WellCare Healthy Choice Member Handbook Insert
Complaints and Appeals

THE BELOW SECTIONS OF YOUR MEMBER HANDBOOK HAVE BEEN REVISED TO READ AS FOLLOWS

HOW TO GET SPECIALTY CARE AND REFERRALS

- If you need care that your PCP cannot give, he or she will REFER you to a specialist who can. If your PCP refers you to another doctor, we will pay for your care. Most of these specialists are WellCare providers. Talk with your PCP to be sure you know how referrals work.

- If you think a specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist.

- There are some treatments and services that your PCP must ask WellCare to approve *before* you can get them. Your PCP will be able to tell you what they are.

- If you are having trouble getting a referral you think you need, contact Member Services at **1-800-288-5441** (TTY **711**).

- If we do not have a specialist in our provider network who can give you the care you need, we will get you the care you need from a specialist outside our plan. This is called an **out-of-network referral**. Your PCP or plan provider must ask WellCare for approval *before* you can get an out-of-network referral. If you are your PCP or plan provider refers you to a provider who is not in our network, you are not responsible for any of the costs except any co-payments as described in this handbook.

- You can get an out-of-network referral. Just ask your PCP to call WellCare and request a referral on your behalf. We will let you know our decision within 3 business days (1 business day if your PCP sends an expedited request).

    - Sometimes we may not approve an out-of-network referral because we have a provider in WellCare that can treat you. If you think our plan provider does not have the right training or experience to treat you, you can ask us to check if your out-of-network referral is medically needed. You will need to ask for a **Plan Appeal**. See page 55 to find out how.

- Sometimes, we may not approve an out-of-network referral for a specific treatment because you asked for care that is not very different from what you can get from WellCare's provider. You can ask us to check if your out-of-network referral for the treatment you want is medically needed. You will need to ask for a **Plan Appeal**. See page 55 to find out how.

- If you think our plan provider does not have the right training or experience to treat you, you can ask us to check if your out-of-network referral is medically needed. You will need to ask for an action appeal. See page 55 to find out how.

- You have access to see all of WellCare's in-network providers listed in the Provider Directory. However, some providers listed may not be accepting new patients. Our Provider Directory will tell you which providers are seeing new patients.

- If you need to see a specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time (a **standing referral**). If you have a standing referral, you will not need a new referral each time you need care.

- *If you have a long-term disease or a disabling illness that gets worse over time*, your PCP may be able to arrange for:
  - your specialist to act as your PCP; or
  - a referral to a specialty care center that deals with the treatment of your illness.

You can also call Member Services for help in getting access to a specialty care center.

Service Authorization

Prior Authorization:

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

Procedures And Services	Comments
Durable Medical Equipment	
Durable Medical Equipment Purchases and Rentals	All DME rentals require authorization. DME purchase items that are $250 or less do NOT require authorization.
Orthotics and Prosthetics	Purchase items that are $500 or less per line item do NOT require authorization.
Home Health Services	
Home Health Care Services	Includes skilled therapy services in a home setting.
Inpatient Services	
Domiciliary, Rest Home & Custodial Services	
Elective Inpatient Procedures	Clinical updates required for continued length of stay.
Electroconvulsive Therapy (ECT)	
Inpatient Admissions	Clinical updates required for continued length of stay.
Long-Term Acute Care Hospital (LTACH) Admissions	Clinical updates required for continued length of stay.
NICU/Sick Baby Admission	Notification is required within 24 hours following admission. Clinical updates required for continued length of stay.
Observations	Observation services will not require authorization; however, preplanned procedures will be subject to outpatient authorization requirements. Clinical updates required for continued length of stay.
Rehabilitation Facility Admissions	Clinical updates required for continued length of stay
Residential Treatment Services	
Skilled Nursing Facility Admissions	

Procedures And Services	Comments
Outpatient Services	
Advanced Radiology services: CT, CTA, MRA, MRI, Nuclear Cardiology, Nuclear Medicine, OB Ultrasounds, PET & SPECT Scans	Please ask your doctor or the plan. *No authorization is required for the first three OB ultrasounds.*
Ambulance Transportation (non-emergent)	
Ambulatory Surgery Center Procedures	Please ask your doctor or the plan.
Assertive Community Treatment	
Behavioral Health Outpatient Services	Some services require prior authorization. Please ask your doctor or the plan. Some services may require annual registration. Please ask your doctor or the plan.
Cardiology Services: Cardiac Imaging, Cardiac Catheterization, Diagnostic Cardiac Procedures and Echo Stress Tests	Please ask your doctor or the plan.
Cosmetic Procedures (ALL)*	Please ask your doctor or the plan.
Cytogenetic, Molecular Diagnostic and Reproductive Medicine Laboratory Testing (ALL)* Note: Some tests are handled by CareCore. Please refer to Lab Management section below as well.	Please ask your doctor or the plan.
Electroconvulsive Therapy (ECT)	
Intensive Outpatient Program (IOP)	
Investigational and Experimental Procedures and Treatment	Please ask your doctor or the plan.
Laboratory (Routine) Testing	Lab testing must be performed by LabCorp, Quest or other entities contracted for lab services.
Laboratory Management (Certain Molecular and Genetic Tests)	Please ask your doctor or the plan.

Procedures And Services	Comments
Office Visits and Treatment	Please ask your doctor or the plan.
Ophthalmology Procedures	Please ask your doctor or the plan.
Outpatient Hospital Procedures and Services	Please ask your doctor or the plan.
Pain Management Treatment	Please ask your doctor or the plan.
Partial Hospitalization Program (PHP)	
Physical and Occupational Therapy	Please ask your doctor or the plan.
Psychological Testing	
Radiation Therapy Management	Please ask your doctor or the plan.
Sleep Diagnostics	Please ask your doctor or the plan.
Sterilization Procedures	Please ask your doctor or the plan.
Speech Therapy	
Speech Therapy	

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

Call our toll-free Member Services number at **1-800-288-5441** (TTY **711**). Or send your request in writing to **WellCare, P.O. Box 31368, Tampa, FL 33631-3368.**

You will also need to get prior authorization if you are getting one of these services now, but need to continue or get more of the care. This is called **concurrent review**.

What happens after we get your service authorization request:

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

We may decide to deny a service authorization request or to approve it for an amount that is less than requested. These decisions will be made by a qualified health care

professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor or may be a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, we use to make decisions about medical necessity.

After we get your request we will review it under a **standard** or **fast track** process. You or your doctor can ask for a fast track review if it is believed that a delay will cause serious harm to your health. If your request for a fast track review is denied, we will tell you and your case will be handled under the standard review process.

We will fast track your review if:

- A delay will seriously risk your health, life, or ability to function;
- Your provider says the review must be faster:
- You are asking for more a service you are getting right now;

In all cases, we will review your request as fast as your medical condition requires us to do so but no later than mentioned below.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals or fair hearings you will have if you don't agree with our decision. (See also the Plan Appeals and Fair Hearing sections later in this handbook.)

Timeframes for prior authorization requests:

- **Standard review**: We will make a decision about your request within 3 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.

- **Fast track review**: We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

Timeframes for concurrent review requests:

- **Standard review**: We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 14

days after we received your request. We will tell you by the 14th day if we need more information.

- **Fast track review**: We will make a decision within 1 work day of when we have all the information we need. You will hear from us no later than 72 hours after we received your request. We will tell you within 1 work day if we need more information.

Special timeframes for other requests:

- If you are in the hospital or have just left the hospital and you are asking for home health care we will make a decision within 72 hours of your request.
- If you are getting inpatient substance use disorder treatment, and you ask for more services at least 24 hours before you are to be discharged, we will make a decision within 24 hours of your request.
- If you are asking for mental health or substance use disorder services that may be related to a court appearance, we will make a decision within 72 hours of your request.
- If you are asking for an outpatient prescription drug we will make a decision within 24 hours of your request.
- A step therapy protocol means we require you to try another drug first, before we will approve the drug you are requesting. If you are asking for approval to override a step therapy protocol, we will make a decision with 24 hours for outpatient prescription drugs. For other drugs, we will make a decision within 14 days of your request.

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

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

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling **1-800-288-5441** (TTY **711**) or writing to **WellCare, P.O. Box 31368, Tampa, FL 33631**.

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

We will notify you by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If we do not respond to a request to override a step therapy protocol on time, your request will be approved.

If you think our decision to deny your service authorization request is wrong, you have the right to file a Plan Appeal with us. See the Plan Appeal section later in this handbook.

Other Decisions About Your Care:

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

Timeframes for other decisions about your care:

- In most cases, if we make a decision to reduce, suspend or stop a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.
- We must tell you at least 10 days before we make any decision about long-term services and supports, such as home health care, personal care, CDPAS, adult day health care, and nursing home care.
- If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving all information we need for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. These notices are not bills. **You will not have to pay for any care you received that was covered by the plan or by Medicaid even if we later deny payment to the provider.**

Plan Appeals

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

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

Your provider can ask for reconsideration:

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

You can file a Plan Appeal:

If you think our decision about your service authorization request is wrong, you can ask us to look at your case again. This is called a **Plan Appeal**.

- You have **60 calendar days** from the date of the Initial Adverse Determination notice to ask for a Plan Appeal.
- You can call Member Services **1-800-288-5441** (TTY **711**) if you need help asking for a Plan Appeal, or following the steps of the appeal process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.
- You can ask for a Plan Appeal, or you can have someone else, like a family member, friend, doctor or lawyer, ask for you. You and that person will need to sign and date a statement saying you want that person to represent you.
- We will not treat you any differently or act badly toward you because you ask for a Plan Appeal.

Aid to Continue while appealing a decision about your care:

If we decided to reduce, suspend or stop services you are getting now, you may be able to continue the services while you wait for your Plan Appeal to be decided. **You must ask for your Plan Appeal:**

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

If your Plan Appeal results in another denial, you may have to pay for the cost of any continued benefits that you received.

You can call, write, to ask for a Plan Appeal. When you ask for a Plan Appeal, or soon after, you will need to give us:

- Your name and address
- Enrollee number
- Service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors' letters or other information that explains why you need the service.
- Any specific information we said we needed in the Initial Adverse Determination notice.
- To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records and other documents we used to make the Initial Adverse Determination. If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review. You can ask to see these documents or ask for a free copy by calling **1-800-288-5441** (TTY **711**).

Give us your information and materials by phone, fax, or mail**:**

Phone……	**1-800-288-5441 (TTY 711)**
Fax……	**1-866-201-0657**
Mail……..……..	**WellCare Appeals Department** **P.O. Box 31368** **Tampa, FL 33631**

If you ask for a Plan Appeal by phone, unless it is fast tracked, you must also send your Plan Appeal to us in writing.

If you are asking for out of network service or provider:

- If we said that the service you asked for is not very different from a service available from a participating provider, you can ask us to check if this service is medically necessary for you. You will need to ask your doctor to send this information with your Plan Appeal:
  1) a statement in writing from your doctor that the out of network service is very different from the service the plan can provide from a participating provider. Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for.
  2) two medical or scientific documents that prove the service you are asking for is more helpful to you and will not cause you more harm than the service the plan can provide from a participating provider.

  If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal. See the External Appeal section later in this handbook.

- lf you think our participating provider does not have the correct training or experience to provide a service, you can ask us to check if it is medically necessary for you to be referred to an out of network provider. You will need to ask your doctor to send this information with your appeal:
  1) a statement in writing that says our participating provider does not have the correct training and experience to meet your needs, and
  2) that recommends an out of network provider with the correct training and experience who is able to provide the service.

  Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for. If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal. See the External Appeal section later in this handbook.

- If your doctor does not send this information, we will still review your action appeal. However, you may not be eligible for an external appeal. See page 59 for more information about external appeals.

What happens after we get your Plan Appeal:

- Within 15 days, we will send you a letter to let you know we are working on your Plan Appeal.
- We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.
- You can also provide information to be used in making the decision in person or in writing. Call WellCare at **1-800-288-5441** (TTY **711**) if you are not sure what information to give us.
- Plan Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- You will be given the reasons for our decision and our clinical rationale, if it applies. The notice of the Plan Appeal decision to deny your request or to approve it for an amount that is less than requested is called an **Final Adverse Determination**.
- **If you think our Final Adverse Determination is wrong**:
    - you can ask for a Fair Hearing. See the Fair Hearing section of this handbook.
    - for some decisions, you may be able to ask for an External Appeal. See the External Appeal section of this handbook.
    - you may file a complaint with the New York State Department of Health at **1-800-206-8125**.

Timeframes for Plan Appeals:

- **Standard Plan Appeals**: If we have all the information we need we will tell you our decision within 30 calendar days from when you asked for your Plan Appeal.

- **Fast track Plan Appeals**: If we have all the information we need, fast track Plan Appeal decisions will be made in 2 working days from your Plan Appeal but not more than 72 hours from when you asked for your Plan Appeal.
    - We will tell you within in 72 hours if we need more information.

- If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will make a decision about your appeal within 24 hours.
- We will tell you our decision by phone and send a written notice later.

Your Plan Appeal will be reviewed under the fast track process if:

- If you or your doctor asks to have your Plan Appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied we will tell you and your Plan Appeal will be reviewed under the standard process; **or**
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided; **or**
- If your request was denied when you asked for home health care after you were in the hospital; or
- If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital.

If we need more information to make either a standard or fast track decision about your Plan Appeal we will:

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

You or your representative may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling **1-800-288-5441** (TTY **711**) or writing.

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

If you do not receive a response to your Plan Appeal or we do not decide in time, including extensions, you can ask for a Fair Hearing. See the Fair Hearing section of this handbook.

If we do not decide your Plan Appeal on time, and we said the service you are asking for is:
1) not medically necessary; 2) experimental or investigational; 3) not different from care you can get in the plan's network; or 4) available from a participating provider who has correct training and experience to meet your needs, the original denial will be reversed. This means your service authorization request will be approved.

External Appeals

You have other appeal rights if we said the service you are asking for was:

1) not medically necessary;
2) experimental or investigational;
3) not different from care you can get in the plan's network; or
4) available from a participating provider who has correct training and experience to meet your needs.

For these types of decisions, you can ask New York State for an independent **External Appeal**. This is called an External Appeal because it is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment, clinical trial, or treatment for a rare disease. You do not have to pay for an External Appeal.

Before you ask for an External Appeal:

- You must file a Plan Appeal and get the plan's Final Adverse Determination; **or**
- If you have not gotten the service, and you ask for a fast track Plan Appeal, you may ask for an expedited External Appeal at the same time. Your doctor will have to say an expedited External Appeal is necessary; **or**
- You and the plan may agree to skip the plan's appeals process and go directly to External Appeal; **or**
- You can prove the plan did not follow the rules correctly when processing your Plan Appeal.

You have **4 months** after you receive the plan's Final Adverse Determination to ask for an External Appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the External Appeal within 4 months of when you made that agreement.

To ask for an External Appeal, fill out an application and send it to the Department of Financial Services. You can call Member Services at **1-800-288-5441** (TTY **711**) if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, **1-800-400-8882**
- Go to the Department of Financial Services' web site at www.dfs.ny.gov
- Contact the health plan at **1-800-288-5441** (TTY **711**)

Your External Appeal will be decided in 30 days. More time (up to 5 work days) may be needed if the External Appeal reviewer asks for more information. You and the plan will be told the final decision within 2 days after the decision is made.

You can get a faster decision if:

- Your doctor says that a delay will cause serious harm to your health: or
- You are in the hospital after an emergency room visit and the hospital care is denied by the plan.

This is called an **expedited External Appeal**. The External Appeal reviewer will decide an expedited appeal in 72 hours or less.

If you asked for inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will continue to pay for your stay if:

- you ask for a fast track Plan Appeal within 24 hours, AND
- you ask for a fast track External Appeal at the same time.

We will continue to pay for your stay until there is a decision made on your appeals. We will make a decision about your fast track Plan Appeal in 24 hours. The fast track External Appeal will be decided in 72 hours.

The External Appeal reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

If you ask for a Plan Appeal, and you receive a Final Adverse Determination that denies, reduces, suspends or stops your service, you can ask for a Fair Hearing. You may ask for a Fair Hearing or ask for an External Appeal, or both. If you ask for both a Fair Hearing and an External Appeal, the decision of the fair hearing officer will be the one that counts.

Fair Hearings

You may ask for a Fair Hearing from New York State if:

- You are not happy with a decision your local Department of Social Services or the State Department of Health made about your staying or leaving WellCare.

- You are not happy with a decision we made to restrict your services. You feel the decision limits your Medicaid benefits. You have 60 calendar days from the date of the Notice of Intent to Restrict to ask for a Fair Hearing. If you ask for a Fair Hearing within 10 days of the Notice of Intent to Restrict, or by the effective date of the restriction, whichever is later, you can continue to get your services until the Fair Hearing decision. However, if you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for the decision.

- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Medicaid benefits. You must file a complaint with WellCare. If WellCare agrees with your doctor, you may ask for a Plan Appeal. If you receive a Final Adverse Determination, you will have 120 calendar days from the date of the Final Adverse Determination to ask for a state Fair Hearing.

- You are not happy with a decision that we made about your care. You feel the decision limits your Medicaid benefits. You are not happy we decided to:
  - reduce, suspend or stop care you were getting; or
  - deny care you wanted;
  - deny payment for care you received; or
  - did not let you dispute a co-pay amount, other amount you owe or payment you made for your health care.

You must first ask for a Plan Appeal and receive a Final Adverse Determination. You will have 120 calendar days from the date of the Final Adverse Determination to ask for a Fair Hearing.

If you asked for a Plan Appeal, and receive a Final Adverse Determination that reduces, suspends, or stops care you getting now, you can continue to get the services your doctor ordered while you wait for your Fair Hearing to be decided. You must ask for a fair hearing within 10 days from the date of the Final Adverse Determination or by the time the action takes effect, whichever is later. However, if you choose to ask for services to be continued, and you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for a decision.

- You asked for a Plan Appeal, and the time for us to decide your Plan Appeal has expired, including any extensions. If you do not receive a response to your Plan Appeal or we do not decide in time, you can ask for a Fair Hearing.

The decision you receive from the fair hearing officer will be final.

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

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

When you ask for a Fair Hearing about a decision WellCare made, we must send you a copy of the **evidence packet.** This is information we used to make our decision about your care. The plan will give this information to the hearing officer to explain our action. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before your hearing, you can call **1-800-288-5441** (TTY **711**) to ask for it.

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

Complaint Process

Complaints:

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

You can call Member Services [Insert appropriate health plan toll-free number] if you need help filing a complaint, or following the steps of the complaint process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.

We will not make things hard for you or take any action against you for filing a complaint.

You also have the right to contact the New York State Department of Health about your complaint at **1-800-206-8125** or write to: Complaint Unit, Bureau of Consumer Services, OHIP DHPCO 1CP-1609, New York State Department of Health, Albany, New York 12237

You may also contact your local Department of Social Services with your complaint at any time. You may call the New York State Department of Financial Services at (**1-800-342-3736**) if your complaint involves a billing problem.

How to File a Complaint with Our Plan:

You can file a complaint, or you can have someone else, like a family member, friend, doctor or lawyer, file the complaint for you. You and that person will need to sign and date a statement saying you want that person to represent you.

To file by phone, call Member Services **1-800-288-5441** (TTY **711**), Monday–Friday, 8 a.m. to 6 p.m. If you call us after hours, leave a message. We will call you back the next work day. If we need more information to make a decision, we will tell you.

You can write us with your complaint or call the Member Services number and request a complaint form. It should be mailed to **WellCare, P.O. Box 31370, Tampa, FL 33631-3370**.

What happens next:

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

- who is working on your complaint
- how to contact this person
- if we need more information

You can also provide information to be used reviewing your complaint in person or in writing. Call WellCare at **1-800-288-5441** (TTY **711**) if you are not sure what information to give us.

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

After we review your complaint:

- We will let you know our decision in 45 days of when we have all the information we need to answer your complaint, but you will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.
- When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint but you will hear from us in no more than 7 days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in 3 work days.
- You will be told how to appeal our decision if you are not satisfied and we will include any forms you may need.
- If we are unable to make a decision about your Complaint because we don't have enough information, we will send a letter and let you know.

Complaint Appeals:

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

How to make a complaint appeal:

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

What happens after we get your complaint appeal:

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

- who is working on your complaint appeal
- how to contact this person
- if we need more information

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

If we have all the information we need you will know our decision in 30 work days. If a delay would risk your health you will get our decision in 2 work days of when we have all the information we need to decide the appeal. You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at **1-800-206-8125**.