



Healthy Futures
Start with a Plan.

Member Handbook

Family Health Plus





FAMILY HEALTH PLUS

This handbook will tell you how to use your WellCare Family Health Plus Plan. Put this handbook where you can find it when you need it.

If you would like to receive this member handbook in a different language, please contact WellCare Customer Service at 1-800-288-5441.

Si desea recibir este manual para miembros en un idioma diferente, por favor comuníquese con el Servicio a Miembros de WellCare al 1-800-288-5441.

Если вы желаете получить этот справочник участника на каком-либо ином языке, пожалуйста, обратитесь в Отдел обслуживания участников WellCare по тел. 1-800-288-5441.

如果您需要該會員手冊的不同語言版本，請聯繫 WellCare 會員服務中心，電話：1-800-288-5441。

NEW MEMBER QUESTIONNAIRE

Please complete and return in the enclosed envelope.

Date:

Name: (Last, first, middle)

Address: (Street)

City: State: ZIP Code: Phone:

Date of Birth: Member ID#:

Primary Care or Family Physician's Name:

1. What is the main language spoken in your home?

2. What is the main language read in your home?

3. If English is not the main language spoken and/or read in your home, is there a family member who speaks and reads English to help you interpret? Yes No

4. When did you last see a doctor? Never In the past 6 months More than 6 months ago

5. What was the reason for your last visit to the doctor?

6. Are you currently receiving treatment for any medical, mental health, alcohol or substance abuse conditions? Yes No

7. If you answered yes to the last question, who was the treating provider?

.....

8. Are you pregnant? Yes No

9. If you answered yes to the last question, are you receiving prenatal care? If so, from whom?

Prenatal Care Provider:

10. If you are a female age 40 or over, have you had a mammography in the last 2 years? Yes No

11. Do you smoke? Yes No

12. Have you ever been a member of a managed care plan before? Yes No

13. Has a doctor ever diagnosed or have you experienced any of the following? (Please check all that apply.)

Heart problems

Arthritis

Cancer

High cholesterol

Seizures

Bowel problems

Kidney failure

Urinary problems

Anxiety/stress

Thyroid problems

Developmental disability

High blood pressure

Pain

Ankle or leg swelling

Tuberculosis

Breathing problems

Diabetes/high blood sugar

Depression

HIV

Blood disease

14. Are any of these conditions getting worse? Yes No
15. Do you have any questions about these conditions? Yes No
16. How many times have you been hospitalized in the past year? (Check one box.)
 0 1 2 or more For what?.....
17. How many times were you seen in the hospital emergency room in the last 6 months? (Check one box.)
 0 1 2 or more For what?.....
18. How many prescription medicines do you take? (Check one box.)
 0 1 2 or more For what?.....
19. Do you have any questions about the medications you take? Yes No
20. Have you made formal written arrangements for another person to act as your health care agent and make medical decisions for you if you become unable to do so? Yes No
21. How do you rate your health? (Check one box.)
 Excellent Good Fair Poor
22. Are you currently being treated for any psychiatric illness? Yes No
23. How would you rate your state of emotional well-being? (Check one box.)
 Excellent Good Fair Poor
24. Have you scheduled a visit with your WellCare Primary Care Provider? Yes No
25. Do you have any problem getting around? Yes No
 If yes, do you use any assistive devices such as a cane or a wheelchair?
 Please specify:
26. Do you have a hearing impairment? Yes No
 If yes, do you use any assistive devices such as a hearing aid?
 Please specify:
27. Have you ever been told by a doctor or nurse that you have vision problems? Yes No
 If yes, do you require special assistance to help you see?
 Please specify:
28. Are you or is anyone in your family going to have an operation or special test in the next month?
 Yes No
 Please specify:
29. Will anyone need to have a prescription filled or refilled in the next month? Yes No
 Please specify
30. When was your last dental visit? (Check one box.)
 In the past 6 months More than 6 months ago Never
31. Do you have a dentist that you see regularly? Yes No
32. Do you need to see a dentist? Yes No

THANK YOU! Please return this survey in the postage-paid envelope we have provided.

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WELCOME TO WELLCARE HEALTH PLAN'S FAMILY HEALTH PLUS PROGRAM

We are glad that you chose WellCare Family Health Plus. We want to be sure you get off to a good start as a new Family Health Plus (FHPlus) member. In order to get to know you better, we will get in touch with you in the next two or three weeks. You can ask us any questions you have, or get help making appointments. If you need to speak with us before we call on you, however, just call us at 1-800-288-5441 (TTY/TDD: 1-877-247-6272).

HOW MANAGED CARE WORKS

The Plan, Our Providers and You

- No doubt you have seen or heard about the changes in health care. Many people now get their health benefits through managed care. Many counties in New York State, including New York City, offer a choice of FHPlus managed care health plans. In some counties, however, there may only be one plan that offers FHPlus. Under FHPlus, people must join a managed care health plan in order to be able to receive health care benefits.
- WellCare has a contract with the State Department of Health to meet the health care needs of people in FHPlus. In turn, we choose a group of health care providers to help us meet your needs. These doctors and specialists, hospitals, labs and other health care facilities make up our “provider network.” You’ll find a list in our provider directory. If you don’t have a provider directory, call Customer Service to get a copy.
- When you join our plan, one of our plan providers takes care of you. Most of the time that person will be your PCP (Primary Care Provider). If you need to have a test, see a specialist or go into the hospital, your PCP will arrange it. Your PCP is available to you every day, day and night. If you need to speak to him or her after hours or weekends, leave a message and tell us how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases, you can “self-refer” to certain doctors for some services. See page 7 for details.
- You may be restricted to certain plan providers if you have been identified as a restricted recipient. Below are examples of why you may be restricted:
 - Getting care from several doctors for the same problem
 - Getting medical care more often than needed
 - Using prescription medicine in a way that may be dangerous to your health
 - Allowing someone other than yourself to use your plan ID card

HOW TO USE THIS HANDBOOK

- This handbook will help tell you how your new health care system will work and how you can get the most from WellCare Family Health Plus. This handbook is your guide to health services. It tells you the steps to take to make the plan work for you.
- The first part of this handbook will tell you what you need to know right away. The rest of the handbook can wait until you need it. Use it for reference or check it out a bit at a time.
- When you have a question, check this handbook or call Customer Service. You can also call the managed care staff at your local Department of Social Services. Be sure to tell them you are in the FHPlus Program.
- Those who live in New York City or Dutchess, Rockland, Orange or Ulster counties should call the New York Medicaid CHOICE HelpLine. The number is 1-800-505-5678.


HELP FROM CUSTOMER SERVICE

There is someone to help you at Customer Service Monday through Friday, 8am–6pm. Call 1-800-288-5441 (TTY/TDD: 1-877-247-6272). If you need help at other times, call the same number and leave a message. Someone will call you back within one business day.

- You can call to get help **anytime you have a question**. You may call us to choose or change your PCP, to ask about benefits and services, to get help with referrals, to replace a lost ID card, to report a pregnancy or the birth of a new baby, or **ask about any change that might affect your benefits** (for example, you get a job that offers health care coverage).
- We offer **free sessions** to explain our health plan and how we can best help you. It's a great time for you to ask questions and meet other members. If you'd like to come to one of the sessions, call us to find a time and place that are best for you.
- **If you do not speak English**, we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have a group of people who can help. We will also help you find a PCP who can serve you in your language.
- **For people with disabilities:** If you use a wheelchair, are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a particular provider's office is wheelchair-accessible or is equipped with communications devices. Also, we have services like:
 - TTY/TDD machine (1-877-247-6272)
 - Information in large print
 - Case management
 - Help in making or getting to appointments
 - Names and addresses of providers who specialize in your disability

YOUR HEALTH PLAN ID CARD

After you enroll, we'll send you a welcome letter. Your WellCare card should arrive within 14 days after your enrollment date. Your card has your PCP's name and phone number on it. It will also have your Client Identification Number (CIN). If it's wrong, call us right away. Carry your ID card at all times and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member.



Member Name:
<Your Name Here>

Member ID #:
<XXXXXXXXXX>

Primary Care Physician:
<Dr. Name Here>
<Dr. Address>
<Dr. City, St, Zip>

Family Health Plus

Date of Birth:
<XX/XX/XXXX>

Effective Date:
<XX/XX/XXXX>

Co-Pays:
<XXXXXXX>

PCP Telephone #:
<XXX-XXX-XXXX>

Customer Service: 1-800-288-5441/TTY 1-877-247-6272

Members: Present this card to receive services from network providers. For benefits, provider network or general information, call Customer Service at 1-800-288-5441 (TTY 1-877-247-6272). If you have a medical emergency, go to the nearest emergency room and call your PCP within 48 hours.

Hospital: Except in emergencies, hospitalization must be arranged by a WellCare physician. In case of emergency hospitalization, please call member's PCP or WellCare at 1-800-288-5441.

Dental: If you need to find a dentist or change your dentist, please call Healthplex at 1-800-468-9868.

Medical claims are to be mailed to:	
WellCare P.O. Box 31372 Tampa, FL 33631-3372	Rx Bin: 603286 Rx PCN: 01410000 Rx GRP: 856257

PART I: FIRST THINGS YOU SHOULD KNOW

HOW TO CHOOSE YOUR PCP

- You may have already picked your PCP to serve as your regular doctor. This person could be a doctor or a nurse practitioner. **If you have not chosen a PCP, you should do so right away.** If you do not choose a PCP within 30 days, we will choose one for you. Each family member can have a different PCP, or you can choose one PCP to take care of the whole family. A pediatrician treats children. Family practice doctors treat the whole family. Internal medicine doctors treat adults. Customer Service can help you choose a PCP.
- With this handbook, you should have a **provider directory**. This is a list of all the doctors, clinics, hospitals, labs and others who work with WellCare. It lists the address, phone and special training of the doctors. The provider directory will show which doctors and providers are taking new patients. You should call their offices to make sure that they are taking new patients at the time you choose a PCP.

You may want to find a doctor:

- Whom you have seen before
- Who understands your health problems
- Who is taking new patients
- Who can serve you in your language
- Who is easy to get to

- Women can also choose one of our **OB/GYN** doctors to deal with women’s health issues. Women do not need a PCP referral to see a plan OB/GYN doctor. They can have routine checkups (twice a year), follow-up care if there is a problem or regular care during pregnancy.
- We also contract with **FQHCs** (Federally Qualified Health Centers). All FQHCs give primary and specialty care. Some consumers want to get their care from FQHCs because the centers have a long history in the neighborhood. Maybe you want to try them because they are easy to get to. You should know that you have a choice. You can choose any one of the providers listed in our directory. Or you can sign up with a primary care physician at one of the FQHCs that we work with, listed below. Just call Customer Service at 1-800-288-5441 (TTY/TDD: 1-877-247-6272) for help.

FQHCs	Number of locations
Whitney M. Young Jr. Health Center Inc. (Albany)	1
Dr. Martin Luther King Jr. (Bronx)	1
Hunts Point Multi-Service Center	3
Institute For Urban Family Health	1
Morris Heights Health Center	1
Soundview Health Center	4
Urban Health Plan	3
Hudson River Healthcare Inc. (Dutchess)	5
Bedford Stuyvesant Family Health Center (Kings)	1
Lutheran Medical Center	4
Betances Health Center (New York)	1
Charles B. Wang Community Health Center	2
Institute for Urban Family	2
Ryan/Chelsea Community Health Center	1
W. F. Ryan Community Health Center	3

FQHCs	Number of locations
Hudson River Healthcare Inc. (Orange)	1
Middletown Community Health Center	3
The Greater Hudson Valley Family Health Center	1
Joseph P. Addabbo Family Health Center (Queens)	4
Chinatown Action for Progress Inc	1
Rockland Community Medical and Dental Care	2
Ulster Institute for Urban Family Health	4

- FQHCs (Federally Qualified Health Centers) give primary and specialty care. Some people want to get their care from FQHCs because the centers have a long history in the neighborhood. Besides primary and specialty care, FQHCs have social support services, case management and classes to help you stop smoking, control diabetes or lose weight. We have all these services too, but if you decide you want to get your care from an FQHC, you can disenroll from our health plan at any time. For information, call Customer Service at 1-800-288-5441 (TTY/TDD: 1-877-247-6272).
- In almost all cases, your doctors will be WellCare providers. **There are two instances when you can still see another doctor that you had before you joined WellCare.** In both cases, however, your doctor must agree to work with WellCare.
 1. You are more than three months pregnant when you join and you are getting prenatal care. In that case, you can keep your doctor until after your delivery and follow-up care.
 2. At the time you join, you have a life-threatening disease or condition that gets worse with time. In that case, you can ask to keep your doctor for up to 60 days.
- You may be able to choose a specialist to act as your PCP (primary care provider) if you have a long-lasting illness like HIV/AIDS or other long-term health problems. Members should contact Customer Service to get a referral to a specialist who will coordinate that member's primary and specialty care. Your PCP and WellCare must agree your care should be handled by a specialist. Your PCP and the plan must agree to a plan for your treatment. While acting as PCP, the specialist may treat you without a referral from the original PCP. Your specialist may OK referrals, procedures, tests and other medical services.
- If you need to, you can change your PCP in the first 30 days after your first appointment with your PCP. After that, WellCare allows you or your child(ren) to change your PCP once every six months without cause, or more often if you have a good reason. You can also change your OB/GYN or a specialist to which your PCP has referred you.

After 30 days from your first visit with your PCP and before six months, WellCare allows its members to choose a new PCP if:

- You or your child(ren) need special care for an acute or chronic condition and both you and WellCare agree that a new PCP is in your or your child's best interest.
- You move to a place where it takes more than 30 minutes or 30 miles to get to your PCP.

There are other situations where WellCare may change your PCP after 30 days from your first appointment with your PCP and before six months. Please call Customer Service if you would like to discuss your situation. The toll-free number is 1-800-288-5441 (TTY/TDD: 1-877-247-6272). We are available weekdays, 8am to 6pm Eastern.

- If your **provider leaves WellCare**, we will tell you within 15 days from when we know about this. If you wish, you may be able to see that provider if you are more than three months pregnant or if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor for up to 60 days after delivery. If you are seeing a doctor regularly for an ongoing condition, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with WellCare during this time. If any of these conditions apply to you, check with your PCP or call Customer Service at 1-800-288-5441 (TTY/TDD: 1-877-247-6272).

HOW TO GET REGULAR CARE

“Regular care” means exams, regular checkups, shots or other treatments to keep you well, advice when you need it, and referral to the hospital or specialists when needed. It means you and your PCP working together to keep you well or to see that you get the care you need. Day or night, your PCP is only a phone call away. Be sure to call him or her whenever you have a medical question or concern. If you call after hours or weekends, leave a message and tell us where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how the health plan works.

- Your care must be “**medically necessary**.” The services you get must be needed:
 - To prevent, or diagnose and correct, what could cause more suffering, or
 - To deal with a danger to your life, or
 - To deal with a problem that could cause illness, or
 - To deal with something that could limit your normal activities.
- Your PCP will take care of most of your health care needs, but you must have an appointment to see your PCP. If ever you can’t keep an appointment, call to let your PCP know. As soon as you choose a PCP, call to make a first appointment. Your PCP will need to know as much about your medical history as you can tell him or her. If you can, prepare for your first appointment. Make a list of your medical background, any problems you have now, and the questions you want to ask your PCP. In most cases, your first visit should be within three months of your joining the plan.
- If you need care before your first appointment, call your PCP’s office to explain the problem. He or she will give you an earlier appointment. (You should still keep the “first” appointment.)
- Use the following list as an appointment guide for our limits on how long you may have to wait after your request for an appointment:
 - Your first appointment and routine physicals: within 12 weeks
 - Urgent care: within 24 hours
 - Non-urgent sick visits: within three days
 - Routine, preventive care: within four weeks
 - First pre-natal visit: within three weeks during first trimester (two weeks during the second, one week during the third)
 - First family planning visit: within two weeks
 - Follow-up after a behavioral health ER or inpatient visit: five days
 - Non-urgent behavioral health visit: two weeks.

HOW TO GET SPECIALTY CARE AND REFERRALS

- If you need care that your PCP cannot give, he or she will **refer** you to a specialist who can. If your PCP refers you to another doctor, you are not responsible for any costs except the usual co-payments as described later in this handbook. Most of these specialists are plan providers. Talk with your PCP to be sure you know how referrals work. If you think the specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist. There are some treatments and services that your PCP must ask our plan to approve before you can get them. Your PCP will be able to tell you what they are.

If we do not have a specialist in our plan who can give you the care you need, we will get you the care you need from a specialist outside our plan. Your PCP can call us to ask for our OK for you to see an out-of-network specialist. You will not have to pay for any costs except the usual co-payments. These are described later in this handbook. If your PCP or WellCare refers you to a provider outside our network, you are not responsible for any costs except the usual co-payments as described later in this handbook.

- If you need to see a specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time (a “**standing referral**”). If you have a standing referral, you will not need a new referral for each time you need care.
- If you have a long-term disease or a disabling illness that gets worse over time, your PCP may be able to arrange for:
 - Your specialist to act as your PCP
 - A referral to a specialty care center that deals with the treatment of your problem
 - Hospice services if you are terminally ill
- If you are having trouble getting a referral you think you need, contact Customer Service at 1-800-288-5441 (TTY/TDD: 1-877-247-6272).

You can also call Customer Service for help in getting access to a specialty care center.

GET THESE SERVICES WITHOUT A REFERRAL

Women's Services

You do not need a referral from your PCP to see one of our providers IF

- You are pregnant, or
- You need OB/GYN services, or
- You need family planning services, or
- You want to see a midwife, or
- You need to have a breast or pelvic exam.

Family Planning

- You can get the following family planning services: advice for birth control, prescription birth control, pregnancy tests, sterilization or a medically necessary abortion. During your visits for these things, you can also get tests for sexually transmitted infections, a breast cancer exam or a pelvic exam.
- You do not need a referral from your PCP to get these services. You can use your Plan ID card to see one of WellCare's family planning providers. Check the WellCare Provider Directory or call Customer Service for help in finding a provider.

HIV Testing and Counseling

- You can get HIV testing and counseling anytime you have family planning services. You do not need a referral from your PCP. Just make an appointment with a family planning provider.
- If you want HIV testing and counseling but not as part of a family planning service, your PCP can arrange it for you. Or you can visit an anonymous HIV testing and counseling site. For information, call the New York State HIV Counseling Hotline at 1-800-872-2777 or 1-800-541-AIDS.
- If you need HIV treatment after the testing and counseling service, your PCP will help you get follow-up care.

Please note that New York City Department of Health and Mental Hygiene facilities offer free and confidential STD/HIV services for non-enrolled sexual and needle-sharing partners.

Eye Care

You do not need a referral from your PCP for an eye exam or to get new glasses. You just choose one of our participating providers. But remember that you are limited to eye exams and new glasses once every two years. However, enrollees diagnosed with diabetes may self-refer to any participating provider for a dilated eye (retinal) examination once in any 12-month period. If you need to see an eye specialist for care of an eye disease or defect, your PCP will refer you.

Behavioral Health Assessment

You may go for one mental health and one chemical dependence (including alcohol and/or substance abuse) assessment without a referral in any 12-month period. You must use a Magellan Behavioral Health provider, but you do not need an approval from your PCP. If you need more visits, your PCP will help you get a referral.

Dental Care

What is generally covered? Regular and routine dental services, supplies and devices needed for health conditions. You may refer yourself to a plan provider.

EMERGENCIES

You are always covered for emergencies. An **emergency** means a medical or behavioral condition:

- That comes on suddenly, and
- Has pain or other symptoms

This would make a person with an average knowledge of health fear that someone will suffer serious harm to body parts or functions or cause serious disfigurement without care right away. Examples of an emergency are:

- A heart attack or severe chest pain
- Bleeding that won't stop or a bad burn
- Broken bones
- Trouble breathing/convulsions/loss of consciousness
- When you feel you might hurt yourself or others
- If you are pregnant and have signs like pain, bleeding, fever or vomiting

Examples of **non-emergencies** are colds, sore throat, upset stomach, minor cuts and bruises or sprained muscles.

If you believe you have an emergency, here's what to do:

Call 911 or go to the emergency room. You do not need your plan's or your PCP's approval before getting emergency care, and you are not required to use our hospitals or doctors.

If you are not sure, call your PCP or WellCare.

Tell the person you speak with what is happening. Your PCP or a WellCare Customer Service representative will:

- Tell you what to do at home,
- Tell you to come to the PCP's office, or
- Tell you to go to the nearest emergency room.

If you are out of the area when you have an emergency:

- Go to the nearest emergency room.

Remember, you do not need prior approval for emergency services.

- Use the emergency room only if you have an EMERGENCY.
- The emergency room should NOT be used for problems like the flu, sore throats or ear infections.
- If you have questions, call your PCP or WellCare at 1-800-288-5441 (TTY/TDD: 1-877-247-6272).

URGENT CARE

You may have an injury or an illness that is not an emergency but still needs prompt care. This could be ...

- An episode of persistent vomiting or diarrhea
- A sprained ankle
- A bad splinter you can't remove

You can get an appointment for an urgent care visit for the same or next day. If you are at home or away, call your PCP anytime, day or night. If you cannot reach your PCP, call us at 1-800-288-5441 (TTY/TDD: 1-877-247-6272). Tell the person who answers what is happening. They will tell you what to do.

WE WANT TO KEEP YOU HEALTHY

Besides the regular checkups you need, here are some other ways to keep you in good health:

- Health education classes
- Grief/loss support
- Stress management
- Prenatal care and nutrition
- Breast feeding and baby care
- Stop-smoking classes
- Asthma counseling and self-management training
- Diabetes counseling and self-management training
- Weight control
- Cholesterol control

Call Customer Service at 1-800-288-5441 (TTY/TDD: 1-877-247-6272) to find out more and get a list of upcoming classes.

PART 2—YOUR BENEFITS AND PLAN PROCEDURES

The rest of this handbook is for your information when you need it. It lists the covered and the non-covered services available under FHPlus. If you have a complaint, the handbook tells you what to do. The handbook has other information you may find useful. Keep this handbook handy for when you need it.

BENEFITS

FHPlus covers a comprehensive set of health care services or benefits. WellCare will provide or arrange for all of the covered services. You can get a few services, however, without going through your PCP. These include emergency care, family planning/HIV testing and counseling, and specific “self-referral” services, as mentioned in Part 1.

CO-PAYMENTS

FHPlus members are required to make co-payments when receiving certain medical care and services. Some people are exempt and do not have to make these payments. See the following list of services that require co-payments and information about who is exempt. If you have questions, you may call Customer Service at 1-800-288-5441 (TTY/TDD: 1-877-247-6272) or the Department of Health’s Family Health Plus Information Line at 1-877-934-7587.

Service	Co-Payment
• Brand-name prescription drugs	\$6 for each prescription and refill
• Generic prescription drugs	\$3 for each prescription and refill
• Clinic visit	\$5 per visit
• Physician visit	\$5 per visit
• Dental service visit	\$5 per visit up to a total of \$25 per year
• Lab tests	\$0.50 per test
• Radiology services (like diagnostic X-rays, ultrasound, nuclear medicine and oncology services)	\$1 per radiology service
• Inpatient hospital stay	\$25 per stay
• Non-urgent emergency room visit	\$3 per visit
• Over-the-counter medications (e.g., for smoking cessation and diabetes)	\$0.50 per medication
• Medical supplies (e.g., for diabetes and enteral formulae)	\$1 per supply

Your doctor may have to get prior authorization from us before writing your prescription for certain medications. Your doctor can work with WellCare to make sure you get the medications that you need. Learn more about prior authorization later in this handbook.

- You have a choice in where you fill your prescriptions. You can go to any pharmacy that participates with our plan or you can fill your prescriptions by using a mail-order pharmacy. For more information on your options, please contact Customer Service at 1-800-288-5441 (TTY/TDD: 1-877-247-6272).

Co-payments do not apply to the following services:

- Emergency services
- Family planning services and supplies
- Mental health clinics
- Chemical dependence clinics
- Mental illness drugs (psychotropic)
- Tuberculosis drugs
- Prescription drugs for a resident of an adult care facility

You do not have to pay the co-payments if you are:

- Under age 21
- Pregnant
- A resident of a community-based residential facility licensed by the Office of Mental Health or the Office of People with Developmental Disabilities (OPWDD)
- Not able to pay the co-payment at any time and you tell the provider that you are unable to pay

Family Health Plus members who cannot afford the co-payment may not be denied a service based on their inability to pay. Your provider cannot refuse to give you care or services because you are unable to pay. (However, you will still owe the unpaid co-pay amounts to the provider and the provider may ask you for payment later or send you a bill.)

SERVICES COVERED BY OUR PLAN

You must get these services from the providers who are in our plan. All services must be medically necessary and provided or referred by your PCP (primary care provider).

Regular Medical Care

- Office visits with your PCP
- Referrals to specialists
- Eye/hearing exams

Preventive Care

- Regular checkups
- Tests and procedures ordered by your PCP or specialist
- Smoking-cessation counseling
- Access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for enrollees ages 19 and 20 years

Maternity Care

Women in FHPlus who become pregnant will qualify for Medicaid because the financial requirements are different and the family size is changed. If you become pregnant while you are enrolled in FHPlus, you have a choice to make. You may want to change coverage from FHPlus to Medicaid. Medicaid covers more services than FHPlus, which you may or may not need, depending on your medical needs. However, you may need to see a different doctor if you change from FHPlus to Medicaid. You should discuss this choice with your doctor and the local Department of Social Services office or HRA so that you can make the decision that best meets your needs.

Your baby will be eligible for Medicaid. Babies can't be covered under FHPlus—it is a program for adults from 19 through 64 years of age. In order to be sure your baby will have access to all the services covered by Medicaid, you need to let your local Department of Social Services or HRA office know when you are pregnant, and your doctor should notify WellCare. They can get started arranging for coverage for your baby before it is born, regardless of the choice you have made for yourself. You should select your baby's doctor as soon as possible.

If you stay in FHPlus, we will cover:

- Pregnancy care
- Doctors/midwife and hospital services
- Post-partum care
- Smoking-cessation counseling for pregnant women (six sessions during pregnancy and six sessions during post-partum during a calendar year).

Home Health Care

WellCare can arrange for some home health care visits (up to 40 per year), but this is generally only done to avoid your having to stay in a hospital. Your doctor must agree that your medical needs can be met at home with this help. Here are some times when this would be covered:

- If you stay in the hospital less than 48 hours after giving birth
- If you stay in the hospital less than 96 hours after a Cesarean birth
- Other visits as needed and ordered by your PCP/specialist

Vision Care

FHPlus covers emergency vision care and the following preventive and routine vision care provided once in any 24-month period:

- One eye exam
- Either one pair of prescription eyeglass lenses and a frame, or prescription contact lenses where medically necessary
- One pair of medically necessary occupational eyeglasses. Occupational eyeglasses are special glasses that help you perform your job duties.

Dental Care

WellCare believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with Healthplex, an expert in providing high-quality dental services. Covered services include regular and routine dental services such as preventive dental checkups, cleaning, X-rays, fillings and other services for you and your family members to check for any changes or abnormalities that may require treatment and/or follow-up care. **You do not need a referral from your PCP to see a dentist.**

How to Access Dental Services

- If you need to find a dentist or change your dentist, please call Healthplex at 1-800-468-9868. Customer Service representatives are there to help you. Many speak your language or have a contract with Language Line Services.
- You will receive a separate dental ID card with the name of your assigned dentist. Show your dental ID card to access dental benefits.
- You can also self-refer to a dental clinic that is operated by an academic dental center. The three Academic Dental Centers are:

Columbia University Health Care 630 West 168th Street New York, NY 212-342-4160	New York University Dental Center 345 East 24th Street New York, NY 212-998-9870 or 9872	SUNY at Stony Brook Dental School Nicolls Road, Sullivan Hall Stony Brook, NY 631-632-8989
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Have a Question? If you want to learn more about how to access dental care or have a question, do not hesitate to call Healthplex at 1-800-468-9868.

Hospital Care

- Inpatient care
- Outpatient care
- Lab, X-ray, other tests

Emergency Care

- Emergency care services are procedures, treatments or services needed to evaluate or stabilize an emergency.
- After you have received emergency care, you may need other care to make sure you remain in stable condition. Depending on the need, you may be treated in the emergency room, in an inpatient hospital room or in another setting. These are called post-stabilization services.
- For more about emergency services, see page 8.

Behavioral Health Services

WellCare offers Behavioral Health Services through a contract with Magellan Behavioral Health.

If you want to learn more about how to access Mental Health Services, or if you have a question, please call Magellan Behavioral Health 1-800-241-1103 (TTY/TDD 1-877-342-6815).

WellCare will cover up to 60 outpatient visits and 30 inpatient visits a year for Behavioral Health Services.

Behavioral Health Services include Chemical Dependence Services (including alcohol and substance abuse services) and Mental Health Treatment Services.

Detoxification Services (Inpatient Detoxification and Inpatient or Outpatient Withdrawal Services) do not count towards the limits mentioned above.

Specialty Care

Includes the services of other practitioners, including:

- Occupational, physical and speech therapists — Limited to 20 visits per therapy per calendar year
- Midwives
- Audiologists
- Cardiac rehabilitation

Other Covered Services

- Emergency ambulance
- Durable medical equipment (DME)
- Hospice services
- Hearing aids/supplies
- Prosthetics/orthotics
- Court-ordered services, if covered by the plan
- TB diagnosis and treatment—You can choose to go either to your PCP or to the county public health agency for diagnosis and/or treatment. You do not need a referral to go to the county public health agency.

Pharmacy Benefit

Family Health Plus members must use their plan ID card to get:

- Prescription drugs
- Insulin and diabetic supplies (e.g., insulin syringes, blood glucose test strips, lancets and alcohol wipes)
- Smoking-cessation agents, including over-the-counter (OTC) products
- Select OTC medications, such as (Prilosec OTC, Loratadine, Zyrtec, vitamins)
- Hearing-aid batteries
- Enteral formulae
- Emergency contraception (six per calendar year)

You must use a pharmacy that accepts our plan.

Co-payments apply for most medications. Some members are not required to pay these co-payments. For a list of the co-payments, refer to the co-payment chart found on page 10.

Your doctor may have to get prior authorization from us before writing your prescription for certain medications. Your doctor can work with WellCare to make sure you get the medications that you need. Learn more about prior authorization later in this handbook.

SERVICES NOT COVERED

These services are not available from WellCare. If you get any of these services, you may have to pay the bill.

- Cosmetic surgery if not medically needed
- Routine foot care (for those 21 years and older)
- Personal and comfort items
- Infertility treatments
- Services from a provider that is not part of WellCare (unless WellCare or your PCP sends you to that provider)
- Those services not given an approval in advance by your PCP
- Personal care services
- Private duty nursing services
- Medical supplies (like bandages), non-prescription drugs (OTCs like aspirin)
- Nursing home stays that are permanent
- Non-emergency transportation (unless you are 19 or 20 and in the C/THP program)

NOTE—If you are 19 or 20 in the C/THP program, call LogistiCare to reserve a ride or to find out more information. Call 1-866-417-0292 Monday through Friday, from 8am to 5pm. TTY/TDD users may call 1-866-288-3133.

You may have to pay for any service that your PCP does not approve. Also, if before you get a service, you agree to be a “private pay” or “self-pay” patient, you will have to pay for the service. This includes:

- Non-covered services (listed above)
- Unauthorized services
- Services provided by providers not part of the plan

If you have any questions, call Customer Service at 1-800-288-5441 (TTY/TDD: 1-877-247-6272).

SERVICE AUTHORIZATION AND ACTIONS

Prior Authorization and Timeframes

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization**. You or someone you trust can ask for this.

The following treatments and services must be approved before you get them:

- A specialist visit by a participating provider requires authorization from your Primary Care Provider
- Surgical procedures, inpatient services, specialist services by non-participating providers
- Some tests require prior authorization by your PCP and WellCare's Medical Management
- Experimental or investigational health services requested by the member

Asking for approval of a treatment or service is called a **service authorization request**. To get approval for these treatments or services you need to:

Call (or have your doctor call) our toll-free Customer Service number at 1-800-288-5441 (TTY/TDD: 1-877-247-6272) or send your request in writing to:

WellCare Appeals Department, P.O. Box 31368, Tampa, FL 33631

You will also need to get prior authorization if you are getting one of these services now, but need to continue or get more of the care. This includes a request for home health care while you are in the hospital or after you have just left the hospital. This is called **concurrent review**.

What happens after we get your service authorization request?

The health plan has a review team to be sure you get the services we promise. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against medically acceptable standards.

Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **action**. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor or may be a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

After we get your request, we will review it under a **standard** or **fast-track** process. You or your doctor can ask for a fast-track review if it is believed that a delay will cause serious harm to your health. If your request for a fast-track review is denied, we will tell you and your case will be handled under the standard review process. If you are in the hospital or have just left the hospital and we receive a request for home health care, we will handle the request as a fast-track review. In all cases, we will review your request as fast as your medical condition requires us to do so but no later than mentioned below.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals or fair hearings you will have if you don't agree with our decision.

Timeframes for prior authorization requests:

- Standard review: We will make a decision about your request within three work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.
- Fast-track review: We will make a decision and you will hear from us within three work days. We will tell you by the third work day if we need more information.

Timeframes for concurrent review requests:

- Standard review: We will make a decision within one work day of when we have all the information we need, but you will hear from us no later than 14 days after we received your request. We will tell you by the 14th day if we need more information.
- Fast-track review: We will make a decision within one work day of when we have all the information we need.

However, if you are in the hospital or have just left the hospital, and you ask for home health care on a Friday or day before a holiday, we will make a decision no later than 72 hours of when we have all the information we need.

In all cases, you will hear from us no later than three work days after we received your request. We will tell you by the third work day if we need more information.

If we need more information to make either a standard or fast-track decision about your service request, we will:

- Write and tell you what information is needed. If your request is in a fast-track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-800-288-5441 (TTY/TDD: 1-877-247-6272) or writing.

You or someone you trust can file a complaint with the plan if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-800-206-8125.

We will notify you by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If you are not satisfied with this answer, you have the right to file an action appeal with us. See the Action Appeal section later in this handbook.

Other Decisions About Your Care

Sometimes we will do a concurrent review on the care you are receiving to see if you still need the care. We may also review other treatments and services you have already received. This is called **retrospective review**. We will tell you if we take these other actions.

Timeframes for notice of other actions:

- In most cases, if we make a decision to reduce, suspend or terminate a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.
- If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving necessary information for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. You will not have to pay for any care you received that was covered by the plan or by FHPlus even if we later deny payment to the provider.

HOW OUR PROVIDERS ARE PAID

You have the right to ask us whether we have any special financial arrangement with our physicians that might affect your use of health care services. You can call Customer Service at 1-800-288-5441 (TTY/TDD: 1-877-247-6272) if you have specific concerns. We also want you to know that most of our providers are paid in one or more of the following ways.

- If our PCPs work in a clinic or health center, they probably get a salary. The number of patients they see does not affect this.
- Our PCPs who work from their own offices may get a set fee each month for each patient for whom they are the PCP. The fee stays the same whether the patient needs one visit or many—or even none at all. This is called capitation.
- Sometimes providers get a set fee for each person on their patient list, but some money (maybe 10 percent) can be held back for an incentive fund. At the end of the year, this fund is used to reward PCPs who have met the standards for extra pay that were set by WellCare.
- Providers may also be paid by fee-for-service. This means they get a plan-agreed-upon fee for each service they provide.

YOU CAN HELP WITH PLAN POLICIES

We value your ideas. You can help us develop policies that best serve our members. If you have ideas, tell us about them. Maybe you'd like to work with one of our member advisory boards or committees. Call Customer Service to find out how you can help.

INFORMATION FROM CUSTOMER SERVICE

Here is information you can get by calling Customer Service at 1-800-288-5441 (TTY/TDD: 1-877-247-6272):

- A list of names, addresses, and titles of WellCare's Board of Directors, Officers, Controlling Parties, Owners and Partners.
- A copy of the most recent financial statements/balance sheets, summaries of income and expenses.
- A copy of the most recent individual direct pay subscriber contract.
- Information from the State Insurance Department about consumer complaints about WellCare.
- How we keep your medical records and member information private.
- In writing, we will tell you how our plan checks on the quality of care to our members.
- We will tell you which hospitals our health providers work with.
- If you ask us in writing, we will tell you the guidelines we use to review conditions or diseases that are covered by our plan.
- If you ask in writing, we will tell you the qualifications needed and how health care providers can apply to be part of our plan.
- If you ask, we will tell you:
 - whether our contracts or subcontracts include physician incentive plans that affect the use of referral services, and, if so,
 - information on the type of incentive arrangements used; and
 - whether stop-loss protection is provided for physicians and physicians groups.
- Information about how our company is organized and how it works.

KEEP US INFORMED

Call Customer Service whenever these changes happen in your life:

- You change your name, address or telephone number
- You have a change in circumstances that will affect your eligibility for FHPlus
- You are pregnant
- You give birth
- You become covered under other health insurance

OPTIONS

1. If YOU want to leave WellCare

You can try us for 90 days. You can ask to leave our plan for any reason at any time during those 90 days, if there is another FHPlus plan available where you live. If you do not leave during the first 90 days of your coverage, you must stay in the plan for nine more months, unless you have a good reason (“good cause”). At the end of your first year in our plan, if you want to, you can change to another plan if there is another FHPlus plan available where you live.

These are examples of “good cause”:

- Our health plan cannot provide a suitable primary care provider for you within acceptable travel times (if providers are routinely within 30 minutes or 30 miles from where you live).
- Our health plan does not meet New York State requirements and members are harmed because of it.
- You move out of our service area.
- You, the plan and the LDSS all agree that disenrollment is best for you.
- We do not offer an FHPlus covered service that you can get from another FHPlus plan.
- You need a service that is related to a benefit we have chosen not to cover and getting the service separately would put your health at risk.
- We have not been able to provide services to you as we are required to under our contract with the State.

To disenroll or change plans:

- Call the Managed Care staff at your local Department of Social Services if you live in Rensselaer County. They can help you disenroll or transfer to another health plan if there is another Family Health Plus plan available where you live.
- If you live in Albany, New York City or Dutchess, Rockland, Orange or Ulster counties, call New York Medicaid CHOICE at 1-800-505-5678 and tell them you want to transfer to another Family Health Plus plan. The New York Medicaid CHOICE counselors can help you disenroll or change health plans if there is another Family Health Plus plan available where you live.

You can transfer over the phone or ask for a Transfer Package. You will get a notice that the change will take place by a certain date. We will provide the care you need until then.

It will take between two and six weeks to process, depending on when your request is received. You can ask for faster action if you believe the timing of the regular process will cause added damage to your health. You can also ask for faster action if you have complained because you did not agree to the enrollment. Just call your local Department of Social Services or New York Medicaid CHOICE.

2. You could become ineligible for WellCare's FHPlus program

You may have to leave WellCare if you:

- Move out of the county or service area
- Have a change in income that makes you ineligible for FHPlus
- Join an HMO or other insurance plan through work
- Receive Medicare coverage
- Join a Long-term Home Health Care Program
- Are incarcerated
- Turn 65 years of age

You are “**guaranteed**” coverage by WellCare during the first six months of your enrollment—even if you are no longer eligible for FHPlus. The reasons for your losing eligibility must not be related to death, moving out of state or incarceration. During this time, you can get the services that our plan covers. Guaranteed coverage does not apply if you choose to leave WellCare.

3. We can ask you to leave WellCare

You can also lose your membership in WellCare, if you often:

- Refuse to work with your PCP in regard to your care
- Don't keep appointments
- Go to the emergency room for non-emergency care
- Don't follow WellCare rules
- Don't fill out forms honestly or don't give true information (fraud)
- Cause abuse or harm to plan members, providers or staff
- Act in ways that make it hard for us to do our best for you and other members even after we have tried to fix the problems

4. You may want to change from FHPlus to Medicaid with a “spend down”

FHPlus doesn't cover all the services that Medicaid does (like medical supplies), and some FHPlus services have limits that Medicaid doesn't.

If you have medical needs that could be better met by Medicaid and you qualify, you may be eligible for Medicaid with a “spend down.”

If your income is higher than that allowed for Medicaid, but you have medical bills that are greater than the amount your income is over the Medicaid level, those bills could help you qualify for Medicaid. This only applies to people who:

- Are under age 21, or
- Are disabled or blind, or
- Have children under age 21, or
- Are over age 65, or
- Are pregnant (see below also).

You should contact your local Department of Social Services or HRA to see if this is an option for you. If so, they will have you disenroll from WellCare so that you can receive Medicaid benefits. You can ask that this be done quickly if you feel that waiting will damage your health or if you have complained because you did not agree to the FHPlus enrollment.

5. If you become pregnant while enrolled in Family Health Plus

If you become pregnant, you are eligible for Medicaid. You have the choice of staying in FHPlus or changing to Medicaid. You may decide to change to Medicaid because it covers more services. You can stay in WellCare, but you should ask your doctor if he or she would continue seeing you as a Medicaid patient, if you change.

Your newborn will automatically be eligible for Medicaid and will be enrolled in WellCare. You should contact WellCare and your local Department of Social Services office or HRA to discuss these options and your decision.

ACTION APPEALS

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization**. Asking for approval of a treatment or service is called a **service authorization request**. This process is described earlier in this handbook. Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **action**.

If you are not satisfied with our decision about your care, there are steps you can take.

Your provider can ask for reconsideration:

If we made a decision that your service authorization request was not medically necessary or was experimental or investigational; and we did not talk to your doctor about it, your doctor may ask to speak with the plan's medical director. The medical director will talk to your doctor within one workday.

You can file an action appeal:

- If you are not satisfied with an action we took or what we decide about your service authorization request, you have 60 business days after hearing from us to file an action appeal.
- You can do this yourself or ask someone you trust to file the action appeal for you. You can call Customer Service at 1-800-288-5441 (TTY/TDD: 1-877-247-6272) if you need help filing an action appeal.
- We will not treat you any differently or act badly toward you because you file an action appeal.
- The action appeal can be made by phone or in writing. If you make an action appeal by phone, it must be followed up in writing to WellCare Appeals Department, P.O. Box 31368, Tampa, FL 33631.

Your action appeal will be reviewed under the fast-track process:

- If you or your doctor asks to have your action appeal reviewed under the fast-track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied, we will tell you and your action appeal will be reviewed under the standard process; or
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided; or
- If your request was denied when you asked for home health care after you were in the hospital.
- Fast-track action appeals can be made by phone and do not have to be followed up in writing.

What happens after we get your appeal:

- Within 15 days, we will send you a letter to let you know we are working on your action appeal.
- Action appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- Before and during the action appeal, you or your designee can see your case file, including medical records and any other documents and records being used to make a decision on your case.
- You can also provide information to be used in making the decision in person or in writing. Call WellCare at 1-800-288-5441 (TTY/TDD: 1-877-247-6272) if you are not sure what information to give us.

If you are appealing our decision that the out-of-network service you asked for was not different from a service that is available in our network, ask your doctor to send us:

1. a written statement that the service you asked for is different from the service we have in our network; and
 2. two pieces of medical evidence (published articles or scientific studies) that show the service you asked for is better for you, and will not cause you more harm than the service we have in our network.
- You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, any further appeal rights you have will be explained or you or someone you trust can file a complaint with the New York State Department of Health at 1-800-206-8125.

Timeframes for Action Appeals:

- Standard action appeals: If we have all the information we need, we will tell you our decision within 30 days from your action appeal. A written notice of our decision will be sent within two work days from when we make the decision.
- Fast-track action appeals: If we have all the information we need, fast-track action appeal decisions will be made in two work days from your action appeal. We will tell you in three work days after giving us your action appeal, if we need more information. We will tell you our decision by phone and send a written notice later.
- If we need more information to make either a standard or fast-track decision about your action appeal, we will:
 - Write you and tell you what information is needed. If your request is in a fast-track review, we will call you right away and send a written notice later.
 - Tell you why the delay is in your best interest.
 - Make a decision no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-800-288-5441 (TTY/TDD: 1-877-247-6272) or writing WellCare at:

WellCare Appeals Department, P.O. Box 31368, Tampa, FL 33631.

You or someone your trust can file a complaint with the plan if you don't agree with our decision to take more time to review your action appeal. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-800-206-8125.

If your original denial was because we said:

- The service was not medically necessary; or
- The service was experimental or investigational; or
- The out-of-network service was not different from a service that is available in our network; and we do not tell you our decision about your action appeal on time, the original denial against you will be reversed. This means your service authorization request will be approved.

Aid to continue while appealing a decision about your care:

In some cases you may be able to continue the services while you wait for your action appeal case to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for a fair hearing:

- Within 10 days from being told that your request is denied or care is changing; or
- By the date the change in services is scheduled to occur.

If your fair hearing results in another denial, you may have to pay for the cost of any continued benefits that you received. The decision you receive from the fair hearing officer will be final.

EXTERNAL APPEALS

If the plan decides to deny coverage for a medical service you and your doctor asked for because:

- The service was not medically necessary; or
- The service was experimental or investigational ; or
- The out-of-network service was not different from a service that is available in our network; you can ask New York State for an independent external appeal. This is called an external appeal because it is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment, clinical trial or treatment for a rare disease. You do not have to pay for an external appeal.

Before you appeal to the state:

1. You must file an action appeal with the plan and get the plan's final adverse determination; or
2. If you had a fast-track action appeal and are not satisfied with the plan's decision, you can choose to file a standard action appeal with the plan or go directly to an external appeal; or
3. You and the plan may agree to skip the plan's appeals process and go directly to external appeal.

You have 45 days after you receive the plan's final adverse determination to ask for an external appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the external appeal within 45 days of when you made that agreement.

Additional appeals to your health plan may be available to you if you want to use them. However, if you want an external appeal, you must still file the application with the State Department of Insurance within 45 days from the time the plan gives you the notice of final adverse determination or when you and the plan agreed to waive the plan's appeal process.

You will lose your right to an external appeal if you do not file an application for an external appeal on time.

To ask for an external appeal, fill out an application and send it to the State Insurance Department. You can call Customer Service at 1-800-288-5441 (TTY/TDD: 1-877-247-6272) if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The external appeal application says what information will be needed.

Here are some ways to get an application:

- Call the State Insurance Department, 1-800-400-8882.
- Go to the State Insurance Department's Web site at www.ins.state.ny.us.
- Contact the health plan at 1-800-288-5441 (TTY/TDD: 1-877-247-6272).

Your external appeal will be decided in 30 days. More time (up to five work days) may be needed if the external appeal reviewer asks for more information. You and the plan will be told the final decision within two days after the decision is made.

You can get a faster decision if your doctor says that a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in three days or less. The reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may also ask for a fair hearing if the plan decided to deny, reduce or end coverage for a medical service. You may request a fair hearing and ask for an external appeal. If you ask for a fair hearing and an external appeal, the decision of the fair hearing officer will be the one that counts.

FAIR HEARINGS

In some cases you may ask for a fair hearing from New York State.

- You are not happy with a decision your local Department of Social Services or the State Department of Health made about your staying in or leaving WellCare.
- You are not happy with a decision that we made about medical care you were getting. You feel the decision limits your Family Health Plus benefits or that we did not make the decision in a reasonable amount of time.
- You are not happy about a decision we made that denied medical care you wanted. You feel the decision limits your Family Health Plus benefits.
- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Family Health Plus benefits. You must file a complaint with WellCare. If WellCare agrees with your doctor, you may ask for a state fair hearing.
- The decision you receive from the fair hearing officer will be final.

If the services you are now getting are scheduled to end, you can choose to ask to continue the services your doctor ordered while you wait for your case to be decided. However, if you choose to ask for services to be continued, and the fair hearing is decided against you, you may have to pay the cost for the services you received while waiting for a decision.

You can use one of the following ways to request a Fair Hearing:

1. By phone, call toll-free 1-800-342-3334
2. By fax, 518-473-6735
3. By internet, www.otda.state.ny.us/oah/forms.asp
4. By mail,
NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Manage Care Hearing Unit
P.O. Box 22023
Albany, New York 12201-2023

Remember, you can complain anytime to the New York State Department of Health by calling 1-800-206-8125.

COMPLAINT PROCESS

Complaints

We hope our health plan serves you well. If you have a problem, talk with your PCP, or call or write Customer Service. Most problems can be solved right away. If you have a problem or dispute with your care or services, you can file a complaint with the plan. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to our complaint procedure described below.

You can ask someone you trust (such as a legal representative, a family member or friend) to file the complaint for you. If you need our help because of a hearing or vision impairment, or if you need translation services, or help filing the forms, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

You also have the right to contact the New York State Department of Health about your complaint at 1-800-206-8125 or write to: NYS Department of Health, Division of Managed Care, Bureau of Managed Care Certification and Surveillance, Corning Tower ESP Room 1911, Albany, NY 12237. You may also contact your local Department of Social Services with your complaint at any time. You may call the New York State Insurance Department at 1-800-342-3736 if your complaint involves a billing problem.

How to File a Complaint with the Plan:

To file by phone, call Customer Service at 1-800-288-5441 (TTY/TDD: 1-877-247-6272) from 8am to 6pm. If you call us after hours, leave a message. We will call you back the next work day. If we need more information to make a decision, we will tell you.

You can write us with your complaint or call the Customer Service number and request a complaint form. It should be mailed to 110 Fifth Avenue, 3rd Floor, New York, NY 10011.

What happens next:

If we don't solve the problem right away over the phone or after we get your written complaint, we will send you a letter within 15 work days. The letter will tell you:

- Who is working on your complaint
- How to contact this person
- If we need more information

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters, your case will be reviewed by one or more qualified health care professionals.

After we review your complaint:

- We will let you know our decision in 45 days of when we have all the information we need to answer your complaint, but you will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.
- When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint, but you will hear from us in no more than seven days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in three work days.
- You will be told how to appeal our decision if you are not satisfied, and we will include any forms you may need.
- If we are unable to make a decision about your complaint because we don't have enough information, we will send a letter and let you know.

Complaint Appeals

If you disagree with a decision we made about your complaint, you or someone you trust can file a **complaint appeal** with the plan.

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have at least 60 business days after hearing from us to file an appeal.
- You can do this yourself or ask someone you trust to file the appeal for you.
- The appeal must be made in writing. If you make an appeal by phone, it must be followed up in writing. After your call, we will send you a form that is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal?

After we get your complaint appeal, we will send you a letter within 15 work days. The letter will tell you:

- Who is working on your complaint appeal
- How to contact this person
- If we need more information

Your complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about your complaint. If your complaint appeal involves clinical matters, your case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, that were not involved in making the first decision about your complaint.

If we have all the information we need, you will know our decision in 30 work days. If a delay would risk your health, you will get our decision in two work days of when we have all the information we need to decide the appeal. You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-800-206-8125.

MEMBER RIGHTS AND RESPONSIBILITIES

Your Rights

As a member of WellCare, you have a right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation.
- Be told where, when and how to get the services you need from WellCare.
- Be told by your PCP what is wrong, what can be done for you, and what will likely be the result in language you understand.
- Get a second opinion about your care.
- Give your OK to any treatment or plan for your care after that plan has been fully explained to you.
- Refuse care and be told what you may risk if you do.
- Get a copy of your medical record, and talk about it with your PCP. You can ask that your medical record be amended or corrected, if needed.
- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract or your OK.

- Use WellCare’s complaint system to settle any complaints, or you can complain to the New York State Department of Health or the local Department of Social Services any time you feel you were not fairly treated.
- Use the State Fair Hearing system.
- Appoint someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment.
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

Your Responsibilities

As a member of WellCare, you agree to:

- Work with your PCP to guard and improve your health.
- Find out how your health care system works.
- Listen to your PCP’s advice and ask questions when you are in doubt.
- Call or go back to your PCP if you do not get better, or ask for a second opinion.
- Treat health care staff with the respect you expect yourself.
- Tell us if you have problems with any health care staff. Call Customer Service.
- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for true emergencies.
- Call your PCP when you need medical care, even if it is after hours.

ADVANCE DIRECTIVES

There may come a time **when you can’t decide about your own health care**. By planning in advance, you can arrange now for your wishes to be carried out.

- First, let family, friends and your doctor know what kinds of treatment you do or don’t want.
- Second, **you can appoint an adult you trust to make decisions for you**. Be sure to talk with your PCP, your family or others close to you so they will know what you want.
- Third, it is best if you **put your thoughts in writing**. The documents listed below can help. You do not have to use a lawyer, but you may wish to speak with one about this. You can change your mind and these documents at any time. We can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can’t speak for yourself.

Health Care Proxy—With this document, you name another adult that you trust (usually a friend or family member) to decide about medical care for you if you are not able to do so. If you do this, you should talk with the person so they know what you want.

CPR and DNR—You have the right to decide if you want any special or emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you do not want special treatment, including cardiopulmonary resuscitation (CPR), you should make your wishes known in writing. Your PCP will provide a DNR (Do Not Resuscitate) order for your medical records. You can also get a DNR form to carry with you and/or a bracelet to wear that will let any emergency medical provider know about your wishes.

Organ Donor Card—This wallet-sized card says that you are willing to donate parts of your body to help others when you die. Also, check the back of your driver’s license to let others know if and how you want to donate your organs.

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.

Effective Date of this Privacy Notice: July 15, 2010

We are required by law to protect the privacy of health information that may reveal your identity. We are also required by law to provide you with a copy of this Privacy Notice which describes not only our legal duties and health information privacy practices, but also the rights you have with respect to your health information.

This Privacy Notice applies to the Following WellCare Entities:

WellCare of Florida, Inc.	WellCare Health Plans of New Jersey, Inc.
HealthEase of Florida, Inc.	Harmony Health Plan of Illinois, Inc.
WellCare of New York, Inc.	WellCare Prescription Insurance, Inc.
WellCare of Connecticut, Inc.	WellCare Health Insurance of Arizona, Inc.
WellCare of Louisiana, Inc.	WellCare Health Insurance of Illinois, Inc.
WellCare of Georgia, Inc.	WellCare Health Insurance of New York, Inc.
WellCare of Ohio, Inc.	WellCare Specialty Pharmacy, Inc.
WellCare of Texas, Inc.	

We may change our privacy practices from time to time. If we make any material revisions to this Notice, we will provide you with a copy of the revised Notice which will specify the date on which such revised Notice becomes effective. The revised Notice will apply to all of your health information from and after the date of the Notice.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

1. Treatment, Payment, and Business Operations. *We may use your health information or share it with others to help treat your condition, coordinate payment for that treatment, and run our business operations. For example:*

Treatment. We may disclose your health information to a health care provider that provides treatment to you. We may use your information to notify a physician who treats you of the prescription drugs you are taking.

Payment. We will use your health information to obtain premium payments, specialty pharmacy payments, or to fulfill our responsibility for coverage and the provision of benefits under a health plan, such as processing a physician claim for reimbursement for services provided to you.

Health Care Operations. We may also disclose your health information in connection with our health care operations. These include fraud and abuse detection and compliance programs, customer service and resolution of internal grievances.

Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives, as well as health-related benefits or services that may be of interest to you.

Your Authorization. In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any

purpose. You may also revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those as described in this Notice.

Family Members, Relatives or Close Friends Involved In Your Care. Unless you object, we may disclose your health information to your family members, relatives or close personal friends identified by you as being involved in your treatment or payment for your medical care. If you are not present to agree or object, we may exercise our professional judgment to determine whether the disclosure is in your best interest. If we decide to disclose your health information to your family member, relative or other individual identified by you, we will only disclose the health information that is relevant to your treatment or payment.

Business Associates. We may disclose your health information to a “business associate” that needs the information in order to perform a function or service for our business operations. Third party administrators, auditors, lawyers, and consultants are some examples of business associates.

2. Public Need. *We may use your health information, and share it with others, in order to comply with the law or to meet important public needs that are described below:*

- if we are required by law to do so;
- to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities;
- to government agencies authorized to conduct audits, investigations, and inspections, as well as civil, administrative or criminal investigations, proceedings, or actions, including those agencies that monitor programs such as Medicare and Medicaid;
- to a public health authority if we reasonably believe you are a possible victim of abuse, neglect or domestic violence;
- to a person or company that is regulated by the Food and Drug Administration for: (i) reporting or tracking product defects or problems, (ii) repairing, replacing, or recalling defective or dangerous products, or (iii) monitoring the performance of a product after it has been approved for use by the general public;
- if ordered by a court or administrative tribunal to do so, or pursuant to a subpoena, discovery or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure;
- to law enforcement officials to comply with court orders or laws, and to assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person;
- to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public, which we will only share with someone able to help prevent the threat;
- for research purposes;
- to the extent necessary to comply with workers’ compensation or other programs established by law that provide benefits for work-related injuries or illness without regarding to fraud;
- to appropriate military command authorities for activities they deem necessary to carry out their military mission;
- to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined;
- in the unfortunate event of your death, to a coroner or medical examiner, for example, to determine the cause of death;
- to funeral directors as necessary to carry out their duties; and
- in the unfortunate event of your death, to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under law.

3. Partially De-Identified Information. We may use and disclose “partially de-identified” health information about you for public health and research purposes, or for business operations, if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will not contain any information that would directly identify you

(such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

We want you to know that you have the following rights to access and control your health information.

1. Right to Access Your Health Information. You have the right to inspect and obtain a copy of your health information except for health information: (i) contained in psychotherapy notes; (ii) compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding; and (iii) with some exceptions, information subject to the Clinical Laboratory Improvements Amendments of 1988 (“CLIA”). If we use or maintain an electronic health record (“EHR”) for you, you have the right to obtain a copy of your EHR in electronic format, and you have the right to direct us to send a copy of your EHR to a third party you clearly designate.

If you would like to access your health information, please send your written request to the address listed on the last page of this Privacy Notice. We will ordinarily respond to your request within 30 days if the information is located in our facility, and within 60 days if it is located off-site at another facility. If we need additional time to respond, we will let you know as soon as possible. We may charge you a reasonable, cost-based fee to cover copy costs and postage. If you request a copy of your EHR, we will not charge you any more than our labor costs in producing the EHR to you.

We may not give you access to your health information if it: (1) is reasonably likely to endanger the life and physical safety of you or someone else; (2) refers to another person and your access is likely to cause harm to that person; or (3) a health care professional determines that your access as the representative of another person is likely to cause harm to that person or any other person. If you are denied access for one of these reasons, you are entitled to a review by a health care professional, designated by us, who was not involved in the decision to deny access. If access is ultimately denied, you will be entitled to a written explanation of the reasons for the denial.

2. Right to Amend Your Health Information. If you believe we have health information about you that is incorrect or incomplete, you may request in writing an amendment to your health information. If we do not have your health information, we will give you the contact information of someone who does. You will receive a response within 60 days after we receive your request. If we did not create your health information or your health information is already accurate and complete, we can deny your request and notify you of our decision in writing. You can also submit a statement that you disagree with our decision, which we can rebut. You have the right to request that your original request, our denial, your statement of disagreement, and our rebuttal be included in future disclosures of your health information.

3. Right to Receive an Accounting of Disclosures. You have the right to receive an accounting of disclosures of your health information made by us and our business associates. You may request such information for the six year period prior to the date of your request. Accounting of disclosures will not include disclosures: (i) for payment, treatment or health care operations; (ii) made to you or your personal representative; (iii) you authorized in writing (iv) made to family and friends involved in your care or payment for your care; (v) for research, public health or our business operations; (vi) made to federal officials for national security and intelligence activities and (vii) incident to a use or disclosure otherwise permitted or required by law.

If you would like to receive an accounting of disclosures, please write to the address listed on the last page of this Privacy Notice. If we do not have your health information, we will give you the contact information of someone who does. You will receive a response within 60 days after your request is received. You will receive one request annually free of charge, but we may charge you a reasonable, cost-based fee for additional requests within the same twelve-month period.

4. Right to Request Additional Privacy Protections. You have the right to request that we place additional restrictions on our use or disclosure of your health information. If we agree to do so, we will abide by our agreement except in an emergency situation. We do not need to agree to the restriction unless the information pertains solely to a health care item or service that you have paid for out of pocket and in full.

5. **Right to Request Confidential Communications.** You have the right to request that we communicate with you about your health information by alternative means or via alternative locations provided that you clearly state that the disclosure of your health information could endanger you. If you wish to receive confidential communications via alternative means or locations, please submit your written request to the address listed and how or where you wish to receive communications.

6. **Right to Notice of Breach of Unencrypted Health Information.** Our policy is to encrypt our electronic files containing your health information so as to protect the information from those who should not have access to it. If, however, for some reason we experience a breach of your unencrypted health information, we will notify you of the breach. If we have more than ten people that we cannot reach because of outdated contact information, we will post a notification either on our website (www.wellcare.com) or in a major media outlet in your area.

7. **Right To Obtain A Paper Copy Of This Notice** You have the right at any time to obtain a paper copy of this Privacy Notice, even if you receive this Privacy Notice electronically. Please send your written request to the address listed on the last page of this Privacy Notice or visit our website at www.wellcare.com.

MISCELLANEOUS

1. **Contact Information.** If you have any questions about this Privacy Notice, you may contact the Privacy Officer at 1-866-530-9491, call the toll-free number listed on the back of your membership card, visit www.wellcare.com, or write to us at:

WellCare Health Plans, Inc.
Attention: Privacy Officer
P.O. Box 31386
Tampa, FL 33631-3386

2. **Complaints.** If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information above. You also may submit a written complaint to the U.S. Department of Health and Human Services. If you choose to file a complaint, we will not retaliate in any way if you choose to file a complaint.

3. **Additional Rights.** Special privacy protections may apply to certain information involving HIV/AIDS, mental health, alcohol and drug abuse, sexually transmitted diseases, and reproductive health. Please see the attached chart entitled *Information Regarding More Protective State Privacy Laws for WellCare Health Plans* for additional information. If the law in the state where you reside affords you greater rights than described in this Notice, we will comply with these laws.

IMPORTANT PHONE NUMBERS

Your PCP.....	- - - -
WellCare Family Health Plus	
Customer Service.....	1-800-288-5441
TTY/TDD.....	1-877-247-6272
Magellan Behavioral Health	1-800-241-1103 (TTY/TDD 1-877-342-6815)
Emergency Room.....	911
New York State Department of Health (Complaints).....	1-800-206-8125
Local Department of Social Services (see listing below by area)	
Albany	518-447-7492
New York City.....	718-557-1399 or 1-877-472-8411 (toll-free within the five boroughs of New York City)
Dutchess.....	845-486-3000
Greene	518-943-3200
Orange	845-291-4000
Rensselaer.....	518-270-3928
Rockland.....	845-364-3040
Ulster	845-334-5000
New York Medicaid CHOICE	1-800-505-5678
Your Pharmacy	- - - -
Your Other Health Providers	- - - -
.....	- - - -
.....	- - - -



110 Fifth Avenue, 3rd Floor
New York, NY 10011
1-800-288-5441 (TTY/TDD 1-877-247-6272)