

WellCare of New Jersey
**Member
Handbook**





WellCare of New Jersey Caring For You and Your Family

Welcome to WellCare Health Plans of New Jersey! We are glad you joined our family. As you work with everyone at WellCare, you will see that we put you and your family first so you get better care.

We wish you good health!

You are our priority. We work hard to make sure you get the care you need to stay healthy. We work with many providers, hospitals, labs and other health care facilities to give you and your family all of the services offered by NJ FamilyCare. These providers will coordinate all of your care needs.

This Member Handbook will tell you more about your benefits and how your Health Plan works. Please read it and keep it in a safe place. We hope it will answer most of your questions. If it does not, please call Member Services at **1-888-453-2534** (TTY: **711**). Our friendly staff is trained to answer all of your questions. To learn more, visit us at **www.wellcare.com/New-Jersey**

Discrimination Is Against the Law

WellCare Health Plan complies with all applicable federal civil rights laws. We do not exclude or treat people in a different way based on race, color, national origin, age, disability or sex.

We have free aids and services to help people with disabilities communicate with us. That includes help such as sign language interpreters. We can also give you info in other formats. Those formats include large print, audio, accessible electronic formats and Braille.

If English is not your first language, we can translate for you. We can also provide written info in other languages.

If you need these services, call us at **1-888-453-2534**. TTY users can call **711**. We're here for you Monday–Friday from 8 a.m. to 6 p.m.

Do you feel that we did not give you these services? Or do you feel we discriminated in some way? If so, you can file a grievance in person, by mail, fax, or email. You can reach us at WellCare Grievance Department, P.O. Box 31384, Tampa, FL 33631-3384. You can reach us by phone at **1-866-530-9491**; TTY **711**. Our fax is **1-866-388-1769**. Our email is **OperationalGrievance@wellcare.com**. If you need help filing a grievance, a WellCare Civil Rights Coordinator can help you.

You can also file a civil rights complaint online with the U.S. Dept. of Health and Human Services, Office for Civil Rights. Go to the Complaint Portal at <http://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. File by mail to: U.S. Dept. of Health and Human Services, 200 Independence Ave. SW., Room 509F, HHH Building, Washington, DC 20201. You can call them at **1-800-368-1019**, **1-800-537-7697** (TTY).

You can get complaint forms at <http://www.hhs.gov/ocr/office/file/index.html>.

If English is not your first language, we can translate for you. We can also give you info in other formats. That includes Braille, audio and large print. Just give us a call toll-free. You can reach us at **1-888-453-2534**. For TTY, call **711**.

Si el español es su lengua materna, podemos brindarle servicios de traducción. También podemos proporcionarle información en otros formatos, como braille, audio y letra de imprenta grande. Simplemente, llámenos sin cargo al **1-888-453-2534**. Para TTY llame al **711**.

如果中文是您的母語，我們可以為您翻譯。我們也可以用其它格式為您提供資訊。這些格式包括布萊葉文、音頻及大字體。僅需撥打我們的免費電話。您可以撥打 **1-888-453-2534** 聯絡我們。TTY 用戶請撥打 **711**。

귀하의 모국어가 한국어 인 경우, 통역서비스를 제공해 드립니다. 점자, 오디오, 큰 활자 등 다른 형식으로 된 정보도 제공해 드릴 수 있습니다. 무료 전화 1-888-453-2534 (TTY 711) 번으로 전화 주십시오.

Se o Português for a sua língua materna, nós podemos traduzir para si. Também lhe podemos fornecer as informações noutros formatos, tais como Braille, áudio e impressão grande. Estes serviços são gratuitos. Entre em contacto connosco através da linha de atendimento gratuita 1-888-453-2534 (TTY: 711).

જો ગુજરાતી તમારી પ્રથમ ભાષા હોય, તો અમે તમારા માટે ભાષાંતર કરી શકીશું. અન્ય સ્વરૂપોમાં પણ અમે તમને માહિતી આપી શકીશું. તેમાં બ્રેઈલ, ઓડિયો અને મોટી પ્રિન્ટનો સમાવેશ થાય છે. માત્ર અમે ટોલ ફ્રી પર કોલ કરો. 1-888-453-2534 પર તમે અમારો સંપર્ક કરી શકશો. TTY માટે અહીં કોલ કરો 711.

Jeżeli Państwa językiem ojczystym jest język polski, możemy to przetłumaczyć. Możemy również przekazać informacje w innych formatach. Obejmuje to alfabet Braille'a, audio i dużą czcionkę. Wystarczy zadzwonić do nas pod bezpłatny numer. Jesteśmy dostępni pod numerem telefonu 1-888-453-2534. Osoby niedosłyszające mogą zadzwonić pod numer TTY: 711.

Se l'italiano è la Sua lingua madre, possiamo tradurre per Lei. Possiamo anche fornirle gratuitamente le informazioni in altri formati, tra cui stampa a caratteri grandi, Braille o audio. Può chiamarci al numero verde **1-888-453-2534** e al numero TTY **711**.

إذا كانت لغتك الأصلية هي اللغة العربية، فنحن باستطاعتنا الترجمة لك. ويمكننا أيضاً إعطائكم المعلومات في أشكال أخرى مثل طريقة البرaille للمكفوفين والصوت والمطبوعات ذات الحجم الكبير. هذه الخدمات تقدم مجاناً وبدون مقابل. فقط قم بالاتصال على رقم التلفون المجاني: **1-888-453-2534** أو (TTY 711).

Kung hindi ka nagsasalita ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika. Kasama dito ang Braille, audio at malalaking letra. Tumawag ng libre sa **1-888-453-2534** (TTY 711).

Если русский Ваш основной родной язык, мы можем перевести для Вас. Мы также можем предоставить информацию в других форматах, например, на шрифте Брайля, записанную на аудионосителях и распечатанную крупным шрифтом. Просто позвоните нам по бесплатному номеру **1-888-453-2534** (TTY 711).

Si Kreyòl se lang natifnatal ou, nou ka tradui pou ou. Nou ka ba w enfòmasyon an tou sou lòt fòm. Sètadi Bray, sou fòm odyo, ak an gwo karaktè. Annik rele nou nan nimewo pou apèl gratis la. Ou ka kontakte nou nan **1-888-453-2534**. Pou TTY, rele **711**.

अगर आपकी मातृ भाषा हृदी है तो हम आप के लिए अनुवाद कर सकते हैं। हम आपको ब्रेल, ऑडियो और बड़े प्रटि जैसे अन्य रूप में भी जानकारी दे सकते हैं। ये सेवाएं बनिा शुल्क हैं। बस हमें इस टोल फ्री नंबर पर कॉल करें **1-888-453-2534** पर (TTY 711).

Nếu Tiếng Việt là ngôn ngữ chính của quý vị, chúng tôi có thể thông dịch cho quý vị. Chúng tôi cũng có thể cung cấp cho quý vị thông tin ở các định dạng khác như chữ nổi Braille, âm thanh và bản in cỡ lớn. Chỉ cần gọi chúng tôi theo số miễn phí **1-888-453-2534** (TTY **711**).

Si votre langue maternelle est le français, nous pouvons faire la traduction. Nous pouvons également vous fournir l'information dans des formats comme le braille, en version audio et imprimé en gros caractères. Il suffit de nous appeler au numéro sans frais **1-888-453-2534** (TTY 711).

گراردو آپ کی مادری زبان ہے تو ہم آپ کے لیے ترجمہ کر سکتے ہیں۔ ہم آپ کو دوسری اشکال میں بھی معلومات فراہم کر سکتے ہیں۔ ان میں بریل، آڈیو اور بڑے حروف شامل ہیں۔ محض ایک ٹول فری کال کریں۔ آپ ہم سے **1-888-453-2534** پر رابطہ کر سکتے / سکتی ہیں۔ TTY کے لیے **711** پر کال کریں۔

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The WellCare Dictionary

As you read this handbook, you will see some words we use throughout. Here is what those words mean.

Words/Phrases

Advance Directive: A legal document, like a living will or durable power of attorney, that tells your providers and family how you wish to be cared for if you cannot make your wishes known yourself

Benefits/Services: Health care covered by our plan

Durable Power of Attorney: A legal document that authorizes another person to make decisions for you if you cannot

Emergency: A very serious medical condition that must be treated right away

Grievance: This is a complaint or expression of dissatisfaction. It might involve the health plan, its staff, or any network provider, facility, or their staff. An example of a grievance includes complaints about difficulty getting an appointment or treatment.

Health Plan: A plan like ours that works with health care providers to provide care to keep you and your family healthy

Identification (ID) Card: A card we give you that shows you are a member in our plan

Immunizations: Shots that can help keep you and your children safe from many serious diseases

Inpatient: When you get admitted to a hospital

Medically Necessary Services: Medical and dental services you need to get well and stay healthy

Member: You or someone who has joined our health plan

Words/Phrases

Out-of-Network: A term we use when a provider is not contracted with our plan

Outpatient: When you get treated at a medical facility, but are not admitted as an inpatient

Post-Stabilization Services: Follow-up care after you leave the hospital to make sure you get better

Preferred Drug List (PDL): A list of drugs that has been put together by the health plan's doctors and pharmacists

Prescription: A drug for which your provider writes an order

Prior Authorization (PA)/Referrals: When we need to approve care or prescriptions before you get them

Primary Care Dentist (PCD): A licensed dentist who is the health care provider who supervises, coordinates, and provides initial and primary dental care to patients; who initiates referrals for specialty care; and who maintains the continuity of patient care

Primary Care Provider (PCP): Your personal doctor who helps manage all your health care needs

Provider: Those who work with us to give medical care, like doctors, hospitals, pharmacies and labs

Provider Network: All of the providers who have a contract with us to give care to our members

Specialist: A provider who has been to medical school, trained and practices in a specific field of medicine

Treatment: The care you get from providers and facilities

TTY: A special number to call if you have trouble hearing or speaking



Important Phone Numbers

Member Services (Including Vision and Pharmacy inquiries)	1-888-453-2534 (TTY: 711)
NJ Hopeline • 24/7 suicide prevention hotline	1-855-654-6735 www.njhopeline.com
NJ Speak Up • 24/7 phone line for the mental health needs of mothers and children	1-800-328-3838 https://nj.gov/health/fhs/maternalchild/mentalhealth/about-disorders/
Dental Member Services (Liberty Dental Plan)	1-888-352-7924
PerformCare • Single point of access for behavioral health care for minors	1-877-652-7624 www.performcarenj.org
Reach NJ: IME Addictions Access Center • 24/7 phone line for screening and referral to substance use disorder treatment	1-844-276-2777 or 1-844-REACH NJ (732-2465)
WellCare's 24-hour Nurse Advice Line	1-800-919-8807 (TTY: 711)

Keep these numbers near your phone. You can call 24 hours a day, 7 days a week. Our normal business hours are Monday through Friday from 8 a.m. through 6 p.m.



Getting Started With Us

Here are a couple of important things to remember as you get started with WellCare.

Check Your Identification (ID) Card and Keep It in a Safe Place

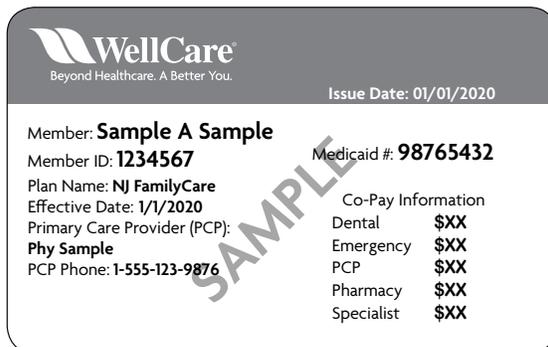
You will get your WellCare ID card in the mail. If you do not get it within 7 days after you become a member, please call Member Services toll-free at **1-888-453-2534** (TTY: **711**) Monday through Friday, 8 a.m. through 6 p.m., and we will send you another ID card. You can also order a new one at www.wellcare.com/New-Jersey.

- Keep your ID card with you at all times. You must show it every time you get care. Your ID card has information about your plan; and
- Carry with you your State of New Jersey Health Benefits Identification card (HBID). You use this to access services that are covered directly by Medicaid Fee for Service (FFS).

You also need to look over the details on your ID card. It shows your primary care provider's (PCP) information. You will also see your effective date (the date you became a WellCare member). What if the PCP listed is not correct? Please call Member Services and we will make the change for you. We will also send you a new ID card with the new PCP. Please call toll-free **1-888-453-2534** (TTY: **711**), Monday through Friday from 8 a.m. through 6 p.m.

Getting Started With Us

If you lose your ID card, you can get a new one. Just call Member Services at **1-888-453-2534**. (TTY: **711**). You can also log on to our website at **www.wellcare.com/New-Jersey** to ask for a new ID card.



Get to Know Your Primary Care Provider (PCP)

Your PCP is your partner in health. He or she helps arrange all of your medical care. He or she may hire someone, such as a physician's assistant, to help care for you.

This includes:

- Regular checkups;
- Immunizations; and
- Referrals to other providers, like specialists.

We encourage all our new members to visit their PCPs and dentist within the first 90 days (3 months) of joining our plan. This includes those in NJ's Division of Developmental Disabilities (DDD) program.

Are you pregnant? You should get prenatal care within 3 days to 3 weeks of joining our plan. This depends on your risk factors and how long you have been pregnant. Your physician must see you within:

- 3 weeks of a positive pregnancy test (home or laboratory);
- 3 days of identification of high risk;
- 7 days of request in first and second trimester; and
- 3 days of first request in third trimester.

This helps your PCP to get to know your health history. Plus, he or she can create a plan of care for you.

Also, be sure to get your medical records from any doctors you have seen in the past. This will help your PCP. Do you need help with this? Call Member Services at **1-888-453-2534** (TTY: **711**). You can reach us Monday through Friday from 8 a.m. to 6 p.m.

The PCPs in our network are trained in different specialties, including:

- Family and internal medicine;
- Pediatric; and
- General practice;
- Obstetrics/Gynecology (OB/GYN).
- Geriatrics;

Do you have special medical needs? If you regularly require complex, highly specialized care that you get from a specialist, you can make a request to have your specialist act as your Primary Care Provider (PCP). If appropriate and available, your specialist can then act as your PCP, and he or she will arrange and coordinate all of your routine health care needs in addition to the medical needs he/she usually treats.

Call Member Services for more details.

Call **1-888-453-2534** (TTY: **711**) Monday through Friday from 8 a.m. through 6 p.m.

If you did not choose a PCP before joining our plan, we chose one for you based on:

- Where you may have received services before;
- Where you live;
- Your language preference;
- Whether the doctor is accepting new patients; and
- Gender (in the case of an OB/GYN).

If you are not happy with our PCP choice, no problem. If for any reason you are not satisfied with your PCP assignment, you can change your PCP at any time. Our Member Services representatives will be available to assist you in choosing a new PCP. You can reach them toll-free at **1-888-453-2534** (TTY: **711**), Monday through Friday from 8 a.m. through 6 p.m.

When choosing your new PCP, remember: Our providers are sensitive to the needs of many cultures;

- We have providers who speak your language and understand your traditions and customs;

Getting Started With Us

- We can tell you about a provider’s schooling, residency and qualifications; and
- You can pick the same PCP for your entire family or a different one for each family member (depending on each family member’s needs).

You or your authorized representative should contact your PCP for an appointment as soon as possible after you have enrolled. Otherwise, WellCare will try to contact you or your representative to schedule a physical. Here are the time frames you can expect to hear from us or your PCP:

- For children (under 21), within 90 days of enrollment;
- For adults, within 180 days of enrollment; and
- For adult DDD members, within 90 days of enrollment

We have a few ways for you to find PCPs and other providers in your area:

- *Find a Provider/Pharmacy Tool:*
 - This tool is on our website www.wellcare.com/New-Jersey/Find-a-Provider;
 - You can search for a provider within a certain distance of your home, by name or by practice type; and
 - Because we are always adding new providers to our network, this is the best way to get our most current provider network information
- *Call us:*
 - We can help you find a provider right over the phone.
- *Our printed Provider Directory:*
 - Call Member Services to ask us to mail you a printed Provider Directory;
 - Providers are listed by county and specialty;
 - In the Provider Directory you will find:
 - ◇ PCPs; ◇ Specialists;
 - ◇ Hospitals; ◇ Behavioral Health Providers; and
 - ◇ Pharmacies; ◇ Dentists and Dental Specialists.
- These providers make up our “provider network” or “network.”

The *Find a Provider* tool helps you search for providers. We are always adding new providers to our network. The *Find a Provider* tool has our most current network information. Visit www.wellcare.com/New-Jersey/Find-a-Provider to use *Find a Provider*.

The New Jersey Smiles Directory is also on our website. You can find it in the *Provider Directories* section of the website at www.wellcare.com/en/New-Jersey/Members/Medicaid-Plans/NJ-FamilyCare. Just scroll down on the web page and you will find the directory. This directory lists dentists for children 6 years old and younger.

If for any reason you are not satisfied with your PCP, you are having difficulty choosing a PCP or you are not happy with our PCP choice, or any reason you are not satisfied with your PCP assignment you can change your PCP at any time. Would you like to change your PCP? Our Member Services representatives will be available to assist you in choosing a new PCP. You can reach them toll-free at **1-888-453-2534 (TTY: 711)**, Monday through Friday from 8 a.m. through 6 p.m. You can ask for the change through our website too. We will send you a new member ID card with your new PCP listed on it.

PCP changes made between the 1st and 10th of the month go into effect right away. Changes made after the 10th of the month take effect at the beginning of the next month. We will send you a new ID card with your new PCP listed on it.

WellCare reserves the right to deny a request for a PCP change. Below are situations where we may deny a request:

- If a PCP asks that a member not be included on the PCP's list of patients; and
- If a PCP has too many patients to take any more.

A PCP may choose not to see you if the PCP feels that he or she is not able to get along with you or is not able to meet your health care needs.

If this happens, you may choose a new PCP or we will assign you to a new PCP. Call Member Services at **1-888-453-2534 (TTY: 711)** to ask us to help.

What if your PCP or other provider decides to leave out network? We will send you a letter if your PCP or other provider leaves our network. The letter gives you details about the change and how we handle it. You can find a new PCP in our network.

Just visit www.wellcare.com/New-Jersey/Find-a-Provider to use the *Find a Provider/Pharmacy* tool. To ask for a copy of the Provider Directory, please call Member Services at **1-888-453-2534 (TTY: 711)**. We are here Monday through Friday from 8 a.m. through 6 p.m.

If you currently have a treatment plan with your PCP, you might be able to continue with that PCP for up to 120 days after he or she leaves the network. Call Member Services to learn more.

Remember, we have PCP and specialist coverage 24 hours a day, 7 days a week.

Complete your Health Risk Assessment

It is important to fill out your Health Risk Assessment. When you complete this form, we can make sure you get the care you need.

- The Health Risk Assessment form is part of your welcome packet;
- We have also included a postage-paid envelope to return the form to us; and
- If you need a form, please call Member Services at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.

Remember to Use the 24-Hour Nurse Advice Line

Our 24-hour Nurse Advice Line is open every day of the week. Please call the toll-free number when you are not sure what kind of care you need.

When you call, a nurse will ask you questions. Give as many details as you can. For example, say where it hurts, what it looks like and what it feels like. The nurse can help you decide if you:

- Need to go to your PCP for a normal or urgent visit, an Urgent care center, a hospital; or you
- Can care for yourself at home.

You can get help with problems such as:

- Back pain;
- A cough or cold or the flu; or
- A cut or burn;
- Dizziness or you feel sick.

What if you think you have a real medical emergency? This might be broken bones, heavy bleeding or swelling. Please call **911** or go to the nearest emergency room.

In an Emergency ...

Please call **911** or go to the nearest emergency room.

We will talk more about emergencies on **Page 61** of this handbook.



24-Hour Nurse Advice Line
toll-free number:
1-800-919-8807 (TTY: 711)

Call Us

Please call us with any questions. Our Member Services team is ready to help you. Call us Monday through Friday from 8 a.m. through 6 p.m. The toll-free number is **1-888-453-2534** (TTY: **711**).

It is important to tell us if there is a major change in your life. For example, if you:

- Get married or divorced;
- Have a baby or adopt a child;
- Experience the death of your spouse or child;
- Start a new job; and/or
- Get health insurance from another company.

Call us any time you need help. We can help you:

- Get a replacement ID card;
- Change your PCP;
- Find and choose a provider;
- Make an appointment with a provider;
- Update your contact information, such as your mailing address and phone number; and/or
- Get a schedule of workshops and educational event details.

We want you to be comfortable when you work with us and your providers. Do you speak a different language? Do you need something in Braille, large print or audio? We have translation and alternate format services at no cost to you. Please call us if you need this.

Please leave a message if you call us after business hours with a non-urgent request. We will call you back within one business day. Our Nurse Advice Line is available 24 hours a day, 7 days a week for health concerns. You can also write to our Member Services team:



WellCare
Attn: Member Services
P.O. Box 31370
Tampa, FL 33631-3370

Our Website

You may be able to find answers on our website. Go to www.wellcare.com/New-Jersey and click on *Members* for information about:

- Our Member Handbook;
- Our *Find a Provider* search tool;
- Member newsletters; and
- Your member rights and responsibilities.



Our website:
www.wellcare.com/New-Jersey

On our website, you can also:

- Change your PCP;
- Update your address and phone number; and
- Order your Member Materials like your ID Card, Member Handbook, and Provider Directory.

Members who need substance use disorder treatment services can call the Interim Management Entity (IME) at **1-844-276-2777**. You can also call Reach NJ at **1-844-REACH NJ (732-2465)**.

Know Your Rights and Responsibilities

You have rights and responsibilities as a member of our Plan. You can read about these later in this handbook.

If You Have Other Health Insurance

Do you or anyone else in your family have health insurance with another company? If so, we need to know. For example:

- If you work and have health insurance through your employer;
- If your children have health insurance through their other parent; and
- If you have lost health insurance you had previously told us about

It is important to give us this information. It can cause problems with you getting care and possible bills if you do not.

To learn more, please read the Third Party Liability (TPL) guide included with your Welcome Packet.

Hold on to This Handbook

This handbook has valuable information, including:

- Your benefits and services and how to get them;
- Advance directives (please see the Advance Directives section in this handbook on **Page 110**);
- How to use our appeals and grievances process when you are not happy with a decision we made; and
- How we protect your privacy

What if you lose your handbook? Please call Member Services at **1-888-453-2534** (TTY: **711**) if you lose your handbook. We will send you a new one. You can also find the handbook at www.wellcare.com/New-Jersey/Members/Medicaid-Plans/NJ-FamilyCare.

Our Provider Directory

To find a provider, visit the Find a Provider tool at www.wellcare.com/New-Jersey/Find-a-Provider. Would you like a copy of our printed Provider Directory? We will be happy to send you one. There is no cost to you. Please call Member Services toll-free at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.

Care Basics

You will get your care from providers, hospitals and others in our provider network. We, or a network provider, must approve your care.

Medically Necessary

The care we approve must be “medically necessary.” This means the care, services or supplies you request are needed for your treatment. They must:

- Be necessary to treat or diagnose your condition, keep you healthy, prevent illness, or prevent your current medical condition from getting worse;
- Follow accepted medical practices;
- Not be for convenience only;
- Be in the right amount and offered at the right place and at the right time; and
- Be safe for you.

Making and Getting to Your Medical Appointments

Our guidelines make sure you get to your medical appointments in a timely manner. This is also called access to care. Our providers must give you the same office hours as patients with other insurance. Members in NJ’s Division of Developmental Disabilities (DDD) program may choose network PCPs outside of their home county.

This table shows how long it should take to get to an appointment.

Type of Provider	Drive Time/Distance if You Live in an Urban Area	Drive Time/Distance if You Live in a Rural Area
PCPs and Specialists	30 minutes to get to your appointment	20 miles
Hospitals	15 miles	15 miles

How long should you wait for an appointment? That depends on the kind of care you need. Keep these times in mind as you set appointments.

Type of Appointment	Type of Care	Appointment Time
Medical	Emergency	Right away (both in and out of our service area), 24 hours a day, 7 days a week (prior authorization is not required for emergency services)
	Urgent	Within 24 hours (1 day) of your request
	PCP pediatric sickness	Within 24 hours (1 day) of your request
	PCP adult sickness	Within 72 hours (3 days) of your request
	Routine/wellness PCP visits	Within 28 days of your request
	Specialist visit	4 weeks (1 month) of your request
	Non-emergency hospital visits	4 weeks (1 month) of your request
	Follow-up care after a hospital stay	As needed
Dental	Emergency	Within 48 hours (2 days) or sooner if needed
	Urgent	Within 72 hours (3 days) of your request
	Routine visits	Within 30 days of your request
Behavioral Health and Substance Use Disorder Treatment	Emergency	Right away (both in and out of our service area), 24 hours a day, 7 days a week (prior authorization is not required for emergency services)
	Urgent	Within 24 hours (1 day) of your request
	Routine visits	Within 10 days of your request

Cost Sharing

If you are a member of NJ FamilyCare Plan C or D, you will be required to pay a co-pay for certain services. These co-pay amounts are included in the chart of covered services that begins on **Page 28**. If you are a member of NJ FamilyCare Plan D, you may also be required to pay a monthly premium.

A **premium** is an amount you pay to the State each month for your health care coverage. It is based on your income.

A **co-pay** is what you pay to a provider for care at the time it is given.

Here are important facts about premiums and co-pays:

- If you do not pay your monthly premium on time, you could be disenrolled from the NJ FamilyCare program;
- You pay your premium to NJ FamilyCare, not WellCare;
- You can find your co-pay amounts on your WellCare member ID card. (We also list them in the *Services Covered by WellCare* section of this handbook that begins on **Page 28**);

Your monthly premiums and co-pays cannot be more than 5% of your annual income. Keep track of this. Let the NJ FamilyCare Health Benefits Coordinator know if you do go over the 5% mark in a calendar year. You can call the NJ FamilyCare Health Benefits Coordinator at **1-800-701-0710**.

If you are over 55 years old, benefits received are reimbursable to the State of New Jersey from your estate (this includes premiums).

This is to remind you that the Division of Medical Assistance and Health Services (DMAHS) has the authority to file a claim and lien against the estate of a deceased Medicaid client or former client to recover all Medicaid payments for services received by that client on or after age 55. Your estate may be required to pay back DMAHS for those benefits.

The amount that DMAHS may recover includes, but is not limited to, all capitation payments to any managed care organization or transportation broker, regardless of whether any services were received from an individual or entity that was reimbursed by the managed care organization or transportation broker. DMAHS may recover

these amounts when there is no surviving spouse, no surviving children under the age of 21, no surviving children of any age who are blind and no surviving children of any age who are permanently and totally disabled as determined by the Social Security Administration. This information was provided to you when you applied for NJ FamilyCare.

To learn more, visit https://www.state.nj.us/humanservices/dmahs/clients/The_NJ_Medicaid_Program_and_Estate_Recovery_What_You_Should_Know.pdf.

If You Get a Bill from a Provider

Do not pay it. Please call Member Services right away at **1-888-453-2534** (TTY: **711**) if you get a bill from a provider (either an in-network or out-of-network provider). We will help to resolve the issue.

Patient Payment Liability

What is the Patient Payment Liability (PPL) for Cost of Care? It is the portion you pay for room and board if you live in a nursing facility or assisted living facility. The amount is based on your available income. It is determined by your local County Welfare Agency. PPL does not apply to medical services. PPL must be paid by the member or other source (such as the member's family) directly to the facility. A care manager will discuss whether PPL applies to you.



Your Health Plan

Services Covered By WellCare

Here is a list of covered services. Member Services is available if you have any questions. Call **1-888-453-2534** (TTY: **711**) Monday through Friday from 8 a.m. through 6 p.m.

Some services are paid for directly by Medicaid Fee-for-Service (FFS) instead of by WellCare. They are listed here as “covered by FFS.” To get these services, you can talk with:

- Your PCP;
- Our Member Services team, at **1-888-453-2534** (TTY: **711**); and
- For substance use disorder treatment services, you can call the Interim Management Entity (IME) at **1-844-276-2777**.

You can get help on how to see a provider you choose. You should get all covered non-emergency health care services through our network providers.

- If you get services from providers who are not in our network or if you get services that are not covered benefits, you may be responsible for payment of these services; and
- If you get services from providers who are not in our network but you have an authorization, the out-of-network services will be covered.

We will tell you if your plan benefits change. You can find updated benefit information in our member newsletters and at www.wellcare.com/New-Jersey. Do you have questions? Please call Member Services toll-free at **1-888-453-2534** (TTY: **711**) Monday through Friday from 8 a.m. through 6 p.m.

Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Abortions	Covered by FFS. Abortions and related services, including (but not limited to) surgical procedure; anesthesia; history and physical exam; and lab tests.			
Acupuncture	Covered by WellCare.			

Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Autism Services	Covered by WellCare. Only covered for members under 21 years of age with Autism Spectrum Disorder. Covered services include physical, occupational, and speech therapies; augmentative and alternative communication services and devices; sensory integration services; and Applied Behavior Analysis (ABA) treatment.			
Blood and Blood Products	Covered by WellCare. Whole blood and derivatives, as well as necessary processing and administration costs, are covered. Coverage is unlimited (no limit on volume or number of blood products). Coverage begins with the first pint of blood.			
Bone Mass Measurement	Covered by WellCare. Covers one measurement every 24 months (more often if medically necessary), as well as physician's interpretation of results.			
Cardiovascular Screenings	Covered by WellCare. For all persons 20 years of age and older, annual cardiovascular screenings are covered. More frequent testing is covered when determined to be medically necessary.			
Chiropractic Services	Covered by WellCare. Covers manipulation of the spine.			
Colorectal Screening	Covered by WellCare. Covers any expenses incurred in conducting colorectal cancer screening at regular intervals for beneficiaries 50 years of age or older, and for those of any age deemed to be at high risk of colorectal cancer.			
Colorectal Screening: Barium Enema	Covered by WellCare. When used instead of a flexible sigmoidoscopy or colonoscopy, covered once every 48 months.			
Colorectal Screening: Colonoscopy	Covered by WellCare. Covered once every 120 months, or 48 months after a screening flexible sigmoidoscopy.			

Your Health Plan

Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Colorectal Screening: Fecal Occult Blood Test	Covered by WellCare. Covered once every 12 months.			
Colorectal Screening: Flexible Sigmoidoscopy	Covered by WellCare. Covered once every 48 months.			
Dental Services	Covered by WellCare. Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical, as well as adjunctive services. Examples of covered services include (but are not limited to) routine oral exams, fillings, crowns, X-rays and other diagnostic imaging, extractions and other oral surgical procedures, cleanings/prophylaxis (including dental scaling), topical fluoride treatments, root canal treatment, dentures, and fixed prosthodontics (bridgework).	Covered by WellCare. Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical, as well as adjunctive services. Examples of covered services include (but are not limited to) routine oral exams, fillings, crowns, X-rays and other diagnostic imaging, extractions, and other oral surgical procedures cleanings/prophylaxis (including dental scaling),	Covered by WellCare. Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical, as well as adjunctive services. Examples of covered services include (but are not limited to) routine oral exams, fillings, crowns, X-rays and other diagnostic imaging, extractions and other oral surgical procedures, cleanings/prophylaxis (including dental scaling), topical fluoride treatments, root canal treatment, dentures, and fixed prosthodontics (bridgework). Orthodontics (with age restrictions and documentation of medical necessity) is also covered when NJ FamilyCare requirements are met. Some services require prior authorization.	Orthodontics are covered up to age 19 for NJ FamilyCare C and D members. NJ FamilyCare C and D members have a \$5 co-pay per dental visit (except for diagnostic and preventive services).

(Dental Services continued on next page)

Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
<p>Dental Services (continued)</p>	<p>Orthodontics (with age restrictions and documentation of medical necessity) is also covered when NJ FamilyCare requirements are met.</p> <p>Some services require prior authorization.</p> <p>Orthodontics are covered up to age 21 for NJ FamilyCare A and ABP members.</p>	<p>topical fluoride treatments, root canal treatment, dentures, and fixed prosthodontics (bridgework).</p> <p>Orthodontics (with age restrictions and documentation of medical necessity) is also covered when NJ FamilyCare requirements are met.</p> <p>Some services require prior authorization.</p> <p>Orthodontics are covered up to age 19 for NJ FamilyCare B members.</p>		
<p>Diabetes Screenings</p>	<p>Covered by WellCare.</p> <p>Screening is covered (including fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>			

Your Health Plan

Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Diabetes Supplies	Covered by WellCare. Covers blood glucose monitors, test strips, insulin, injection aids, syringes, insulin pumps, insulin infusion devices, and oral agents for blood sugar control. Covers therapeutic shoes or inserts for those with diabetic foot disease. The shoes or inserts must be prescribed by a podiatrist (or other qualified doctor) and provided by a podiatrist, orthotist, prosthetist, or pedorthist.			
Diabetes Testing and Monitoring	Covered by WellCare. Covers yearly eye exams for diabetic retinopathy, as well as foot exams every six months for members with diabetic peripheral neuropathy and loss of protective sensations.			
Diagnostic and Therapeutic Radiology and Laboratory Service - You should receive your results within 24 hours in emergency and urgent care cases - You should receive your results within 10 business days in non-emergency and non-urgent care cases.	Covered by WellCare. Covered, including (but not limited to) CT scans, MRIs, EKGs, and X-rays.			
Durable Medical Equipment (DME)	Covered by WellCare.			

Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Emergency Care	Covered by WellCare. Covers emergency department and physician services.		Covered by WellCare. Covers emergency department and physician services. NJ FamilyCare C members have a \$10 co-payment.	Covered by WellCare. Covers emergency department and physician services. NJ FamilyCare D members have a \$35 co-payment.
EPSDT (Early and Periodic Screening Diagnosis and Treatment)	Covered by WellCare. Coverage includes (but is not limited to) well child care, preventive screenings, medical examinations, vision and hearing screenings and services (as well as any treatment identified as necessary as a result of examinations or screenings), immunizations (including the full childhood immunization schedule), lead screening, and private duty nursing services. Private duty nursing is covered for eligible EPSDT beneficiaries under 21 years of age who live in the community and whose medical condition and treatment plan justify the need.	Covered by WellCare. For NJ FamilyCare B, C, and D members, coverage includes early and periodic screening and diagnostic medical examinations, dental, vision, hearing, and lead screening services. <i>For NJ FamilyCare B, C, and D members, coverage for treatment services identified as necessary through an examination is limited to those services that are available under the plan's benefit package, or specified services under the FFS program.</i>		

Your Health Plan

Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Family Planning Services and Supplies	<p>Covered by WellCare.</p> <p>Covered services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices (including pregnancy test kits, condoms, diaphragms, Depo-Provera injections, and other contraceptive supplies and devices), counseling, continuing medical supervision, continuity of care and genetic counseling.</p> <p>Services furnished by out-of-network providers are covered by Medicaid Fee-for-Service.</p> <p><i>Exceptions: Services primarily related to the diagnosis and treatment of infertility are not covered (whether furnished by in-network or out-of-network providers).</i></p>			
Federally Qualified Health Centers (FQHC)	<p>Covered by WellCare.</p> <p>Includes outpatient and primary care services from community-based organizations.</p>			
Hearing Services/ Audiology	<p>Covered by WellCare.</p> <p>Covers routine hearing exams, diagnostic hearing exams and balance exams, otologic and hearing aid examinations prior to prescribing hearing aids, exams for the purpose of fitting hearing aids, follow-up exams and adjustments, and repairs after warranty expiration.</p> <p>Hearing aids, as well as associated accessories and supplies, are covered.</p>			
Home Health Agency Services	<p>Covered by WellCare.</p> <p>Covers nursing services and therapy services by a registered nurse, licensed practical nurse or home health aide.</p>			

Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Hospice Care Services	<p>Covered by WellCare.</p> <p>Covers drugs for pain relief and symptoms management; medical, nursing, and social services; and certain durable medical equipment and other services, including spiritual and grief counseling.</p> <ul style="list-style-type: none"> • Covered in the community as well as in institutional settings. • Room and board included only when services are delivered in institutional (non-residence) settings. Hospice care for enrollees under 21 years of age shall cover both palliative and curative care. <p>NOTE: Any care unrelated to the enrollee’s terminal condition is covered in the same manner as it would be under other circumstances.</p>			
Immunizations	<p>Covered by WellCare.</p> <p>Influenza, Hepatitis B, pneumococcal vaccinations, and other vaccinations recommended for adults are covered.</p> <p>The full childhood immunization schedule is covered as a component of EPSDT.</p>			
Inpatient Hospital Care	<p>Covered by WellCare.</p> <p>Covers stays in critical access hospitals; inpatient rehabilitation facilities; inpatient mental health care; semi-private room accommodations; physicians’ and surgeons’ services; anesthesia; lab, X-ray, and other diagnostic services; drugs and medication; therapeutic services; general nursing; and other services and supplies that are usually provided by the hospital.</p>			
Inpatient Hospital Care: Acute Care	<p>Covered by WellCare.</p> <p>Includes room and board; nursing and other related services; use of hospital/Critical Access Hospital facilities; drugs and biologicals; supplies, appliances, and equipment; certain diagnostic and therapeutic services, medical or surgical services provided by certain interns or residents-in-training; and transportation services (including transportation by ambulance).</p>			

Your Health Plan

Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Inpatient Hospital Care: Psychiatric	Covered by WellCare. <i>For coverage details, please refer to the Behavioral Health chart on Page 47.</i>			
Mammograms	Covered by WellCare. Covers a baseline mammogram for women age 35 to 39, a mammogram every year for those 40 and over, and for those with a family history of breast cancer or other risk factors. More screenings are available if medically necessary.			
Maternal and Child Health Services	Covered by WellCare. Covers medical services, including related newborn care and hearing screenings. Also covers childbirth education, as well as lactation (breastfeeding) supplies and support services.			
Medical Day Care (Adult Day Health Services)	Covered by WellCare. A program that provides preventive, diagnostic, therapeutic and rehabilitative services under medical and nursing supervision in an ambulatory (outpatient) care setting to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living.	<i>Not covered for NJ FamilyCare B, C, or D members.</i>		

Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Nurse Midwife Services	Covered by WellCare.		Covered by WellCare. \$5 co-payment for each visit (except for prenatal care visits)	
Nursing Facility Services	Covered by WellCare. Members may have patient pay liability.	Not covered for NJ FamilyCare B, C, or D members.		
Nursing Facility Services: Long Term (Custodial Care)	Covered by WellCare. Covered for those who need Custodial Level of Care (MLTSS). Members may have patient pay liability.	Not covered for NJ FamilyCare B, C, or D members.		
Nursing Facility Services: Nursing Facility (Hospice)	Covered by WellCare. Hospice care can be covered in a Nursing Facility setting. <i>*See Hospice Care Services.</i>	Not covered for NJ FamilyCare B, C, or D members.		
Nursing Facility Services: Nursing Facility (Skilled)	Covered by WellCare. Includes coverage for Rehabilitative Services that take place in a Nursing Facility setting.	Not covered for NJ FamilyCare B, C, or D members.		

Your Health Plan

Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Nursing Facility Services: Nursing Facility (Special Care)	Covered by WellCare. Care in a Special Care Nursing Facility (SCNF) or a separate and distinct SCNF unit within a Medicaid-certified conventional nursing facility is covered for members who have been determined to require intensive nursing facility services beyond the scope of a conventional nursing facility.	<i>Not covered for NJ FamilyCare B, C, or D members.</i>		
Organ Transplants	Covered by WellCare. Covers medically necessary organ transplants including (but not limited to): liver, lung, heart, heart-lung, pancreas, kidney, liver, cornea, intestine, and bone marrow transplants (including autologous bone marrow transplants). Includes donor and recipient costs.			
Outpatient Surgery	Covered by WellCare.			
Outpatient Hospital/ Clinic Visits	Covered by WellCare.		Covered by WellCare. \$5 co-payment per visit (no co-payment if the visit is for preventive services).	

Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Outpatient Rehabilitation (Occupational Therapy, Physical Therapy, Speech Language Pathology)	Covered by WellCare. Covers physical therapy, occupational therapy, speech pathology, and cognitive rehabilitation therapy.	Covered by WellCare. Covers physical, occupational, and speech/language therapy. For NJ FamilyCare B, C, and D members, limited to 60 days per therapy per calendar year.		
Pap Smears and Pelvic Exams	Covered by WellCare. Pap tests and pelvic exams are covered every 12 months for all women, regardless of determined level of risk for cervical or vaginal cancers. Clinical breast exams for all women are covered once every 12 months. All laboratory costs associated with the listed tests are covered. Tests are covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes.			
Personal Care Assistance	Covered by WellCare. Covers health-related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a beneficiary's written plan of care.	Not covered for NJ FamilyCare B, C, or D members.		

Your Health Plan

Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Podiatry	<p>Covered by WellCare.</p> <p>Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts.</p> <p><i>Exceptions: Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.</i></p>		<p>Covered by WellCare.</p> <p>Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts.</p> <p>\$5 co-payment per visit for NJ FamilyCare C and D members.</p> <p><i>Exceptions: Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition</i></p>	

Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Prescription Drugs	<p>Covered by WellCare.</p> <p>Includes prescription drugs (legend and non-legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins such as high potency A, D, E, iron, zinc and minerals, including potassium, and niacin. All blood-clotting factors are covered.</p>		<p>Covered by WellCare.</p> <p>Includes prescription drugs (legend and non-legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins, such as high potency A, D, E, iron, zinc, and minerals, including potassium, and niacin. All blood-clotting factors are covered.</p> <p>For NJ FamilyCare C and D members, there is a \$1 co-payment for generic drugs, and a \$5 co-payment for brand name drugs.</p>	
Physician Services – Primary and Specialty Care	<p>Covered by WellCare.</p> <p>Covers medically necessary services and certain preventive services in outpatient settings.</p>		<p>Covered by WellCare.</p> <p>Covers medically necessary services and certain preventive services in outpatient settings.</p> <p>\$5 co-payment for each visit (except for well-child visits in accordance with the recommended schedule of the American Academy of Pediatrics; lead screening and treatment, age-appropriate immunizations; prenatal care; and pap smears, when appropriate).</p>	

Your Health Plan

Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Private Duty Nursing	<p>Covered by WellCare.</p> <p>Private duty nursing is covered for members who live in the community and whose medical condition and treatment plan justify the need.</p> <p>Private Duty Nursing is only available to EPSDT beneficiaries under 21 years of age, and to members with MLTSS (of any age).</p>			
Prostate Cancer Screening	<p>Covered by WellCare.</p> <p>Covers annual diagnostic examination including digital rectal exam and prostate-specific antigen (PSA) test for men 50 and older who are asymptomatic, and for men 40 and over with a family history of prostate cancer or other prostate cancer risk factors.</p>			
Prosthetics and Orthotics	<p>Covered by WellCare.</p> <p>Coverage includes (but is not limited to) arm, leg, back, and neck braces; artificial eyes; artificial limbs and replacements; certain breast prostheses following mastectomy; and prosthetic devices for replacing internal body parts or functions. Also covers certified shoe repair, hearing aids, and dentures.</p>			
Renal Dialysis	<p>Covered by WellCare.</p>			
Routine Annual Physical Exams	<p>Covered by WellCare.</p>		<p>Covered by WellCare.</p> <p>No co-payments.</p>	

Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
<p>Smoking/ Vaping Cessation</p>	<p>Covered by WellCare.</p> <p>Coverage includes counseling to help you quit smoking or vaping, medications such as Bupropion, Varenicline, nicotine oral inhalers, and nicotine nasal sprays, as well as over-the-counter products including nicotine transdermal patches, nicotine gum, and nicotine lozenges.</p> <p>The following resources are available to support you in quitting smoking/vaping:</p> <ul style="list-style-type: none"> • NJ Quitline: Design a program that fits your needs and get support from counselors. Call toll free 1-866-NJ-STOPS (1-866-657-8677) (TTY: 711), Monday through Friday, from 8 a.m. to 8 p.m. (except holidays) and Saturday, from 11 a.m. to 5 p.m., Eastern Time. The program supports 26 different languages. Learn more at njquitline.org. • NJ QuitNet: Free peer support and trained counselors, available 24 hours a day, seven days a week at quitnet.com. • NJ Quitcenters: Receive professional face-to-face counseling in individual or group sessions. Locate a center by calling 1-866-657-8677 (TTY: 711) or visit quitnet.com. 			
<p>Transportation (Emergency) (Ambulance, Mobile Intensive Care Unit)</p>	<p>Covered by WellCare.</p> <p>Coverage for emergency care, including (but not limited to) ambulance and Mobile Intensive Care Unit.</p>			

Your Health Plan

Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
<p>Transportation (Non-Emergent) (Non-Emergency Ambulance, Medical Assistance Vehicles/MAV, Livery, Clinic)</p>	<p>Covered by WellCare.</p> <p>Medicaid Fee-for-Service covers all non-emergency transportation, such as mobile assistance vehicles (MAVs), and non-emergency basic life support (BLS) ambulance (stretcher). Livery transportation services, such as bus and train fare or passes, car service and reimbursement for mileage, are also covered.</p> <p>May require medical orders or other coordination by the health plan, PCP, or providers.</p>	<p>Covered by WellCare.</p> <p>Medicaid Fee-for-Service covers non-emergency transportation, such as mobile assistance vehicles (MAVs), and non-emergency basic life support (BLS) ambulance (stretcher).</p> <p>May require medical orders or other coordination by the health plan, PCP, or providers.</p> <p>Exceptions: Livery transportation services are not covered for NJ FamilyCare B, C, or D members.</p>		

Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
<p>Urgent Medical Care</p>	<p>Covered by WellCare. Covers care to treat a sudden illness or injury that is not a medical emergency, but is potentially harmful to your health (for example, if your doctor determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your condition from getting worse).</p>		<p>Covered by WellCare. Covers care to treat a sudden illness or injury that is not a medical emergency, but is potentially harmful to your health (for example, if your doctor determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your condition from getting worse). NOTE: There may be a \$5 co-payment for urgent medical care provided by a physician, optometrist, dentist, or nurse practitioner.</p>	

Your Health Plan

Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Vision Care Services	<p>Covered by WellCare.</p> <p>Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses.</p> <p>Yearly exams for diabetic retinopathy are covered for member with diabetes.</p> <p>A glaucoma eye test is covered every five years for those 35 or older, and every 12 months for those at high risk for glaucoma.</p> <p>Certain additional diagnostic tests are covered for members with age-related macular degeneration.</p>		<p>Covered by WellCare.</p> <p>Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses.</p> <p>Yearly exams for diabetic retinopathy are covered for member with diabetes.</p> <p>A glaucoma eye test is covered every five years for those 35 or older, and every 12 months for those at high risk for glaucoma.</p> <p>Certain additional diagnostic tests are covered for members with age-related macular degeneration.</p> <p>\$5 co-payment per visit for Optometrist services.</p>	
Vision Care Services: Corrective Lenses	<p>Covered by WellCare.</p> <p>Covers one pair of lenses/frames or contact lenses every 24 months for beneficiaries age 19 through 59, and once per year for those 18 years of age or younger and those 60 years of age or older.</p> <p>Covers one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens.</p>			

Behavioral Health Benefits

WellCare of New Jersey covers a number of Behavioral Health benefits for you. Behavioral Health includes both Mental Health services and Substance Use Disorder Treatment services. Some services are covered for you by WellCare of New Jersey while some are paid for directly by Medicaid Fee-for-Service (FFS). You will find details in the chart below.

When requesting prior authorization or otherwise making arrangements to receive a BH service – you and your provider should call the **Interim Management Entity (IME)** for services covered by FFS at **1-844-276-2777**, and you and your provider should call Member Services for all WellCare of New Jersey plan covered services toll-free at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.

Service/ Benefit	Members in DDD, and MLTSS	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Mental Health					
Adult Mental Health Rehabilitation (Supervised Group Homes and Apartments)	Covered by WellCare	Covered by FFS.	Not covered for NJ FamilyCare B, C, and D members.		
Inpatient Psychiatric	Inpatient Psychiatric services are covered by WellCare for members in DDD and MLTSS.	Covered by WellCare Coverage includes services in a general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF) , or critical access hospital.			

Your Health Plan

Service/ Benefit	Members in DDD, and MLTSS	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Independent Practitioner Network or IPN (Psychiatrist, Psychologist, or APN)	Covered by WellCare	Covered by FFS.			
Outpatient Mental Health	Covered by WellCare	Covered by FFS. Coverage includes services received in a General Hospital Outpatient setting, Mental Health Outpatient Clinic/Hospital services, and outpatient services received in a Private Psychiatric Hospital . Services in these settings are covered for members of all ages.			
Partial Care (Mental Health)	Covered by WellCare	Covered by FFS. Limited to 25 hour per week (5 hours per day, 5 days per week). Prior authorization required.			
Acute Partial Hospitalization Mental Health/ Psychiatric Partial Hospitalization	Covered by WellCare	Covered by FFS. Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge. Prior authorization required for Acute Partial Hospitalization.			
Psychiatric Emergency Services (PES)/ Affiliated Emergency Services (AES)	Covered by FFS for all members.				

Service/ Benefit	Members in DDD, and MLTSS	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Substance Use Disorder Treatment	The American Society of Addiction Medicine (ASAM) provides guidelines to help determine what kind of substance use disorder (SUD) treatment is appropriate for a person who needs SUD services. Some of the services in this chart show the ASAM level associated with them (which includes “ASAM” followed by a number).				
Ambulatory Withdrawal Management with Extended On-Site Monitoring/ Ambulatory Detoxification <i>ASAM 2 – WM</i>	Covered by WellCare.	Covered by FFS.			
Inpatient Medical Detox/ Medically Managed Inpatient Withdrawal Management (Hospital-based) <i>ASAM 4 – WM</i>	Covered by WellCare for all members.				
Long Term Residential (LTR) <i>ASAM 3.1</i>	Covered by WellCare.	Covered by FFS.			

Your Health Plan

Service/ Benefit	Members in DDD, and MLTSS	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Office-Based Addiction Treatment (OBAT)	Covered by WellCare. Covers coordination of patient services on an as-needed basis to create and maintain a comprehensive and individualized SUD plan of care and to make referrals to community support programs as needed.				
Non-Medical Detoxification/ Non-Hospital Based Withdrawal Management ASAM 3.7 – WM	Covered by WellCare.	Covered by FFS.			
Opioid Treatment Services	Covered by WellCare.	Covered by FFS. Includes coverage for Methadone Medication Assisted Treatment (MAT) and Non-Methadone Medication Assisted Treatment . Coverage for Non-Methadone Medication Assisted Treatment includes (but is not limited to) FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; substance use disorder counseling; individual and group therapy; and toxicology testing.			
Substance Use Disorder Intensive Outpatient (IOP) ASAM 2.1	Covered by WellCare.	Covered by FFS.			

Service/ Benefit	Members in DDD, and MLTSS	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Substance Use Disorder Outpatient (OP) <i>ASAM 1</i>	Covered by WellCare.	Covered by FFS.			
Substance Use Disorder Partial Care (PC) <i>ASAM 2.5</i>	Covered by WellCare.	Covered by FFS.			
Substance Use Disorder Short Term Residential (STR) <i>ASAM 3.7</i>	Covered by WellCare.	Covered by FFS.			

WellCare's Extra Benefits

Stay Connected Program (High Risk Pregnancies/Chronic Conditions)	Provides a free cellphone to members who do not have a telephone and are engaged in a care management program for a high-risk pregnancy or chronic condition
SafeLink Cell Program	Provides a free smartphone per household. Includes 1,000 minutes of talk time monthly, unlimited text messaging and 1G of data per month.
Healthy Rewards Program	Provides rewards, such as gift cards and e-gift cards, to members who complete specific preventive health, wellness and engagement activities

WellCare's Extra Benefits	
Over-the-Counter (OTC)	Provides \$10 worth of OTC items each month, per head of household. No prescription required.
XtraSavings Program	<p>OTC4Me Provides member with discounts on more than 500 over-the-counter items. Members will receive a 20% discount on their first order and 10% on each order after that. Plus, shipping is free for each order of \$25 or more.</p> <p>CVS Discount Card Members get a 20% discount on health-related CVS pharmacy branded items. One discount card will be mailed per household.</p>

Services Not Covered By WellCare or Fee For Service (FFS)

Non-Covered Services

- All claims arising directly from services provided by or in institutions owned or operated by the federal government, such as Veterans Administration hospitals;
- All services that are not medically necessary;
- Any services or items furnished for which your provider does not normally charge;
- Cosmetic surgery;
Exception: When it is medically necessary and approved.
- Experimental organ transplants;
- Respite care (except for MLTSS members);
- Rest cures, personal comfort and convenience items, services and supplies not directly related to your care, including:
 - Guest meals and accommodations;
 - Telephone charges;
 - Travel expenses; and
 - Take-home supplies and similar costs.

Exception: Costs incurred by an accompanying parent(s) for an out-of-state medical intervention are covered under EPSDT services.

- Services billed for which the corresponding health care records do not adequately and legibly reflect the requirements of the procedure described or procedure code used by the billing provider;
- Services involving the use of equipment in facilities, the purchase, rental or construction of which has not been approved by applicable laws of the State of New Jersey;
- Services or items furnished for any condition or accidental injury that arise out of and in the course of employment for which any benefits are available under the provisions of any workers' compensation law, temporary disability benefits law, occupational disease law, or similar legislation, whether you claim or receive benefits, and whether any recovery is obtained from a third party for resulting damages;

Your Health Plan

- Services or items furnished for any sickness or injury that occur while you are on active duty in the military;
- Services or items reimbursed based upon submission of a cost study when there are no acceptable records or other evidence to substantiate either the costs allegedly incurred or beneficiary income available to offset those costs;
- Services in an inpatient psychiatric institution (that is not an acute care hospital) if you are under 65 years of age or over 21 years of age;
- Services outside of the United States and its territories;
- Services primarily for the diagnosis and treatment of infertility, including:
 - Sterilization reversals and related office visits (medical or clinic);
 - Drugs;
 - Laboratory services; and
 - Radiological and diagnostic services and surgical procedures.
- Services provided to all persons without charge; services and items provided without charge through programs of other public or voluntary agencies;
- Part of any benefit that is covered or payable under any health, accident or other insurance policy (including any benefits payable under the NJ no-fault automobile insurance laws), any other private or governmental health benefit system, or through any similar third-party liability, which includes the provision of the Unsatisfied Claim and Judgment Fund; and
- Voluntary services or informal support provided by a relative, friend, neighbor or member of your household (except if provided through participant direction)

Services Covered By Fee For Service (FFS)

Besides your covered managed care services, you may get some services that the Medicaid Fee for Service (FFS) program covers. These services are listed below. To get these services, see providers who accept Medicaid members. You do not need a referral from your PCP. (A referral is when we need to approve your care before you get it.) Do you have questions, need help finding providers, or scheduling appointments? If you do, please call Member Services toll-free at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.

Services include:

- Medically necessary abortion services;
- Non-emergency transportation;
- Sex abuse examinations and related diagnostic tests;
- Intermediate care facility/intellectual disability services; and
- Family Planning Services and Supplies from an out-of-network provider.

A list of services covered by FFS can be found in *Services Covered by WellCare* section that begins on **Page 28**.

How To Get Covered Services

Call your PCP (or PCD for dental) when you need regular care. He or she will send you to a specialist for tests, specialty care and other covered services that he or she does not provide. We will cover this care.

If your PCP or PCD does not offer a covered service that you need, ask how you can get it.

Prior Authorization

Sometimes your PCP, PCD, or another provider may need to ask us to approve care before you get a service or prescription. This is called “Prior authorization (PA).” Your PCP, PCD or another provider will contact us for this approval. If we do not approve the request, we will let you know, including with a written notice. This written notice will give you details about how to file an appeal if you disagree with our decision.

These services need prior authorization:

- DME rentals, DME purchases over \$250, orthotics and prosthetics over \$500;
- Home health services;
- Elective inpatient procedures;
- Inpatient admissions;
- Long-term acute care hospital admissions;
- Inpatient rehabilitation facility admissions;
- Skilled nursing facility admissions;
- Advanced radiology;
- Genetic and reproductive lab testing;
- Investigation and experimental procedures;
- Outpatient therapy services;
- Select outpatient procedures (please contact Member Services for specific procedures); and
- Select dental and all orthodontic procedures.

Prior Authorization Guidelines for Dental Treatment

We make a Prior Authorization (PA) decision for non-emergency services within 14 calendar days of the request or sooner. Do you have questions or need help? If you do, please call Member Services toll-free at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.

What if you switch to WellCare from Medicaid Fee-for-Service (FFS) coverage or another managed care plan? If you have a PA for dental care from a provider that you are already seeing who is not in our network, you can keep getting care from that provider. This can continue for a transitional period or until you are seen by your Primary Care Dentist (PCD) and a new plan of care is created. This is true even if the services have not been started, unless the treating dentist changes the treatment plan.

Prior authorization means we must approve a service before you can get it so that your dentist can be paid by WellCare to provide it.

This PA will be good until its expiration date or for six months, whichever is longer. This includes PAs for orthodontic services that were previously approved by FFS or another managed care plan. A PA for orthodontic services will be valid as long as you:

- Are eligible for services through WellCare; and
- Do not surpass the age limit for orthodontic services.

What if you started services in an FFS program before you joined WellCare? In that case, we will pay for the dental services that were approved and started before you joined our plan. The services must be completed within 90 days after you joined our plan.

- These dental services will include (but are not limited to): crowns (cast, porcelain fused to metal and ceramic), cast post and core, endodontic treatment, and fixed and removable prosthetics (dentures and bridges);
- What if services are started in FFS, are completed after the 90-day limit, but were done by a WellCare network provider? We will cover the started codes and services. The dentist must follow our PA rules for any services planned but not started; and
- What happens if services are started in FFS, completed within the 90-day limit, but were done by a non-plan provider? WellCare will pay the non-plan provider.

You or your provider can ask us to make a fast decision for a PA instead. (A fast decision is made within 24 hours.) You can ask for this if you or your provider think(s) that waiting for

a decision could put your life or health in danger. To ask, please call Member Services at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.

Sometimes we may need more time to make a fast decision. If so, we will decide no later than 72 hours after the receipt of the request for service.

Dental Treatment for members with Special Health Care Needs (SHCN) in an Operating room (OR) or Ambulatory Surgical Center (ASC)

Members with Special Health Care Needs (“SHCN”) may require treatment to be performed in a hospital setting/operating room (“OR”) or ambulatory surgical center (“ASC”) facility setting as an outpatient service.

WellCare’s dental vendor, Liberty Dental Plan, offers care management for dental services for SHCN members, upon request. To ask for this, please call Liberty Dental Plan’s Member Services Department at **1-888-352-7924** (TTY: **711**). Care managers are trained to help members and providers arrange services. They will work one-on-one to help coordinate oral health care needs.

To do this, they:

- May ask questions to get more information about your health conditions;
- Will work with PCPs and PCDs to arrange services needed and to help you understand your health care needs;
- Will provide information to help you understand how to care for yourself and how to access services, including local resources;
- Will assist with coordination of appointments and transportation; and
- Will accompany you to any appointments as needed.

Services Available Without Authorization

You do not need approval from us or your PCP or PCD for these services:

- DME purchases under \$250, orthotics and prosthetics under \$500;
- Emergency or urgent care services;
- Emergency transportation services;
- Observation services;

- Routine lab tests;
- Dialysis;
- Hospice services;
- Office visits with in-network specialists;
- Routine and emergency dental services; for example diagnostic and preventive dental visits, filling, uncomplicated extractions;
- Routine radiology services; and
- Select outpatient procedures. (Please contact Member Services for specific procedures)

Even though you do not need approval for these services, you will need to pick a network provider. Please see your *Provider Directory* to choose one. You can also use the *Find a Provider* tool at www.wellcare.com/New-Jersey/Find-a-Provider. Once you make your choice, call them to set up an appointment. You must have your ID card at your visit.

You or your PCP/specialist can ask us to make a fast decision for a PA instead. (A fast decision is made within 24 hours.) You can ask for this if you or your PCP/specialist think(s) that waiting for a decision could put your life or health in danger.

You do not need a referral to get Family Planning services. You may also get these services at a Federally Qualified Health Center (FQHC) or from an out-of-network Medicaid provider.

The FFS program will cover the cost of these services.

Services from Providers Not in Our Network

Sometimes a service you need is not available through a provider in our network.

If this happens, we will cover it out-of-network. (Prior approval may be needed.)

Do you use an out of network provider that you think offers the best service to meet your medical or dental needs? Please contact Member Services to ask about adding this provider to our network. Also, the provider can contact us about joining our network at www.wellcare.com/New-Jersey/Become-a-Provider.

Do you have a chronic condition that requires ongoing care from a specialist? If so, you

can request a **standing referral** to that specialist. A **standing referral** means that you will be able to see your specialist on a regular basis without needing to get a referral from your PCP. Do you have questions or need help with a **standing referral**? If you do, please call Member Services toll-free at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.

Utilization Management

Health plans commonly use utilization management (UM). UM makes sure members get the right care at the right place. It helps manage costs and deliver quality health care. Our UM program has four parts:

- Prior authorization: Get our approval before you get a service;
- Prospective reviews: Before you get care, we make sure it is right for you;
- Concurrent reviews: We review your care as you get it to see if something else might be better for you; and
- Retrospective reviews: We find out if the care you got was appropriate.

We sometimes cannot approve coverage for services or care. Our Medical Director makes these decisions. You should know:

- Decisions are based on the best use of care and services;
- The people who make decisions do not get paid to deny care (no one does); and
- We do not promote denial of care in any way.

Do you have questions about our UM program? Please call toll-free at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.

Second Medical or Dental Opinion

Ask your PCP or PCD when you want a second opinion about your care.

- He or she will ask you to pick another network provider in your area;
- If you cannot find one, you can choose a provider who is not in our network by getting a prior authorization (PA); and
- You must go to a provider in our network for any tests the second provider orders.

You can contact us to assist you with arranging a second opinion with an out-of-network

provider. Please call Member Services at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m. Your PCP or PCD will review the second opinion. Once you receive your second opinion, you and your provider can decide the best way to proceed with your care.

You do not need a PA or referral to any dentist or dental specialist in the WellCare network. The procedure to get a second dental opinion is the same as for second medical opinions.

After-Hours Care

If you get sick or hurt when your PCP's office is closed, and it's not an emergency, you can call your PCP anyway. The number is on your ID card.

Your PCP's office will have a doctor "on call." This doctor is available 24 hours a day, 7 days a week. He or she will call you back and tell you what to do.

If you cannot reach your PCP's office, you may go to an urgent care center.

Also, remember you can call the Nurse Advice Line any time at **1-800-919-8807**.

Emergency Care

An Emergency Medical Condition is any medical condition severe enough that a sensible person with an average knowledge of medicine and health could reasonably expect that, without immediate medical attention, a person in that condition might be in danger of:

- Serious harm to their health;
- Serious impairment to their normal bodily functions;
- Serious harm to an organ or other body part; or
- In the case of a pregnant woman, danger to her health or the health of her unborn child.

For a pregnant woman having contractions, it is considered an emergency if there is not enough time to safely transport her to another hospital before delivery, or if any transportation may be a threat to the safety of the woman or her unborn child.

For dental emergencies, such as pain, swelling or bleeding in the mouth, or a tooth knocked out, call your dentist first. If you cannot reach your dentist, or if you do not have a dentist, contact Liberty Dental at **1-888-352-7924** (TTY: **711**). See the "Dental Emergency" section on **Page 77**.

In an emergency, please call **911**, or go to the nearest hospital emergency room right away.

What if you are not sure if it is an emergency? Call our 24-Hour Nurse Advice Line at **1-800-919-8807** (TTY: **711**) or your PCP. You do not need prior authorization (pre-approval) for emergency care or urgent health care, whether in-network or out-of-network. We will cover this care. These services are available 24 hours a day, 7 days a week.

Show your WellCare ID card at the ER. Ask the staff to call us. The ER provider will decide if it is an emergency. Please let your PCP know when you are in the hospital. Do this as soon as you can. Also let him or her know if you get care in an ER or urgent care center.

We will pay for all services related to the exam. We will not deny a claim for an emergency medical exam that would have appeared to be an emergency to an average person but was later found not to be an emergency.

Post Stabilization Care

Post-stabilization Care Services are covered services related to an emergency medical condition that are provided after that condition is brought under control and stabilized. This includes services and treatment provided to keep your condition stable, as well as services provided to improve or completely resolve your condition.

Members with Special Needs

For **adults**, members with Special Needs include:

- Members with chronic and/or complicated medical conditions that require specialized treatment;
- Members with physical, mental, or developmental disabilities (including members eligible for MLTSS);
- Members who need treatment for Substance Use Disorders; and
- Members who are homebound.

Additional details on **children** with special needs can be found in the section “Children with Special Health Care Needs” on **Page 63**.

WellCare ensures continuity of care and a seamless transition of care for our members who are currently working with a non-participating provider. When a newly enrolled member or existing member presents to the Plan with an existing relationship with a non-participating provider, the member may continue an ongoing course of treatment

during a condition-specific transitional period or until the member is evaluated by his/her primary care provider or specialists and a new plan of care is mutually established.

Member can work with a specialty care manager to guide the member and the non-participating provider throughout the continuity of care path.

WellCare will ensure that members receive necessary services through a network of providers that specialize in treating members with special health care needs, including referrals to specialty care facilities, such as a Pediatric Medical Day Care Facility. Our network of providers consists of specialized providers with experience and expertise in treating members with special needs.

WellCare will also allow for standing referrals for members who need long-term specialty care. A member can get a standing referral for up to 6 months at a time and/or 6 or more visits.

We have a 24-hour crisis line. If you think you or a family member is having a behavioral health crisis, call this number anytime (24 hours a day, seven days a week) at **1-800-411-6485**. A trained person will listen to your problem. He or she will help you decide the best way to handle the crisis.

Children with Special Health Care Needs

The Care Management team refers services to children with special health care needs. Services may include:

- Psychiatric care and substance use disorder (SUD) counseling for DDD members;
- Crisis intervention; and
- Inpatient hospital services.

The Care Management team also provides education and arranges other types of care. These include:

- Well-child care;
- Health promotion and disease prevention;
- Coordination of health care needs with specialists;
- Diagnostic and intervention strategies;
- Coordination of home health care therapies;
- Coordination of ongoing ancillary services;

- Coordination of long-term management of ongoing medical complications; and
- WellCare will cover continuation of services with providers who are out-of-network when it is in your best medical interest.

Children with special needs also have Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefits to help keep them healthy. We help promote and maintain the health of your children from birth until they are 21 years old. This program helps keep your child's immunizations and well-child visits on track and reminds parents to have their child's PCP screen for medical problems early and keep checking for problems to help prevent serious disease as the child grows. Children with special needs have an additional dental benefit of four preventive dental visits per year.

If your child has a condition that needs ongoing care from a participating specialist or has a life-threatening or disabling condition or disease, you can ask your child's PCP for a "standing referral." This lets your child go to the specialist as often as needed to treat the condition.

Children with a special need may be able to have a participating specialist as their PCP. You may also request a referral to certain care facilities for highly specialized care or to continue care with a non-participating doctor when necessary.

Dental Special Needs Care

WellCare's dental vendor, Liberty Dental Plan (LDP), has policies in place to provide oversight of complex case management and coordination of dental services for those requiring dental special needs care. Members with complex dental problems and/or special dental health care needs can request additional assistance in coordinating dental services by contacting Liberty Dental Plan's Member Service Department at **1-888-352-7924**.

- Consultation and information available to caregivers include oral hygiene instruction to help maintain a member's oral health between dental visits. The Care Manager assigned to oversee the member's oral health will create a "Dental Management Plan" to assist in the coordination of care;
- Members with developmental disabilities and special needs may require more frequent diagnostic, preventive and periodontal visits if medically necessary: four visits annually without prior authorization; and

- Dental services can be provided as follows:
 - Mobile Dental Practice – The provider travels to locations using portable dental equipment to provide dental services outside of the dental office/clinic in settings that include but are not limited to facilities, schools and residences; and
 - Mobile Dental Practice (utilizing van) – The provider uses a vehicle specifically equipped with dental equipment to provide dental services within the van.

Please also see the section about dental treatment for members with Special Health Care Needs (SHCN) in an Operating Room (OR) or Ambulatory Surgical Center (ASC), located on **Page 58**.

Homebound Members

All members identified as homebound receive all services offered by the member's health plan, either within the home or within the community. The goal is to identify the member's special needs and then use a holistic approach to treat those needs.

Some services include:

- Care Management
- Home Health Services – registered nurse, physical therapy, occupational therapy, speech therapy
- Nutritional Services
- Telehealth Providers – medical and psychiatric needs
- Immunizations
- Transportation
- Psychotherapy

Care Management

The purpose of the Care Management program is to identify, support, and engage our most vulnerable members at any point in the health care continuum by integrating medical, behavioral, and socioeconomic assistance to members in a holistic care management approach. This includes assistance with health and risk assessments, coordination of care/benefits, service delivery, community resources, and education to ensure members live a happier healthier life in your community.

Your Health Plan

All members have access to care management at any time. The member can self-refer to the program using the following methods:

- Member Services;
- Access to a 24-hour nurse advice hotline and a 24-hours crisis hot line given to the member during the initial Comprehensive Needs Assessment; and
- Care Management toll-free line.

All members referred, contacted, and who agree to participate in the Care Management Program will receive a focused Care Needs Assessment (CNA) within 30 days of identification or referral to the care management team. This assessment will identify any health care needs followed by the creation of an individualized care plan that is shared with the family and any physician involved with your care. This care plan can be used as a road map to ensure optimal health care needs.

Our care managers are trained to help you, your family and your PCP. They will help arrange services you may need to manage your health. This includes referrals to special care facilities. We want you to know how to take care of yourself and stay in good health.

Our Care Management Programs offer you a care manager and other outreach workers. They will work one-on-one with you to help coordinate your health care needs. To do this, they:

- May ask you questions to learn more about your condition;
- Will work with your PCP to arrange services you need and help you understand your condition;
- Will give you information to help you know how to care for yourself and how to get services, including local resources;
- Will assist with coordination of appointments and transportation; and
- Will accompany you to any medical appointments as needed.

All new members (except DDD and DCP&P members) are screened with the Initial Health Screening Tool. This is used to see if you have any physical and/or behavioral health needs that must be treated right away. We will also check to see if you need a more detailed screening. That screening is called the Comprehensive Needs Assessment. All new DDD and DCP&P members will automatically receive a Comprehensive Needs Assessment.

Your special needs will be identified through a Comprehensive Needs Assessment that we will do. Within 30 days of this assessment, we will work with you to design a care plan.

What do we do with the results from your Comprehensive Needs Assessment? We decide what medical and behavioral health care you may need. This could include care from specialists, durable medical equipment, medical supplies, home health services and social services.

A care plan will be developed for you based on the needs that are found through the Comprehensive Needs Assessment or the NJ Choice Assessment. This will make sure that all your needs are met, and that you receive the care and services you need.

Out-of-Area Emergency Care

It is vital to get care when you are sick or hurt, even when you travel. Please call Member Services if you get sick or injured while traveling. The toll-free number is **1-888-453-2534** (TTY: 711). These numbers are on the back of your ID card.

- Go to the nearest hospital if you have an emergency while traveling. It does not matter if you are not in our service area;
- Show your ID card;
- Call your or as soon as you can; and
- Ask the hospital staff to call us. We can tell them how to file your claim.

Treatment of Minors

WellCare covers care for members younger than 18, following all applicable laws.

Treatment is covered when requested by the minor's parent(s) or the minor's legal guardian. New Jersey law allows minors to make health care decisions for themselves in some cases.

Treatment without parental/guardian consent is allowed in these cases:

- When a minor goes to an emergency room for treatment of an emergency medical condition, the minor will be treated without parental consent;

- When minors want family planning services, maternity care or services related to sexually transmitted diseases (STDs). These services will be covered without parental/guardian consent when medically necessary; and
- When minors who live on their own and have their own Medicaid ID number as head of their own household need treatment.

Urgent Care

Urgent care is treatment of a condition that is not an emergency, but needs treatment within 24 hours to prevent it from getting worse. Some examples of these conditions include:

- Cold, cough or sore throat;
- Cramps;
- Ear infection;
- Bruises, minor cuts or burns;
- Rashes or minor swelling;
- Backaches from a pulled muscle;
- Low-grade fever;
- Sprains;
- Toothache;
- Broken natural teeth or lost fillings or crowns;
- Swelling around the tooth;
- Discomfort due to tooth eruption — examples include teething in babies or toddlers, or wisdom teeth in older children or adults;
- Pain or discomfort following dental treatment; and
- Severe pain.

Are you unsure if you need urgent care? Please call your PCP or PCD or the Nurse Advice line at **1-800-919-8807** (TTY: **711**).

**Urgent care services do not need prior approval.
You do not need to see a network provider for urgent care.
You will need to show your WellCare ID card to the urgent care provider.**

Also, ask the urgent care provider or their staff to call us. You do not need approval to get urgent care. Be sure to let your PCP or PCD know if you get urgent care, so he or she can provide follow-up care.

Remember, you can also get urgent care when you travel out of state.

Pregnancy and Newborn Care

Taking care of yourself when you are pregnant can help you and your unborn baby stay healthy. You should see your PCP within 3 days to 3 weeks after you join our plan if you are pregnant. (This depends on your risk factors and how long you have been pregnant.)

Refer to **Page 14** of this handbook for a prenatal schedule timeline. Be sure to go to all your prenatal and postpartum (after birth) visits. Member Services can help set up these visits. Just call us at **1-888-453-2534 (TTY: 711)**. We are here Monday through Friday from 8 a.m. through 6 p.m.

Please let us know when you become pregnant. We can give you information about having and caring for your baby. We can also sign you up for our Healthy Rewards Program.

Here are a few other things to remember:

- If you have a baby while you are a WellCare member, we will cover the child up to 60 days after delivery;
- You must call your County Welfare Agency/Board of Social Services to get your baby's Medicaid ID number. You must do this within 60 days of your child's birth. Call us to give us this number; and
- You need to choose a PCP for your baby. This lets your baby get check-ups and immunizations. You must do this by the time your baby is born. If you do not, we will choose one for you.

WellCare BabySteps Maternity Care Management Program

WellCare BabySteps is a free program for our pregnant moms. The goal of the program is to keep you healthy and provide the best opportunity for you to have a healthy

baby. To do this, our BabySteps care coordinators will reach out to you for a maternity assessment. This helps us learn if care management or care coordination could help you and your unborn baby with any issues during your pregnancy. The care coordinators will also give you information about our Healthy Rewards program and help you sign up.

Women, Infants and Children (WIC)

WIC is a nutrition program. It is for women (pregnant and those who have recently had a baby), infants and children. The program provides:

- Nutrition education;
- Nutritious food;
- Referrals to other health, welfare and social services; and
- Support for mothers who breastfeed.

If you are pregnant, ask your PCP about WIC. Call your local WIC agency to see if you are eligible and to apply for this program. You must make an appointment to talk with them. You will need proof of New Jersey residency and your income. Below is a list of WIC agencies and contact information.

Region	Agency Name	Service Area
North	St. Joseph’s WIC Program 185 Sixth Ave. Paterson, NJ 07524 1-973-754-4575 Email: wic@sjhmc.org	Bergen, Morris and Passaic counties (except the city of Passaic – see next)
	Passaic WIC Program 333 Passaic St. Passaic, NJ 07055 1-973-365-5620 Email: passaicwic@cityofpassaicnj.gov	City of Passaic
	North Hudson WIC Program 407 39 th St. Union City, NJ 07087 1-201-866-4700 Email: klazarowitz@nhcac.org Email: rlavagnino@nhcac.org	Hudson County (except Bayonne and Jersey City – see next)
	Jersey City WIC Program 199 Summit Ave. Suite A2 Jersey City, NJ 07304 1-201-547-6842 Email: help@JCWIC.org	Bayonne and Jersey City

Your Health Plan

Region	Agency Name	Service Area
North (continued)	East Orange WIC Program 185 Central Ave. Suites 505 & 507 East Orange, NJ 07018 1-973-395-8960 Email: Chesney.blue@eastorange-nj.gov	Essex County: Belleville, Bloomfield, Caldwell, Cedar Grove, East Orange, Essex Falls, Fairfield, Glen Ridge, Livingston, Millburn, Montclair, North Caldwell, Nutley, Orange, Roseland, South Orange, Verona, West Caldwell and West Orange
	Newark WIC Program 110 Williams St. Newark, NJ 07102 1-973-733-7628 Email: cummingsp@ci.newark.nj.us	Essex County: Belleville, Bloomfield, East Orange, Irvington, Maplewood, Newark, Orange and South Orange
	Rutgers - NJMS WIC Program UMDNJ WIC Program Stanley Bergen Bld. (GA-06) 65 Bergen Ave. Newark, NJ 07107 1-973-972-3416	Essex County: Irvington and Newark (also open to NJ residents being treated at UMDNJ)
Central	Trinitas WIC Program 40 Parker Road Elizabeth, NJ 07208 1-908-994-5141 Email: aotokiti@trinitas.org	Union County (except city of Plainfield – see next)
	Plainfield WIC Program 510 Watchung Ave. Plainfield, NJ 07060 1-908-753-3397 Email: prema.achari@plainfieldnj.gov	City of Plainfield

Region	Agency Name	Service Area
Central (continued)	NORWESCAP WIC Program 350 Marshall St. Phillipsburg, NJ 08865 1-908-454-1210 1-800-527-0125 Email: quinnn@norwescap.org	Hunterdon, Somerset, Sussex and Warren counties (except Franklin Township – see next)
	VNA of Central Jersey WIC Program 888 Main St. Belford, NJ 07718 1-732-471-9301 Email: Robin.McRoberrts@vnacj.org	Middlesex and Monmouth counties and Franklin Township in Somerset County
	The Children’s Home Society of NJ’s Mercer WIC Program 416 Bellevue Ave. Trenton, NJ 08618 1-609-498-7755 Website: www.chsofnj.org Email: jmartin@chsofnj.org	Mercer County
	Ocean County WIC Program 175 Sunset Ave. P.O. Box 2191 Toms River, NJ 08754 1-732-341-9700, ext. 7520 Email: megmccarthy@ochd.org	Ocean County
South	Burlington County WIC Program Raphael Meadow Health Center 15 Pioneer Blvd. P.O. Box 6000 Westampton, NJ 08060 1-609-267-4304 Email: ddas@co.burlington.nj.us	Burlington County

Region	Agency Name	Service Area
South (continued)	Gateway CAP 10 Washington St. Bridgeton, NJ 08302 1-856-451-5600 Email: tricounty_WIC@gatewaycap.org	Camden, Cape May, Cumberland and Salem counties
	Gloucester County WIC Program 204 E. Holly Ave. Sewell, NJ 08080 1-856-218-4116 Email: kmahmoud@co.gloucester.nj.us	Gloucester County

Interested in Breastfeeding?

Breastfeeding is the healthiest choice for your baby. Lactation Services supports women who want to breastfeed. Counseling, classes, breast pumps and supplies are offered. Also provided are educational materials to help reinforce healthy and successful breastfeeding.

WellCare covers breast pumps and supplies. For a list of breast pump suppliers, please call Member Services at **1-888-453-2534** (TTY: **711**) or contact the BabySteps Care Manager.

WellCare covers:

- Standard electric breast pumps (non-hospital-grade);
- Manual breast pumps; and
- Hospital grade electric breast pumps (when medically necessary).

Our BabySteps program is a maternity care management program that consists of a team of care coordinators, social workers and RN care managers. If you would like to enroll, please call Member Services at **1-888-453-2534** (TTY: **711**).

There are other ways you can get help:

1. Ask your OB/GYN about breastfeeding and recommended classes
2. Call the Women Infants and Children (WIC) Program at **1-800-328-3838** (TTY: **711**) to connect to your local WIC office to speak with a lactation specialist. This is also the WIC 24-hour referral line.

3. Call the La Leche League of Garden State at **1-877-452-5324** or log in to <http://www.lllgardenstate.org/local-support.html>.
4. Call the National Breastfeeding Helpline at **1-800-994-9662** (TTY: **1-888-220-5446**).
5. Call the NJ WIC State office at **1-609-292-9560**.
6. Go to the NJ WIC website at <https://www.state.nj.us/health/fhs/wic/index.shtml>.

Dental Care

Dental care is important to your overall health. You should see your dentist at least once every 6 months. Regular dental care helps protect your teeth and your general health. It is important to set up a dental exam with your primary care dentist (PCD) soon after you join our plan. Your child should have a dental check-up before age 12 months or soon after the eruption of his or her first tooth.

Your dental benefits are covered through Liberty Dental Plan, our dental services provider. With Liberty Dental Plan, a primary care dentist (PCD) coordinates your dental care. WellCare members can choose a Primary Care Dentist at any time.

Upon initial enrollment, Liberty assigns WellCare members to the nearest Primary Care Dentist based on such factors as language, cultural preference, previous history of the member or another family member, etc.

WellCare members can change Primary Care Dentists at any time by calling Liberty toll free: **1-888-352-7924** (TTY: **711**). You may also find a dentist for your child at www.insurekidsnow.gov. You can also use our Provider Directory to find a pediatric dentist in our network. You can use the *Find a Provider* tool at www.wellcare.com/New-Jersey/Find-a-Provider. If you want a printed copy of the Provider Directory, call Member Services. We can also help you make an appointment. Call us at **1-888-453-2534** (TTY: **711**). We are here for you Monday through Friday from 8 a.m. through 6 p.m.

The New Jersey Smiles Directory is also on our website. This directory lists dentists who participate with WellCare and treat children 6 years or younger. You can find it in the *Provider Directories* section of the website at www.wellcare.com/en/New-Jersey/Members/Medicaid-Plans/NJ-FamilyCare. Just scroll down on the web page and you will find the directory.

Children should visit a general dentist who treats young children or a pediatric dentist for a dental evaluation before their first birthday or when the first tooth comes in. Caring for baby teeth helps ensure the future of your child's dental health.

What if you need a service but do not know if it is more medical than dental? You may need dental care that includes treatment of a condition that can be major or life-threatening, such as a jaw fracture, or the removal of a tumor. In these cases, services given by a dentist will be considered dental. Services most often taken care of by a physician (medical doctor) will be considered medical.

WellCare will help you to decide which services should be treated by a physician instead of a dentist. You can also ask your PCP or PCD for more information. (For example, if you need surgery for a fractured jaw.) He or she will be able to explain the difference and tell you if a prior approval is needed for treatment. If you need a referral to a medical or dental specialist, please call Member Services toll-free at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.

Prior authorization is not needed for these services:

- Oral evaluation: 1 every six months;
- Prophylaxis: 1 every six months (for all ages);
- Fluoride treatments: 1 every six months (for all ages);
- Sealants: Covered for members under 16 years of age – permanent molars and bicuspids;
- Restorative services: silver or tooth colored fillings;
- Simple extractions; or
- Additional preventive and diagnostic services are available to members with special needs with documentation of medical necessity.

Some dental services need prior authorization. Ask your dentist if your treatment needs prior approval.

For information on Prior Authorization Guidelines for Dental Treatment and for Prior Authorization Guidelines for Dental Treatment for members with Special Health Care Needs (SHCN) in an Operating Room (OR) and Ambulatory Surgical Center (ASC), please see **Page 58**.

Dental care not only helps protect your teeth, but it can also protect your general health. You should visit your dentist every 6 months for exams and cleanings, unless your dentist makes a different recommendation. You should complete the follow-up care recommended by your dentist and keep your appointments. And perform daily oral hygiene as recommended.

Tips for dental health:

- Brush your teeth twice a day;
 - Floss your teeth at least once a day;
 - See your dentist for an oral exam every six months (or as directed); and
- Complete all needed treatment. Follow-up care is important!**

Dental Emergency

You can get emergency care 24 hours a day, 7 days a week.

If you need emergency dental care, please call your dentist right away. Your provider's after-hours response system lets members reach an on-call dentist 24 hours a day, seven days a week. If you cannot reach your dentist or call service, please call Liberty Dental at **1-888-352-7924** (TTY: **711**).

Most dental emergencies are best treated in a dental office and not a hospital emergency department. A dental emergency that would be appropriately treated in a hospital emergency department would include a broken jaw and/or facial bones, dislocated jaw, severe swelling or oral facial infection, or uncontrolled oral bleeding.

You can go to any dentist for emergency care to relieve pain, treat an infection or treat knocked-out, loosened, or broken teeth. You do not need a referral for dental emergency services provided by a dentist in a dental office or a physician in the ER. Show your WellCare ID Card to access these services.

If you are out of the service area, call our Nurse Advice Line any time at **1-800-919-8807** (TTY: **711**) for help with emergency or urgent dental care. They can help if you do not have a primary care dentist.

Urgent dental conditions can include:

- Broken teeth;
- Broken denture;
- Teething difficulties (permanent or baby tooth);
- Lost filling or crown;
- Facial swelling; and
- Dental pain.

Call your primary care dentist or the Nurse Advice Line if you do not have a primary care dentist or if you are unsure if you have an urgent dental condition.

Non-emergency dental services are only covered when provided by an in-network dentist. Services that need prior approval must meet Plan guidelines. Your dentist can provide more information about prior approval and which services require it.

It is important to follow up with your dentist after any emergency or urgent care you receive.

Family Planning

Family planning is a covered benefit. Covered services include:

- Advice and/or prescriptions for birth control;
- Breast cancer exam;
- Genetic testing and counseling;
- HIV/AIDS testing;
- Sterilization;
- Pelvic exams; and
- Pregnancy tests.

You can choose where to get these services.

- To pick a provider from our network, look through our Provider Directory or call Member Services at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.; or
- You can also get family planning services from any Medicaid Fee-for-Service (FFS) provider, even if they are not in our network. In this case, you must show your New Jersey Health Benefit ID card (HBID card). You do not need a referral.

Do you have any questions? Please call Member Services toll-free at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.

Hysterectomy and Sterilization

If you choose to have surgery such as a hysterectomy or vasectomy to prevent having children, the provider who performs the surgery must fully explain the surgery and its results. This is true for both men and women.

You will need to sign a form before you have the surgery. The form states that you understand that the surgery is permanent, that your provider has told you about the many non-permanent types of birth control available to you, and has answered all of

your questions. The form also says the decision to be sterilized is all yours. The form must be signed at least 30 days before the surgery.

We can provide you with a translator or an interpreter to help you if English is not your primary language.

Gender Identity Nondiscrimination

WellCare does not discriminate on the basis of a member's gender identity or expression, or on the basis that they are a transgender person.

WellCare's non-discrimination policies prohibit the following:

1. Denying, canceling, limiting, or refusing to issue or renew a contract on the basis of a covered person's or prospective covered person's gender identity or expression, or for the reason that the covered person or prospective covered person is a transgender person;
2. Demanding or requiring a payment or premium that is based in whole or in part on a covered person's or prospective covered person's gender identity or expression, or for the reason that the covered person or prospective covered person is a transgender person;
3. Designating a covered person's or prospective covered person's gender identity or expression, or the fact that a covered person or prospective covered person is a transgender person, as a preexisting condition for which coverage will be denied or limited; or
4. Denying or limiting coverage, or denying a claim, for services including but not limited to the following, due to a covered person's gender identity or expression or for the reason that the covered person is a transgender person:
 - a. Health care services related to gender transition if coverage is available for those services under the contract when the services are not related to gender transition, including but not limited to hormone therapy, hysterectomy, mastectomy, and vocal training; or
 - b. Health care services that are ordinarily or exclusively available to individuals of one sex when the denial or limitation is due only to the fact that the covered person is enrolled as belonging to the other sex or has undergone, or is in the process of undergoing, gender transition.
5. The plan will still perform reviews to determine whether or not services are medically necessary.

Utilization Review and Management

In performing utilization review and management, WellCare will not discriminate on the basis of a covered person's or prospective covered person's gender identity or expression or on the basis that the covered person or prospective covered person is a transgender person. This includes:

1. Determination of medical necessity and prior authorization protocols for transition-related care are based on the most recent, published medical standards set forth by nationally recognized medical experts in the transgender health field, including the World Professional Association of Transgender Health's Standards of Care.
2. WellCare does not categorically exclude coverage for a particular transition-related treatment, if the treatment is the only medically necessary treatment available for the person.
3. WellCare does not establish broad categorical exclusion of specific services for transition-related care or gender dysphoria treatment, including broad exclusions for only a subset of covered persons, or impose utilization controls that make it so there is no viable treatment covered for a covered person's condition.

Non-Participating Providers and Out-of-Area Coverage

WellCare understands that some medically necessary procedures for transition-related care require specialized providers who may not be available in the network.

1. WellCare provides and will arrange for out-of-area or non-participating provider coverage of services when medically necessary services can only be provided elsewhere, including when a specific service is not offered by any participating providers or when participating providers do not have the appropriate training or expertise to meet the particular health needs of a transgender enrollee, at no additional cost.
2. WellCare cooperates with non-participating providers accessed at the member's option by establishing cooperative working relationships with such providers for accepting referrals from them for continued medical care and management of complex health care needs and exchange of member information, where appropriate, to assure provision of needed care within the scope of this contract. WellCare will not deny coverage of transition-related care for a covered diagnostic, preventive or treatment service solely on the basis that the diagnosis was made by a non-participating provider.

Behavioral Health Care – Members in DDD or MLTSS

We cover behavioral health services for those members in NJ's Division of Developmental Disabilities (DDD) program, as well as members in MLTSS.

We are here to help any time you think you need behavioral health care. This includes substance use disorder (SUD) treatment and mental health services. We have several ways to help you find a behavioral health provider.

- Use the *Find a Provider* tool at www.wellcare.com/New-Jersey/Find-a-Provider;
- Look through your provider directory; or
- Call us at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.

What to Do if You Need Help

Call us if you experience any of the following. We will assist you in finding providers who can help.

- Always feeling sad;
- Feeling hopeless and/or helpless;
- Feelings of guilt or worthlessness;
- Problems sleeping;
- No appetite;
- Weight loss or gain;
- Loss of interest in the things you like;
- Problems paying attention;
- Your head, stomach or back hurts, and your provider has not found a cause;
- Prescription medication, drug and/or alcohol problems; and/or
- Addiction to or abuse or misuse of prescription medication.

What to Do in a Behavioral Health Emergency or if You Are Out of the Plan's Service Region

Do you think your health is at risk? Some people feel as though they could hurt themselves or others. If you have feelings like this, please call **911** or go to the nearest hospital. You do not need preapproval for a behavioral health emergency.

A provider may think you need more care after your emergency visit to improve or resolve your health problem. We will cover this care. Please follow up with your PCP within 24 to 48 hours after you leave the hospital.

The hospital where you get your emergency care may be out of our service area. If so, you will be taken to a network facility when you are well enough to travel.

Make sure to read the *Emergency Care* section of this handbook. It has more information about what to do in an emergency.

Behavioral Health Care – Members not in DDD or MLTSS

If you are not in the DDD or MLTSS programs, most of your behavioral health care (mental health and substance use disorder treatment) will be covered by Medicaid Fee-for-Service (FFS). You do not need a referral from your PCP to see a behavioral health provider.

If you are 18 years of age or older and need behavioral health care:

- Call your PCP or psychiatrist; and/or
- Call the IME Addictions Access Center 24/7 at **1-844-276-2777** or **1-844-REACH NJ (732-2465)**. The Interim Managing Entity (IME) is a single point of entry for Substance Use Disorder (SUD) services and questions.

For behavioral health care for children younger than 18 years of age:

- Call the New Jersey Children's System of Care at **1-877-652-7624** (TTY: **1-877-294-4356**).

If you have a crisis after-hours and need help, reach out to our Behavioral Health Crisis Line at anytime (24 hours a day, seven days a week) at **1-800-411-6485**.

Office Based Addiction Treatment (OBAT) Services

WellCare covers Office Based Addiction Treatment (OBAT) services for members with substance use disorder diagnoses including opioid, alcohol or poly-substance abuse.

Office Based Addiction Treatment services and office based Medication Assisted Treatment (MAT) services are available to all WellCare of New Jersey members. WellCare has established a network of providers to provide these services. These providers have business relationships with community providers such as Substance Use Disorder (SUD) counselors. These providers will create an individual care plan and maintain a comprehensive individualized SUD plan of care for each member utilizing this benefit. This will be used as a guide to coordinate your services within the context of your individual plan of care. Your providers will assist you in obtaining needed support services, counseling, social services, recovery supports, family education, and/or referrals to appropriate levels of care.

The service also includes the use of peer supports. Peers are individuals who will provide non-clinical assistance and support through all stages of the recovery process through “lived” experience of substance use disorder and sustained recovery. Peers provide their shared experience to allow others to benefit from their past experience to assist the beneficiary to maintain sobriety.

Disease Management Program

WellCare has a Disease Management/Chronic Care Improvement Program (DM/CCIP). The program helps members (and their caregivers) with long-term health issues. Members in the program get information and health coaching. This helps you make good choices and manage your conditions. It can help you improve your health and quality of life.

The program is offered to our members with the conditions listed in the chart in this section. Program members get services from a team of registered nurses and health professionals.

When you join the program, you will get welcome letters with information on how to get more help and services. You will also be told how to leave the program if you wish to do so.

You will work with a Care Manager to create a care plan. The care plan maps steps to help you reach your health care goals. It includes input from your PCP and specialists. If the member is a minor, we will get input from the member’s caregiver. This program is voluntary. A provider may refer you to the program or you can refer yourself. If you are enrolled in the program, you can leave at any time.

Topics that the program addresses include:

Disease	Topics Covered
Asthma	<ul style="list-style-type: none"> • Understanding asthma • Avoiding triggers • Ways to self-monitor asthma <ul style="list-style-type: none"> - Using a peak flow meter - Using an inhaler - Following an asthma action plan • Taking medications as prescribed • Counseling on the right way to use controller medications • Physical activity • Maintaining overall health <ul style="list-style-type: none"> - Regular follow-up with providers - Resources and tools for asthma • Using durable medical equipment as needed
Diabetes	<ul style="list-style-type: none"> • Understanding diabetes, including the need for: <ul style="list-style-type: none"> - Testing to measure your average blood sugar level - Cholesterol testing - Need for annual eye exam - Managing blood pressure - Monitoring kidney disease • Symptoms and treatment of high and low blood sugar • Nutrition guidance <ul style="list-style-type: none"> - Setting healthy eating goals - Importance of meal planning • Physical activity • Taking medications as prescribed

Disease	Topics Covered
Diabetes (Cont.)	<ul style="list-style-type: none"> • Maintaining overall health <ul style="list-style-type: none"> - Sick day plan - Preventive diabetic screenings - Resources and tools for diabetes • Provision of durable medical equipment as needed <ul style="list-style-type: none"> - Blood glucose monitoring – glucometers - Scales - Blood pressure cuffs
Coronary Artery Disease (CAD)	<ul style="list-style-type: none"> • Understanding CAD, including the need for cholesterol screening • Symptoms and treatment of CAD • Nutrition guidance <ul style="list-style-type: none"> - Setting healthy eating goals - Following a low-salt diet • Taking medications as prescribed • Physical activity <ul style="list-style-type: none"> - Tips for staying active • Maintaining overall health <ul style="list-style-type: none"> - Regular follow-up with providers - Managing risk factors <ul style="list-style-type: none"> ◇ Smoking ◇ Cholesterol ◇ Blood pressure ◇ Stress - Resources and tools for CAD • Durable medical equipment when needed <ul style="list-style-type: none"> - Blood pressure cuffs - Scales

Disease	Topics Covered
Congestive Heart Failure (CHF)	<ul style="list-style-type: none"> • Understanding CHF • Symptoms and treatment of CHF • Nutrition guidance <ul style="list-style-type: none"> - Setting healthy eating goals - Following a low sodium diet • Taking medications as prescribed • Evaluation for and counseling on the appropriate use of Angiotensin Converting Enzyme Inhibitors (ACE inhibitors) and Angiotensin II receptor blockers (ARBs) • Physical activity <ul style="list-style-type: none"> - Tips for staying active • Maintaining overall health <ul style="list-style-type: none"> - Regular follow-up with providers - Resources and tools for CHF • Durable medical equipment as needed <ul style="list-style-type: none"> - Scales - Blood pressure cuffs
Chronic Obstructive Pulmonary Disease (COPD)	<ul style="list-style-type: none"> • Understanding COPD • Avoiding triggers • Self-monitoring <ul style="list-style-type: none"> - Using an inhaler • Taking medications as prescribed • Using controller medications • Maintaining overall health <ul style="list-style-type: none"> - Regular follow-up with providers - Quitting smoking - Resources and tools for COPD • Durable medical equipment when needed <ul style="list-style-type: none"> - Oxygen

Disease	Topics Covered
High Blood Pressure (Hypertension)	<ul style="list-style-type: none"> • Understanding blood pressure • Treating high blood pressure • Nutrition guidance <ul style="list-style-type: none"> - Setting healthy eating goals • Taking medications as prescribed • Physical activity <ul style="list-style-type: none"> - Tips for staying active • Maintaining overall health <ul style="list-style-type: none"> - Regular follow-up with providers - Managing risk factors <ul style="list-style-type: none"> ◇ Smoking ◇ Stress - Tools for managing high blood pressure • Durable medical equipment as needed • Blood pressure cuffs • Scales
Smoking Cessation	<ul style="list-style-type: none"> • Learning about your smoking triggers • Preparing to quit • Quit plan • Quit methods • Nicotine replacement • Finding support • Getting through withdrawal • Staying smoke-free
Weight Management	<ul style="list-style-type: none"> • Preparing to lose weight • Weight-loss goals • Weight management plan • Nutrition • Physical activity

Would you like to learn more about this program? Please call Disease Management at **1-866-635-7045** (TTY: **711**).

Prescriptions

You will need to get your prescriptions from providers in our plan's network. You can go to any pharmacy in our network to get them filled.

Our Provider Directory lists the pharmacies in our health plan. You can search for a network pharmacy using the *Find a Provider* tool at www.wellcare.com/New-Jersey/Find-a-Provider. You can also call Member Services at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m. At the pharmacy, you may need to show your ID card to pick up your prescription. Some covered drugs may have a co-pay for NJ FamilyCare Plan C and D members. Please see the *Services Covered by WellCare* section starting on **Page 28** to learn more.

Remember to ask your provider and pharmacist about generic drugs.

Generic drugs work the same as brand-name drugs. They have the same active ingredients but usually cost less. In some cases, we may require you to use the generic version of a drug that is prescribed for you instead of the brand name. However, if the brand name version of the drug is medically necessary, your prescribing provider can ask us to approve it.

Preferred Drug List

We have a Preferred Drug List (PDL). Doctors and pharmacists create this list of drugs. Our providers use this list when they prescribe a drug. Our PDL is at www.wellcare.com/New-Jersey/Members/Medicaid-Plans/NJ-FamilyCare/Pharmacy-Services. The PDL includes drugs that may be subject to:

- Prior authorization;
- Step therapy; and
- Quantity limits;
- Age or gender limits.

Sometimes your provider will need to send us a Coverage Determination Request (CDR). This is for drugs that need prior authorization. It is also used for drugs not on our PDL. We allow a pharmacy to give you a 72-hour supply of any drug that needs a prior authorization, while you wait for a prior authorization decision. This can be obtained whether or not the drug is on our PDL.

We will not cover some drugs, including:

- Those used for weight loss;
- Those used to help you get pregnant;
- Those used for erectile dysfunction;
- Those that are for cosmetic purposes or to help you grow hair;
- DESI (Drug Efficacy Study Implementation) drugs and drugs that are identical, related or similar to such drugs;
- Investigational drugs or experimental use; and
- Those used for any purpose that is not medically accepted.

In most cases, you do not need a prior authorization for prescriptions ordered for Mental Health or Substance Use Disorder (SUD)-related conditions. Exceptions include:

- If the prescribed drug is not related to your behavioral health or SUD-related conditions; or
- If the prescribed drug does not conform to the formulary rules.

Can I get any medication I want?

All drugs your providers prescribe for you may be covered if they are on our PDL. You may need pre-approval if your provider prescribes drugs not on our PDL or makes a change in your medication treatment plan.

Some medications might have step therapy requirements. This means you may need to try another drug before we approve the one your provider asked for first. We may not approve the requested drug if you do not try the other drug first unless your provider tells us why it is medically necessary for you to have the other drug. You may appeal our decision if we deny a medication. Your provider can start this process for you.

Over-the-Counter (OTC) Drugs

You can get some OTC drugs at the pharmacy with a prescription. Some of the OTC drugs we cover include:

- Diphenhydramine;
- Meclizine;
- H2 receptor antagonists;
- Ibuprofen;
- Multi-vitamins/multivitamins with iron;
- Insulin syringes;
- Non-sedating antihistamines;
- Iron supplements;
- Dental care products such as toothbrushes, toothpaste, dental floss, mouthwash and other products;
- Topical antifungals;
- Urine test strips;
- Coated aspirin;
- Antacids; and
- Proton pump inhibitors.

Pharmacy Lock-In

You may see different providers for your care. Each provider may prescribe a different drug for you. This can be dangerous. To help with this, we have a Pharmacy Lock-In program.

This helps coordinate your drug and medical care needs. If we think our pharmacy lock-in program would help you, we will restrict you to a single pharmacy and/or provider for a certain period of time. We will send you a letter if we do this. We will also tell your PCP.

Here is how it works:

- You get all of your prescriptions from one pharmacy and/or one provider. It helps the pharmacist understand your prescription needs;
- A 72-hour emergency supply of medication at pharmacies other than the assigned lock-in pharmacy is permitted to assure the delivery of necessary medication required; and

- In an interim/urgent basis when the assigned pharmacy does not immediately have the medication, you can get a 72-hour emergency supply at another pharmacy.

If you are enrolled in the Lock-In Program, you can change pharmacies and/or Primary Care Provider for valid reasons such as traveling, relocation, or if your medication is out of stock at the assigned pharmacy. The unassigned pharmacy must contact the pharmacy help desk on your behalf to get a temporary override or to help you with being reassigned to a new pharmacy.

- What if you do not agree with the lock-in decision? In that case, you can file an appeal with us by calling us at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m. or writing to:



WellCare of New Jersey
Pharmacy Department
P.O. Box 31397
Tampa, FL 33631-3397

You have up to 60 calendar days from the date on the letter we send you about your lock-in status to request an appeal. NJ FamilyCare Plan A and ABP members can also request a Medicaid Fair Hearing. Those members have up to 20 calendar days from the date on the letter we send you about your lock-in status to request a Medicaid Fair Hearing (please note that this is shorter than the usual 120 days available to request a Fair Hearing during other types of appeal). If you plan to request both an appeal and a Medicaid Fair Hearing, you should request them at the same time.

Do you have other questions about our lock-in program? Please call us at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.

Transition of Care

Making sure you get the care you need is important to us. We will work with you to make sure you get your health care services, whether:

- You are leaving another health plan and just starting with us;
- One of your providers leaves our network;
- You transition from Medicaid Fee-for-Service (FFS) to our Plan; or
- You are transitioning to adulthood and need help choosing an adult primary care provider (PCP).

You may already be receiving ongoing care from a provider who is not in our network. In this case, you can keep getting care from that provider. This can continue for a transitional period or until you are seen by your PCP and a new plan of care is created.

Please call Member Services to help arrange your care. Call **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.

Transportation

To arrange for any non-emergency transport, please call LogistiCare (NJ FamilyCare's transportation vendor) at **1-866-527-9933**. If you need assistance scheduling transportation, you can contact your PCP for help, or call Member Services toll-free at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.

- All rides must be for a medical service, like a provider visit or dialysis.
- For routine appointments, you must ask for a ride at least 2 business days before you need it
- Please have the following ready when you call for a ride:
 - Your NJ FamilyCare ID number, found on your Health Benefits Identification (HBID) card;
 - Your pick-up address and ZIP code;
 - Name, phone number and address of medical provider you are seeing;
 - Appointment time and date; and
 - A list of any special transportation needs you may have.
- Please be ready and waiting at least 15 minutes before your ride is scheduled.

Planning Your Care

We want to tell you about prevention and planning for your care needs.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

All members younger than 21 years, including those receiving Managed Long Term Services and Supports, are entitled to receive any medically necessary service, including (but not limited to):

- Physician and hospital services;
- Home care services (including personal care and private duty nursing);
- Medical equipment and supplies;
- Rehabilitative services;
- Vision care, hearing services, and dental care; and
- Any other type of remedial care recognized under state law or specified by the Secretary of the Department of Health and Human Services.

Our plan's coverage of these services is based upon medical necessity and isn't limited in amount, scope or duration, regardless of the limits that normally apply to members 21 or older. When a member younger than 21 requires a medically necessary service that is not listed as part of the standard benefit package, the member or their authorized representative should call us at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m. so that we can make sure that the service can be appropriately delivered and coordinated.

For NJ FamilyCare B, C, and D members, coverage includes all preventive screening and diagnostic services, medical examinations, immunizations, dental, vision, lead screening, and hearing services. However, coverage for treatment services that are identified as necessary through examinations or screenings is limited to services that are included under our plan's benefit package, or specified services through the Medicaid Fee-for-Service (FFS) program.

Services covered under EPSDT include:

- A comprehensive health and developmental history, including assessments of both physical and mental health development as well as any diagnostic and treatment services that are medically necessary to correct or improve a physical or mental condition identified during a screening visit;
- A comprehensive unclothed physical exam including vision and hearing screening, dental inspection, and nutritional assessment;
- Behavioral health assessment;
- Growth and development chart;
- Vision, hearing and language screening;
- Nutritional health and education;
- Lead risk assessment and testing, as appropriate;
- Age-appropriate immunizations;
- Appropriate laboratory tests;
- Dental screening by PCP and referral to a dentist for a dental visit by age 1;
- Referral to specialists and treatment, as appropriate;
- Any needed services as part of a treatment plan that is approved as medically necessary by us; and
- Preventive dental visits as directed by the Primary Care Dentist (PCD), as well as all needed treatment services.

The well-child check-up is an important part of the EPSDT program. Your child's PCP will:

- Do a comprehensive head-to-toe physical and behavioral health exam;
- Give any needed immunizations (shots);
- Do any needed blood and urine tests;
- Look into your child's mouth and check his or her teeth;
- Test your child for tuberculosis (TB) and lead (when age appropriate);
- Give you health tips and education based on your child's age;
- Talk to you about your child's growth, development and eating habits; and
- Measure your child's height, weight, blood pressure, vision and hearing.

These well-child check-ups are done at certain ages. (We will talk about these later in this section.) It is crucial that you get your child these exams. They can help to find health concerns before they get bigger. Also, your child can get his or her needed shots.

Do you need help to set up a visit? Please call Member Services at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m. Do you need to cancel the appointment? Please reschedule it as soon as you can.

Preventive Health Guidelines

Making regular use of preventive medical and dental services is an important way to stay healthy. You should see your PCP on a regular basis and be sure to get the screenings and tests that are recommended for you. You should also see your dentist on a regular basis twice a year (or as recommended) for oral exams, any necessary X-rays, dental cleanings, and fluoride treatments. The guidelines in the charts that follow show recommendations for when you should get certain preventive tests, screenings or other services. Please keep in mind that these are recommendations, and that they do not take the place of your PCP's judgment. Always talk with your PCP about the care that is right for you and your family.

Age	Screening	Frequency
18 and older	Blood Pressure, Height and Weight	Every year
20–35 years	Cholesterol	Every 5 years
35 years and older	Cholesterol	Every year
Female 20 years and older	Pap Smear	Every 3 years
Female 24 years and younger	Chlamydia	Once a year
Female 35–39 years	Mammogram	One test to set a baseline for later screenings
Female 40 years and older	Mammogram	Once a year
45 years and older	Colorectal Cancer	Initially at age 45, then per provider recommendations

Your Health Plan

Age	Screening	Frequency
40 years and older if you have family history of cancer or other risk factors	Prostate Cancer	Once a year
50 years and older	Prostate Cancer	Once a year
50 years and older	Hearing	Every 3 years
Female 65 years and older	Osteoporosis	Every 2 years
65 years and older	Vision	Every 2 years

Immunization-Screening Recommendations for Adults

Tetanus-diphtheria and acellular pertussis (Td/Tdap)	18 years and older, Tdap: once, if you have never previously received a dose of the vaccine. Then a Td booster vaccine every 10 years
Varicella (VZV)	All adults who have not had chicken pox should receive 2 doses of single-antigen varicella vaccine if not previously vaccinated or the second dose if they have received only 1 dose.
Measles, mumps, rubella (MMR)	1 or 2 doses. Adults born during or after 1957 who do not have a record of being vaccinated or having had these infections, talk to your PCP.
Pneumococcal polysaccharide (PPSV)	For adults 65 years and older, all adults who smoke or have certain chronic medical conditions – 1 dose. May need a second dose if identified at risk.
Seasonal influenza	All adults annually
Hepatitis A vaccine (HepA)	All unvaccinated individuals who anticipate close contact with an international adoptee or those with certain high-risk behaviors.
Hepatitis B vaccine (HepB)	Adults at risk, 18 years and older – 3 doses

Immunization-Screening Recommendations for Adults	
Meningococcal conjugate vaccine (MCV)	Ask your physician for more information
Herpes Zoster (Shingles)	Age 60 and older
Haemophilus influenza type b (Hib)	For eligible members who are at high-risk and who have not previously received Hib vaccine – 1 dose, talk to your PCP

Pediatric Preventive Health Guidelines (Newborn to 21 Years of Age)

These guidelines are suggestions only. You may need other services.

Age	Screening and Timing
Newborn	Well-baby* check-up at birth Hearing test Newborn screening blood tests
2–4 days	Well-baby check-up if discharged less than 48 hours after delivery Newborn screening blood tests
1 month	Well-baby check-up Newborn screening blood test if not already completed
2 months	Well-baby check-up Newborn screening blood test if not already completed
4 months	Well-baby check-up
6 months	Well-baby check-up
9 months	Well-baby check-up Lab testing: blood lead
12 months (1 year)	Well-baby check-up Lab testing: blood lead, hemoglobin or hematocrit First dental exam** and preventive dental visits
15 months	Well-baby check-up Lab testing: urine and blood lead if not done at 9 months or 12 months

Your Health Plan

Age	Screening and Timing
18 months	Well-baby check-up Dental visit
24 months (2 years)	Well-baby check-up Lab testing: blood lead Dental visits twice a year or as recommended by Primary Care Dentist (PCD)
3 years	Well-child* check-up Eye screening Dental visits twice a year or as recommended by Primary Care Dentist (PCD)
4 and 5 years	Well-child check-up each year Eye screening Lab testing: urine test at age 5 years Dental visits twice a year or as recommended by Primary Care Dentist (PCD)
6–10 years	Well-child check-up every year Dental visits twice a year or as recommended by Primary Care Dentist (PCD)
11 and 12 years	Well-child check-up every year Dental visits twice a year or as recommended by Primary Care Dentist (PCD)
13–21 years	Well-adolescent* check-up every year Females should have a pelvic exam and Pap smear between ages 18 and 21 years Lab testing: urine by age 16 Dental visits twice a year or as recommended by Primary Care Dentist (PCD)

**Well-baby, well-child and well-adolescent check-ups/physical exams consist of an exam with infant totally undressed or older child undressed and suitably covered, health history, developmental and behavioral assessment, health education (sleep position counseling from birth through 9 months, injury/violence prevention and nutrition counseling), height, weight, test for obesity (BMI), vision, dental and hearing screening, head circumference at birth through 24 months and blood pressure at least every year beginning at age 3.*

**Regular dental visits are recommended to begin by age 1. Be sure to keep your appointments and complete all recommended treatment.

These services are provided as needed:

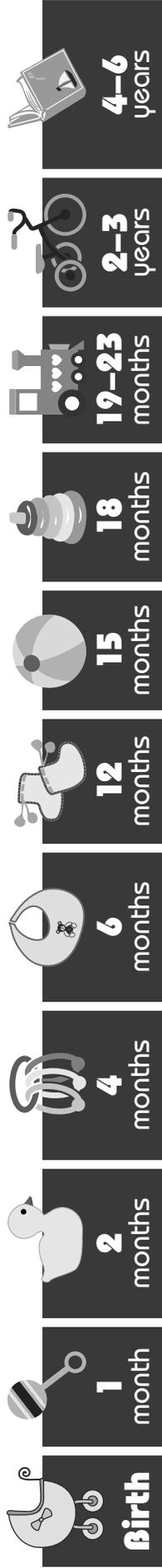
- Hemoglobin or hematocrit at ages 4, 18, and 24 months and ages 3 years through 21 years;
- Lead risk assessment and/or tests from age 6 months to age 6 years;
- Tuberculosis risk assessment and/or tests from age 12 months through age 21 years;
- Heart disease risk assessments and cholesterol tests from age 2 years through age 21 years;
- Sexually transmitted infections test from age 11 years through age 21 years; and
- “Catch up” on any shots that have been missed at an earlier age.

Legal Disclaimer: Always talk with your provider(s) about the care that is right for you. This material does not replace your provider’s advice. It is based on third-party sources. We present it for your information only. Also, WellCare does not guarantee any health results.

Pediatric Immunization Guidelines

The guidelines on the next few pages are from the Centers for Disease Control and Prevention (CDC). You can also find these on the CDC website at www.cdc.gov. Do you have any questions? Please talk with your child’s PCP.

2020 Recommended Immunizations for Children from Birth Through 6 Years Old



Age	Recommended Immunizations
Birth	HepB
1 month	HepB
2 months	RV, DTaP, Hib, PCV13, IPV
4 months	RV, DTaP, Hib, PCV13, IPV
6 months	RV, DTaP, Hib, PCV13, IPV
12 months	HepB, Hib, PCV13, IPV
15 months	DTaP, Hib, PCV13, IPV
18 months	DTaP, Hib, PCV13, IPV
19-23 months	DTaP, Hib, PCV13, IPV
2-3 years	MMR, Varicella
4-6 years	MMR, Varicella

Is your family growing? To protect your new baby against whooping cough, get a Tdap vaccine. The recommended time is the 27th through 36th week of pregnancy. Talk to your doctor for more details.

 Shaded boxes indicate the vaccine can be given during shown age range.

NOTE: If your child misses a shot, you don't need to start over. Just go back to your child's doctor for the next shot. Talk with your child's doctor if you have questions about vaccines.

FOOTNOTES:
 * Two doses given at least four weeks apart are recommended for children age 6 months through 8 years of age who are getting an influenza (flu) vaccine for the first time and for some other children in this age group.
 † Two doses of HepA vaccine are needed for lasting protection. The first dose of HepA vaccine should be given between 12 months and 23 months of age. The second dose should be given 6 months after the first dose. All children and adolescents over 24 months of age who have not been vaccinated should also receive 2 doses of HepA vaccine.
 If your child has any medical conditions that put him at risk for infection or is traveling outside the United States, talk to your child's doctor about additional vaccines that he or she may need.

See back page for more information on vaccine-preventable diseases and the vaccines that prevent them.

For more information, call toll-free
1-800-CDC-INFO (1-800-232-4636)
 or visit
www.cdc.gov/vaccines/parents



U.S. Department of Health and Human Services
 Centers for Disease Control and Prevention



American Academy of Pediatrics
 DEDICATED TO THE HEALTH OF ALL CHILDREN™

Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Disease	Vaccine	Disease spread by	Disease symptoms	Disease complications
Chickenpox	Varicella vaccine protects against chickenpox.	Air, direct contact	Rash, tiredness, headache, fever	Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs)
Diphtheria	DTaP* vaccine protects against diphtheria.	Air, direct contact	Sore throat, mild fever, weakness, swollen glands in neck	Swelling of the heart muscle, heart failure, coma, paralysis, death
Hib	Hib vaccine protects against <i>Haemophilus influenzae</i> type b.	Air, direct contact	May be no symptoms unless bacteria enter the blood	Meningitis (infection of the covering around the brain and spinal cord), intellectual disability, epiglottitis (life-threatening infection that can block the windpipe and lead to serious breathing problems), pneumonia (infection in the lungs), death
Hepatitis A	HepA vaccine protects against hepatitis A.	Direct contact, contaminated food or water	May be no symptoms, fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine	Liver failure, arthralgia (joint pain), kidney, pancreatic and blood disorders
Hepatitis B	HepB vaccine protects against hepatitis B.	Contact with blood or body fluids	May be no symptoms, fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain	Chronic liver infection, liver failure, liver cancer
Influenza (Flu)	Flu vaccine protects against influenza.	Air, direct contact	Fever, muscle pain, sore throat, cough, extreme fatigue	Pneumonia (infection in the lungs)
Measles	MMR** vaccine protects against measles.	Air, direct contact	Rash, fever, cough, runny nose, pink eye	Encephalitis (brain swelling), pneumonia (infection in the lungs), death
Mumps	MMR** vaccine protects against mumps.	Air, direct contact	Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain	Meningitis (infection of the covering around the brain and spinal cord), encephalitis (brain swelling), inflammation of testicles or ovaries, deafness
Pertussis	DTaP* vaccine protects against pertussis (whooping cough).	Air, direct contact	Severe cough, runny nose, apnea (a pause in breathing in infants)	Pneumonia (infection in the lungs), death
Polio	IPV vaccine protects against polio.	Air, direct contact, through the mouth	May be no symptoms, sore throat, fever, nausea, headache	Paralysis, death
Pneumococcal	PCV13 vaccine protects against pneumococcus.	Air, direct contact	May be no symptoms, pneumonia (infection in the lungs)	Bacteremia (blood infection), meningitis (infection of the covering around the brain and spinal cord), death
Rotavirus	RV vaccine protects against rotavirus.	Through the mouth	Diarrhea, fever, vomiting	Severe diarrhea, dehydration
Rubella	MMR** vaccine protects against rubella.	Air, direct contact	Sometimes rash, fever, swollen lymph nodes	Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, birth defects
Tetanus	DTaP* vaccine protects against tetanus.	Exposure through cuts in skin	Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever	Broken bones, breathing difficulty, death

* DTaP combines protection against diphtheria, tetanus, and pertussis.

** MMR combines protection against measles, mumps, and rubella.

Talk to your child’s doctor or nurse about the vaccines recommended for their age.

	Flu Influenza	Tdap Tetanus, diphtheria, pertussis	HPV Human papillomavirus	Meningococcal		Pneumococcal	Hepatitis B	Hepatitis A	Polio	MMR Measles, mumps, rubella	Chickenpox Varicella
				MenACWY	MenB						
7-8 Years	Shaded	Shaded				Shaded	Shaded	Shaded	Shaded	Shaded	Shaded
9-10 Years			Shaded			Shaded	Shaded	Shaded	Shaded	Shaded	Shaded
11-12 Years		Shaded	Shaded			Shaded	Shaded	Shaded	Shaded	Shaded	Shaded
13-15 Years			Shaded			Shaded	Shaded	Shaded	Shaded	Shaded	Shaded
16-18 Years					Shaded	Shaded	Shaded	Shaded	Shaded	Shaded	Shaded

More information: Everyone 6 months and older should get a flu vaccine every year.

All 11- through 12- year olds should get one shot of Tdap.

All 11- through 12- year olds should get a 2-shot series of HPV vaccine. A 3-shot series is needed for those with weakened immune systems and those who start the series at 15 years or older.

All 11- through 12- year olds should get one shot of meningococcal conjugate (MenACWY). A booster shot is recommended at age 16.

Teens 16–18 years old **may** be vaccinated with a serogroup B meningococcal (MenB) vaccine.

 These shaded boxes indicate when the vaccine is recommended for all children unless your doctor tells you that your child cannot safely receive the vaccine.

 These shaded boxes indicate the vaccine should be given if a child is catching up on missed vaccines.

 These shaded boxes indicate the vaccine is recommended for children with certain health or lifestyle conditions that put them at an increased risk for serious diseases. See vaccine-specific recommendations at www.cdc.gov/vaccines/hcp/acip-recs/.

 This shaded box indicates children not at increased risk may get the vaccine if they wish after speaking to a provider.



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Disease	Vaccine	Disease spread by	Disease symptoms	Disease complications
Chickenpox	Varicella vaccine protects against chickenpox.	Air, direct contact	Rash, tiredness, headache, fever	Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs)
Diphtheria	Tdap* and Td** vaccines protect against diphtheria.	Air, direct contact	Sore throat, mild fever, weakness, swollen glands in neck	Swelling of the heart muscle, heart failure, coma, paralysis, death
Hepatitis A	HepA vaccine protects against hepatitis A.	Direct contact, contaminated food or water	May be no symptoms, fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine	Liver failure, arthralgia (joint pain), kidney, pancreatic and blood disorders
Hepatitis B	HepB vaccine protects against hepatitis B.	Contact with blood or body fluids	May be no symptoms, fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain	Chronic liver infection, liver failure, liver cancer
Human Papillomavirus	HPV vaccine protects against human papillomavirus.	Direct skin contact	May be no symptoms, genital warts	Cervical, vaginal, vulvar, penile, anal, oropharyngeal cancers
Influenza (Flu)	Flu vaccine protects against influenza.	Air, direct contact	Fever, muscle pain, sore throat, cough, extreme fatigue	Pneumonia (infection in the lungs)
Measles	MMR*** vaccine protects against measles.	Air, direct contact	Rash, fever, cough, runny nose, pink eye	Encephalitis (brain swelling), pneumonia (infection in the lungs), death
Meningococcal Disease	MenACWY and MenB vaccines protect against meningococcal disease.	Air, direct contact	Sudden onset of fever, headache, and stiff neck, dark purple rash	Loss of limb, deafness, nervous system disorders, developmental disabilities, seizure disorder, stroke, death
Mumps	MMR*** vaccine protects against mumps.	Air, direct contact	Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain	Meningitis (infection of the covering around the brain and spinal cord), encephalitis (brain swelling), inflammation of testicles or ovaries, deafness
Pertussis	Tdap* vaccine protects against pertussis.	Air, direct contact	Severe cough, runny nose, apnea (a pause in breathing in infants)	Pneumonia (infection in the lungs), death
Pneumococcal Disease	Pneumococcal vaccine protects against pneumococcal disease.	Air, direct contact	May be no symptoms, pneumonia (infection in the lungs)	Bacteremia (blood infection), meningitis (infection of the covering around the brain and spinal cord), death
Polio	Polio vaccine protects against polio.	Air, direct contact, through the mouth	May be no symptoms, sore throat, fever, nausea, headache	Paralysis, death
Rubella	MMR*** vaccine protects against rubella.	Air, direct contact	Sometimes rash, fever, swollen lymph nodes	Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, birth defects
Tetanus	Tdap* and Td** vaccines protect against tetanus.	Exposure through cuts on skin	Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever	Broken bones, breathing difficulty, death

*Tdap combines protection against diphtheria, tetanus, and pertussis.

**Td combines protection against diphtheria and tetanus.

***MMR combines protection against measles, mumps, and rubella.

If you have any questions about your child's vaccines, talk to your child's doctor or nurse.

Recommended Adult Immunization Schedule for ages 19 years or older

UNITED STATES
2020

How to use the adult immunization schedule

- 1** Determine recommended vaccinations by age (**Table 1**)
- 2** Assess need for additional recommended vaccinations by medical condition and other indications (**Table 2**)
- 3** Review vaccine types, frequencies, and intervals and considerations for special situations (**Notes**)

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/acip) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American College of Physicians (www.acponline.org), American Academy of Family Physicians (www.aafp.org), American College of Obstetricians and Gynecologists (www.acog.org), and American College of Nurse-Midwives (www.midwife.org).

Vaccines in the Adult Immunization Schedule*

Vaccines	Abbreviations	Trade names
<i>Haemophilus influenzae</i> type b vaccine	Hib	ActHIB® Hiberix® PedvaxHIB®
Hepatitis A vaccine	HepA	Havrix® Vaqta®
Hepatitis A and hepatitis B vaccine	HepA-HepB	Twinrix®
Hepatitis B vaccine	HepB	Engerix-B® Recombivax HB® Hepelisav-B®
Human papillomavirus vaccine	HPV vaccine	Gardasil 9®
Influenza vaccine (inactivated)	IIV	Many brands
Influenza vaccine (live, attenuated)	LAIV	FluMist® Quadrivalent
Influenza vaccine (recombinant)	RIV	Flublok® Quadrivalent
Measles, mumps, and rubella vaccine	MMR	M-M-R® II
Meningococcal serogroups A, C, W, Y vaccine	MenACWY	Menactra® Menveo®
Meningococcal serogroup B vaccine	MenB-4C MenB-FHbp	Bexsero® Trumenba®
Pneumococcal 13-valent conjugate vaccine	PCV13	Prenar 13®
Pneumococcal 23-valent polysaccharide vaccine	PPSV23	Pneumovax® 23
Tetanus and diphtheria toxoids	Td	Tenivac® Tdvax™
Tetanus and diphtheria toxoids and acellular pertussis vaccine	Tdap	Adacel® Boostrix®
Varicella vaccine	VAR	Varivax®
Zoster vaccine, recombinant	RZV	Shingrix
Zoster vaccine live	ZVL	Zostavax®

*Administer recommended vaccines if vaccination history is incomplete or unknown. Do not restart or add doses to vaccine series if there are extended intervals between doses. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to the local or state health department
- Clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System at www.vaers.hhs.gov or 800-822-7967

Injury claims

All vaccines included in the adult immunization schedule except pneumococcal 23-valent polysaccharide (PPSV23) and zoster (RZV, ZVL) vaccines are covered by the Vaccine Injury Compensation Program. Information on how to file a vaccine injury claim is available at www.hrsa.gov/vaccinecompensation.

Questions or comments

Contact www.cdc.gov/cdc-info or 800-CDC-INFO (800-232-4636), in English or Spanish, 8 a.m.–8 p.m. ET, Monday through Friday, excluding holidays.



Download the CDC Vaccine Schedules App for providers at www.cdc.gov/vaccines/schedules/hcp/schedule-app.html.

Helpful information

- Complete ACIP recommendations: www.cdc.gov/vaccines/hcp/acip-recs/index.html
- General Best Practice Guidelines for Immunization (including contraindications and precautions): www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
- Vaccine information statements: www.cdc.gov/vaccines/hcp/vis/index.html (including case identification and outbreak response): www.cdc.gov/vaccines/pubs/surv-manual
- Travel vaccine recommendations: www.cdc.gov/travel
- Recommended Child and Adolescent Immunization Schedule, United States, 2020: www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Table 1

Recommended Adult Immunization Schedule by Age Group, United States, 2020

Vaccine	19–26 years	27–49 years	50–64 years	≥65 years
Influenza inactivated (IIV) or Influenza recombinant (RIV) or		1 dose annually		
Influenza live, attenuated (LAIV)		1 dose annually		
Tetanus, diphtheria, pertussis (Tdap or Td)		1 dose Tdap, then Td or Tdap booster every 10 years		
Measles, mumps, rubella (MMR)		1 or 2 doses depending on indication (if born in 1957 or later)		
Varicella (VAR)		2 doses (if born in 1980 or later)	2 doses	
Zoster recombinant (RZV) (preferred) or			2 doses	
Zoster live (ZVL)			1 dose	
Human papillomavirus (HPV)	2 or 3 doses depending on age at initial vaccination or condition	27 through 45 years		
Pneumococcal conjugate (PCV13)		1 dose		65 years and older
Pneumococcal polysaccharide (PPSV23)		1 or 2 doses depending on indication		1 dose
Hepatitis A (HepA)		2 or 3 doses depending on vaccine		
Hepatitis B (HepB)		2 or 3 doses depending on vaccine		
Meningococcal A, C, W, Y (MenACWY)		1 or 2 doses depending on indication, see notes for booster recommendations		
Meningococcal B (MenB)	19 through 23 years	2 or 3 doses depending on vaccine and indication, see notes for booster recommendations		
Haemophilus influenzae type b (Hib)		1 or 3 doses depending on indication		

Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection

Recommended vaccination for adults with an additional risk factor or another indication

Recommended vaccination based on shared clinical decision-making

No recommendation/Not applicable

Table 2

Recommended Adult Immunization Schedule by Medical Condition and Other Indications, United States, 2020

Vaccine	Pregnancy	Immuno-compromised (excluding HIV infection)	HIV infection CD4 count		Asplenia, complement deficiencies	End-stage renal disease; or on hemodialysis	Heart or lung disease, alcoholism ¹	Chronic liver disease	Diabetes	Health care personnel ²	Men who have sex with men
			<200	≥200							
IIV or RIV or LAIV											1 dose annually or 1 dose annually
Tdap or Td	1 dose Tdap each pregnancy										1 dose Tdap, then Td or Tdap booster every 10 years
MMR		NOT RECOMMENDED									1 or 2 doses depending on indication
VAR		NOT RECOMMENDED									2 doses
RZV (preferred) or ZVL	DELAY										2 doses at age ≥50 years or 1 dose at age ≥60 years
	NOT RECOMMENDED										
HPV	DELAY	3 doses through age 26 years									2 or 3 doses through age 26 years
PCV13											1 dose
PPSV23											1, 2, or 3 doses depending on age and indication
HepA											2 or 3 doses depending on vaccine
HepB											2 or 3 doses depending on vaccine
MenACWY											1 or 2 doses depending on indication, see notes for booster recommendations
MenB	PRECAUTION										2 or 3 doses depending on vaccine and indication, see notes for booster recommendations
Hib		3 doses HSCT ³ recipients only									1 dose

Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection
 Recommended vaccination for adults with an additional risk factor or another indication
 Precaution—vaccination might be indicated if benefit of protection outweighs risk of adverse reaction
 Delay vaccination until after pregnancy if vaccine is indicated
 Not recommended/contraindicated—vaccine should not be administered
 No recommendation/Not applicable

1. Precaution for LAIV does not apply to alcoholism. 2. See notes for influenza; hepatitis B; measles, mumps, and rubella; and varicella vaccinations. 3. Hematopoietic stem cell transplant.

Notes

Recommended Adult Immunization Schedule, United States, 2020

***Haemophilus influenzae* type b vaccination**

Special situations

- **Anatomical or functional asplenia (including sickle cell disease):** 1 dose if previously did not receive Hib; if elective splenectomy, 1 dose, preferably at least 14 days before splenectomy
- **Hematopoietic stem cell transplant (HSCT):** 3-dose series 4 weeks apart starting 6–12 months after successful transplant, regardless of Hib vaccination history

Hepatitis A vaccination

Routine vaccination

- **Not at risk but want protection from hepatitis A** (identification of risk factor not required): 2-dose series HepA (Havrix 6–12 months apart or Vaqta 6–18 months apart [minimum interval: 6 months]) or 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: 4 weeks between doses 1 and 2/5 months between doses 2 and 3])

Special situations

- **At risk for hepatitis A virus infection:** 2-dose series HepA or 3-dose series HepA-HepB as above
- **Chronic liver disease** (e.g., persons with hepatitis B, hepatitis C, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase [ALT] or aspartate aminotransferase [AST] level greater than twice the upper limit of normal)
- **HIV infection**
- **Men who have sex with men**
- **Injection or noninjection drug use**
- **Persons experiencing homelessness**
- **Work with hepatitis A virus** in research laboratory or with nonhuman primates with hepatitis A virus infection
- **Travel in countries with high or intermediate endemic hepatitis A**
- **Close, personal contact with international adoptee** (e.g., household or regular babysitting) in first 60 days after arrival from country with high or intermediate endemic hepatitis A (administer dose 1 as soon as adoption is planned, at least 2 weeks before adoptee's arrival)

- **Pregnancy** if at risk for infection or severe outcome from infection during pregnancy
- **Settings for exposure, including** health care settings targeting services to injection or noninjection drug users or group homes and nonresidential day care facilities for developmentally disabled persons (individual risk factor screening not required)

Hepatitis B vaccination

Routine vaccination

- **Not at risk but want protection from hepatitis B** (identification of risk factor not required): 2- or 3-dose series (2-dose series HepB at least 4 weeks apart [2-dose series HepB only applies when 2 doses of HepB are used at least 4 weeks apart] or 3-dose series Engerix-B or Recombivax HB at 0, 1, 6 months [minimum intervals: 4 weeks between doses 1 and 2/8 weeks between doses 2 and 3/16 weeks between doses 1 and 3]) or 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: 4 weeks between doses 1 and 2/5 months between doses 2 and 3])

Special situations

- **At risk for hepatitis B virus infection:** 2-dose (HepB) or 3-dose (Engerix-B, Recombivax HB) series or 3-dose series HepA-HepB (Twinrix) as above
- **Chronic liver disease** (e.g., persons with hepatitis C, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase [ALT] or aspartate aminotransferase [AST] level greater than twice upper limit of normal)
- **HIV infection**
- **Sexual exposure risk** (e.g., sex partners of hepatitis B surface antigen [HBsAg]-positive persons; sexually active persons not in mutually monogamous relationships; persons seeking evaluation or treatment for a sexually transmitted infection; men who have sex with men)
- **Current or recent injection drug use**
- **Percutaneous or mucosal risk for exposure to blood** (e.g., household contacts of HBsAg-positive persons; residents and staff of facilities for developmentally disabled persons; health care and public safety personnel with reasonably anticipated risk for

exposure to blood or blood-contaminated body fluids; hemodialysis, peritoneal dialysis, home dialysis, and predialysis patients; persons with diabetes mellitus age younger than 60 years and, at discretion of treating clinician, those age 60 years or older)

- **Incarcerated persons**
- **Travel in countries with high or intermediate endemic hepatitis B**
- **Pregnancy** if at risk for infection or severe outcome from infection during pregnancy (HepB) not currently recommended due to lack of safety data in pregnant women)

Human papillomavirus vaccination

Routine vaccination

- **HPV vaccination recommended for all adults through age 26 years:** 2- or 3-dose series depending on age at initial vaccination or condition:
- **Age 15 years or older at initial vaccination:** 3-dose series at 0, 1–2, 6 months (minimum intervals: 4 weeks between doses 1 and 2/12 weeks between doses 2 and 3/5 months between doses 1 and 3; repeat dose if administered too soon)
- **Age 9 through 14 years at initial vaccination and received 1 dose or 2 doses less than 5 months apart:** 1 dose
- **Age 9 through 14 years at initial vaccination and received 2 doses at least 5 months apart:** HPV vaccination complete, no additional dose needed.
- **If completed valid vaccination series with any HPV vaccine, no additional doses needed**

Shared clinical decision-making

- **Age 27 through 45 years based on shared clinical decision-making:**
- 2- or 3-dose series as above

Special situations

- **Pregnancy through age 26 years:** HPV vaccination is not recommended until after pregnancy; no intervention needed if vaccinated while pregnant; pregnancy testing not needed before vaccination

Notes

Recommended Adult Immunization Schedule, United States, 2020

Influenza vaccination

Routine vaccination

- **Persons age 6 months or older:** 1 dose any influenza vaccine appropriate for age and health status annually
- For additional guidance, see www.cdc.gov/flu/professionals/index.htm

Special situations

- **Egg allergy, hives only:** 1 dose any influenza vaccine appropriate for age and health status annually
- **Egg allergy more severe than hives** (e.g., angioedema, respiratory distress): 1 dose any influenza vaccine appropriate for age and health status annually in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions
- **LAIW should not be used** in persons with the following conditions or situations:
 - History of severe allergic reaction to any vaccine component (excluding egg) or to a previous dose of any influenza vaccine
 - Immunocompromised due to any cause (including medications and HIV infection)
 - Anatomic or functional asplenia
 - Cochlear implant
 - Cerebrospinal fluid–oropharyngeal communication
 - Close contacts or caregivers of severely immunosuppressed persons who require a protected environment
 - Pregnancy
 - Received influenza antiviral medications within the previous 48 hours

- **History of Guillain-Barré syndrome within 6 weeks of previous dose of influenza vaccine:** Generally should not be vaccinated unless vaccination benefits outweigh risks for those at higher risk for severe complications from influenza

Measles, mumps, and rubella vaccination

Routine vaccination

- **No evidence of immunity to measles, mumps, or rubella:** 1 dose
- **Evidence of immunity:** Born before 1957 (health care personnel, see below), documentation of receipt of MMR vaccine, laboratory evidence of immunity or disease (diagnosis of disease without laboratory confirmation is not evidence of immunity)

Special situations

- **Pregnancy with no evidence of immunity to rubella:** MMR contraindicated during pregnancy; after pregnancy (before discharge from health care facility), 1 dose
- **Nonpregnant women of childbearing age with no evidence of immunity to rubella:** 1 dose
- **HIV infection with CD4 count ≥ 200 cells/ μ L for at least 6 months and no evidence of immunity to measles, mumps, or rubella:** 2-dose series at least 4 weeks apart; MMR contraindicated in HIV infection with CD4 count < 200 cells/ μ L
- **Severe immunocompromising conditions:** MMR contraindicated
- **Students in postsecondary educational institutions, international travelers, and household or close, personal contacts of immunocompromised persons with no evidence of immunity to measles, mumps, or rubella:** 2-dose series at least 4 weeks apart if previously did not receive any doses of MMR or 1 dose if previously received 1 dose MMR
- **Health care personnel:**
 - **Born in 1957 or later with no evidence of immunity to measles, mumps, or rubella:** 2-dose series at least 4 weeks apart for measles or mumps or at least 1 dose for rubella
 - **Born before 1957 with no evidence of immunity to measles, mumps, or rubella:** Consider 2-dose series at least 4 weeks apart for measles or mumps or 1 dose for rubella

Meningococcal vaccination

Special situations for MenACWY

- **Anatomical or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:** 2-dose series MenACWY (Menactra, Menveo) at least 8 weeks apart and revaccinate every 5 years if risk remains
 - **Travel in countries with hyperendemic or epidemic meningococcal disease, microbiologists routinely exposed to *Neisseria meningitidis*:** 1 dose MenACWY (Menactra, Menveo) and revaccinate every 5 years if risk remains
 - **First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) and military recruits:** 1 dose MenACWY (Menactra, Menveo)
- Shared clinical decision-making for MenB**
- **Adolescents and young adults age 16 through 23 years (age 16 through 18 years preferred) not at increased risk for meningococcal disease:** Based on shared clinical decision-making, 2-dose series MenB-4C at least 1 month apart or 2-dose series MenB-FHbp at 0, 6 months (if dose 2 was administered less than 6 months after dose 1, administer dose 3 at least 4 months after dose 2); MenB-4C and MenB-FHbp are not interchangeable (use same product for all doses in series)

Special situations for MenB

- **Anatomical or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use, microbiologists routinely exposed to *Neisseria meningitidis*:** 2-dose primary series MenB-4C (Bexsero) at least 1 month apart or 3-dose primary series MenB-FHbp (Trumenba) at 0, 1–2, 6 months (if dose 2 was administered at least 6 months after dose 1, dose 3 not needed); MenB-4C and MenB-FHbp are not interchangeable (use same product for all doses in series); 1 dose MenB booster 1 year after primary series and revaccinate every 2–3 years if risk remains
- **Pregnancy:** Delay MenB until after pregnancy unless at increased risk and vaccination benefits outweigh potential risks

Pneumococcal vaccination

Routine vaccination

- **Age 65 years or older** (immunocompetent—see www.cdc.gov/mmwr/volumes/68/wr/mm6846a5.htm?s_cid=mm6846a5_w): 1 dose PPSV23
- If PPSV23 was administered prior to age 65 years, administer 1 dose PPSV23 at least 5 years after previous dose

Shared clinical decision-making

- **Age 65 years and older** (immunocompetent): 1 dose PCV13 based on **shared clinical decision-making**
- If both PCV13 and PPSV23 are to be administered, PCV13 should be administered first
- PCV13 and PPSV23 should be administered at least 1 year apart
- PCV13 and PPSV23 should not be administered during the same visit

Special situations

(see www.cdc.gov/mmwr/volumes/68/wr/mm6846a5.htm?s_cid=mm6846a5_w)

- **Age 19 through 64 years with chronic medical conditions (chronic heart [excluding hypertension], lung, or liver disease, diabetes), alcoholism, or cigarette smoking:** 1 dose PPSV23
- **Age 19 years or older with immunocompromising conditions (congenital or acquired immunodeficiency [including B- and T-lymphocyte deficiency, complement deficiencies, phagocytic disorders, HIV infection], chronic renal failure, nephrotic syndrome, leukemia, lymphoma, Hodgkin disease, generalized malignancy, iatrogenic immunosuppression [e.g., drug or radiation therapy], solid organ transplant, multiple myeloma) or anatomical or functional asplenia (including sickle cell disease and other hemoglobinopathies):** 1 dose PCV13 followed by 1 dose PPSV23 at least 8 weeks later, then another dose PPSV23 at least 5 years after previous PPSV23; at age 65 years or older, administer 1 dose PPSV23 at least 5 years after most recent PPSV23 (note: only 1 dose PPSV23 recommended at age 65 years or older)

- **Age 19 years or older with cerebrospinal fluid leak or cochlear implant:** 1 dose PCV13 followed by 1 dose PPSV23 at least 8 weeks later; at age 65 years or older, administer another dose PPSV23 at least 5 years after PPSV23 (note: only 1 dose PPSV23 recommended at age 65 years or older)

Tetanus, diphtheria, and pertussis vaccination

Routine vaccination

- **Previously did not receive Tdap at or after age 11 years:** 1 dose Tdap, then Td or Tdap every 10 years

Special situations

- **Previously did not receive primary vaccination series for tetanus, diphtheria, or pertussis:** At least 1 dose Tdap followed by 1 dose Td or Tdap at least 4 weeks after Tdap and another dose Td or Tdap 6–12 months after last Td or Tdap (Tdap can be substituted for any Td dose, but preferred as first dose); Td or Tdap every 10 years thereafter
- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36
- For information on use of Td or Tdap as tetanus prophylaxis in wound management, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm

Varicella vaccination

Routine vaccination

- **No evidence of immunity to varicella:** 2-dose series 4–8 weeks apart if previously did not receive varicella-containing vaccine (VAR or MMRV [measles-mumps-rubella-varicella vaccine] for children); if previously received 1 dose varicella-containing vaccine, 1 dose at least 4 weeks after first dose
- Evidence of immunity: U.S.-born before 1980 (except for pregnant women and health care personnel [see below]), documentation of 2 doses varicella-containing vaccine at least 4 weeks apart, diagnosis or verification of history of varicella or herpes zoster by a health care provider, laboratory evidence of immunity or disease

Special situations

- **Pregnancy with no evidence of immunity to varicella:** VAR contraindicated during pregnancy; after pregnancy (before discharge from health care facility) 1 dose if previously received 1 dose varicella-containing vaccine or dose 1 of 2-dose series (dose 2: 4–8 weeks later) if previously did not receive any varicella-containing vaccine, regardless of whether U.S.-born before 1980
- **Health care personnel with no evidence of immunity to varicella:** 1 dose if previously received 1 dose varicella-containing vaccine; 2-dose series 4–8 weeks apart if previously did not receive any varicella-containing vaccine, regardless of whether U.S.-born before 1980
- **HIV infection with CD4 count ≥ 200 cells/ μ L with no evidence of immunity:** Vaccination may be considered (2 doses, administered 3 months apart); VAR contraindicated in HIV infection with CD4 count < 200 cells/ μ L
- **Severe immunocompromising conditions:** VAR contraindicated

Zoster vaccination

Routine vaccination

- **Age 50 years or older:** 2-dose series RZV (Shingrix) 2–6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon), regardless of previous herpes zoster or history of ZVL (Zostavax) vaccination (administer RZV at least 2 months after ZVL)
 - **Age 60 years or older:** 2-dose series RZV 2–6 months apart (minimum interval: 4 weeks; repeat if administered too soon) or 1 dose ZVL if not previously vaccinated. RZV preferred over ZVL (if previously received ZVL, administer RZV at least 2 months after ZVL)
- #### Special situations
- **Pregnancy:** ZVL contraindicated; consider delaying RZV until after pregnancy if RZV is otherwise indicated
 - **Severe immunocompromising conditions (including HIV infection with CD4 count < 200 cells/ μ L):** ZVL contraindicated; recommended use of RZV under review

Advance Directives

Many people today worry about the medical care they would get if they became too sick to make their wishes known. Some people may not want to spend months or years on life support. Others may want every step taken to lengthen their lives.

It is a good idea to make an advance directive. An advance directive is a legal document in which you state instructions about your medical care. This document can help your family and doctors know how to treat you if you can't say what you want or speak for yourself if you become too sick to tell them.

Written advance directives in New Jersey fall into two main groups a “proxy directive” and an “instruction directive (living will)”. It is up to you whether you want to have both or just one.

- **Proxy directive (durable power of attorney for health care)**

This is a document you use to appoint a person to make health care decisions for you in the event you become unable to make them yourself. This document goes into effect whether your inability to make health care decisions is temporary or permanent. The person that you appoint is known as your “health care representative.” They are responsible for making the same decisions you would have made under the circumstances. If they are unable to determine what you would want in a specific situation they are to base their decision on what they think is in your best interest; and/or

- **Instruction directive (living will)**

This is a document you use to tell your provider and family about the kinds of situations where you would want or not want to have life-sustaining treatment in the event you are unable to make your own health care decisions. You can also include a description of your beliefs, values, and general care and treatment preferences. This will guide your provider and family when they have to make health care decisions for you in situations not specifically covered by your advance directive.

If you have an advance directive:

- Keep a copy of your advance directive for yourself;
- Also give a copy to the person you choose to be your medical power of attorney;
- Give a copy to each one of your providers;
- Take a copy with you if you have to go to the hospital or the emergency room; and
- Keep a copy in your car if you have one.

You can also talk to your provider if you need help or have questions. Your provider can help you make one. Talk to him or her about your care options and what to include in the document.

Call Member Services at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m. You may also visit **<https://www.state.nj.us/health/advancedirective/ad/>** for more information on advanced directives.



Important Member Information

Member Grievances and Appeals

If you have a complaint about our plan, a provider, or your care under our plan, you can file a grievance (a formal complaint). If you disagree with a decision we have made to limit, deny, or reduce a health care service, you can challenge that decision by filing an appeal.

If your primary language is not English, you can file a grievance or appeal in your primary language, and we will communicate with you in that language. If you need help to do this, or if you need an alternate format like Large Print, call us toll-free at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m. We will provide any reasonable assistance you request if you need help with a grievance or appeal. This includes, but is not limited to, helping you to complete forms, explaining how the grievance or appeal process works, and providing an interpreter if you need one.

If you file a grievance or an appeal, we will not discriminate against you in any way. We will not disenroll you from our plan or take any other action against you because you filed a grievance or appeal.

Grievances

A grievance, sometimes called a complaint, is when you tell us you are not happy with us, a provider, or a service. Grievances may be about, but are not limited to:

- Quality-of-care issues;
- Wait times during provider visits;
- The way your providers or others act or treat you;
- Unclean provider offices; and
- Not getting the information you need.

You can file a grievance at any time by calling us or writing us a letter. To file by phone, please call **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.

To write us, mail to:



WellCare
Grievance Department
P.O. Box 31384
Tampa, FL 33631-3384

You can file your grievance yourself or someone can file it for you. This includes your PCP or another provider. We must have your written consent before someone can file a grievance for you. You may file a grievance at any time. The forms to file a grievance (or appeal) are on our website located at <https://www.wellcare.com/New-Jersey/Members/Medicaid-Plans/NJ-FamilyCare/Member-Rights-and-Policies/Appeals-and-Grievances>.

Do you need help to file a grievance? Please call Member Services at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.

Within 5 business days of receipt, we will mail you a letter to tell you that we received your grievance. We will take action to address your grievance, and we will mail you a Resolution Letter within 30 days telling you what action we took.

Appeals

Utilization Management Appeal Process:

Service Denial/Limitation/Reduction/Termination based on Medical Necessity

You and your provider should receive a notification letter within 2 business days of any health plan decision to deny, reduce, or terminate a service or benefit. If you disagree with the plan's decision, you (or your provider, with your written permission) can challenge it by requesting an *appeal*.

Important Member Information

See the summary below for the time frames to request an appeal.

Stages	Time Frame for Member/Provider to Request Appeal	Time Frame for Member/Provider to Request Appeal with Continuation of Benefits for Existing Services	Time Frame for Appeal Determination to be reached	FamilyCare Plan Type
<p>Internal Appeal</p> <p>The Internal Appeal is the first level of appeal, administered by the health plan.</p> <p>This level of appeal is a formal internal review by health care professionals selected by the plan who have expertise appropriate to the case in question, and who were not involved in the original determination.</p>	60 calendar days from date on initial notification/denial letter	<ul style="list-style-type: none"> • On or before the last day of the current authorization; or • Within 10 calendar days of the date on the notification letter, whichever is later 	30 calendar days or less from health plan's receipt of the appeal request	A/ABP B C D
<p>External/IURO Appeal</p> <p>The External/IURO appeal is an external appeal conducted by an Independent Utilization Review Organization (IURO).</p>	60 calendar days from date on Internal Appeal notification letter	<ul style="list-style-type: none"> • On or before the last day of the current authorization; or • Within 10 calendar days of the date on the Internal Appeal notification letter, whichever is later 	45 calendar days or less from IURO's decision to review the case	A/ABP B C D

Important Member Information

Stages	Time Frame for Member/ Provider to Request Appeal	Time Frame for Member/Provider to Request Appeal with Continuation of Benefits for Existing Services	Time Frame for Appeal Determination to be reached	FamilyCare Plan Type
Medicaid Fair Hearing	120 calendar days from date on Internal Appeal notification letter	<p><i>Whichever is the latest of the following:</i></p> <ul style="list-style-type: none"> • On or before the last day of the current authorization; or • Within 10 calendar days of the date on the Internal Appeal notification letter, or • Within 10 calendar days of the date on the External/IURO appeal decision notification letter 	A final decision will be reached within 90 calendar days of the Fair Hearing request.	A/ABP only

Important Member Information

Initial Adverse Determination

If our plan decides to deny your initial request for a service, or to reduce or stop an ongoing service that you have been receiving for a while, this decision is also known as an adverse determination. We will tell you and your provider about this decision as soon as we can, often by phone. You will receive a written letter explaining our decision within two business days.

If you disagree with the plan's decision, you, your provider (with your written permission) can challenge the decision by requesting an appeal. You or your provider can request an appeal either orally (by phone) or in writing. To request an appeal orally, you can call Member Services at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m. Please remember that if your appeal is requested orally, you will need to follow up by sending a written, signed letter confirming your appeal request as soon as you can. Written appeal requests should be mailed to the following address:

Send Your Written Appeal Requests Here	
<p>WellCare Health Plans Attn: Appeals Department P.O. Box 31368 Tampa, FL 33631-3368</p>	<p>WellCare Health Plans Attn: Medication Appeals P.O. Box 31398 Tampa, FL 33631-3398 Fax: 1-866-201-0657</p>

You have **60 calendar days** from the date on the initial adverse determination letter to request an appeal.

You can request copies of any of your records that are related to the denial or adverse decision that you are appealing. Call Member Services to request them. We will provide them to you at no cost. You and your provider can also send us any additional information, files or records that you may have that you want us to consider in your case.

Internal Appeal

The first stage of the appeal process is a formal internal appeal to the plan (called an Internal Appeal). Your case will be reviewed by a doctor or another health care professional, selected by our plan who has expertise in the area of medical knowledge appropriate for your case. We will be careful to choose someone who was not involved

in making the original decision about your care. We must make a decision about your appeal within 30 calendar days (or sooner, if your medical condition makes it necessary).

If your appeal is denied (not decided in your favor), you will receive a written letter from us explaining our decision. The letter will also include information about your right to an External Independent Utilization Review Organization (IURO) Appeal, and/or your right to a Medicaid State Fair Hearing, and how to request these types of further appeal. You will also find more details on those options later in this section of the handbook.

Expedited (fast) Appeals

You may request an expedited (fast) appeal if you feel that your health will suffer if we take the standard amount of time (up to 30 calendar days) to make a decision about your appeal. Also, If your provider informs us that taking up to 30 calendar days to reach a decision could seriously jeopardize your life or health, or your ability to fully recover from your current condition attain, we must make a decision about your appeal within 72 hours.

External (IURO) Appeal

If your Internal Appeal is not decided in your favor, you (or your provider acting on your behalf with your written consent) can request an External (IURO) Appeal by completing the **External Appeal Application** form. A copy of the *External Appeal Application* form will be sent to you with the letter that tells you about the outcome of your Internal Appeal. You or your provider must mail the completed form to the following address within **60 calendar days** of the date on your Internal Appeal outcome letter:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care
P.O. Box 329
Trenton, NJ 08625-0329

You may also **fax** the completed form to **1-609-633-0807**, or send it by email to **ihcap@dobi.nj.gov**. If a copy of the *External Appeal Application* is not included with your Internal Appeal outcome letter, please call Member Services at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m. to request a copy.

External (IURO) Appeals are not conducted by the plan. These appeals are reviewed by an Independent Utilization Review Organization (IURO), which is an impartial third-party review organization that is not directly affiliated with either the plan or the State of New

Important Member Information

Jersey. The IURO will assign your case to an independent physician, who will review your case and make a decision. If the IURO decides to accept your case for review, they will make their decision within 45 calendar days (or sooner, if your medical condition makes it necessary).

You can also request an expedited, or fast, External (IURO) Appeal, just as you can with Internal Appeals. To request an expedited appeal, you or your provider should fax a completed copy of the *External Appeal Application* form to the Department of Banking and Insurance at **1-609-633-0807**, and ask for an expedited appeal on the form in **Section V, Summary of Appeal**. In the case of an expedited External (IURO) Appeal, the IURO must make a decision about your appeal *within 48 hours*.

If you have questions about the External (IURO) Appeal process, or if you would like to request assistance with your application, you can also call the New Jersey Department of Banking and Insurance's toll-free telephone number at **1-888-393-1062 (option 3)**.

Please note: There are some services that the IURO will not review. If the letter you receive about the outcome of your appeal does not include information about your option to request an External (IURO) review, this is probably the reason. However, if you have questions about your options, you can call Member Services at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.

The External (IURO) Appeal is optional. You do not need to request an External (IURO) appeal before you request a Medicaid State Fair Hearing. Once your Internal Appeal is finished, you have the following options for requesting an External (IURO) Appeal *and/or* a Medicaid State Fair Hearing:

- You can request an External (IURO) Appeal, wait for the IURO's decision, and **then** request a Medicaid State Fair Hearing, if the IURO did not decide in your favor.
- You can request an External (IURO) Appeal **and** a Medicaid State Fair Hearing **at the same time** (just keep in mind that you make these two requests to different government agencies).
- You can request a Medicaid State Fair Hearing *without* requesting an External (IURO) Appeal.

Also, please note: Medicaid Fair Hearings are only available to NJ FamilyCare Plan A and ABP members.

Medicaid State Fair Hearing

You can request a Medicaid State Fair Hearing after your Internal Appeal is finished (and our plan has made a decision). Medicaid State Fair Hearings are administered by staff from the New Jersey Office of Administrative Law. You have up to **120 calendar days** from the date on your **Internal Appeal outcome letter** to request a Medicaid State Fair Hearing. You can request a Medicaid State Fair Hearing by writing to the following address:



Fair Hearing Section
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712

If you make an expedited (fast) Medicaid State Fair Hearing request, and you meet all of the requirements for an expedited appeal, a decision will be made within 72 hours of the day the state agency received your Medicaid Fair Hearing request.

Please note: The deadline for requesting a Medicaid State Fair Hearing is always 120 days from the date on the letter explaining the outcome of your *Internal Appeal*. This is true even if you request an External (IURO) Appeal in the meantime. The 120-day deadline to ask for a Medicaid State Fair Hearing always starts from the outcome of your *Internal Appeal*, not your External (IURO) Appeal.

Continuation of Benefits

If you are asking for an appeal because the plan is stopping or reducing a service or a course of treatment that you have already been receiving, you can have your services/benefits continue during the appeal process. The plan will automatically continue to provide the service(s) while your appeal is pending, as long as all of the following requirements are met:

- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider; and
- You (or your provider, acting on your behalf with your written consent) file(s) the appeal within **10 calendar days** of the date on the initial adverse determination letter, or on or before the final day of the original authorization, **whichever is later**.

Important Member Information

Your services will *not* continue automatically during a Medicaid State Fair Hearing. If you want your services to continue during a Medicaid State Fair Hearing, you must request that *in writing* when you request a Fair Hearing, and you must make that request within:

- **10 calendar days** of the date on the Internal Appeal outcome letter; **or** within
- **10 calendar days** of the date on the letter informing you of the outcome of your External (IURO) Appeal, if you requested one; **or**
- On or before the final day of the original authorization, ***whichever is later***.

Please note: If you ask to have your services continue during a Medicaid State Fair Hearing and the final decision is not in your favor, you may be required to pay for the cost of your continued services.

Do you have any questions about the appeal process? Please call Member Services at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.

Your WellCare Membership

When you join our WellCare Plan, it is called enrollment. Leaving our WellCare Plan is called disenrollment.

Enrollment

These individuals are eligible to enroll in WellCare:

- Pregnant women;
- People in the Supplemental Security Income (SSI) program;
- Children from families who meet certain income limits; and
- Aged, blind or disabled individuals.

All enrollment and disenrollment requests are subject to verification and approval by the New Jersey the Division of Medical Assistance and Health Services (DMAHS).

Do you need more information on who is eligible?

Please visit www.njfamilycare.org/who_eligbl.aspx.

There is usually a period of 30 to 45 days between when you complete your NJ FamilyCare application and your start date with us. During this time, your benefits will continue to be covered by Medicaid Fee-for-Service (FFS) or your current health plan. Your health plan membership starts the first day of the month after you are approved. What happens if you need care while this is being done? In that case, you get it through regular Fee for Service (FFS) or your current health plan.

When you signed your enrollment application/Plan Selection form, you approved the release of your medical records. The State's Health Benefits Coordinator (HBC) gave us this information to help you move to our plan.

Disenrollment

You can disenroll from our plan for any reason in the first 90 days after you enroll or after you receive a notice of enrollment with a new plan (whichever is later). You can also disenroll from our plan for any reason during the Annual Open Enrollment Period, which runs from October 1 to November 15 every year. At any other time, you cannot disenroll without “good cause.” Good cause reasons for disenrollment include, but are not limited to:

- Our plan failing to provide services;
- Our plan failing to respond to you within the required period of time if you file a grievance or appeal;
- Poor quality of care; or
- Your discovery that you have substantially more convenient access to a PCP that participates with another MCO in your area.

All disenrollment requests are subject to verification and approval by the New Jersey the Division of Medical Assistance and Health Services (DMAHS). If you request a “good cause” disenrollment, DMAHS may decide that there is not good cause. If you disagree with this decision, you may request and receive a State Fair Hearing.

If you have questions, please call Member Services at the number provided below.

What if you want to change health plans?

You can call the State’s Health Benefits Coordinator (HBC) at **1-800-701-0710**

(TTY: **1-800-701-0720**). Visit www.njfamilycare.org for available hours. Please call our Member Services team at **1-888-453-2534** (TTY: **711**) for more help. We are here Monday through Friday from 8 a.m. through 6 p.m.

Recertification

Keep Your Benefits — Remember to Renew Every Year!

Thank you for trusting WellCare with your health care needs. We value members like you. We want to remind you to renew your NJ FamilyCare coverage every year. If you do not renew, you could lose your health care coverage and be disenrolled from our plan.

Ways to Renew Your Coverage:

- By Mail – Complete the renewal form that was sent to you and return it as soon as possible. Do you need a new form? Please call NJ FamilyCare at **1-800-701-0710** (TTY: **1-800-701-0720**);
- By Phone – Call **1-800-701-0710** (TTY: **1-800-701-0720**); or
- In Person – Visit your local County Welfare Agency/Board of Social Services office.

When should I renew?

- You must fill out a Renewal Application every year to keep your coverage; or
- You can call NJ FamilyCare at **1-800-701-0710** (TTY: **1-800-701-0720**) to learn your renewal date or ask for a renewal form.

A WellCare of New Jersey Community Relations Specialist may be able to help you with your renewal application. The Community Relations Specialists will assist you in completing your renewal application.

- Call **1-888-453-2534** to set an appointment; and
- Be sure to report any changes. If your address has changed, please call NJ FamilyCare at **1-800-701-0710** or log in to your WellCare web account to report the change. New ID cards can be mailed to your new address.

Remember to renew your enrollment every year.

Do you have any questions? Please call NJ FamilyCare at **1-800-701-0710**. WellCare of New Jersey cannot process your Medicaid coverage renewal.

Reinstatement

What if you lose your Medicaid eligibility but get it back within 60 days? The State puts you back in our plan automatically. We will send you a letter within 10 days after you become our member again to confirm this. You can choose the same PCP you had before or pick a new one.

Important Member Information

Our Service Area

Our service area is the set of counties where our plan is available. Those counties are:

- Atlantic County
- Bergen County
- Burlington County
- Camden County
- Cape May County
- Cumberland County
- Essex County
- Gloucester County
- Hudson County
- Mercer County
- Middlesex County
- Monmouth County
- Morris County
- Ocean County
- Passaic County
- Salem County
- Somerset County
- Sussex County
- Union County
- Warren County

The only county that our plan is not available is Hunterdon County.

Moving Out of Our Service Area

Please call the Health Benefits Coordinator if you move out of our service area.

The toll-free number is **1-800-701-0710** (TTY **1-800-701-0720**). They will help you choose another health plan. Visit www.njfamilycare.org for available hours.

Important Information About WellCare

Health Plan Structure, Operations and Provider Incentive Programs

We work with your providers to make sure you get the right care at the right time. This includes preventive care. We will sometimes offer providers an incentive or bonus. We do this to encourage them to keep you on track with your wellness visits. Read the *Preventive Health Guidelines* section in this handbook. It has all of the wellness visits you should plan for each year.

To learn more about the structure and operations of our plan, call Member Services at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.

Evaluation of New Technology

We study new technology every year. We also look how we use the technology we already have. We do this for a few reasons. They are to:

- Make sure we know about changes in the industry;
- See how new improvements can be used with the services we give our members; and
- Make sure that our members have fair access to safe and effective care.

We do this review in the following areas:

- Behavioral health procedures;
- Medical devices;
- Medical procedures; and
- Pharmaceuticals.

Fraud, Waste and Abuse

Billions of dollars are lost to health care fraud every year. What is health care fraud, waste and abuse? It is when false information is given on purpose. This can be done by a member or provider.

Here are some other examples of provider and member fraud, waste and abuse:

- Billing for a more expensive service than what was actually given;
- Forging or altering bills or receipts;
- Billing more than once for the same service;

Important Member Information

- Misrepresenting procedures performed to obtain payment for services that are not covered;
- Billing for services not actually performed;
- Overbilling us or a member;
- Falsifying a patient's diagnosis to justify tests, surgeries or other procedures that are not medically necessary;
- Waiving patient co-pays or deductibles;
- Filing claims for services or medications not received; and
- Using someone else's WellCare ID and/ or HBID card.

Do you know of any fraud, waste and abuse? Please call our 24-hour fraud hotline. The toll-free number is **1-866-685-8664** (TTY: **711**). You can leave a message. You do not have to leave your name. We will call you back if you leave a phone number. We do this to make sure the information is complete and accurate.

You can also report fraud on our website, www.wellcare.com/New-Jersey. Reporting fraud, waste and abuse through our website is also kept private.

When You Have NJ FamilyCare and Other Insurance

Who pays when you have NJ FamilyCare and other coverage?

If you have NJ FamilyCare and other health insurance coverage, each type of coverage is called a "payer." There are rules to follow when there is more than one payer. These rules decide who pays first. They also decide how much each payer pays for each service. In some cases, a member may have only one payer, NJ FamilyCare. In some cases, a member may have multiple other payers, including Medicare or other health insurance.

Many members have other health insurance or Medicare as their primary payer (the insurance that pays first). This includes people who belong to a Medicare Advantage (MA) health plan.

When you join a NJ FamilyCare Health Plan, NJ FamilyCare is usually the payer of last resort. This means Medicare and/or your other health insurance pay for covered services first. Your NJ FamilyCare Health Plan will usually pay for covered services last.

To learn more, please see the *Third-Party Liability* booklet. It was part of your Welcome Packet. You may also visit http://www.state.nj.us/humanservices/dmahs/home/Medicaid_TPL_Coverage_Guide.pdf.

Services Beyond Health Care

Through Community Connections, you can connect to a wide range of services that help you live a better, healthier life.



Call to get the help you need.

1-866-775-2192

It can be hard to focus on your health if you have problems with your housing, or if you worry about having enough food to feed your family. WellCare of New Jersey can connect you to resources in your community to help you manage issues beyond your medical care that may affect the health of you or your loved ones.

WellCare's Community Connections is here for you.

Call our **Community Connections Help Line** at **1-866-775-2192** to talk to a **Peer Coach** if you:

- Have trouble getting enough food to feed you or your family;
- Worry about your housing or living conditions;
- Find it hard to get to appointments, work or school because of transportation issues;
- Feel unsafe or are experiencing domestic violence. If you are in immediate danger, call **911**;
- Have other types of need such as:
 - Financial Assistance (utilities, rent); and
 - Affordable childcare.
- Job/education assistance;
- Family supplies – diapers, formula, cribs, and more; or
- Caregiver assistance and support

MyWellCare Mobile App

With our app, you will have health information at your fingertips.

The MyWellCare app on your smartphone or tablet lets you:

- See your member ID card;
- Search for providers, quick-care clinics and hospitals;
- View wellness services available to you; and
- View appointment reminders.

So go ahead – download MyWellCare today. It is free at both Apple and Android app stores.

Not registered? It is easy!

Download the MyWellCare app on your smartphone, select your State and under “Product,” select “Medicaid.”

- Accept the Agreement;
- Several icons will come up; click on any “Icon” to get the “Member Login Screen”
- Click on “Not Registered” at the bottom; and
- Complete the Registration.

That is it! You are ready to get health information anywhere, anytime!

Be sure to tell Member Services if you want to get text messages from us with reminders and information. You can call them toll-free at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.

Member Rights

As our member, you have the right to:

- Get information about our plan, services, practitioners, and providers, and to be able to communicate and be understood with the assistance of a translator if needed;
- Get information about appeals in a language you understand;
- Get information and make recommendations about your rights and responsibilities;
- Know the names and titles of the providers caring for you;
- Be treated with respect and dignity;
- Have your privacy protected;
- Choose your PCP from our network of providers;
- Decide with your provider on the care you get;
- Have services that promote a meaningful quality of life and autonomy, independent living in your home and other community settings, as long as it is medically and socially feasible, and preservation and support of your natural support systems;
- Talk openly about the care you need, no matter the cost or benefit coverage, your treatment options and the risks involved (this information must be given in a way you understand);
- Have the benefits, risks and side effects of medications and other treatments explained to you;
- Know about your health care needs after you leave your provider's office or get out of the hospital;
- Know how our providers are paid. To learn more, please call us at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday from 8 a.m. through 6 p.m.;
- A second medical opinion (or dental opinion);
- Refuse care, as long as you agree to be responsible for your decision;
- Refuse to take part in any medical research;
- File an appeal or grievance about your plan or the care we provide; also, know that if you do, it will not change how you are treated; and to know that you cannot be disenrolled from your plan for filing an appeal;
- Have a choice of providers;

Important Member Information

- Call **911** in an emergency without prior authorization;
- A medical screening exam in the emergency room (ER);
- Be free from balance billing;
- Be free from hazardous procedures or any form of restraint (either chemical or physical) or seclusion;
- Ask for and get a copy of your medical records from providers; also, ask that the records be changed/corrected if needed (requests must be received in writing from you or the person you choose to represent you; the records will be provided at no cost; they will be sent within 14 days of receipt of the request);
- Have your records kept private;
- Make your health care wishes known through advance directives;
- Have an opportunity to suggest changes to our policies and procedures;
- Appeal medical or administrative decisions by using our appeals and grievances process;
- Exercise these rights no matter your sex, age, race, ethnicity, income, education or religion;
- Have our staff observe your rights;
- Have all of these rights apply to the person legally able to make decisions about your health care; and
- Receive quality services, which include:
 - Accessibility;
 - Authorization standards;
 - Availability;
 - Coverage; and
 - Coverage outside of our network.

Member Responsibilities

As our member, you have the responsibility to:

- Read your Member Handbook to understand how our plan works;
- Carry your member ID card at all times;
- Give information that we and your providers need to provide care to you;
- Follow plans and instructions for care that you have agreed on with your provider;
- Understand your health problems;
- Help set treatment goals that you and your provider agree to;
- Show all your ID cards to each provider when you get care;
- Schedule appointments for all non-emergency care through your PCP;
- Get a referral from your PCP for specialty care, when necessary;
- Cooperate with the people who provide your health care;
- Be on time for appointments;
- Tell your provider's office if you need to cancel or change an appointment;
- Pay your co-pays (if any) to providers;
- Respect the rights and property of all providers;
- Respect the rights of other patients;
- Not be disruptive at your provider's office;
- Know the medicines you take, what they are for and how to take them the right way; and
- Let us know within 48 hours, or as soon as possible, if you are admitted to the hospital or get emergency room care.



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