office

MAKING A COMPLAINT TO CHANGE A DECISION ON WHAT THE PLAN WILL PAY FOR

Here we tell you what you can do if you have problems getting the care you think we should give you. Giving care includes things like:

- Approving care
- Paying for care
- Assigning someone to your care
- Continuing to provide care you have been getting

Problems getting the care you think we should give include:

- If you are not getting the care you want, and you think the plan should pay for it.
- If we will not approve the care your doctor or other doctors want to give you, and you think the plan should pay for this care.
- If you learn that we plan to reduce or stop pay for care you have been getting, and you think this will harm your health.
- If you get care you thought the plan would pay for, and we said we would not pay.

Asking for Care or Payment from the Plan

You can take 2 steps if you have problems getting care or paying for care.

A new person will take a look at your case. He/she will not have been part of the first decision. This person will also be someone who did not work directly with anyone in the first decision. If you aren't happy with the result, there may be another step you can take.

Step 1—Notice of Proposed Action by the Plan

First, we will send you a Notice of Proposed Action. It talks about your care or paying for care you already received. When we make an action, we give our view of how care for members applies to your specific case. You can ask for a “fast initial decision” if you have a request for quick care. In the review, you or your representative can look at your case papers and care records.

Step 2—Administrative Review of the Notice of Proposed Action by the Plan

If you don't like what we decide in the first step, you, your doctor, or representative can ask us to reconsider. This is known as an “administrative review” or a “request for reconsideration.” You can ask for a quick review. We will decide to change or keep the first decision.

How do you file your administrative review of the Notice of Proposed Action?

You, your doctor, or representative can file for a review.

You can write us to ask for a review. You must also fill out a review request form. You can get this form from Customer Service. Call 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

You can also give it orally. You must sign a review request form if you give it orally.

This is only if it is not a fast or quick review.

We will mail you a letter in 10 days saying that we got your review. This is only if it is not a quick review. We will send you a decision letter instead if we decide on your review in less than 10 days.

How soon must you file your administrative review?

Send it within 30 days of the date when we notified you. We will mail you a denial if we don't get the request in time.

How do you get benefits when you're waiting on a review decision? What rights do you have?

Please see “How can my benefits be continued during a review or hearing” later in this section.

What if you want a fast review?

You, any doctor, or representative can ask us for a fast review. Call 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

Deliver a written report to:

WellCare of Georgia
Attn: Appeals Department
P.O. Box 31368
Tampa, FL 33631-3368
Fax: 1-866-201-0657

Ask for a fast review. We will give you a fast review right away if a doctor says it's needed. If you ask for a fast review without a doctor, we will decide if it is a "must" for your health. We will work to get in touch with you if we feel your fast review is not needed.

We will also send you a letter within 2 days. You will need to ask your doctor to support a fast review. If your doctor agrees, we will give you a review right away. The letter will tell you how to send a complaint if your doctor doesn't support a fast review and you don't like what your doctor says.

A regular review is in 45 days.

How soon must we decide on your review?

- For pay for care you received—a regular review is within 45 days after we get your review.
- For a standard decision about care—a regular review is within 45 days after we get your review. We will make it sooner if your health needs it.
- For a fast decision about care—we have 72 hours after we get your review to decide. We will make it sooner if your health needs us to.

It can take up to 14 more days if you ask for a longer review. You can ask for this in writing or by phone. Reasons why you may need a longer review include:

- Extra tests
- Delay of records
- Need time to get more information

We will mail you a letter called a "Notice of Adverse Action." It will talk about your rights to disagree if a decision is not in your favor. We will also try to contact you in person.

How can you give proof and/or allegations of fact or law?

We will let you give comments or information for your review in writing or in person. Call 1-866-231-1821 (TTY/TDD: 1-877-247-6272) to give this in person.

Can you review your case file?

Yes. Your doctor or representative can review it as well, if you let us know in writing. Call us at 1-866-231-1821 (TTY/TDD: 1-877-247-6272) to do so.

APPEALING FOR AN ADMINISTRATIVE LAW HEARING OR DCH HEARING

You can ask for a hearing with an Administrative Law judge (Medicaid) or a DCH hearing (PeachCare for Kids) if you don't like the review decision. You must ask for a hearing within 30 days of the decision.

MAKING COMPLAINTS TO THE PLAN FOR ISSUES NOT CLASSIFIED AS ADMINISTRATIVE REVIEWS

First, call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272) with a complaint. A doctor may not make a complaint for you. We must get a complaint within 1 year of when the issue you were unhappy about took place. We will try to fix the problem over the phone. You can also write to us with your complaint.

You have the right to complain about:

- Quality of service
- Office waiting times
- Doctor behavior
- Condition of the places where you get care
- If you were taken out of the plan without asking
- If we don't give you a fast review
- If we don't give you a longer review time

We will try to fix any complaint you have. We try to do this by phone, especially if it is because:

- We don't have enough information.
- We don't have the right information.

We will have you speak with a support person if your complaint can't be fixed right away over the phone by Customer Service.

We will mail you a letter within 10 days of us getting your complaint. We will mail you a decision letter if we can fix your problem in this time.

A doctor will review your case if your complaint has medical issues.

We make decisions within 45 days of getting your complaint. We will mail you a letter with the results. It will tell you how to make a second-level complaint.

You must write to us with a second-level complaint. You should send this within 30 days of getting your decision.

Send the letter to the Appeals and Grievance Committee (AGC). The AGC is made of members that were not first involved with your case.

You can also do a second-level complaint in person. Tell us about this in your written request. The AGC meets every Thursday from 9am to 10:30am Eastern. We will touch base with you to set up a time.

You will have 15 minutes to give your side of the case. The AGC will then ask any questions. You will get a decision letter within 5 days of this meeting.

Some contacts for a review or complaint:

Office of Commissioner of Insurance
Life & Health
Regulatory Services Division
Suite 604, West Tower
Two Martin Luther King, Jr. Drive
Atlanta, GA 30334
Phone: 1-404-657-7742
Fax: 1-404-657-7743

Georgia Department of Human Resources
Office of Regulatory Services
Health Care Section
Two Peachtree Street, NW
Suite 33-250
Atlanta, GA 30303-3142
Phone: 1-404-657-5550
Fax: 1-404-657-8934

We keep track of all reviews and complaints to help us improve our service to you. We give this information to the State.

Administrative Law Hearing (Medicaid) or DCH Hearing (PeachCare for Kids) (available after a review)

You can ask for an Administrative Law or DCH Hearing after a review. Write to:

Medicaid–
Department of Community Health
Legal Services Section
General Counsel's Office
Two Peachtree Street, NW 40th Floor
Atlanta, Georgia 30303-3159

PeachCare for Kids–
PeachCare for Kids
Attn: Resolution Coordinator
Two Peachtree Street, NW
Atlanta, GA 30303-3159

You or your representative are the only ones that can request a hearing. Your doctor cannot. You must request a hearing within 30 days of the review decision.

How can my benefits be continued during a review or hearing?

For your benefits to continue:

- You must send your review within 10 days of the Notice of Adverse Action if filing orally (15 days by writing and by mail).
- The review or hearing must be about an end or reduction in care.
- The care must have been asked for by a plan doctor.
- The original pay term for care cannot be expired.
- You must request a longer term for care.

We will mail you a denial letter if you do not ask for this in time.

If we let your benefits continue during a review or hearing, you can keep getting them until:

- You drop the review or hearing.
- 10 days pass from an oral request (15 days from a mailed request). This is from the date of the plan's action. You must not have requested a hearing with benefits until we have decided.
- A decision you don't like is made.
- The care approval expires or service limits are met.

You may have to pay for the cost of your care during a review or hearing. This is if we don't agree with your complaint.

If we don't decide in your favor, the plan may recover the cost of care during your case. If we decide in your favor and you didn't get benefits during your case, we will get you care right away. We will approve and pay for the care.

By state law, we will pay for services you did not agree with during your review or hearing.

Exhaustion of Grievance Procedures

You must take part in the plan's review and complaint process before you can take legal action.

WHERE TO FIND EXTRA HELP

COMMUNITY RESOURCE GUIDE

Sometimes you may need extra help. You can get help just by calling 211. Here are the types of help you can get.

Basic Needs

- Food banks
- Clothing
- Shelters
- Rent and utilities

Support for Children and Families

- Child care
- Success by Six (after school programs)
- Head Start (family centers)
- Summer camps
- Outdoor play
- Tutoring
- Protection services

Volunteer Employment Support

- Out-of-work benefits
- Money help
- Job training
- Rides
- Education

Support for Older and Disabled People

- Home health care
- Adult day care
- Meals-on-Wheels
- Respite care
- Rides
- Homemaker services

The 211 line is a national service. It was started in Atlanta by the United Way, which still supports the help line.

WELLCARE OF GEORGIA MEMBER RIGHTS

You have the right:

- To get information about the plan, its services, and its doctors and providers.
- To get information about your rights and responsibilities.
- To know the names and titles of doctors and other health providers caring for you.
- To be treated with respect.
- To be treated with dignity.
- To have the right to privacy.
- To decide with your doctor on the care you get.
- To talk openly about care you need for your health, no matter the cost or benefit coverage, and the choices and risks involved. The information must be given in a way you understand.
- To have the risks, benefits, and side effects of medications and other treatments explained to you.
- To know about your health care needs after you get out of the hospital or leave the doctor's office.
- To refuse care, as long as you agree to be responsible for your decision.
- To refuse to take part in any medical research.
- To complain about the plan or the care it provides. Also, to know that if you do, it will not change how you are treated.
- To not be responsible for the plan's debts.
- To be free from any form of restraint or seclusion as a means of force, discipline, convenience, or revenge.
- To have access to your medical records.
- To have your records kept private.
- To make your health care wishes known through advance directives.
- To have a say in the plan's member rights.
- To appeal medical or administrative decisions by using the plan or the State's grievance process.
- To exercise these rights no matter your sex, age, race, ethnicity, income, education, or religion.
- To have all plan staff observe your rights.
- To have all the above rights apply to the person legally able to make decisions about your health care.

WELLCARE OF GEORGIA MEMBER RESPONSIBILITIES

You have the responsibility:

- To give information that the plan and its doctors and providers need to provide care.
- To follow plans and instructions for care that you have agreed on with your doctor.
- To understand your health problems.
- To help set treatment goals that you and your doctor agree to.
- To read the member handbook to understand how the plan works.
- To carry your member card at all times.
- To carry your Medicaid card at all times.
- To show your ID cards to each provider.
- To schedule appointments for all non-emergency care through your doctor.
- To get a referral from your doctor for specialty care.
- To cooperate with the people who provide your health care.
- To be on time for appointments.
- To tell the doctor's office if you need to cancel or change an appointment.
- To pay co-payments to providers as specified by the Georgia Families program.
- To respect the rights of all providers.
- To respect the property of all providers.
- To respect the rights of other patients.
- To not be disruptive in your doctor's office.
- To know the medicines you take, what they are for, and how to take them the right way.
- To make sure your doctor has copies of all previous medical records.
- To let your plan know within 48 hours, or as soon as possible, if you are admitted to the hospital or get emergency room care.

WELLCARE NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Why WellCare Provides This Notice

WellCare¹ is required by law to maintain the privacy of Protected Health Information (“PHI”) and to provide individuals with oral, written, or electronic notice of WellCare’s legal duties and privacy practices with respect to PHI. PHI includes information that can be used to identify you and has been created or received about your past, present, or future health or condition, the provision of health care to you, or the payment for this health care.

This notice explains our privacy practices that are applicable to you, a valued member of WellCare. We appreciate the confidence and trust that you have bestowed upon us. Your privacy is very important to us, and we take this duty seriously.

WellCare is required to follow the privacy practices that are described in this notice. However, we reserve the right to change the terms of this notice and our privacy practices at any time. Any changes to our policies and procedures will apply to the PHI we already have in our possession. If we make material change to our policies and procedures about your PHI, we will update this notice, post a new notice on our Web site at <http://www.wellcare.com>, and, to the extent required by applicable law, promptly mail a notice of the changes to you.

2. WellCare Needs Information to Provide Services

The types of PHI we collect on each of our members will include, but not necessarily be limited to: (i) the information that you provide to us or that we receive from regulatory authorities, your employer, or benefits plan sponsor on an application or any other form, in person or in writing, electronically or by telephone (such as your name, address, Social Security number, date of birth, dependent information, marital status, health or medical history, employment information, and other insurance carrier history); and (ii) your contact and affiliation in any form with any of our agents, business partners, or any other party (such as medical records, health care claims, premium payments, verification of your eligibility, appeal and grievance information, information to process requests for health care authorizations, and enrollment applications).

3. Treatment, Payment, and Health Care Operations

We use and disclose your PHI primarily for your treatment, payment, and our health care operations. The following list describes the most common uses and disclosures that WellCare and its business partners may make that are permitted by law.

¹ This Notice of Privacy Practices is applicable to the following subsidiaries of WellCare Health Plans, Inc.: WellCare of Florida, Inc., HealthEase of Florida, Inc., WellCare of New York, Inc., WellCare of Connecticut, Inc., WellCare of Louisiana, Inc., WellCare of Georgia, Inc., WellCare of Ohio, Inc., Harmony Behavioral Health, Inc., Harmony Behavioral Health of Florida, Inc., Harmony Health Plan of Illinois, Inc., WellCare Prescription Insurance, Inc., WellCare Health Insurance of Arizona, Inc., WellCare Health Insurance of Illinois, Inc., and WellCare Health Insurance of New York, Inc.

- To a doctor, a hospital, or other health care provider in order to provide your medical care.
- To pay claims for covered services provided to you by doctors, hospitals, or other health care providers.
- For the daily operations of WellCare, including but not limited to, processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of health care professionals, and determining premiums.
- To your plan sponsor to permit them to perform plan administration functions.
- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you.

4. Other Uses and Disclosures of PHI

WellCare may use or disclose information about you:

- To your family and friends if you are unavailable to communicate, such as in a medical or other emergency.
- When disclosure is required by federal, state, or local law, judicial or administrative proceedings, or law enforcement officials. For example, we make disclosures to regulatory agencies when a law requires that we report information. We may also disclose PHI pursuant to subpoena as part of a judicial or administrative proceeding.
- To government agencies for public health activities or health oversight activities, such as disclosures to agencies that regulate Medicare and Medicaid services.
- To appropriate authorities regarding abuse, neglect, or domestic violence.
- To military authorities.
- For research purposes in limited circumstances.
- For procurement, banking, or transplantation of organs, eyes, or tissue.
- To a coroner, medical examiner, or funeral director.

5. Uses and Disclosure Requiring Authorization

In other situations, WellCare will require a specific authorization before we use or disclose your PHI. For example, WellCare will seek your authorization before using or disclosing your PHI if we seek to offer unsolicited marketing resources to you for a purpose that is not related to your health benefits or health condition. You have the right to revoke such an authorization at any time by notifying us in writing.

6. Your Individual Rights

A. Access—You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page and per hour for staff time to locate and copy your information and postage.

B. Confidential Communications—You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life threatening situation. We will accommodate your request if it is reasonable.

C. Amendment—You have the right to request an amendment of information we maintain about you if you believe that it is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will provide you a written explanation of the denial.

D. Accounting—You have the right to receive a list of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, or health care operations, and certain other activities. If you request this information more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

E. Notice—All WellCare members and prospective members have the right to receive a written copy of this notice upon request at any time.

F. Restrictions—You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.

G. Contact—All of your applicable privacy rights can be exercised by contacting WellCare. If you wish to write to us, please write to the Chief Privacy Officer. If you call us, please call the toll-free phone number on your membership card and a Customer Service associate will assist you. You may also call the number below.

WellCare Health Plans, Inc.
Attention: Chief Privacy Officer
8735 Henderson Road, Ren. 2
Tampa, FL 33634
Phone: (813) 290-6200

7. Complaints

If you believe this policy has been violated with respect to information about you or your covered dependents and you wish to file a complaint with us, it may be done either verbally or in writing. You may also file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights (OCR). We will not retaliate against you for filing a complaint.

Effective Date: October 1, 2006

If you have any questions about the information contained in this handbook, please call Customer Service toll-free at 1-866-231-1821 (TTY/TDD: 1-877-247-6272) Monday–Friday, 7am–7pm Eastern.

 **WellCare**[®]
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WellCare
means better
care.

