

HEALTH EASE MEMBER HANDBOOK

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WELCOME TO HEALTHEASE!

This is your member handbook. The information in this book will tell you how your health plan works. Please read it carefully. Please also keep your handbook in a safe place so you may refer to it when you need it.

GETTING STARTED

It's easy! Just follow these steps and you will be on your way to getting the health care you need with HealthEase:

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

You should have already received your HealthEase ID card in the mail. If you have not received your ID card, please call our Customer Service Department, toll-free, at 1-800-278-0656.

Whenever you need health care, you need to give your ID card to the health care provider. Your card contains important information about your health care coverage. Be sure to keep this card and your Medicaid gold card with you at all times.

Please take the time to look at the information on your ID card. Check the Primary Care Physician (PCP) name listed on the card. If you want to change your PCP for any reason, call our Customer Service Department, toll-free, 1-800-278-0656.

The date your HealthEase membership starts is listed on your ID card.

2nd—Schedule a visit with your Primary Care Physician (PCP).

Your PCP will take care of all routine medical care for you and will arrange for specialists or hospital care if needed. For non-emergency health needs, call your PCP at the number on your ID card.

It is important that you get to know your PCP. Please call your doctor's office to set an appointment for a checkup. As a new member of our health plan, you **MUST** be seen by your PCP within 90 days of joining. If you are pregnant, you **MUST** be seen by your PCP within 30 days of the start of your membership in HealthEase.

It is also important that you request the release of your medical records from doctors you have seen prior to your enrollment with HealthEase. Please contact our Customer Service Department, toll-free at 1-800-278-0656 if you need help requesting this information from your previous providers.

You can ask your PCP for your current medical records. If you need any help with this, you can call Customer Service.

3rd—Learn how to use your health care benefits – it's easy!

It's easy to use your HealthEase health plan benefits. For non-emergency health needs, call your PCP at the number on your ID card. Your PCP will handle all routine medical care for you and arrange for specialist or hospital care if it is needed.

4th—Get to know your Personal Health Advisor.

HealthEase has a Personal Health Advisor available to answer health care questions or concerns that you may have. When you are not sure what kind of medical care you need, please call your Personal Health Advisor. It is a free service! A trained medical professional is available to you any time, any day. Your Personal Health Advisor can be reached, toll-free, at 1-800-919-8807.

5th—In an emergency.

For a REAL MEDICAL EMERGENCY, go to the nearest emergency room or call 911. This handbook explains more about your health plan and how to access health care. Please read it carefully with special attention to the Emergency Care section of this booklet where you can find a list of examples of what is a real medical emergency.

6th—Call-in your monthly over-the-counter product order.

This handbook also has information about the products that you can get through your new over-the-counter product benefit. Do not mail this form back to us. Each month you can choose up to \$25 of the items listed in the brochure for your household. Call us with your order each month. Items of your choice will be mailed directly to you. Call, toll-free, 1-800-278-0656.

7th—Call HealthEase Customer Service if you need any assistance.

Call us with any questions you may have. Interpretation services and alternative communication systems are available, free of charge, for all foreign languages. Just call. A Customer Service representative can help you weekdays, 8am to 7pm, EST. Call, toll-free, 1-800-278-0656. You may also use our automated service 24 hours a day, 7 days a week for the following services:

- Request ID cards
- Change your PCP
- Request your over-the-counter products
- Get a list of doctors in the health plan
- Get a list of pharmacies in the health plan

8th—Your enrollment in HealthEase is voluntary.

You may disenroll during your open enrollment. You may also disenroll for good cause at any time during your enrollment. Call a Choice Counselor toll-free at 1-866-454-3959. The toll-free hearing impaired number for a Choice Counselor is 1-866-467-4970.

9th—HealthEase members have certain rights and responsibilities.

Florida law requires that your health care providers recognize your rights and that you respect the rights your providers have, too. Please read a summary of your rights and responsibilities included in this booklet. You will also see them posted in your doctor's office.

10th—For information on how to get dental, vision, and behavioral health benefits, please see the information in this handbook.

You are now ready to begin using all the health benefits you receive with HealthEase. We look forward to serving you.

MEMBER INFORMATION

Enrollment in HealthEase

HealthEase serves children and adults eligible to be in Florida’s Medicaid program. Medicaid is the state and federal partnership that provides health coverage for selected groups of children and adults with low incomes.

Three basic groups can get Medicaid:

- People in Supplemental Security Income (SSI) program;
- Children and families; and
- Aged, blind, and disabled people, including people needing institutional care (also known as “SSI-related” Medicaid).

A person must meet certain eligibility requirements in order to get Medicaid. The Social Security Administration sets eligibility for the SSI program. The Florida Department of Children and Families (DCF) determines all other Medicaid eligibility including programs for children and families; aged; blind and disabled; and institutional care. If you want to know more about how to qualify for Florida’s Medicaid program, please call **1-866-454-3959 (TTY/TTD: 1-866-467-4970)** to speak with a Choice Counselor representative. (Choice Counselor is a state-sponsored helpline that helps you enroll in the health plan of your choice.)

It’s Your Choice

Most Medicaid beneficiaries are required to get services through managed care. After you are approved for Medicaid, you will be sent information on managed care providers in your area, like HealthEase. You must choose your plan within 30 days. If you do not, the State will choose a plan for you.

HealthEase offers all the benefits of Medicaid plus:

TANF (Broward)

- Adult vision services including unlimited eye exams and eyeglasses, if medically necessary
- Adult dental benefits such as X-rays, an annual exam, and two cleanings per year
- Up to \$25 per month for selected personal care items for every household
- Circumcision up to 1 year of age

TANF (Duval)

- Adult vision services including unlimited eye exams and eyeglasses, if medically necessary
- Adult dental benefits such as unlimited fillings (silver—up to 3 surfaces), periodontic deep cleanings, X-rays, an annual exam, and two cleanings per year
- Up to \$25 per month for selected personal care items for every household
- Circumcision up to 1 year of age

SSI

- Adult vision services including unlimited eye exams and eyeglasses, if medically necessary
- Adult dental benefits such as unlimited fillings (silver—up to 3 surfaces), clear fillings, restorations, crown (1 per 5 years), periodontic deep cleanings, X-rays, an annual exam, and two cleanings per year
- Up to \$25 per month for selected personal care items for every household
- Circumcision up to one year of age
- Meals on Wheels—10 free meals delivered to your home after leaving a hospital or skilled nursing facility, as medically necessary
- Respite Program— Once per month parents or guardians of children with special needs are given a 3 hour break from ongoing care-giving responsibilities

If you qualify for Medicaid and would like to learn about joining HealthEase, you should call the Choice Counselor Helpline at 1-866-454-3959 (TTY/TTD users, please call 1-866-467-4970).

Your Identification (ID) Card

Every member of HealthEase health plan will get a HealthEase ID card. Show this ID card and your Medicaid gold card to doctors when you want to get health care. Show it to hospitals and pharmacies too. This card shows you are a member of HealthEase. Keep it with you at all times. Do not let anyone else use your card. If you do, you may lose your benefits.

What do I do if I lose my ID card?

If you lose your HealthEase ID card, call HealthEase Customer Service, toll-free, 1-800-278-0656. A new card will be mailed to you right away. If you lose your Medicaid card, call your caseworker at the Department of Children and Families.

Your Doctor

Your HealthEase Primary Care Physician (PCP) is the doctor who will care for you. Call your PCP at the phone number on your ID card when you need medical care at a doctor's office. Your doctor's office will make an appointment for you to get care.

Call now to make an appointment to see your HealthEase doctor. The phone number is on your HealthEase ID card. As a member of HealthEase, you must make an appointment to see your doctor within 90 days of the start of your membership in the plan. If you are pregnant, you must see your doctor within 30 days of the start of your membership. The start date of your membership with HealthEase is printed on your ID card.

Some of our providers may not have malpractice insurance. If they do not, they must have a notice in their office saying so. If you are not sure if your doctor has it, please ask your doctor.

HealthEase makes sure our doctors are fit to see you. We check their education and training. We look at their experience. Call Customer Service at 1-800-278-0656 if you have questions about this.

Some doctors may not perform certain services based on religious or moral beliefs.

Changing your Primary Care Doctor

If you want to change your doctor, call HealthEase Customer Service. We will be happy to help you. The toll-free phone number is 1-800-278-0656. Your family members who are enrolled with HealthEase can each choose a different PCP or the same PCP, depending on your needs.

HOW TO GET YOUR MEDICAL SERVICES

Care for HealthEase members is provided through doctors, hospitals, and other providers who are contracted with HealthEase. A HealthEase participating doctor or HealthEase must approve all your care.

HealthEase will pay for the cost of care that is approved by HealthEase. If your care is not approved by HealthEase, you may have to pay for the cost of the care.

How to Get Authorized Services

Call your PCP when you need regular health care. Your PCP will provide your regular health care needs. Your doctor will arrange for you to have tests if you need them and may also refer you to a HealthEase specialist. HealthEase will pay for this care. If your doctor or HealthEase does not arrange for or approve your care, you will have to pay the bill. Be sure your doctor gives you approval if you need to see a specialist. If you need care by a doctor that is not a participating HealthEase doctor, call your PCP for help.

Second Medical Opinion

If you want a second medical opinion about your health care, call your PCP and request one. You may choose a HealthEase doctor or a doctor that is in your service area that is not a HealthEase doctor. Tests that are ordered for a second medical opinion must be done by a HealthEase provider.

Your PCP will review your second medical opinion and decide on a treatment plan that is best for you. If you choose a HealthEase doctor, the cost of the second medical opinion will be paid by HealthEase. If you choose a doctor that is not a HealthEase doctor, you may have to pay for a part of the bill for the second medical opinion.

You or your doctor may ask HealthEase for a faster, “expedited,” pre-service decision. Ask for this to get an approved or discontinued service for which you cannot wait for a standard decision to be made, because waiting could place your life, health, or daily functions in serious danger. To request a faster pre-service decision, call Customer Service, toll-free, at 1-800-278-0656 Monday through Friday, 8am to 7pm EST (except for holidays). You can also bring a written request to HealthEase or fax your request to 813-262-2907. Be sure to ask for a fast or expedited review.

PERSONAL HEALTH ADVISOR (24-HOUR NURSE HOTLINE)

Personal Health Advisor is HealthEase’s 24 hours-a-day, 7 days a week—every day of the year—nurse advice line offered at no cost to you. Call your PCP or the Personal Health Advisor at 1-800-919-8807 (TDD: 1-800-955-8770) anytime someone in your family is sick or hurt or in need of medical advice. You will get friendly, helpful advice. The nurse will ask you some questions about your problem. Tell her where it hurts. What it looks like and what it feels like. The nurse can help you decide if you need to:

- Go to the hospital
- Go to the doctor
- Care for yourself at home

You can get help with problems like:

Cuts	Dizziness
Back pain	Crying baby
Feeling Sick	Coughing
Burns	Colds, flu

A nurse is there to help. So call Personal Advisor *before* you call a doctor or go to the hospital. **If you think it is an emergency, call 911 or your local emergency services first.**

If you need care while away from the HealthEase service area (the county you live in), call us, toll-free, 1-800-278-0656.

You can see participating dermatologists, podiatrists, and chiropractors without approval from your PCP or HealthEase. For visits to a participating obstetrician/gynecologist, members do not need to get an authorization for one visit every year.

To see one of these specialists, you do have to pick one of the specialists from the HealthEase provider directory. You should have received a copy of the directory. If you would like to have another copy of the HealthEase provider directory, please call our Customer Service Department at 1-800-278-0656. We will mail one to you.

Services Available without Authorization

You do not need approval from your doctor or HealthEase to get these services from participating providers:

- Podiatry
- Dermatology
- Expanded adult dental
- Chiropractor
- Yearly eye exams and glasses
- Family planning (any participating Medicaid provider)
- One annual obstetrician/gynecologist visit per year is allowed without authorization

Even though you do not need authorization or approval for these services, you DO need to choose one of these specialists from the HealthEase Provider Directory for your health care. Call to make an appointment. Tell them you are a HealthEase member. Show them your HealthEase ID card.

How to Get After-Hours Medical Care

If you become sick after your doctor's regular office hours, and it is NOT an emergency, call your doctor or the Personal Health Advisor. Your PCP number is printed on your ID card. Do not go to the hospital first. HealthEase will provide care within 24 hours for all urgently needed care.

What to Do in an Emergency

You have a Primary Care doctor who should see you first for all medical needs. If you have an emergency such as:

- Heavy blood loss
- Heart attack
- Severe cuts requiring stitches
- Loss of consciousness

- Poisoning
- Severe chest pains
- Loss of breath
- Broken bones

...then you should go to the nearest emergency room. If you are not sure if it is an emergency, call your HealthEase doctor. Call 911 for emergency transportation if you need it.

An emergency is a condition that you believe will cause the following if you do not get help at once:

- Serious harm to your health (this includes a pregnant woman or her unborn baby);
- Serious injury to the body;
- Serious damage of a body part;
- Serious damage of an organ.

For pregnant women, these medical problems may be an emergency:

- If you think there is not enough 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.

You will need to show your HealthEase and Medicaid ID cards at the emergency room. Ask the staff in the emergency room to call HealthEase.

Let your doctor know as soon as you can when you are in the hospital. Let him/her know if you receive care in an emergency room.

The ER doctor will decide if your visit is an emergency. If it is not an emergency, you will be given the choice to stay or leave the hospital. If you choose to stay, you will have to pay for your care.

HealthEase will cover follow-up care to emergency treatment that your doctor says is medically necessary. Prior authorization is not required to receive this care regardless of whether you receive this care within or outside of the HealthEase network.

Out-of-Area Emergency Care

It is important to get care when you are sick or injured. If you become ill while traveling, call HealthEase toll-free at 1-800-278-0656. If you have a true emergency while traveling, go to the nearest medical facility. It doesn't matter if you are not in the plan's service area. Show your HealthEase ID card. Call your doctor as soon as you can. Ask the staff at the ER to call HealthEase.

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

Pregnancy and Newborn Care

If you have a baby while a member of HealthEase, your newborn will have health coverage with HealthEase from birth.

Pregnant members should call a HealthEase doctor right away to make an appointment for prenatal care. You will also need to choose a HealthEase pediatrician for your baby. If you do not choose a doctor by the time your baby is born, we will assign one for you.

Contact your caseworker from the Department of Children and Families, too. They will assign your baby a Medicaid number. Please call HealthEase and give us the baby's number DCF has given you. Notify HealthEase and DCF of your baby's birth. If the State does not place your new baby on HealthEase, call a Choice Counselor at 1-866-454-3959 (TTY/TTD: 1- 866-467-4970). Ask them to enroll your baby with HealthEase.

Transportation Services

Your plan offers you a free ride to and from your doctor visits and other medical appointments. This is not for emergencies. We can give you the phone numbers to call for a ride if you don't have them.

In an emergency, call 911. An ambulance will take you to the hospital. You will have to pay for the ride if it is not an emergency.

HOW TO GET OTHER HEALTHEASE SERVICES

Prescriptions

Prescriptions must be written or approved by a HealthEase doctor. They must be picked up at a pharmacy that is part of the HealthEase network. A list of pharmacies you can go to is in your HealthEase provider directory.

There is no cost to you for prescriptions. Please note that there is a **(9) prescription limit per month for TANF members and a (17) prescription limit per month for SSI members. Birth control, chemotherapy, and HIV/AIDS drugs DO NOT count towards the prescription limitations.**

Show your HealthEase ID card and your Medicaid gold card when you get your prescription.

A prescription written by a doctor who is not a part of the HealthEase network must be approved by your doctor. You must pick it up at a participating pharmacy. There is no cost to you. If you have questions, call HealthEase Customer Service, toll-free, 1-800-278-0656.

Over-the-Counter Items

Your family can get up to \$25 worth of approved over-the-counter items every month. Items include vitamins, medicines, and health supplies. The list you can choose from is below. Make your selection and then call the over-the-counter program order line, toll-free, 1-800-278-0656. Your order will be mailed to your home.

ITEM	NDC #	BRAND DESCRIPTION	GENERIC COMPARABLE	PRICE
ANALGESICS				
1	52735075812	ADVIL TABS	IBUPROFEN 200MG FC TAB	\$4.00
2	52735079012	ALEVE CAPLETS	NAPROXEN SODIUM 220MG CPL	\$6.00
3	52735070201	BAYER ASPIRIN BAYER EC ASPIRIN (ADULT REGIMEN)	ASPIRIN 325MG CT TAB ASPIRIN EC 81MG TAB	\$3.00 \$4.00
4	52735076123	ECOTRIN MAX-STRENGTH TABS	EC ASPIRIN MAX ST TAB	\$6.00
5	52735073313	TYLENOL EX-STRENGTH CAPLETS	ACETAMINOPHEN EX-ST CPL	\$5.00
6	52735071213	BEN GAY	MUSCLE RUB	\$5.00
7	52735072827			
ANTACIDS				
10	52735053101	MYLANTA GAS 80mg	ANTI-GAS 80MG	\$5.00
11	52735052115	TUMS TABS	ANTACID CHW TAB	\$4.00
12	52735079808	ZANTAC TABS	RANITIDINE HCL 75MG TAB	\$8.00
ANTI-DIAHARREALS				
13	52735054417	IMODIUM CAPLETS	ANTI-DIARRHEAL 2MG CPL	\$4.00
14	52735051144	PEPTO-BISMOL LIQUID	PINK BISMUTH LIQ	\$4.00
ANTI-FUNGALS				
15	52735025228	GYNE-LOTRIMIN CREAM	CLOTRIMAZOLE VAG 1% CRM 1 APP	\$8.00
16	52735072126	TINACTIN CREAM	TOLNAFTATE 1% CRM	\$4.00

ANTI-HEMORRHOIDS

17	31254715012	ANUSOL OINTMENT	ANUSERT HC1 OINTMENT	\$5.00
18	52735071436	PREPARATION-H OINT	PROMPT RELIEF HEM ONT	\$5.00

CHILDREN'S PRODUCTS

19	31031003313	ORAJEL BABY	ORAJEL BABY	\$7.00
20	52735024136	BALMEX OINT	DIAPER RASH ONT	\$4.00
21	52735053826	MYLICON DROPS	GAS RELIEF DRP	\$6.00
23	50383062550	POLY-VI-SOL DROPS	BABY VIT DRP	\$6.00
24	52735057741	MOTRIN SUSPENSION FOR CHILDREN	IBUPROFEN SUSPENSION CHILDREN	\$6.00
25	52735027041	TYLENOL CHILDRENS GRAPE ELIXIR	ACETAMINOPHEN CHILDS GRAPE ELX	\$5.00
26	52735075405	TYLENOL CHILDS CHEW GRAPE TABS	ACETAMINOPHEN CHW GRAPE TAB	\$4.00
27	52735076025	TYLENOL INFANT DROPS	ACETAMINOPHEN PEDIATRIC DRP ALC FREE	\$4.00

COUGH/COLD

28	52735040405	BENADRYL TABLETS	DIPHENHYDRAMINE 25MG CAP	\$4.00
29	52735040241	BENADRYL ELIXIR	DIPHEN HYDRAMINE LIQ ALC FREE	\$4.00
30	52735043320	CHLORASEPTIC	THROAT LOZENGES - CHERRY	\$3.00
31	52735042448	VICKS VAPOR RUB	MEDICATED CHEST RUB	\$4.00
32	52735041941	ROBITUSSIN SYRUP	GUIATUSS SYR	\$4.00
35	52735041326	AFRIN NASAL SPRAY	NASAL DECONGESTANT SPR	\$5.00
66	52735057000	CLARITIN	LORATADINE 10 MG TAB	\$7.00

EYE CARE

36	24385007501	VISINE DROPS	STERIL EYE DROPS IRRITATION RELIEF	\$3.00
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FIRST AID CREAMS & OINTMENTS & ANTISEPTICS

39	52735091143	CALAMINE LOTION	CALAMINE LOT	\$3.00
40	52735074026	CORTAID CREAM	HYDROCORTISONE 1% MAX-ST CRM	\$3.00
42	52735080226	NEOSPORIN OINT	TRIPLE ANTIBIOTIC ONT	\$4.00

FIRST AID SUPPLIES

43	7098330008	COTTON BALLS	COTTON BALLS	\$3.00
44	52735081863	ACE BANDAGE	ATHLETIC BANDAGE	\$5.00
45	52735081661	ADHESIVE TAPE	ADHESIVE TAPE 1" X 5 YARDS	\$3.00
46	52735087513	BAND-AIDS	BAND-AIDS ASSORTED	\$3.00

47	52735081100	BUTTERFLY CLOSURES MED		\$2.00
48	52735077725	EAR WAX REMOVAL	EAR WAX REMOVAL	\$3.00
49	52735088033	J & J GAUZE	STRETCH GAUZE BANDAGE 2" X 5 YDS	\$3.00
50	8246811696	COTTON SWAB	COTTON SWAB	\$4.00
51	3521700245	ORAL THERMOMETER	ORAL THERMOMETER	\$4.00
52	52735091001	ALCOHOL SWABS	ALCOHOL SWABS	\$3.00
75	8770147264	ICE BAG 9"		\$8.00

LAXATIVES

53	52735051401	COLACE SOFTGELS	DOS 100MG SG CAP	\$5.00
54	52735051616	DULCOLAX SUPP	RELIABLE GENTLE LAX SUP	\$4.00
55	52735052506	DULCOLAX TABS	RELIABLE GENTLE LAX TAB	\$4.00
		GLYCERIN SUPPOSITORIES		
56	52735050602	CHILDREN	GLYCERIN CHILDS SUP	\$3.00
57	52735050954	METAMUCIL POWDER	GENFIBER ORANGE POW	\$6.00

PEDICULICIDES

58	52735020341	RID EXTRA STRENGTH SHAMPOO	LICE TREAT MAX STR SHM	\$6.00
59	182405901	B-COMPLEX W/ B12 TABS	B-COMPLEX/B-12 TAB	\$6.00

VITAMINS & MINERALS

60	52735000513	CALTRATE 600 TABS	CALCARB 600 TAB	\$5.00
61	52735001501	CENTRUM TABS	CERTAGEN TAB	\$7.00
62	603069457	FLINTSTONE'S	FRUITY CHW TAB (NF)	\$6.00
63	52735003501	STUART PRENATAL TABS	PRENATAL-S TAB	\$6.00
64	52735005501	VITAMIN C TABS	C CHW 500MG TAB	\$4.00
65	52735006301	VITAMIN E SOFTGELS	E DL ALPHA 400IU SG CAP	\$5.00
67	52735004301	VITAMIN A 10,000 IU	VITAMIN A 10,000 IU	\$3.00

HERBALS

68	2743401619	COQ-10	COQ-10	\$10.00
69	80812514730	GINKO BILOBA	GINKO BILOBA	\$7.00
70	80812513740	GLUCOSAMINE/CHONDROTIN	GLUCOSAMINE/CHONDROTIN	\$10.00
71	2743401310	SAW PALMETO	SAW PALMETO	\$10.00

FAMILY PLANNING

72	2260093050	CONDOMS	CONDOMS	\$3.00
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MISC ITEMS

73		PILL BOX		\$2.00
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Dental Services

HealthEase covers children's dental services that include:

- Annual exam
- Intraoral X-ray
- 2 cleanings per year
- Unlimited fillings, up to 3 surfaces
- Periodontic deep cleanings, once per year
- Periodontic scaling and root planning, 2 per year
- Dentures, complete and partial
- Oral surgery
- Orthodontic treatment

A list of providers that provide these benefits is located in the HealthEase provider directory.

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

TANF (Broward)

- Annual exam
- Intraoral X-rays, once per year
- 2 cleanings per year

TANF (Duval)

- Annual exam
- Intraoral X-rays, once per year
- 2 cleanings per year
- Unlimited fillings (silver—up to 3 surfaces)
- Periodontic deep cleanings, 1 per year
- Periodontic scaling and root planning, 2 per year

SSI (Broward and Duval)

- Annual exam
- Intraoral X-rays, once per year
- Panoramic X-rays
- Periapical X-rays
- Bitewing X-rays
- 2 cleanings per year
- Fluoride treatment
- Prophylaxis cleanings
- Crown (1 per 5 years)
- Unlimited fillings (silver—up to 3 surfaces)
- Clear fillings (for front teeth only)
- Restorations (anterior tooth with minor chip)
- Periodontic deep cleanings, once per year
- Periodontic scaling and root planing, 2 per year
- Diagnostic casts

Atlantic Dental provides these services for members living in Broward County. Call Atlantic Dental to choose a dentist for your care. The toll-free phone number is 1-800-964-7811. A Customer Service person from Atlantic Dental can also answer questions about your dental benefits for you.

Members living in Duval County should call the Duval County Health Department to receive services. You can select a dentist and get answers to any questions you may have. Call 904-253-1230.

Vision Services

Health Ease covers beneficiaries for:

- Glasses and eyeglass repairs for beneficiaries under 21 years of age for eyeglasses that are medically necessary.
- Up to two pairs of eyeglasses per beneficiary, every year.

Adults in the HealthEase health plan are also covered for some vision services. Adults receive unlimited eye exams and unlimited glasses, as medically necessary. A list of vision providers is in your HealthEase provider directory.

Hearing Services

HealthEase covers hearing services to beneficiaries younger than 21 years of age. Covered services include:

- Cochlear implants
- Diagnostic testing
- Hearing aids and/or hearing aid fitting and dispensing,
- Hearing aid repairs and accessories, and
- Newborn hearing screening.

Adult members also receive hearing services as a benefit. Please contact Customer Service to answer any questions you may have.

Meals on Wheels

SSI members in HealthEase health plan receive the meals on wheels benefit. Members receive 10 free meals delivered to their home after leaving a hospital or skilled nursing facility, if medically necessary.

Circumcision

HealthEase is pleased to offer an expanded benefit that provides routine newborn circumcision up to 1 year of age.

Respite Program (SSI only)

Once per month parents or guardians of children with special needs are given a 3 hour break from ongoing care-giving responsibilities

ACCESS TO BEHAVIORAL HEALTH SERVICES

Behavioral health services you can get include inpatient and outpatient hospital services and psychiatric doctor services. You and your children can also get a wide range of mental health and case management services. You can get these services in the community, in your home and in schools. Some of the services include:

- Individual, family, and group therapy
- Social rehabilitation
- Day treatment for adults and children
- Individual and family assessments
- Evaluations
- Treatment planning

Call 1-877-712-5340 if you want to know more. The staff will be happy to help you.

What to Do if You Are Having a Problem

If you are having any of the following feelings or problems you should contact a behavioral health provider:

- Constantly feeling sad
- Feeling hopeless and/or helpless
- Feelings of guilt
- Worthlessness
- Difficulty sleeping
- Poor appetite
- Weight loss
- Loss of interest
- Difficulty concentrating
- Irritability
- Constant pain such as headaches, stomach and back aches

You do not need to call your PCP for a referral for an appointment. An approval for services will be given at the time you call. If you use a provider without getting an approval, you will have to pay the bill.

What to Do in an Emergency or if You Are Out of the HealthEase Service Area

First, decide if you are having a true behavioral health emergency. Do you think that you are a danger to yourself or others? Call “911” or go to the nearest emergency room for attention if you think you are. Follow these steps even if the emergency facility is not in the plan’s service area.

If you need emergency behavioral health help outside the plan’s service area, please tell the plan by calling the number on your ID card. You should also call your PCP if you can and follow-up with your doctor within 24 to 48 hours. For out-of-area emergency care, when you are stable, plans will be made for transfer to an in-network facility.

Obtaining Behavioral Health Services

If you need help finding a behavioral health provider in your area, you can call Harmony Behavioral Health. Call (toll-free) 1-877-712-5340.

You will be given the names of several providers in your local community from which you can choose to call for an appointment. You can also choose a different behavioral health care coordinator or direct service behavioral health care provider within the Plan if one is available.

Behavioral Health Limitations and Exclusions

Adults can get up to 45 inpatient days a year and unlimited outpatient behavioral health services with Medicaid. Medicaid does not include a benefit for substance abuse treatment.

If you or a family member has a substance abuse problem, you should call your local Medicaid provider. You can also ask our Behavioral Health staff to help you with a referral.

ACCESS TO MEDICAL SERVICES

HealthEase has medical staff under contract to offer prompt medical service for all members as follows:

1. Travel time to medical services
 - Within 30 minutes to the doctor's office
 - Within 30 minutes to the hospital
 - Within 1 hour to a specialist
2. Timely treatment
 - Emergency care right away—both in and out of the plan's service area
 - Urgent care within 24 hours. Urgent care is a problem that is not life-threatening.

It could result in serious illness or disability unless medical care is received.

- Routine sick care within a week of the request
- Physical examinations within a month of the request
- Follow-up care as needed

Medicaid Covered Health Services

Please contact the Customer Service Department, toll-free, at 1-800-278-0656 for help with Medicaid benefits that are not covered by our plan.

IMPORTANT INFORMATION YOU SHOULD KNOW ABOUT HEALTHEASE

ENROLLMENT

Voluntary Enrollment

You can join HealthEase by calling the Choice Counselor Helpline at 1-866-454-3959 (TTY/TTD users, please call 1-866-467-4970). For help, please call HealthEase, toll-free, at 1-800-278-0656, to talk to a HealthEase consultant.

Mandated Enrollment

If you do not choose a health plan, the state will choose one for you. If you are currently a HealthEase member, and you don't choose, you will automatically be assigned to HealthEase. Before they assign you to a plan, they will try to reach you several times by phone, mail, and in person. If you do not respond, they will choose one for you. For more information, call the Choice Counselor Helpline at 1-866-454-3959 (TTY/TTD users, please call 1-866-467-4970).

Open Enrollment

After you enroll in a Florida managed plan like HealthEase or the State enrolls you to a plan, you start a 12-month enrollment period. You have 90 days after you are enrolled 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 nine 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 if you want. This is called your Open Enrollment period. Outside your Open Enrollment period, you will only be able to change plans if there is good cause to do so.

If you have any questions about Open Enrollment, you may call the toll-free Choice Counselor Helpline at 1-866-454-3959 (TTY/TTD: 1-866-467-4970).

Reinstatement

If you lose your Medicaid eligibility and get it back within 60 days, the state will place you back in the HealthEase health plan. We will send you a letter within 10 days after you are a member again. You will be assigned to your original Primary Care Physician, unless you tell us otherwise.

Moving Out of the HealthEase Service Area

HealthEase health plan is available to Medicaid beneficiaries in many Florida counties. If you move, please call HealthEase Customer Service. You will want to choose a doctor near your new home. If you move outside our service area, you must call the Choice Counselor Helpline at 1-866-454-3959 (TTY/TTD: 1-866-467-4970) to make another managed care choice. You will continue to use HealthEase doctors until you are disenrolled from HealthEase.

Informed Consent

Your permission is needed for all treatment, except in emergencies when your life is in danger. Sometimes your written consent is needed. You have a right to understand any procedure. You have a right to know the reasons why it is needed. If you do not want to have a procedure done, talk to your doctor. Your doctor will tell you your choices. You make the final decision.

Confidentiality

HealthEase respects your right to privacy. You must sign for us to give out medical information.

It is released only to those involved in your care. We make an exception if we are required to do so by law. Our reports do not identify members.

Physician Incentive Payments

HealthEase works with more than 12,000 providers in Florida. We work hard to give you the health care services you need. You may ask if we have special arrangements with doctors. You may ask if it will affect your doctor's use of referrals. You may ask if it will affect other services you need. Call Customer Service for more information.

Voluntary Disenrollment

You may ask to cancel your membership during Open Enrollment. You may also ask to disenroll for good cause at any time during your enrollment. Call a Choice Counselor toll-free at 1-866-454-3959. The toll-free hearing impaired number for a Choice Counselor is 1-866-467-4970.

Disenrollment will not affect your Medicaid eligibility. You will get Medicaid's benefits instead of HealthEase services.

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

Involuntary Disenrollment

You may lose your HealthEase membership if you:

- Allow someone else to use your HealthEase ID card.
- Miss 3 doctor appointments in a row within 6 months of time.
- Lose your Medicaid eligibility.

The plan cannot disenroll you for the following reasons:

- Pre-existing medical conditions
- Changes in your health status
- Periodically missed appointments

Appeals and Grievance Coordinators and Assistance

For information about or help with filing appeals and grievances, please call one of our health plan's Customer Service Representatives (CSR). Call HealthEase Customer Service, toll-free, 1-800-278-0656. A CSR is available to assist you weekdays, 8am to 7pm. If you would like to contact us in writing, please address your letter to:

HealthEase
Appeals and Grievance
P.O. Box 31370
Tampa, FL 33631-3370

Quality and Member Satisfaction Information

You may ask for information about our plan's quality performance indicators and member satisfaction survey results by calling our Customer Service Department.

Public Information about HealthEase

You can access performance outcome and financial data that is published by the Florida Agency for Health Care Administration at www.FloridaHealthStat.com.

Public Information about Our Health Plans

As of September 10, 2004, in compliance with Florida Statute 641.54(7), we have added the following information to our website:

- You can get performance outcome and financial data that are published by the Florida Agency for Health Care Administration at www.FloridaHealthStat.com.
- The site where this information is located is <http://wellcare.com/HealthPlans/Florida/WhichPlanIsRightForMe.aspx>.

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 has occurred, tell us. Call our 24-hour hotline at 1-866-678-8355.

To learn more call 1-800-278-0656 (TTY/TDD: 1-877-247-6272).

PREVENTIVE HEALTH CARE GUIDELINES

Preventive health care guidelines are in this book for your use. This tells you when you and/or members of your family are due for checkups. The guidelines also list when you or members of your family are due for tests or shots and the names of the shots.

You can use these guidelines to help you remember to see your PCP. We will send you a reminder every year on your birthday to let you know if you have missed any tests.

If you see that you or a family member is missing a checkup, test, or shot, please call your PCP and make an appointment to see them. These guidelines are only a general guide and do not replace your doctor's judgment. Always talk with your doctor to be sure you are getting the right exams, treatment, testing, and care recommendations.

Remember, if you just joined HealthEase, you need to see your PCP within 90 days of joining the plan.

**Preventive Health Guidelines
Adults—21 and Older**

Age	Test and/or Shot	Schedule
21-39 years old	Blood pressure, height, weight, obesity	At least once every 5 years or as advised by your doctor
	Cholesterol test (20 years or older)	Every 5 years
	Cholesterol test (male 35 years or older or if you have diabetes)	Each year
	Cholesterol test, if you have high cholesterol, high blood pressure, are a smoker, and/or are overweight	Routinely and/or as advised by your PCP
	Mammogram for females	Once between the ages of 35 and 39
	Pap smear for females	Each year
	Flu shot	Each year if you have a high risk illness like asthma, diabetes, or emphysema
	Pneumonia shot	Every 5 years if you have heart, liver, kidney disease, diabetes, or cancer
40-64 years old	Blood pressure, height, weight, obesity	At least once every 2 years
	Cholesterol test for men 35 years or older. Or for females 45 years or older. Or if you have diabetes.	Each year
	Cholesterol test if you have high cholesterol, high blood pressure, are a smoker, and/or are overweight	Routinely and/or as advised by your PCP
	Mammogram and Pap smear for females	Each year
	Osteoporosis test for females 60 years or older	Routinely if you are at risk for fractures
	Flu shot	Each year if you have a high risk disease like asthma, diabetes, or emphysema
	Pneumonia vaccine	Every 5 years if you have heart, liver, kidney disease, diabetes, or cancer
	Stool test for hidden blood if you are 40 to 49 years old	Each year if you have a family history of colon cancer
Stool test for hidden blood if you are 50 years or older	Each year	
65 years and older	Blood pressure, height, weight, obesity, flu shot, and stool test for hidden blood	Each year
	Cholesterol test	Every 5 years and each year if you have diabetes
	Cholesterol test if you have high cholesterol, high blood pressure, are a smoker, and/or are overweight	Routinely and/or as advised by your PCP
	Mammogram and Pap smear for females	Each year
	Osteoporosis for females	On a regular basis
	Prostate exam with PSA test for males	Each year or as advised by your PCP
	Pneumonia shot	Once and every 5 to 10 years as needed

**Preventive Health Guidelines
Newborns Up To 21 Years Old**

Age	Well-Baby Checkups and Shot Guide
0-2 weeks	Well-baby checkup*, newborn screening, Hepatitis B (HepB) shot at birth
2 months	Well-baby checkup*, Diphtheria, Tetanus, and Pertussis (DTaP), HepB, Polio (IPV), Pneumococcal (PCV), Haemophilus influenzae type b (Hib) shots
4 months	Well-baby checkup*, DTaP, Hib, IPV, PCV
6 months	Well-baby checkup*, DTaP, HepB, Hib, IPV, PCV
9 months	Well-baby checkup*, blood lead test, hemoglobin or hematocrit
12 months	Well-baby checkup*, blood lead test, Hib, Hepatitis A (HepA), Varicella (Chicken Pox), PCV
15 months	Well-baby checkup*, DTaP, Hib, Measles, Mumps, Rubella (MMR)
18 months	Well-baby checkup*, HepA
24 months	Well-baby checkup*, blood lead test
Flu shots	Each year for kids age 6 to 23 months. And for kids age 6 months and 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**, blood lead test if not already tested
4-6 years	Well-child checkup*, eye screening, MMR, DTaP and IPV sometime between ages 4 and 6, annual dental visit, blood lead test if not already tested, urine test at age 5
7-11 years	Well-child checkup*, annual dental visit
12 years	Well-child checkup*, Meningococcal shot, Tetanus, diphtheria and pertussis shot (Tdap), “catch up” year if needed for MMR, HepB, Varicella, annual dental visit, urine test
13-21 years	Well-adolescent checkup*, “catch up” for missed shots, annual dental visit, urine test as recommended
<p>* Well-baby, child, and adolescent checkups all include height, weight, BMI, blood pressure beginning at age 3, head circumference at 0–24 months, vision and hearing screening.</p> <p>**Dental visits may be recommended younger than 3 years of age.</p>	

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

References: Clinical Preventive Services for Normal-Risk Adults Recommended by the U.S. Preventive Services Task Force, January 2004. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services according to the Advisory Committee on Immunization Practices (ACIP) 2004. 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). Third Report on the National Education Program (NCEP) Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults, May 2001. American Academy of Pediatrics statement “Cholesterol in Childhood” 1998.

ADVANCE DIRECTIVES

Your Medical Care—Your Decision

The law says that you have a right to refuse medical treatment. This includes life-prolonging care. Congress passed the Patient Self Determination Act. It states that we must tell members how to exercise that right with the help of something called “advance directives.”

Advance Directives—Making Your Decision Known

An advance directive is a legal paper. It tells your doctors what type of treatment you want to get (or not get) if you are not able to tell them yourself. There are two types of advance directives—the Living Will and the Durable Power of Attorney for health care decisions. A Living Will shows the type and extent of care you want if you are not conscious and will not wake up. It can be used if you have a condition that will lead to death. A Living Will tells your DOCTOR when to keep up or stop care to prolong your life.

A Durable Power of Attorney for health care decision names the person you choose to make decisions for you. It will be used if you are not able to make decisions. It will also be used if you cannot make your decisions known to your DOCTOR.

A Living Will or Durable Power of Attorney for health care decisions is used when and only when you cannot make decisions yourself. It is used if you cannot make your wishes known to your doctor.

An advance directive is a way of telling your wishes. You can change or cancel your decisions at any time. If you do make changes, you should make them known to your doctor and family members.

How can I get an advance directives form?

You may contact an attorney, your local Legal Aid Office, or the Florida Medical Association. Ask your doctor or call HealthEase Customer Service.

REMEMBER, YOUR HEALTH CARE IS YOUR CHOICE.

MEMBER APPEAL AND GRIEVANCE PROCEDURE

Filing a Grievance with HealthEase

We want you to let us know right away if you have any questions, concerns, or problems about your covered services or the care you receive. Please call Customer Service at 1-800-278-0656 (TTY/TTD: 1-877-247-6272). If you need interpreter services, please call the Customer Service Department and they will assist you.

This section gives the rules for making complaints in different types of situations. State law guarantees your right to make complaints if you have concerns or problems with any part of your medical care as a HealthEase plan member. The State has helped set the rules about what you need to do to make a complaint and what we are required to do when we get a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from HealthEase or penalized in any way if you make a complaint.

What are appeals and grievances?

You have the right to make a complaint if you have concerns or problems about your coverage or care. “Appeals” and “grievances” are the two different types of complaints you can make.

- An appeal is the type of complaint you make when you want us to reconsider and change a decision or action we have made about what services are covered for you or what we will pay for a service. For example, if we refuse to cover or pay for services you think we should cover, you can file an appeal. If HealthEase or one of our contracted providers refuses to give you a service you think should be covered, you can file an appeal. If HealthEase or one of our contracted providers reduces or cuts back on services you have been receiving, you can file an appeal. If you think we are stopping your coverage of a service too soon, you can file an appeal. A representative or estate representative of a deceased member also has a right to file an appeal on behalf of the deceased member.
- A grievance is the type of complaint you make if you have any other type of problem other than an action with HealthEase or one of our contracted providers. For example, you would file a grievance if you have a problem with things such as the quality of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or getting the information you need, or cleanliness or condition of the doctor’s office.

Part I—Making Complaints (called “appeals”) to HealthEase to Change a Decision about What We Will Cover for You or What We Will Pay for

This section explains what you can do if you have problems getting the medical care you think we should provide. We use the word “provide” in a general way to include such things as authorizing care, paying for care, arranging for someone to provide care, or continuing to provide a medical treatment you have been getting. Problems getting the medical care you believe we should provide include the following situations:

- If you are not getting the care you want, and you believe that this care is covered by HealthEase.
- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by HealthEase.

- If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health.
- If you have received care that you believe was covered by HealthEase while you were a member, but we have refused to pay for this care.

Four Possible Steps for Asking for Care or Payment from HealthEase

If you are having a problem getting care or payment for care, there are 2 possible steps you can take to ask for the care or payment you want from us. At each step, your request is considered and a decision is made. If you are unhappy with the decision, there may be another step you can take if you want to continue requesting the care or payment.

STEP 1—The Initial Decision by HealthEase

The starting point is when we make an “initial decision,” “Service Authorization Decision,” or “action” about your medical care or about paying for care you have already received. When we make an initial decision, we are giving our interpretation of how the benefits and services that are covered for members of HealthEase apply to your specific situation. You can ask for a “fast initial decision” if you have a request for medical care that needs to be decided more quickly than the standard time frame. Before and during the appeals process you or your designated representative has the right to view your case file including medical records and any other related documents.

STEP 2—Appealing the Initial Decision by HealthEase

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an “appeal” or a “request for reconsideration.” As explained in Step 1, you can ask for a “fast appeal” if your request is for medical care and it needs to be decided more quickly than the standard time frame. After reviewing your appeal, we will decide whether to stay with our original decision or change this decision and give you some or all of the care or payment you want.

How do you file your appeal of the initial decision?

You, someone you appoint, or your provider, with your written consent, may file this appeal. If you are appointing someone to represent you, you must state so in writing or complete an Appointment of Representation Form, which is available upon request from Customer Service.

An estate representative of a deceased beneficiary may also file with appropriate documentation. You may submit your appeal orally or in writing. If you file orally, you must also submit a written, signed appeal request unless you are filing a fast appeal.

Except for when you file an expedited request, an acknowledgement letter will be mailed to you within 10 calendar days of receiving your appeal. If we can resolve your appeal within this time, an appeal decision letter will be mailed to you instead of an acknowledgement letter.

How soon must you file your appeal?

You must submit your appeal within 30 days of the date of our notification to you. If we have not sent a written notice to you, you may appeal within 365 days of the action.

How do you continue to receive benefits pending an appeal decision and what further rights do you have?

Please see the Medicaid Fair Hearing process located at the end of this section.

What if you want a “fast” or “expedited” appeal?

You, any doctor, or your authorized representative can ask us to give a “fast” appeal (rather than a “standard” appeal) about medical care by calling Customer Service, toll-free, at 1-800-278-0656 Monday through Friday, 8am to 7pm EST, excluding holidays. Or you can deliver a written report to HealthEase, 8735 Henderson Rd. Ren 2, Tampa, FL 33314 or fax it to 1-866-201-0657. Be sure to ask for a “fast” or “expedited” review.

If any doctor asks for a fast appeal for you or supports you in asking for one, and the doctor says that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast appeal.

If you ask for a fast appeal without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast appeal, we will make reasonable efforts to orally notify you. We will also send you a letter, within 2 calendar days, informing you that if you get a doctor’s support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a “grievance” if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast appeal, we will instead give you a standard appeal (typically within 45 calendar days).

How soon must we decide on your appeal?

1. For a decision about payment for care you already received:
 - After we receive your appeal, we have 45 calendar days to make a decision.
2. For a standard decision about your medical care:
 - After we get your appeal, we have up to 45 calendar days to make a decision, but will make it sooner if your health condition requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. You can request an extension, orally or in writing, by calling our Customer Service Department. If we take an extension, we will tell you of the reason for the delay in writing.
3. For a fast decision about medical care:
 - After we get your appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires. However, if you ask for it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. You can ask for an extension, orally or in writing, by calling our Customer Service Department. If we take an extension, we will notify you of the reason for the delay in writing.

For each type of case, a written decision letter, with further appeal rights if not in your favor, will be mailed to you. We will also make reasonable efforts to orally tell you of standard decisions about medical care.

How can you present evidence and/or allegations of fact or law?

You may provide this in writing in your appeal request or in person. To present in person, please contact our Customer Service Department and inform the Customer Service Representative of your request. An appeals coordinator will contact you to arrange a convenient time for you to do this.

Can I review my case file?

You, your representative with your written consent, or an estate representative of a deceased member are allowed, before and during the appeal process, to examine the case file including medical records and any other associated documents and records. To do so, you must notify our Customer Service Department.

STEP 3—Appealing the First Level Appeal Decision

If you are not satisfied with the first-level appeal decision, you may request a second-level appeal to the plan's Appeal and Grievance Committee. To do this, you must file it in writing within 30 calendar days of the first-level decision. This is not required and if you choose to file a second-level appeal, the time you have to file an appeal to the State will be shortened.

STEP 4—Appealing to the Subscriber Assistance Program (SAP)

If you are not satisfied with the first-level appeal decision and choose not to file a second-level appeal, you may request a hearing before the SAP. This agency can also be contacted at anytime during the appeal or grievance process. To do so, you must request a hearing within 365 calendar days or 1 year. The SAP will only hear your case if it involves the availability of health care services, the coverage of benefits, a benefit action/denial made by us, claim payment, handling, or reimbursement for benefits. If you take your concern to a Medicaid Fair Hearing, you may not also request a SAP review.

PART 2—Making Complaints (called “grievances”) to HealthEase for Issues Not Classified as Appeals

If you have a grievance, we encourage you, your authorized representative, or a provider acting on your behalf, with written consent, to first call Customer Service at the number on the cover of this booklet. Grievances must be submitted to the plan within 180 calendar days of when the issue you are grieving about happened. We will try to resolve any grievance that you might have over the phone. However, if you wish to write your grievance to Customer Service rather than calling, you may also do this.

As a HealthEase member, you have the right to file a grievance about problems you have, including:

- Quality of services that you receive;
- Issues such as office waiting times, doctor behavior, adequacy of facilities, or other similar member concerns;
- Involuntary disenrollment situations;
- If you disagree with our decision to process your request for a service under the standard 14 calendar day time period rather than the expedited, 72-hour time frame;
- If you disagree with our decision to process your request for an appeal under the standard 30 day time period rather than the expedited 72-hour time frame; or
- If you disagree with our decision to take a 14-day extension on a request for service, appeal, or grievance.

We will try to resolve any grievance that you might have. We try to solve grievances over the telephone, especially if these grievances are because of misinformation, a misunderstanding, or a lack of information.

Please see the Medicaid Fair Hearing section in this booklet for further rights you have outside of the plan's process.

If your grievance cannot be resolved immediately by the Customer Service Representative, your complaint will be escalated to a Customer Service Grievance Coordinator (CSGC). An acknowledgement letter will be mailed to you within 10 calendar days of receiving your complaint. If we are able to resolve your complaint within this time, a grievance decision letter will be mailed to you instead of an acknowledgement letter.

If your grievance involves medical-related issues, a doctor will review your case. The formal grievance process will be finished within 30 calendar days of the plan receiving your formal grievance, unless the grievance involves the collection of additional information.

These time limitations may be extended by an additional 14 calendar days if we need more information that may affect the outcome of the case. If we decide to take the extension, we will notify you, in writing, that additional information is needed for proper review of the grievance and that we have taken a 14 calendar day extension. You may also request the plan take an extension. To do so, you may submit your request verbally or in writing to the representative assigned to your case.

We will send you a response letter that will delineate the outcome of the investigation along with your right to request a redress (second-level grievance) of the grievance decision. To initiate the second-level grievance, you must submit your request in writing, and within 30 calendar days of receipt of our decision, to the Grievance Committee (GC). This is not required and if you choose to file a second-level grievance, the time you have to file an appeal to the State will be shortened.

In addition to submitting in writing, you have the option to present your case to the committee in person or by teleconference. To do this, please include this in your request. Our committee meets every Thursday from 9am to 10am EST. We will contact you to set up a convenient date to have the meeting.

During the GC, you will be given 10 minutes to present your side of the case. This will be followed by any questions the committee members have. You will be sent a formal decision letter within 5 business days of the GC meeting.

The entire second-level process will be completed within 30 calendar days of receipt, based on all available information at that time.

If you are not satisfied with the second-level grievance decision, you may request a hearing before the Subscriber Assistance Program. These agencies can also be contacted anytime during the appeal or grievance process. However, you must complete the entire appeals and grievance process before the Subscriber Assistance Program will hear your case. To do so, you must request a hearing within 1 year of the when the issue you are grieving about happened.

Other agencies you can contact during or at the completion of the appeals or grievance process:

Subscriber Assistance Program
2727 Mahan Drive
Ft. Knox #1, Mail Stop 26
Tallahassee, FL 32308
Toll-free 1-888-419-3456 or 1-850-921-5458

Department of Financial Services
Consumer Affairs
200 East Gaines Street
Tallahassee, FL 32399
1-800-342-2762

In order for the SAP to hear your grievance the following must be met:

- Your grievance was filed in writing.
- You submitted your request within 1 year of the when the issue you are grieving about happened.
- Your issue concerns the quality of health care services you have received or your issue involves the contractual relationship between you and us.

We are required to keep track of all appeals and grievances in order to report data to the State on a quarterly and annual basis. This information is also used to improve our service to our members.

Medicaid Fair Hearing (available before or after the appeal or grievance process)

At all times during the plan's appeal and grievance steps, you have the right to ask for a Medicaid Fair Hearing. For a Medicaid Fair Hearing, you, someone you appoint to represent you, or a Provider acting on your behalf, with your written consent, can contact the Department of Children and Family Services at:

Office of Appeals Hearings
1317 Winewood Blvd.
Bldg. 5 – Room 203
Tallahassee, FL 32399-0700
1-850-488-1429

You, your representative, or a provider acting on behalf of you and with your written consent must request this within 90 calendar days of the date of the notice of action or initial decision. If you choose this service, you give up the right to the review by the Subscriber Assistance Program.

How can my benefits be continued while my appeal is being considered?

In order for this to occur:

1. You must file your appeal within 10 days of the date of the notice of action if filing orally or within 15 days if filing in writing and submitting via US mail or prior to the intended effective date of our proposed action;
2. The appeal must involve the termination, suspension, or reduction of a previously authorized course of treatment;
3. The services must have been ordered by an authorized provider;
4. The authorization period cannot have expired; and
5. You request an extension of benefits.

If we continue to reinstate your benefits while the appeal is pending, the benefits will continue until one of the following occurs:

1. You withdraw the appeal.
2. 10 calendar days pass from an oral request or 15 calendar days pass from a written (mailed) request from the date of the plan's adverse decision and you have not requested

- a Medicaid Fair Hearing with continuation of benefits until a Medicaid Fair Hearing decision is reached.
3. A Medicaid Fair Hearing decision adverse to you is made.
 4. The authorization expires or authorized service limits are met.

If you request this and your appeal is not decided in your favor, you may be liable for all costs accrued during the review process.

If the final decision of the appeal is not in your favor, the plan may recover the cost of the services furnished while the appeal was pending to the extent they were furnished solely because of the requirements of this section.

If during the Medicaid Fair Hearing, the Medicaid Fair Hearing officer makes a decision in your favor and your benefits were not continued, we will authorize, provide, and pay for services based on the needs of your medical condition as quickly as possible.

The plan will pay for disputed services, in accordance with State policy and regulations, if the services were furnished while the appeal was pending and the decision reverses our decision.

Exhaustion of Grievance Procedure

You must complete the appeal and grievance procedure mentioned here before bringing action by way of arbitration or court action against HealthEase.

The Consumer Call Center at 1-888-419-3456 is available to Medicaid recipients if they have any questions or concerns about quality of medical care.

OTHER PROGRAMS

In addition to the covered benefits listed in this handbook, HealthEase offers the services listed below. These services will be offered in your community.

To find out more about these services, contact either your doctor or the toll-free Customer Service number listed in this handbook.

- Stop smoking programs
- Drug and alcohol abuse programs
- Domestic violence programs
- Pregnancy prevention programs
- Prenatal/Postpartum programs
- Children's programs

HealthEase Prenatal Rewards Program

The HealthEase Prenatal Rewards Program is a program for all women who are pregnant. HealthEase wants to help you and your baby stay healthy. It is important for you to see your OB doctors as soon as you find out you are pregnant so you can be enrolled in this program. When HealthEase is notified that you are pregnant by your OB doctor, you are immediately enrolled into our Prenatal Rewards Program. If you have complications or have other factors that make you high risk, HealthEase will enroll you into our High Risk Pregnancy program and our Prenatal Rewards Program. You will receive trimester and postpartum mailings that include prenatal and newborn educational brochures. If you complete 6 prenatal visits and your postpartum visit between the 3rd and 8th week after delivery, you will receive a stroller. HealthEase wants to reward you for taking care of yourself and your baby. You must have your OB doctor complete the Prenatal Reward Form and fax it to HealthEase to receive the stroller.

Case Management

HealthEase has case management programs to help members with diseases such as asthma, diabetes, HIV/AIDs, and other chronic diseases. HealthEase nurses work one-on-one with you to help coordinate your health care needs. You may be contacted:

- If you request case management
- If you meet criteria for one of HealthEase case management programs
- If your doctor requested you to be placed into case management

Call your doctor or Customer Services number located on your ID card to learn more about these programs.

The MediKids Program

MediKids is the Florida KidCare Health Insurance Program for children under age 5. MediKids must follow all of the same guidelines as any other HealthEase member.

How does MediKids differ from Medicaid?

- There is a small monthly premium.
- The child must not be a dependent of a state employee.
- The child must not be over the age of 5.
- MediKids may not have a Medicaid Fair Hearing.
- Children must enroll during an Open Enrollment period.
- The program is subject to available funds—this is not an entitlement program.
- There is no co-payment for any service provided by HealthEase for a MediKids participant.
- If you are interested in having your child enroll in the MediKids Program or getting more information about the program, call MediKids at 1-877-506-0578.

MEMBER RIGHTS

1. To be provided with information about coverage, services, and use of the health plan.
2. To receive considerate, respectful care and be treated with human dignity.
3. To know the names and titles of all physicians and other health care professionals involved in your medical treatment.
4. To understand your medical condition and health status, recommended course of treatment, alternatives, and risks involved.
5. To actively participate in decisions regarding your medical care.
6. To be informed of continuing health care requirements following discharge from the hospital or office.
7. To refuse treatment, providing you choose to accept responsibility and the consequences of such a decision.
8. To refuse to participate in any medical research projects.
9. To have all complaints forwarded to HealthEase Customer Service for appropriate response.
10. To have access to your medical records and to have the privacy and confidentiality of these records maintained.
11. To complete an advance directive.
12. To make suggestions for improvement to HealthEase.
13. To appeal unfavorable medical or administrative decisions by following the established grievance procedures of HealthEase and the State.
14. To have all the above rights apply to the person having legal authority to make decisions regarding your health care.
15. To have all health plan personnel observe your member rights.
16. To exercise these rights without regard to sex, age, race, ethnic, economic, educational, or religious background.

MEMBER RESPONSIBILITIES

1. To understand how HealthEase works by reading the HealthEase member handbook.
2. To carry your HealthEase ID card and Medicaid card with you at all times. Present them to each provider (doctor, lab, hospital, pharmacy, etc) at the time services are being provided.
3. To select and seek all non-emergency care by appointment through your assigned Primary Care Doctor, to obtain a referral from your doctor for specialty care, and to cooperate with all persons providing your care and treatment.
4. To be on time for appointments.
5. To notify the doctor's office well in advance if you need to cancel or reschedule an appointment.
6. To be respectful of the rights, property, and environment of all providers, employees, other patients and not be disruptive.
7. To be responsible for understanding and following medical advice concerning your treatment and to ask questions if you do not understand or need an explanation.
8. To understand the medications you take, know what they are, what they are for, and how to take them properly.
9. To provide accurate and complete medical information to all providers as may be required in the course of your treatment.
10. To make sure your current doctor has been provided with copies of all previous medical records.
11. To notify HealthEase within 48 hours, or as soon as possible, if you are hospitalized or receive emergency room care.

MEMBER NOTICE OF PRIVACY PRACTICES

(Effective Date: April 14, 2003)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully. As a valued member of our health plan, we want you to be assured of our commitment to protecting your confidential patient information. If you have any questions or concerns, please call the toll-free number on your ID card and a Customer Service representative will assist you.

1. Why have we provided this notice to you?

This notice explains our corporate privacy practices applicable to you, a valued member, of our Health Plan[‡]. This notice describes how medical information about you may be disclosed and used and how you can obtain access to this information. This notice is provided to you for information purposes only.

2. The Health Plan has a legal duty to protect your Protected Health Information.

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. It is our legal responsibility to protect the privacy of the health information that we collect, disclose and use. We refer to this information as “Protected Health Information” or “PHI” for short.

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. PHI does not apply to information that is publicly available.

The Health Plan provides this notice for you in accordance with applicable law about our privacy practices so that you can understand how, why and when we obtain, use and disclose your PHI. We obtain PHI for the purpose of the management of our health benefit plans. The Health Plan requires access to PHI to be restricted to those associates who need it to perform the duties required to provide services to you and all of our members. In order to accomplish the purpose of the disclosure or use of your PHI, we may not disclose or use any more of your PHI than what is necessary to accomplish the purpose of the disclosure or its use.

To avoid unauthorized access and use of your PHI, the Health Plan has in place procedural, physical, and electronic safety measures.

[‡] The Health Plan is owned by WellCare Health Plans, Inc. and is a member of The WellCare Group of Companies, which includes the following: “WellCare” is a trademark used for products and services provided by the WellCare Group of Companies, which includes “WellCare” is a trademark used for products and services provided by the WellCare Group of Companies, which includes WellCare Health Plans, Inc., The WellCare Management Group, Inc., WellCare of Florida, Inc., HealthEase of Florida, Inc., WellCare of New York, Inc., FirstChoice HealthPlans of Connecticut, Inc., Comprehensive Health Management, Inc., WellCare of Louisiana, Inc., Harmony Behavioral Health, Inc., Comprehensive Health Management of Florida, L.C., Harmony Health Systems, Inc., Harmony Health Plan of Illinois, Inc., and Harmony Health Management, Inc.

We have a designated Privacy Officer and a Chief Compliance Officer who are responsible for the development, supervision, implementation, enforcement, and training of our workforce on policies and procedures with respect to the safeguarding of PHI from inappropriate disclosure, access and use as required by relevant law. These measurements that we use include restricted

access for associates within our physical locations and various technical apparatus to protect PHI we store and use electronically.

In addition, your state where you enrolled in our health benefit plan may afford you additional privacy protection.

3. Who receives this notice and when.

The Health Plan will provide this notice to all of our members at the time of enrollment. We will communicate to all affected individuals, at least once every three years that this privacy notice is available together with instructions on how copies of this notice may be obtained.

4. The Health Plan collects various kinds of personal information about you.

The various types of PHI we collect on each of our members are similar to what other high quality health plans collect. This information will include, but is not 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, the Health Plan 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).

5. The Health Plan wants you to know the importance of why we disclose and use your PHI.

In the next two sections we outline activities that play the most vital role in our day-to-day management and which are similar to the operations of other high quality health plans. As permitted by law or unless stated elsewhere, we disclose and use PHI as outlined in the sections below.

The Health Plan offers programs to improve the health of our members, such as our disease management program, which assists our members to partner with their treating physicians to effectively manage chronic conditions like asthma and diabetes. We also offer outreach programs, which are designed to educate our members on how to use the health plan and what services are available to them. Additionally, we use quality investigative measurements to enable us to evaluate, expand and improve the types of services we offer to our members.

The Health Plan 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.

6. How the Health Plan discloses and uses your PHI.

A. We disclose and use your PHI for many reasons. For some of these disclosures or uses, we need your specific authorization. The following list describes the most common disclosures and uses that the Health Plan and its business partners may make that are permitted by law.

- In cases where it is necessary for the daily operations of the Health Plan, the

treatment and care of a member, or other similar activities of the Health Plan.

- To employers who sponsor self-funded health plans, government authorities, and their respective agents, consultants, as well as other insurance companies. In accordance with applicable laws, each of these entities are required to also keep your PHI confidential.
- To other sponsors of health plans for eligibility and enrollment purposes and in accordance with applicable federal and state laws. In accordance with applicable laws, each of these entities is also required to keep your PHI confidential.
- The Health Plan uses PHI internally and shares PHI among affiliated companies commonly owned together with the Health Plan; we share it with our business partners and disclose it to health care providers (such as hospitals, skilled nursing facilities, doctors, and other caretakers); third party administrators; and payors such as health care provider organizations, and other financial partners whom may be responsible for payment for the services or benefits you receive under your health plan. In accordance with applicable laws, each of these entities is also required to keep your PHI confidential.

B. In certain situations, the Health Plan will require a specific authorization before we disclose or use PHI. When these types of cases arise and the member is not able to provide the authorization, we will accept an authorization from a person who is legally authorized to act on behalf of the member (for example, in the situation where a member is incapacitated due to a health condition).

7. When and why we may disclose and collect your PHI from a third party.

The Health Plan has provided the following list to illustrate a few of the reasons why we may disclose your PHI to a third party and what we do with the collected information.

We may disclose to a third party and collect from a third party information about you:

- In a case when a disclosure is required by federal, state or local law, judicial proceedings or law enforcement officials. For example, we make disclosures to law enforcement officials when a law requires that we report information to government agencies. We may also disclose PHI to law enforcement officials when we are ordered to do so by a judicial or administrative proceeding. In addition, we may also disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
- To agencies seeking that information including the government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws. The Health Plan, to the extent allowed by law, may disclose PHI to related entities or unrelated third parties.
- For the relocation of policies or contracts from and to other insurers, HMO's or third party administrators; and facilitation of due diligence activities in connection with the sale, transfer or purchase of health benefits plans or other corporate assets.
- To perform statistics and management data gathering.

- For preventative health processing, disease and case management programs that are offered by the Health Plan and programs by our business partners; the Health Plan or its business partners may perform health and risk assessments; contact and recognize members who may benefit from participation in disease or case management programs; send applicable information to those members and their providers who enroll in the programs, and send out provider and member announcements or screening reminders and education resources.
- For performing mandatory licensing, regulatory compliance/reporting, and public health activities; quality improvement and assessment actions (such as credentialing and peer review of participating network and preferred providers); accreditation by the Accreditation Association for Ambulatory Health Care, Inc. or other relevant organizations; and other activities as listed below.
- To conduct research of health services, performance outcome/measurement and health claims analysis and reporting.
- To accomplish the management of the Health Plan's business activities related to contract administration or the administration of health benefits policies which may involve claims administration and payment, coordination of benefits, coordination of care and other services; utilization, management and review, medical necessity review, response to the members request for services or inquiries; construction of attractiveness of the products offered by us; performance of grievance, external review programs and appeals; programs and benefits breakdown and reporting; fulfillment; fraud investigation and detection of other unauthorized conduct; reinsurance management and stop loss or excess insurance policies and synchronization with reinsurance and stop loss or excess insurers; risk management, actuary and underwriting.

8. The Health Plan's terminated members and their PHI.

We do not destroy the PHI of members who have terminated from the health plan and their PHI continues to be kept private, subject to the same safeguards, policies and procedures as the PHI of active members. The reasons for not destroying the PHI of terminated members include, but are not limited to, (i) legal requirements, which require us to maintain the information; (ii) the information is useful to the health plan; and (iii) other reasons as outlined under the sections of this notice.

9. How you can request other disclosures of your PHI.

A. A member can authorize the Health Plan to disclose his or her PHI to third parties. A member may authorize us to disclose his or her PHI for reasons that we have not described in the sections listed above.

B. To authorize the Health Plan to perform this request, the member may contact a customer service associate by calling the telephone number listed on their membership card and asking for an authorization form to release their PHI. Once you receive the authorization form, provide all of the information on the form and mail it back to us at the following address:

WellCare Health Plans, Inc.
Attention: Customer Service re: Authorizations/PHI
P.O. Box 31370
Tampa, FL 33631-3370

C. At anytime, if you choose to change the authorization from that is on file with us, send us a written notification that you would like to revoke or change the authorization for the person or organization on file with the Health Plan. Be sure to include your printed name, member identification number and sign and date your notification to us.

D. If you want to have access to PHI about yourself, you should contact your provider that created your health records or health history. Your provider may be your dentist, medical treating primary care doctor, specialist, hospital, pharmacy or other health care giver. These providers will have the most complete history for you since they directly treated you. The Health Plan's participating providers (those providers who are participating in our network) are required to provide copies of your medical records to you upon your request. Please be aware that health care providers may charge applicable fees to cover administration costs.

E. You may contact the Health Plan and request from us specific documents that contain information that your providers send to us when they submit encounters or claims to us for payment. Under federal law, however, you may not inspect or have copies of the information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and certain PHI is subject to legal restrictions that prohibits your access.

Depending on the circumstances, a decision to deny access to your PHI may be reviewable.

The Health Plan, where allowed by law, will request that you pay a \$10 administration fee to help cover our costs in the processing of your request.

- If you choose to have a copy of the encounter/claims documents that we maintain on you and your covered dependents, please send a written request to:

WellCare Health Plans, Inc.
Attention: Claims Manager - Request for Claims/Encounter PHI
P.O. Box 31370
Tampa, FL 33631-3370

- In your written request, please include a statement entitled, Request for Claims/Encounter PHI, and include the member's name, member identification number, address, and date of birth for each person whose PHI is requested. In addition, please include a money order, payable to WellCare Health Plans, Inc., for \$10.00 per person for whom the information is requested.
- Each member must print his or her name, and sign and date each request.
- If you are a member who has dependents, each dependent that is 18 years or older must also sign and date each request.
- Please call the toll-free phone number on your membership card and a member services associate will assist you with any questions.

F. If you believe that the information contained in your medical records is not complete or not correct, we ask that you directly contact your health care provider that was responsible for the treatment or provided the service in question. You may have the right to have your physician amend your protected health information.

G. If the Health Plan's records are found to be the source of a proven error, we will amend the records accordingly. Please call the toll-free phone number on your membership card and a member services associate will assist you. We cannot amend or correct any records maintained by a third party or your provider of service.

10. How can you file a complaint if you feel your privacy rights have been violated?

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. If you wish to write to us, please follow the grievance procedures received in your health plan documents. If you call us, please call the toll-free phone number on your membership card and a member services associate will assist you. You may also file a complaint with the U. S. Health and Human Services Office for Civil Rights (OCR). We will not retaliate against you for filing a complaint.

11. This notice to you and our privacy policies are subject to further change.

We are required by law 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.

IMPORTANT PHONE NUMBERS

Your PCP	
HealthEase Customer Service	1-800-278-0656
TTY/TDD	1-877-247-6272
Personal Health Advisor	1-800-919-8807
Fraud and Abuse Hotline	1-866-678-8355
Office of Administrative Hearings (Fair Hearings)	1-850-488-1429
Area Medicaid Offices	
Area 10 – Broward	1-866-875-9131
Area 4 – Baker, Clay, Duval, and Volusia	1-800-273-5880
Local Plan Pharmacy	
Other Health Providers	