



Georgia's
health care choice

Member Handbook

2011-2013



 **WellCare**[®]
of Georgia, Inc.



WELCOME TO WELLCARE

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

- Adult dental services
- Adult vision services
- Free monthly Personal Care Items
- Free Flu Shots
- 24-hour Health Advisor line

(Refer to the Covered Services section, starting on page 6 for specific coverage.)

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

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

Sincerely,

WellCare of Georgia, Inc.



GEOGRAPHIC OVERVIEW

GEORGIA MEDICAID

Georgia Service Regions

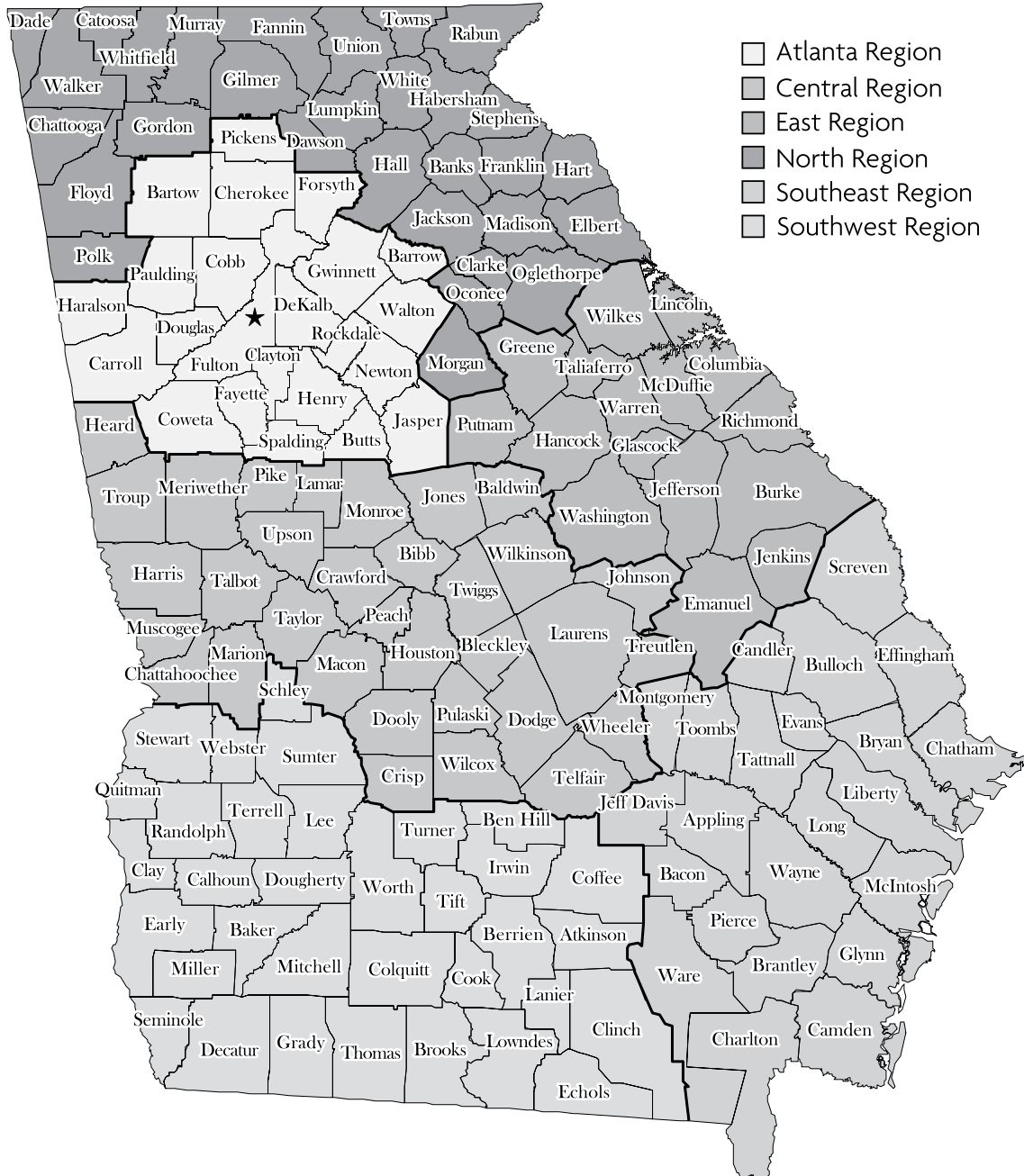


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This is your member handbook. It tells you how Medicaid, PeachCare for Kids™ and your WellCare of Georgia health plan work. Please read it. Keep it in a safe place so you can find it when you need it.

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

GETTING STARTED

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

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

You should have received your WellCare member ID card in the mail. If not, call Customer Service at 1-866-231-1821 (TTY 1-877-247-6272). You can also ask for a new ID card on our website at georgia.wellcare.com.

Show this card to your doctor when you need care.

Your card has important information about your health plan. Keep this card and your Medicaid card with you at all times. Failure to present your ID card at the time of service could cause the provider to incorrectly send you a bill. Don't let anyone else use your card. You may lose your benefits if you do.

Please take the time to look at the information on your ID card. Check the primary care physician (PCP) name on it. You can change your PCP by visiting georgia.wellcare.com or calling Customer Service.

Your member start date is also on your ID card.

Q. What if I lose my ID card?

A. Just call Customer Service at 1-866-231-1821 (TTY 1-877-247-6272) or visit georgia.wellcare.com.

We will mail you a new card.

Call your caseworker at the Georgia Department of Human Services, Division of Family and Children Services if you lose your Medicaid card. Call Georgia Health Partnership if you lose your PeachCare for Kids™ card. The number is 1-866-211-0950.

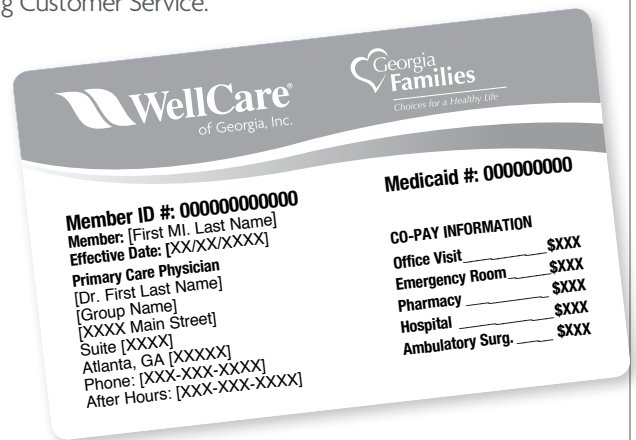
2nd — Changing your primary care physician (PCP).

You can change your PCP. To do this, visit georgia.wellcare.com on the Web or call Customer Service at 1-866-231-1821 (TTY 1-877-247-6272). Then select a PCP from our list of providers. You can also follow these steps to select a PCP if one isn't named on your ID card.

As your personal doctor, your PCP will help you arrange all of the medical care you and your family need. Women can choose a doctor trained in obstetrics/gynecology (OB/GYN) as a PCP. You will find a list of doctors to choose from in your provider directory.

Our providers are sensitive to the needs of many cultures. There are providers who speak your language and understand your traditions and customs.

The provider directory changes often because we are always adding new doctors to our network. You can find the most current list of providers on our website. Go to georgia.wellcare.com. On the site, you can look for doctors, hospitals and pharmacies in your area. You can also get a current directory by calling Customer Service.



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

You can learn more about your providers by calling Customer Service. They can tell you about a provider's schooling or residency, qualifications, or whether he or she accepts new patients. You can also find this information in your provider directory.

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

Your PCP will take care of all your routine medical care. He or she can arrange specialists or hospital care if needed. Call your PCP (unless it's an emergency). The number is on your ID card.

Please get to know your PCP. Call his or her office to schedule a checkup. In fact, we encourage you to see your PCP within 90 days of the start date on your ID card. Please see your PCP within 14 days if you are pregnant.

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

4th — Get to know your Personal Health Advisor.

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

5th — Ask for help in an emergency.

Go to the hospital or call 911 for a real emergency. See the *How to Get Your Medical Services* section for more about emergencies.

6th — Call with your monthly Personal Care Items order.

This handbook has details about the products you can get with the Personal Care Items benefit. Each month, you pick \$10 in items. They will be mailed to you.

Call 1-866-231-1821 (TTY 1-877-247-6272) to order.

7th — Call WellCare Customer Service or visit our website if you need any help.

Call us if you have any questions. Language services for all foreign languages are available. You can also call to ask for your member materials in a different format. This includes different languages, large print and audio tapes. There is no charge.

Customer Service is open weekdays from 7 a.m. to 7 p.m. Eastern. Call toll-free at 1-866-231-1821 (TTY 1-877-247-6272).

We also have plan information on our website. Visit georgia.wellcare.com any time day or night.

8th — Your enrollment in WellCare is your choice.

You can end your WellCare membership during Open Enrollment. You can also end it with "good cause."

Call Customer Service with questions.

9th — Understand your rights and responsibilities.

The law says that your doctor must know what your rights are. It asks that you respect your doctor's rights too. There's more about your rights later in this handbook. You may also see these rights in your doctor's office.

10th — Read this book to learn more. Find out about your dental, vision and mental health benefits.

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

We also have plan information on our website. Visit georgia.wellcare.com any time, day or night.

MEMBER INFORMATION

ENROLLMENT IN WELLCARE OF GEORGIA

Medicaid

WellCare serves kids and adults who are eligible for Georgia's Medicaid program. This program provides health plans for select groups of kids and adults with low incomes. A person must meet certain requirements for Medicaid. The Georgia Department of Family and Children Services decides who is eligible.

You must verify that you are still eligible for Medicaid every six months. You will get a Medicaid review form in the mail. Complete the form and return it to the Department of Family and Children Services (DFCS) office in your county.

PeachCare for Kids™

WellCare also serves kids 18 and younger who enrolled in Georgia's State Children's Health Insurance Program. The program is called PeachCare for Kids™. It's for children who aren't eligible for Medicaid or any other health insurance programs.

How is PeachCare for Kids™ different from Medicaid?

- There's a small monthly payment.
- The child must not be a dependent of a state employee.
- The child must be 18 or younger.
- PeachCare for Kids™ may not have Medicaid Fair Hearing rights.
- There's no co-payment for any service PeachCare for Kids™ members receive.

You can find out more or sign your child up for PeachCare for Kids™ by calling 1-877-427-3224.

WHAT TO DO WHEN YOUR FAMILY SIZE CHANGES

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

HOW TO GET YOUR MEDICAL SERVICES

You can get care from doctors, hospitals and others who are part of our provider network. A doctor in the plan network or the plan must approve your care.

The plan pays for the care it approves. You may have to pay for care the plan doesn't approve.

The plan will approve care that is medically needed. Services that are medically needed:

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

MEDICAID AND PEACHCARE FOR KIDS™ SERVICE REGIONS

You must get care from WellCare network providers in an approved service area. Each county in Georgia belongs to a service area. You can find a list of the areas where you can get care in the front of this handbook. You may have to pay for care you get outside of the service area. An exception is an emergency. You do NOT have to be in the plan's service area to get care in an emergency. Call 911 or visit the nearest hospital in an emergency.

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

COST-SHARING

Medicaid

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

PeachCare for Kids™

PeachCare for Kids™ members don't have co-pays. Instead, they pay a small monthly premium required by the Georgia Department of Community Health. This monthly premium is paid directly to PeachCare for Kids™. The premiums are:

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

A list of covered services and co-payments is on the next few pages. Call Customer Service if you are not sure whether the plan pays for a service.

MEDICAID AND PEACHCARE FOR KIDS™ COVERED SERVICES

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

Benefits	Limits	Co-payments
Ambulatory surgical services		\$3
Childbirth education services		\$0
Dental services (preventive, diagnostic and treatment)		\$0 for members younger than 21 \$0 for members 21 and older
Dental emergency services	Ages 21 and older	\$0
Durable medical equipment		\$0
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services		\$0
Emergency transportation services		\$0
Emergency services		\$0 (if an emergency) \$6 (if not an emergency)
Family planning services and supplies		\$0
Federally qualified health center (FQHC) services		\$2
Health Check services	<ul style="list-style-type: none"> • Medicaid: ages 0 to 21 • PeachCare for Kids™: ages 0 to 19 	\$0
Hearing services	Ages younger than 21: available under EPSDT as part of a written service plan	\$0
Home health services	Social, chore and hearing services, and Meals-on-Wheels are not covered	\$0
Hospice services		\$0
IDEA (Individual Disability Education Act)	Ages 0 to 3, as medically necessary	\$0
Inpatient hospital services	Psychiatric hospitalizations up to 30 days are covered (per treatment episode)	\$12.50 (unless admitted from an emergency room or transferred from another health facility)
Laboratory and radiological services		\$0

Benefits	Limits	Co-payments
Mental health services	<ul style="list-style-type: none"> •Members younger than 21: up to 30 days are covered •Services in a state-operated mental hospital or institution for mental diseases are not covered •Members 21 and older: as medically necessary 	\$0
Nurse midwife services		\$0
Nurse practitioner services		\$0
Nursing facility services	Long-term nursing facility stays (more than 30 days) are not covered	\$0
Obstetrical services		\$0
Occupational therapy services	<ul style="list-style-type: none"> •Members younger than 21: as medically necessary •Members 21 and older: as medically necessary for short-term rehabilitation 	\$0
Orthopedic and prosthetic services	Braces, artificial limbs, artificial eyes, custom molded shoes and diabetic shoes only	\$0
Oral surgery		\$2
Outpatient hospital services		\$3 (non-emergency hospital services)
Physical therapy services	<ul style="list-style-type: none"> •Members younger than 21: as medically necessary •Members 21 and older: as medically necessary for short-term rehabilitation 	\$0
Physician services (PCP visits and specialists)		\$0
Podiatry services	Services for flatfoot, subluxation, routine foot care, supportive devices and vitamin B-12 injections are not covered	\$0
Pregnancy-related services		\$0

Benefits	Limits	Co-payments										
Prescription drugs	See our Preferred Drug List (PDL) for the drugs we cover. This list will also have drugs that may have limits such as prior authorization, quantity limits, step therapy, age limits or gender limits. Medications not on the preferred drug list may be covered with a prior authorization.	<table> <thead> <tr> <th>Cost of Service</th> <th>Co-payment</th> </tr> </thead> <tbody> <tr> <td>\$10.00 or less</td> <td>\$.50</td> </tr> <tr> <td>\$10.01-\$25.00</td> <td>\$1</td> </tr> <tr> <td>\$25.01-\$50.00</td> <td>\$2</td> </tr> <tr> <td>More than \$50.01</td> <td>\$3</td> </tr> </tbody> </table>	Cost of Service	Co-payment	\$10.00 or less	\$.50	\$10.01-\$25.00	\$1	\$25.01-\$50.00	\$2	More than \$50.01	\$3
Cost of Service	Co-payment											
\$10.00 or less	\$.50											
\$10.01-\$25.00	\$1											
\$25.01-\$50.00	\$2											
More than \$50.01	\$3											
Private-duty nursing services		\$0										
Rural health clinic (RHC) services		\$2										
Speech therapy services	<ul style="list-style-type: none"> • Members younger than 21: as medically necessary • Members older than 21: as medically necessary for short-term rehabilitation 	\$0										
Substance abuse treatment services	Inpatient and rehabilitative services covered as part of a written service plan	\$12.50										
Swing bed services		\$0										
Targeted case management	<p>Covered for:</p> <ul style="list-style-type: none"> • Pregnant women under age 21 and other pregnant women at risk for adverse outcomes • Infants and toddlers with established risk for developmental delay 	\$0										
Transplants (heart and lung)	Covered for members younger than 21. Kidney, liver, bone marrow and cornea are only covered transplants for ages 21 and older.	\$0										
Vision services		\$0 for members older than 21										

MEDICAID AND PEACHCARE FOR KIDS™

SERVICES NOT COVERED

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

HOW TO GET APPROVED SERVICES

Call your primary care physician (PCP) when you need regular care. He or she can send you to see a specialist for tests, specialty care and other covered services that your PCP doesn't perform. Your plan pays for this care. If your PCP does not provide an approved service, ask your PCP how to get that service.

Be sure your doctor approves for you to see a specialist. If you need care from a doctor who isn't part of the plan's network, call your doctor for help.

PRIOR AUTHORIZATION TIME FRAMES

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

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

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

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

SERVICES AVAILABLE WITHOUT AUTHORIZATION

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

- Family planning (any plan provider)
- Visits to your PCP
- One women's health visit to an OB/GYN doctor a year
- Yearly eye exams and glasses

- Routine dental care (but not surgery)
- We give women direct access to in-network women's health specialists for routine and preventive health care services.

Having an annual women's exam is one way to promote your health and learn more about your reproductive system. During this exam, your health care provider will:

- Take your medical and gynecological history
- Take your blood pressure, weight and other vital signs
- Examine your body, including your skin, and other systems to check for overall health
- Perform a clinical breast exam
- Check to see if your cervix, ovaries, uterus, vagina, and vulva are of normal size shape, and position
- Check for signs of sexually transmitted infections (STIs), cancer or other abnormalities
- Perform a Pap smear if indicated
- Discuss your potential sexual health needs, such as protection from STIs, and reproductive health needs such as birth control if needed

Even though you do not need approval for these services, you will need to pick a provider from the plan's provider directory. Call to set up an appointment. Tell them you are a WellCare member. Show them your ID card. (You should have received a copy of the provider directory. If you need another copy, call Customer Service. We will mail one to you.)

SERVICES YOU CAN GET WITHOUT AUTHORIZATION AS LONG AS THE PLAN IS NOTIFIED

You do not need approval for the services below. When you get these services, tell the provider you are a member of WellCare and show them your ID card. The provider must then call WellCare. These services include:

- Emergency/urgent care
- Post-stabilization services

Keep reading through this handbook for more information about these types of services.

SECOND MEDICAL OPINION

Call your doctor when you want a second opinion about your care. He or she will ask you to pick a WellCare network doctor in your service area. If you can't find a network doctor, you will be able to pick a doctor who is outside of our network. You don't pay for these services. However, you must go to a network provider for any tests that the second-opinion doctor asks for.

Your doctor will review the second opinion. He or she will then decide the best way to treat you. Remember, you may have to pay for services you get when you see a doctor outside the plan's network without approval.

HOW TO GET AFTER-HOURS MEDICAL CARE

What if you get sick or hurt when your doctor's office isn't open? If it's not an emergency, call your doctor anyway. The number is on your ID card. Your doctor's office will have a doctor on call. He or she will contact you and tell you what to do. You may go to an urgent care center if you can't reach your doctor's office. You don't need prior approval to go to an urgent care center. If you do go to an urgent care center, please call your doctor's office the next day for follow-up care.

WHAT TO DO IN AN EMERGENCY

A medical emergency means your health is in serious danger. The plan will cover this type of care when it's reasonable to think your condition will get worse without care right away.

In the case of an emergency, call 911. Call an ambulance if no 911 service is available in your area, or go to the nearest hospital emergency room (ER) right away. The choice is yours. Call your doctor if you're not sure you have an emergency. You don't need pre-approval for emergency care provided at an urgent care center or the emergency room.

Some examples of emergencies are:

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

An emergency is when the condition could cause:

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

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

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

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

The ER doctor will decide if your visit is an emergency. The ER doctor may decide your condition is not an emergency. The plan will pay for the visit if your symptoms are severe enough to put your health in serious danger. (How much the plan will pay depends on the severity of your symptoms.)

If your condition is not an emergency and your health is not in danger, you can choose to stay. However, you may have to pay for the care in such a case.

Let your PCP know as soon as you can when you are in the hospital and if you get care in an ER or urgent care center.

Your plan will pay for follow-up care that your doctor says you need.

OUT-OF-AREA EMERGENCY CARE

It is important to get care when you are sick or hurt — even when you travel. Call Customer Service toll-free if you get sick or injured while traveling. The number is **1-866-231-1821** (TTY **1-877-247-6272**). If you have an emergency while traveling, go to a hospital. It doesn't matter if you're not in the plan's service area. Show your ID card. Call your doctor as soon as you can. Ask the hospital staff to call WellCare for instructions on how to file your claim.

Out-of-Network

We want to make sure you get the care that you need. If we don't have a network provider who can give you covered services you need, we'll cover these services out-of-network. We'll make sure that the cost to you is no more than it would be if the services were done in-network.

Post-Stabilization Services

It's important that you get care until your condition is stable. The plan will pay for care you get after emergency room care. This is called "post-stabilization" care. You don't need pre-approval for post-stabilization services. However, this care must be needed to maintain, improve or solve your medical condition.

WHAT TO DO IF YOU NEED URGENT CARE

Your doctor should see you first for all care. Go to an urgent care center for a condition that isn't an emergency but needs treatment within 24 hours. These conditions include:

- Injury
- Illness
- Severe pain

Call your doctor if you're not sure you need urgent care. Urgent care center services do not require prior approval. You will need to show your plan and Medicaid cards at the urgent care center. Ask the staff to call WellCare. Let your PCP know if you receive care in an urgent care center so you can get follow-up care.

PREGNANCY AND NEWBORN CARE

If you have a baby while you're a plan member, we will cover your baby from birth.

Moms-to-be should set a time for a prenatal visit with a plan doctor. See the doctor within 14 days of your effective date with the plan or finding out you are pregnant. Call Customer Service for help.

Moms-to-be should also call the plan to find out about having and caring for a baby. The plan can also enroll them in the Prenatal Rewards Program.

Moms will also need to choose a doctor for their baby. The plan will assign one if one isn't chosen.

PREGNANCY CARE GUIDELINES

See your doctor as soon as you know you're pregnant. A doctor can help you know if you're at risk of having the baby too early. It's better to find potential problems sooner when they're easier to treat.¹ Seeing a doctor early and regularly gives you a better chance of having a healthier baby.²

Your doctor will give you tests and care during and after your pregnancy. You can read about these on the next page.

¹*Prenatal and Postpartum Care, The State of Health Care Quality 2005, National Committee for Quality Assurance.*

²*Guidelines for Perinatal Care, Sixth Edition, ©October 2007 by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG).*

THE DOCTOR SHOULD DO THE FOLLOWING:

Each Visit

- Take your weight and blood pressure.
- Ask for a urine sample.
- Measure to see how the baby is growing.
- Listen to the baby's heart rate.
- Ask if you feel the baby moving.
- Ask if you're leaking any liquids.
- Ask if you're eating and taking your vitamins.
- Ask if you're walking, stretching and bending.
- Talk to you about not smoking, drinking alcohol or using drugs.
- Talk to you about what your body will do when the baby is coming.
- Ask you if anyone is hitting or hurting you.
- Ask how you and your family are feeling about the baby coming.
- Ask you about your safety.

First Visit

- Ask you about your other pregnancies or sicknesses.
- Ask you about your mom, dad and grandparents' health and sickness.
- Ask you if you have signed up for WIC.
- Look in your ears, nose and throat.
- Listen to your heart, lungs and tummy.
- Look at your ankles for swelling.
- Ask you to lie down and do an internal exam and Pap smear.
- Take blood to run some tests.
- Give you any shots that you did not get yet.
- Do an ultrasound to listen to the baby's heart rate and see how the baby is doing.
- Talk to you about further testing, as needed.
- Teach you about what to eat, drink and do to have a healthy pregnancy.

Visit Before the Baby Is Born

- Talk to you about what your body will do when the baby is coming.
- Talk to you about what it feels like to have a baby.
- Talk to you about work and going on trips away from home.
- Ask how you and your family are feeling about the baby coming.

First Visit after the Baby Is Born

- Take your weight and blood pressure.
- Give you a Pap test and an exam to make sure you are healing properly.
- Ask if you are eating and taking your vitamins.
- Ask if you are walking, stretching and bending.
- Ask how you and your family are feeling about the baby.
- Talk to you about future babies and planning.

Sources:

Guidelines for Perinatal Care, Sixth Edition, ©October 2007 by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists and supported in part by March of Dimes and the Health Plan Employer Data and Information Set (HEDIS) Standards for Access and Availability, ©2007 by the National Committee for Quality Assurance

Recommendations to Improve Preconception Health and Health Care—United States, MMWR, April 21, 2006/55(RR06); 1–23

Legal Disclaimer: Preventive health guidelines are based on information and recommendations of independent third parties available before printing. These guidelines are not a replacement for your doctor's medical advice. Your doctor may have more up-to-date information. Members should always talk with their doctor(s) about what care and treatment are right for them. The fact that a service or item is in these guidelines is not a guarantee of coverage or payment. Members should look at their own plan coverage papers to see what is or is not a covered benefit. WellCare does not offer medical advice or provide medical care, and does not guarantee any results or outcomes. WellCare does not warrant or guarantee, and shall not be liable for any information that is in these guidelines or that is not in these guidelines or for any recommendations made by independent third parties from whom any of the information was obtained. Version: 08/2008 (revised)

GETTING BEHAVIORAL HEALTH SERVICES

Call Magellan Behavioral Health if you need help with mental health care. The number is **1-800-424-5412** (TTY **1-877-342-6815**). They'll give you a choice of providers and help you find one in your area. You can also get names of providers at www.magellanhealth.com.

You can get other mental health services at the hospital. This includes substance abuse and other care. You can learn more by calling Magellan at **1-800-424-5412** (TTY **1-877-342-6815**). Magellan will be happy to help you.

What to Do if You Need Help

Call Magellan if you have any of the feelings below. They'll give you names of doctors 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 things you like
- Problems paying attention
- Being upset
- Your head, stomach or back hurts, and your doctor hasn't found a cause
- Drug or alcohol problems

Limitations and Exclusions

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

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

Do you think your health is at risk? Do you feel you are a danger to yourself or others? If you do, call 911 or go to the nearest hospital. You don't have to get prior authorization in a mental health emergency.

The doctor may say you need more treatment after the emergency room visit. This could be to stabilize, improve or resolve your health problem. This treatment will be covered by the plan. You should follow up with your primary doctor within 24 to 48 hours once you're allowed to go home.

The hospital where you get care might be out of the plan's service area. If this happens, you will be taken to a plan facility when you are well enough.

Please read pages 11 and 12 for more information on how to get emergency, urgent or post-stabilization care for mental health emergencies

Call Magellan any time you need help. The number is **1-800-424-5412** (TTY **1-877-342-6815**).

ACCESS TO MEDICAL SERVICES

The plan has a medical team to offer quick service to members. You should not have to travel too far or too long to reach network providers. Below is a list that tells you the most you should have to travel to reach a provider:

PCPs:

- No more than eight miles if you live in an urban area
- No more than 15 miles if you live in a rural area

Specialists:

- No more than 30 minutes or 30 miles if you live in an urban area
- No more than 45 minutes or 45 miles if you live in a rural area

Hospitals

- No more than 30 minutes or 30 miles if you live in an urban area
- No more than 45 minutes or 45 miles if you live in a rural area

Pharmacies

- Within 15 minutes or 15 miles in an urban area
- Within 30 minutes or 30 miles in a rural area

We also want to make sure that you get timely care. This list shows different types of care and the most you should have to wait to get it.

- **Emergency care** — right away (this is both in and out of the plan area) and without pre-approval
- **Urgent care** — within 24 hours (urgent care is for a problem that's not life-threatening but could cause sickness or harm with it's not treated)
- **Care for adults** — within 72 hours of request
- **Care for children** — within 24 hours of request
- **Physical exams** — within 21 days of request
- **Follow-up care** — as needed
- Our doctors must give you the same office hours as patients with other insurance.

HOW TO GET OTHER WELLCARE SERVICES

MEDICAID AND PEACHCARE FOR KIDS™ DENTAL SERVICES

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

- Two exams per benefit year
- Dentures — one pair every three years
- Two cleanings per benefit year
- Denture repairs — two adjustments per benefit year
- Two fluoride treatments per benefit year
- Oral surgery
- Orthodontic treatment
- One filling per tooth

WellCare offers expanded dental benefits to adults ages 21 and older. Dental services for adults include:

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

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

PeachCare for Kids™ dental services include:

- Two exams per benefit year
- Dentures — one pair, every three years
- Two cleanings per benefit year
- Denture repairs — two adjustments per benefit year
- Two fluoride treatments per
- Oral surgery benefit year
- Orthodontic treatment
- One filling per tooth

Doral Dental provides these services. Call them at 1-800-205-4715 to choose a dentist. They can also answer your questions about dental care.

MEDICAID AND PEACHCARE FOR KIDS™ VISION SERVICES

The plan pays for:

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

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

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

PeachCare for Kids™ vision services include:

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

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

MEDICAID AND PEACHCARE FOR KIDS™ HEARING SERVICES

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

- Inner ear implants
- Hearing aid fitting and dispensing
- Tests
- Hearing aid repairs and parts
- Hearing aids (one every three years)
- Newborn hearing tests and/or based on medical necessity

PRESCRIPTION DRUG SERVICES

Prescriptions and Pharmacy Access

Q. How do I get a prescription?

A. Prescriptions must be written by a plan doctor.

Q. Which drug stores will fill my prescription?

A. You must get your prescriptions filled at a drug store in the plan network. A list of these drug stores is on the WellCare website. You can also call Customer Service for help at 1-866-231-1821 (TTY 1-877-247-6272).

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

A. Show your ID card when you give your prescription. Some drugs and over-the-counter drugs covered by the plan may have a co-pay. The co-pay is based on the cost of the drug. Call Customer Service to find out if you have a co-pay. Here's a co-pay guide:

Drug Cost	Member Cost
Less than \$10.01	\$.50
Between \$10.01 and \$25	\$1
Between \$25.01 and \$50	\$2
Greater than \$50.01	\$3

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

Preferred Drug List

Q. What medicine does the plan pay for?

A. Medicines the plan pays for are on the Preferred Drug List (PDL). This list is sometimes called a “formulary.” Doctors and pharmacists make the list. Your doctor will use the list when prescribing you medicine. Some drugs will require approval through a Coverage Determination Request (CDR) that your doctor completes. This applies to drugs that require prior authorization and those drugs not listed on the PDL. The list will also have drugs that may have limits such as prior authorization, quantity limits, step therapy, age limits or gender limits. The list is on the WellCare website. You can also call Customer Service to ask for a printed PDL.

Q. Are there medicines WellCare of Georgia will not pay for?

A. The plan does not pay for these medicines:

- Those used for eating problems or weight gain
- Those used to help you get pregnant
- Those that are for cosmetic purposes or help you grow hair
- Those that help you stop smoking
- Barbiturates, except Seconal, Phenobarbital and Mebaral
- Vitamins (some prenatal vitamins and fluoride preparations are covered)
- Over-the-Counter (OTC) drugs (some OTC drugs are covered)
- DESI (Drug Efficacy Study Implementation) drugs and drugs that are identical, related or similar to such drugs
- Investigational or experimental drugs

Q. Can I get any medicine I want?

A. You will get all medicines that are medically necessary. All drugs your doctors order for you, may be covered if they are on the Preferred Drug List (see above). You may be required to follow prior approval procedures if your doctor prescribes certain medicines. Call Customer Service with any questions. In some cases, we require you to try another drug before approving the one you originally asked for. We may not approve your requested drug if you do not try the alternative drug first.

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

A. Generic drugs work the same as brand-name drugs. They have the same active ingredients as brand-name drugs. They just cost less.

Over-the-Counter (OTC) Drugs

Q. Does the plan pay for OTC drugs?

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

- Diphenhydramine
- Meclizine
- H2 receptor antagonists
- Ibuprofen suspension for members under 21 years of age
- Multi-vitamins with iron liquid drops
- Insulin
- Insulin syringes
- Non-sedating antihistamines
- Iron
- Topical antifungals
- Urine test strips
- Coated aspirin

Member Reimbursement

Q. What is a medication Direct Member Reimbursement?

A. Sometimes you may pay for medications with your own money at a retail drug store. You may then submit a claim form and your receipts to recover your costs. This is called Direct Member Reimbursement or DMR.

Q. Where do I send my request?

A. WellCare of Georgia
Reimbursement Department
P.O. Box 31577
Tampa, FL 33631-3577

Q. What do I need to include with each DMR request for approval?

A. Include these items:

- A completed, signed Direct Member Reimbursement form
- A detailed prescription receipt (handwritten receipts will not be accepted) or pharmacy printout with the following information: member name, pharmacy name, physician name, drug name, drug strength, quantity dispensed, day supply and the amount you paid
- A cash register receipt that shows the date the prescription was paid for and what amount was paid

All this information must be included. Otherwise, the DMR will be denied. You will then be able to send in your request again with the missing information.

Q. How much will I get back?

A. If we find that the medication is a covered benefit, you will receive a check for the plan contracted price, not the retail price.

Q. How long should I expect to wait for my reimbursement?

A. It usually takes four to six weeks from the date you mail in the DMR form. Be sure that your form is completed and has all the information. Otherwise, your request may be delayed or denied. Formulary guidelines will apply to all reimbursement requests.

Q. What if I don't like the decision that was made?

A. You may not like the decision we make. You have the right to appeal it. See the Member Grievance and Appeal Procedures section of this handbook for more information on your right to appeal.

Q. Does the plan pay for Personal Care Items?

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

Helpful Pharmacy Terms

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

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

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

Over-the-counter (OTC) drugs — drugs you can buy that are not behind the drug store counter and do not require a doctor's order. OTC drugs that are covered by WellCare of Georgia require a prescription.

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

Preferred Drug List (PDL) — a list of preferred drugs approved by plan doctors and pharmacists. These medicines are safe and may cost less. The plan's drug list may contain medication that may require approval. The PDL — sometimes called a "formulary" — shows doctors which drugs are covered.

Call Customer Service with any pharmacy-related questions.

PERSONAL CARE ITEMS

Your family can get up to \$10 in Personal Care Items each month. This includes vitamins, medicines and health supplies. You can choose items found in the following list. Make your selection and then call toll-free 1-866-231-1821 (TTY 1-877-247-6272) to place your order. Your items will be mailed to your home.

Choose from the list below. You can check our website for the most updated version of this listing.

ID #	Generic Comparable	Brand Description	Quantity	Price
ALLERGY PREVENTION AND TREATMENT				
1	Loratadine 10mg Tablets	Claritin®	10	\$4.00
2	Cetirizine 10mg Tablets	Zyrtec®	14	\$7.00
3	Diphenhydramine 25mg Capsules	Benadryl®	24	\$4.00
ANALGESICS/ANTIPYRETICS				
4	Aspirin 325mg Tablets	Bayer® Aspirin	100	\$3.00
5	Aspirin Enteric Coated 81mg Tablets	Bayer EC® Aspirin (Adult Regimen)	120	\$5.00
6	Enteric Coated Aspirin 325mg Tablets	Ecotrin® Tablets	60	\$5.00
7	Acetaminophen 325mg Tablets	Tylenol® Regular Strength Tablets	100	\$7.00
8	Acetaminophen 500mg Tablets	Tylenol® Extra Strength Caplets	50	\$5.00
9	Acetaminophen 500mg/Caffeine 60mg/Pyrimidine 15mg	Midol®	24	\$7.00
ANTACIDS AND ACID REDUCERS				
10	Simethicone 80mg Tablets	Mylanta® Gas 80mg Tablets	100	\$9.00
11	Omeprazole 20mg	Prilosec®	14	\$10.00
12	Calcium Carbonate 500mg Tablets	Tums® Tablets	150	\$4.00
13	Ranitidine HCL 75mg Tablets	Zantac® Tablets	30	\$8.00
14	Famotidine 10mg Tablets	Pepcid®	18	\$6.00
15	Simethicone 125mg Tablets	Gas-X® Extra Strength	30	\$5.00
ANTI-ARTHRITICS				
16	Acetaminophen 650mg Tablets	Tylenol® Arthritis Pain Tablets	50	\$6.00
17	Glucosamine 1500mg/Chondroitin 1200mg	Glucosamine/Chondroitin DS®	60	\$9.00
ANTICANDIALS (YEAST)				
18	Clotrimazole Vaginal 1% Cream—1 Application	Gyne-Lotrimin®	6oz	\$8.00
ANTIDIARRHEALS AND LAXATIVES				
20	Docusate Sodium 100mg Capsules	Colace® Softgels	60	\$8.00

ID #	Generic Comparable	Brand Description	Quantity	Price
21	Adult Glycerin Suppositories	Fleet® Adult Suppositories	50	\$4.00
22	Bisacodyl 10mg Suppositories	Dulcolax® Suppositories	12	\$6.00
23	Bisacodyl 5mg Tablets	Dulcolax® Tablets	25	\$5.00
24	Loperamide 2mg Capsules	Imodium® Caplets	12	\$5.00
25	Antinausea Liquid	Emetrol®	4oz	\$7.00
26	Bismuth Subsalicylate 262mg Tablets	Pepto-Bismol® Chewable Tablets	30	\$4.00
MOTION SICKNESS MEDICATION				
28	Dimenhydrinate 50mg Tablets	Dramaine® Motion Sickness	12	\$4.00
TOPICAL OINTMENTS AND CREAMS				
29	Diphenhydramine Anti-Itch Cream	Benadryl® Cream	1oz	\$4.00
30	Menthol 10%/Methyl Salicylate 15% Cream	Bengay®	1.25oz	\$3.00
31	Triple Antibiotic Ointment	Neosporin® Ointment	0.5oz	\$5.00
32	Clotrimazole 1% Cream	Lotrimin® AF	0.5oz	\$7.00
33	Tolnaftate 1% Cream	Tinactin® Cream	0.5oz	\$6.00
35	Hydrocortisone 1% Maximum Strength Cream	Cortaid® Cream	0.5oz	\$4.00
COLD, FLU, DECONGESTANT AND SINUS REMEDIES				
36	Oxymetazoline Hydrochloride 0.05% Solution	Afrin® Nasal Spray	1oz	\$5.00
37	Saline Nasal Spray	Ocean® Nasal Spray	1.5oz	\$3.00
38	Throat Lozenges—Assorted Flavors	Halls® Cough Drops	30	\$2.00
39	Guaifenesin 100mg/5ml	Robitussin® Syrup	4oz	\$5.00
40	Guaifenesin 100mg/5ml—Sugar-Free	Robitussin® Sugar-Free Syrup	4oz	\$5.00
41	Vicks Vaporub®	Vicks Vaporub®	3.53oz	\$6.00
42	Acetaminophen 325mg/Dextromethorphan 10mg/ Phenylephrine 5mg Tablets	DayQuil® Caplets	20	\$6.00
43	Acetaminophen 325mg/Dextromethorphan 15mg/ Doxylamine 6.25mg Tablets	NyQuil® Caplets	12	\$4.00
44	ASA 325mg/Sodium Bicarbonate 1916mg/Citric Acid 1000mg Tablets	Alka-Seltzer®	20	\$5.00
45	Guaifenesin 600mg Tablets	Mucinex®	30	\$9.00
46	Guaifenesin 600mg/Dextromethorphan 30mg Tablets	Mucinex-DM®	30	\$10.00
47	Phenylephrine HCL 10mg Tablets	Sudafed® PE	18	\$4.00
48	Acetaminophen 325mg/Guaifenesin 200mg/Phenylephrine 5mg Tablets	Tylenol® Sinus and Congestion Tablets	24	\$5.00

ID #	Generic Comparable	Brand Description	Quantity	Price
DENTAL/DENTURE CARE				
49	Benzocaine 20% Oral Anesthetic	Anbesol®	0.5oz	\$5.00
50	Denture Adhesive Cream	Fixodent®	2.4oz	\$4.00
51	Toothbrush	Toothbrush	1	\$2.00
52	Fluoride Toothpaste	Colgate®	6.4oz	\$3.00
53	Waxed Dental Floss	Waxed Dental Floss	1	\$2.00
EAR CARE				
54	Ear Syringe	Ear Syringe	3oz	\$4.00
55	Carbamide Peroxide (6.5%) Solution	Debrox® Ear Wax Removal	0.5oz	\$7.00
EYE CARE				
56	Polyvinyl Alcohol 0.5%/Povidone 0.6% Lubricant Eye Drops	Murine® Tears	0.5oz	\$5.00
57	Tetrahydrozoline HCl 0.05%	Visine® Drops	0.5oz	\$4.00
FIBER SUPPLEMENTS				
58	Psyllium Husk, Approximately 0.52g	Metamucil®	90	\$9.00
FIRST AID/MEDICAL SUPPLIES				
59	Athletic Bandage	Ace® Bandage	1	\$3.00
60	Adhesive Tape—1/2 Inch x 5 Yards	Adhesive Tape	1	\$2.00
61	Alcohol Swabs	Alcohol Swabs	100	\$2.00
62	Bandages—Assorted	Band-Aids®	30	\$2.00
63	Butterfly Closures	Butterfly® Closures	10	\$2.00
64	Cotton Balls	Cotton Balls	100	\$2.00
65	Cotton Swabs	Q-Tips® Cotton Swabs	120	\$2.00
66	Ice Bag	Ice Bag	1	\$5.00
67	Stretch Gauze Bandage—2 Inches x 5 Yards	Johnson & Johnson® Gauze	1	\$2.00
68	Oral Thermometer	Oral Thermometer	1	\$6.00
69	Flexible Tip Thermometer	Flexible Tip Thermometer	1	\$10.00
70	Thermometer Probe Covers	Thermometer Probe Cover	30	\$3.00
71	Menthol 5% Patches	Icy Hot® Patches—Large	5	\$6.00
72	Corn and Callus Remover	Dr. Scholl's® Corn and Callus Remover	0.33oz	\$5.00
73	Salicylic Acid (17% w/w) Liquid	Compound W® Wart Remover	0.31oz	\$7.00

ID #	Generic Comparable	Brand Description	Quantity	Price
HEMORRHOIDAL PREPARATIONS				
74	Mineral Oil 46.6%/Pramoxine HCL 1%/Zinc Oxide 12.5%	Tucks® Hemorrhoid Ointment	0.7oz	\$4.00
75	Mineral Oil 14%/Petrolatum 71.9%/Phenylephrine 0.25%/Shark Oil 3% Cream	Preparation H® Ointment	2oz	\$8.00
76	Witch Hazel 50% Pads	Tucks® Medicated Pads	100	\$8.00
HEADACHE RELIEF				
78	Acetaminophen 250mg/Aspirin 250mg/Caffeine 65mg Tablets	Excedrin® Migraine	24	\$4.00
79	Acetaminophen 500mg/Diphenhydramin Citrate 38mg Tablets	Excedrin® PM Tablets	50	\$6.00
ANTI-INFLAMMATORY				
80	Ibuprofen 200mg FC Tablets	Advil® Tablets	50	\$5.00
81	Naproxen Sodium 220mg Caplets	Aleve® Caplets	50	\$6.00
82	Ibuprofen 200mg Liquid Gel Caps	Advil® Liquid Gel Caps	20	\$5.00
PEDICULICIDES				
83	Lice Treatment Maximum Strength Shampoo	Rid® Extra Strength Shampoo	4oz	\$10.00
84	Lice Comb	Lice Comb	1	\$7.00
SLEEPING AIDS				
85	Diphenhydramine 25mg Capsules	Unisom® Sleep Tablets	16	\$5.00
VITAMINS AND MINERALS				
86	B-Complex/B-12 Vitamins	B-Complex/B-12 Vitamins	100	\$6.00
87	Adult Multi-Vitamin Tablets	Centrum® Multi-Vitamin Tablets	100	\$9.00
88	Prenatal Vitamins	Stuart Prenatal® Vitamins	100	\$10.00
89	Vitamin C 500mg Tablets	Vitamin C 500mg Tablets	100	\$4.00
90	Vitamin E 400 IU Caplets	Vitamin E 400 IU Caplets	100	\$7.00
91	Vitamin A 10,000 IU Caplets	Vitamin A 10,000 IU Caplets	100	\$4.00
92	Elemental Iron 65mg Tablets	Feosol®	100	\$8.00

ID #	Generic Comparable	Brand Description	Quantity	Price
93	Folic Acid 500mcg Tablets	Folic Acid 400mcg Tablets	100	\$5.00
94	Magnesium 250mg Tablets	Magnesium 250mg Tablets	100	\$3.00
95	Zinc 50mg Tablets	Zinc 50mg Tablets	100	\$5.00
96	Synthetic Vitamin B-1 100mg Tablets	Vitamin B-1 100mg Tablets	100	\$4.00
97	Synthetic B-12 500mcg Tablets	Vitamin B-12 500mcg Tablets	100	\$6.00
98	Synthetic Vitamin B-6 100mg Tablets	Vitamin B-6 100mg Tablets	100	\$5.00
99	Calcium Carbonate 600mg/Vitamin D 400 IU Tablets	Caltrate® 600 + D	60	\$6.00
100	Calcium Carbonate 600mg Tablets	Caltrate® 600	60	\$6.00
CHILDREN'S PRODUCTS				
101	Orajel Baby	Orajel® Baby	0.33oz	\$7.00
102	Tooth and Gum Cleanser	Tooth and Gum Cleanser	1.4oz gel	\$6.00
103	Diaper Rash Ointment	Balmex® Ointment	1oz	\$3.00
104	Salicylic Acid 17% w/v 0.5oz Liquid	Duofilm®	0.5oz	\$7.00
105	Gas Relief Drops	Mylicon® drops	1oz	\$10.00
106	Baby Poly Vitamin Drops 50ml	Poli-Vi-Sol® Drops	50ml	\$7.00
107	Children's Chewable Multi-Vitamins	Flintstones® Multi-Vitamins	100	\$7.00
108	Children's Ibuprofen Suspension 100mg	Motrin® Suspension for Children	4oz	\$5.00
109	Junior Strength Pain Ibuprofen Chewable Tablets 100mg	Motrin® Jr. Strength	24	\$5.00
110	Junior Strength Pain Relief Apap Chewable Tablets 160mg	Tylenol® Jr. Strength	24	\$5.00
111	Acetaminophen Children's Elixir 160mg/5ml	Tylenol® Children's Elixir	4oz	\$5.00
112	Acetaminophen Chewable Tablets	Tylenol® Children's Chewable Tablets	30	\$5.00
113	Children's Cold and Allergy Elixir 5ml	Dimetapp® Cold and Flu Elixir	4oz	\$5.00
114	Infant Ibuprofen Oral Suspension 50mg	Motrin® Infant Drops Dye Free	1oz	\$7.00
115	Acetaminophen Children's Elixir 30ml	Tylenol® Infant Drops	1oz	\$5.00

ID #	Generic Comparable	Brand Description	Quantity	Price
116	Children's Glycerin Suppositories	Children's Glycerin Suppositories	25	\$2.00
117	Diphenhydramine Liquid 5ml—Alcohol Free	Benadryl® Elixir	4oz	\$4.00
HERBALS				
118	CoQ-10 20mg	CoQ-10	30	\$7.00
119	Ginkgo Biloba 60mg	Ginkgo Biloba	30	\$8.00
OTHER ITEMS				
120	Condoms	Condoms	3	\$2.00
121	Pill Box	Pill Box	1	\$2.00
122	Throat Lozenges	Chloraseptic®	30	\$2.00
123	Hand Sanitizer Wipes	Hand Sanitizer Wipes	24	\$4.00
124	Feminine Hygiene Wipes	Feminine Hygiene Wipes	12	\$2.00
125	Premium Medium Baby Diapers	Premium Medium Baby Diapers	18	\$8.00
126	Premium Large Baby Diapers	Premium Large Baby Diapers	16	\$8.00
127	Premium Extra Large Baby Diapers	Premium Extra Large Baby Diapers	14	\$8.00
128	SPF 30 Sunblock	SPF 30 Sunblock	1	\$6.00
129	Preference Facial Tissue	Preference Facial Tissue	1	\$2.00
130	Pregnancy Test	Pregnancy Test	1	\$9.00
131	Fever Strip Thermometer	Fever Strip Thermometer	2.1 oz	\$3.00

- Amount is for each head of household, not each family member.
- If you do not use your \$10 in a month, it does not carry over to the next month.
- Items, quantities and prices may change depending on availability.
- Brand items may be supplied in place of generic items.

PERSONAL HEALTH ADVISOR (24-HOUR NURSE HELPLINE)

Personal Health Advisor is WellCare's 24-hour nurse advice line. You can call seven days a week, every day of the year. There is no charge for this service. Call the Personal Health Advisor at **1-800-919-8807** when you need health advice.

When you call, a nurse will ask you some questions about your problem. Give as many details as you can. Tell the nurse where it hurts, what it looks like and what it feels like. The nurse can help you decide if you need to:

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

You can get help with problems like:

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

Remember, a nurse is always there to help. Call before you call a doctor or go to the hospital. But if you think it is a real emergency, call 911 or your local emergency services first.

DISEASE AND CASE MANAGEMENT PROGRAMS

Case and disease management services are available to help members.

Our Case Management Program offers members help with special health situations. Some — but not all — of the services include:

- Chronic illnesses requiring coordination of many services
- Children with special health care needs
- Transplant
- High-risk pregnancy
- Multiple chronic illnesses

Our Disease Management Program provides support to members with the following conditions:

- Asthma
- Coronary artery disease (CAD)
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- HIV
- Hypertension

Guides are available for people with asthma, diabetes or kidney disease. Call Customer Service for more information or to enroll in the Case or Disease Management Program. You can reach them at **1-866-231-1821** (TTY **1-877-247-6272**).

TRANSPORTATION SERVICES — MEDICAID MEMBERS ONLY

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

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

***Non-emergency transportation is not a covered benefit for PeachCare for Kids™ members.**

OTHER PROGRAMS

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

- Stop-smoking programs
- Domestic abuse support
- Programs for kids
- Drug and alcohol programs
- Programs for moms-to-be and their babies
- **Stay Connected** — this program allows qualified members to get a free cell phone as part of our Case Management program to stay connected to their case manager, their doctor and family members. Please speak to your Case Manager for more information.
- **Free** family fitness membership with access to fitness programs for qualifying members as part of our Case and Disease Management program. This program will allow select members to exercise and learn about fitness and nutrition.
- **Free** baby showers. Members will get gift baskets and tips about keeping mom and baby healthy. There's also a chance to win a free bassinet.

Keeping You and Your Unborn Baby Healthy

As your health plan, we want to help you and your unborn baby stay healthy. One of the ways we can do this is with our Prenatal Program. It's a free service. When you enroll, we will contact you to do a health screening. This screening will help us see if you may benefit from case management. Our registered nurses and licensed social workers will help you deal with any physical, emotional or social concerns.

As part of the program, we will mail you an Educational Booklet called "**Mommy and Baby Matters, Taking Care of Yourself and Your Baby**". It gives basic pre-birth and post-birth useful tips to help you take good care of yourself and baby.

Also, you can join the Prenatal Reward Program. You will receive a baby stroller if you meet the Program guidelines. Details about this Program will be provided when you receive the Educational Booklet mailing.

Please call Customer Service at 1-866-231-1821 (TTY 1-877-247-6272) for more information. Someone can help you Monday through Friday, 7 a.m. to 7 p.m. Eastern.

HEALTH CHECK SERVICES

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

WellCare wants to make sure kids visit their PCPs for checkups at early ages. This can help a child's health later in life.

Q. What is a health checkup?

A. A checkup is a time when your child's PCP will make sure that your child is growing up healthy.

The doctor will:

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

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

Q. Why is a health checkup important?

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

Q. When should a health checkup occur?

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

- At birth, in the hospital
- 2 months old
- 4 months old
- 6 months old
- 9 months old
- 12 months old
- 15 months old
- 18 months old
- 24 months old
- 30 months old
- Every year from age 3 to 19 years old (PeachCare for Kids™ members)
- Every year from age 3 to 21 years old (Medicaid members)

Q. How much does a health checkup cost me?

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

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

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

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

A. The plan can help you get a ride to the doctor. Call Customer Service. Also, see the Transportation section on page 30.

PREVENTIVE HEALTH GUIDELINES — NEWBORN TO 21 YEARS OLD

Age	Well-Baby Checkups and Shot Guide
Newborn	Well-baby checkup* at birth. Hearing test. Newborn screening blood tests and Hepatitis B (HepB) vaccine.
3 to 5 days	Well-baby checkup* as recommended by your doctor, including newborn screening blood tests and hepatitis B (hepB) vaccine if not done at birth. This visit is especially important if your baby was sent home within 48 hours of birth.
1 month	Well-baby checkup.* Second dose of hepB vaccine. Newborn screening blood test if not already completed.
2 months	Well-baby checkup.* Diphtheria, tetanus and pertussis (DTaP), rotavirus (RV), polio (IPV), pneumococcal conjugate (PCV) and haemophilus influenzae type b (Hib) vaccines. Newborn screening blood test if not already completed.
4 months	Well-baby checkup.* DTaP, Hib, IPV, PCV and RV vaccines.
6 months	Well-baby checkup.* DTaP, HepB, IPV, PCV, flu, Hib and RV vaccines. Blood lead risk test.
9 months	Well-baby checkup.* Blood lead test.
12 months	Well-baby checkup.* Blood lead; hemoglobin or hematocrit; Hib, measles, mumps, rubella (MMR); hepatitis A (HepA); varicella (chickenpox); PCV and flu shots. Dental visit as need identified.**

Age	Well-Baby Checkups and Shot Guide
15 months	Well-baby checkup.* DTaP vaccine, urine test and blood lead if not done at 9 months or 12 months.
18 months	Well-baby checkup.* Second dose of HepA vaccine (6 months after the first dose), dental visit.
24 months	Well-baby checkup.* Blood lead test, flu shot, dental visit.
30 months	Well-baby checkup.*
3 years	Well-child checkup.* Eye screening. Dental visit twice a year. Flu shot. Blood lead test if none were performed at ages 12 and 24 months.
4 to 6 years	Well-child checkup* every year. Eye screening between 4–5 years. Dental visit twice a year. Urine test at age 5 years. DTap, IPV, MMR, varicella and flu shots. Blood lead test if none were performed at ages 12 and 24 months.
7 to 10 years	Well-child checkup* every year. Dental visit twice a year. Flu shot every year.
11 and 12 years	Well-child checkup* every year. Meningococcal conjugate (MCV) vaccine, Tetanus, diphtheria and pertussis (Tdap) vaccine, Human Papillomavirus (HPV) vaccine series, flu shot every year. Dental visit twice a year.
13 to 21 years	Well-adolescent checkup* every year. HPV series (if not administered previously). Flu shot every year for ages 13–18. Dental visit twice a year. Urine test by age 16. Females should have a pelvic exam and Pap smear between 18 and 21 years. High-risk members ages 19–21 should have flu shot each year.

NOTES:

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

Your doctor will also perform the following services as needed:

1. Hemoglobin or hematocrit at ages 4, 12, 18, 24 months and 3 years to 21 years old
2. Lead risk assessments and/or testing from 6 to 72 months old
3. Tuberculosis risk assessments and/or testing at ages 1, 6, 12, 18, 24 months and 3 to 21 years old
4. Cardiovascular disease risk assessments and cholesterol screening from age 2 years to 21 years old
5. Sexually transmitted infections testing from age 11 years to 21 years old
6. “Catch up” on any shots that have been missed at an earlier age

**Dental visits may be recommended beginning at 6 months.

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

References:

2008 Bright Futures/American Academy of Pediatrics (www.aap.org)

Committee on Practice and Ambulatory Medicine Recommendations for Preventive Pediatric Health Care, PEDIATRICS, Vol. 105 (3), March 2000, pages 645–646, Copyright © 2000 by the AAP

Recommended Immunization Schedules for Persons Aged 0-18 Years—United States, 2009 approved by the Advisory Committee on Immunization Practices (ACIP), www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#printable, the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP)

Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind, United States—2009, approved by the Advisory Committee on Immunization Practices (www.cdc.gov/nip/acip/), 2008 Bright Futures/American Academy of Pediatrics (www.aap.org) and the American Academy of Family Physicians (www.aafp.org)

American Dental Association (www.ada.org/)

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Version: 01/2009 (revised)

PREVENTIVE HEALTH GUIDELINES—ADULTS 21 AND OLDER

FREQUENCY OF PHYSICAL EXAMINATION

All new members should get a baseline physical exam in the first 90 days of enrollment. Pregnant members should be seen in the first 14 days. The Cleveland Clinic’s recommendations for periodic health exam visits for adults who have no symptoms are:

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

Age	Screening	Frequency
18 years of age and older	Blood pressure, height, body mass index (BMI), alcohol use	Each year from age 18 to 21; then, every 1 to 2 years or at PCP’s recommendation
Men 35 to 65 years of age	Cholesterol (non-fasting TC/HDL)	Every 5 years (more often if elevated)
Women 45 to 65 years of age	Cholesterol (non-fasting TC/HDL)	Every 5 years (more often if elevated)
High risk men and women 20 years of age and older	Cholesterol (non-fasting TC/HDL)	Every 5 years (more often if elevated)
Women 18 years of age and older who are sexually active (consider at age 12 if sexually active)	Chlamydia	Each year and at PCP’s recommendation
Women 18 to 65 years of age (or 3 years after onset of sexual activity, whichever comes first)	Pap smear	Every 1 to 3 years
Women 40 years of age and older	Mammography	Every 1 to 2 years
50 years of age and older	Colorectal	Periodically, depending upon test and risk (e.g. colonoscopy every 10 years if low risk, 2 years if high risk)
Women 65 years of age and older (60 and older if at risk for fractures)	Osteoporosis	Bone mass measurement every 2 years
65 years of age and older	Vision, hearing	Periodically

Age	Screening	Frequency
Immunization		
Tetanus-Diphtheria and acellular pertussis (Td/Tdap)	19 years and older Tdap: Substitute 1-time dose of Tdap for Td, then boost with Td every 10 years	
Varicella (VZV)	All adults without evidence of immunity to varicella should receive 2 doses of single-antigen varicella vaccine if not previously vaccinated or the second dose if they have received only 1 dose, unless they have a medical contradiction	
Measles, Mumps, Rubella (MMR)	Adults born during or after 1957 should receive 1–2 doses unless they have a medical contradiction	
Pneumococcal polysaccharide (PPSV)	65 years of age and older – 1 dose	
Influenza (Flu)	Every year, 50 years of age and older	
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 of age and older – 3 doses	
Meningococcal conjugative vaccine (MCV)	College freshmen living in dormitories not previously vaccinated and others at risk, 18 years of age and older – 1 dose; meningococcal polysaccharide vaccine is preferred for adults older than 56	
Human Papillomavirus	*For eligible members through 26 years of age (3-dose series)	
Zoster	Age 60 and older – 1 dose unless member has a medical condition that constitutes a contraindication	
Haemophilus Influenza type b (Hib)	For eligible members who are at high-risk and who have not previously received Hib vaccine (1 dose)	
Prevention		
Discuss:	<ul style="list-style-type: none"> • Aspirin to prevent cardiovascular events • - Men: 40 years of age and older • - Women: 50 years of age and older • The importance of preventive exams (mammograms and breast self examination for women at high risk and who have family history) • Prostate-specific antigen (PSA) test and rectal exam (for men 40-75 years of age, per PCP's discretion) 	
Counseling	<ul style="list-style-type: none"> • Calcium – 1,000mg a day for women 18 to 50 years of age; 1,200 to 1,500mg a day for women 50 years of age and older • Folic acid – 0.4mg a day for women of childbearing age; 4mg a day for women who have had children with Neural Tube Defects (NTDs) • Breast feeding-women after giving birth • Quitting tobacco; drug and alcohol use; STDs and HIV; nutrition; physical activity; sun exposure; oral health; injury prevention; polypharmacy 	

*Subject to individual state coverage.

References:

Guide to Clinical Preventive Services, 2007: Recommendations of the U.S. Preventive Services Task Force, 2007

Press Release, CDC's Advisory Committee Recommends Human Papillomavirus Vaccination, June 29, 2006

Recommended Adult Immunization Schedule – United States, 2009

Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III), May 2001

Bone Health and Osteoporosis: A Report of the Surgeon General (2004)

Cleveland Clinic www.cchs.net/health/health-info Periodic Health Exams and Cancer Screening

ACG Recommendations on Colorectal Cancer Screening for Average and Higher Risk Patients in Clinical Practice, April 2008

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Version: 02/2010 (updated)

ADVANCE DIRECTIVES

An advance directive is a way to tell others what kind of care you would want if you could not communicate.

One way you can make your wishes known is by completing a Georgia Advance Directive for Healthcare. It will take the place of any other advance directives that you have such as a Living Will or a Durable Power of Attorney for Healthcare. You can choose not to complete a Georgia Advance Directive for Healthcare. If so, your current Living Will and/or Durable Power of Attorney for Health Care will stay in place. This is true as long as it/they were created before June 30, 2007.

Are you thinking about filling out a Georgia Advance Directive for Healthcare? Here are a few things you need to remember.

- It is your choice to fill one out.
- Filling one out does not mean you want to commit suicide, physician-assisted suicide, homicide or euthanasia (mercy killing).
- Filling one out will not affect anything that is based on your life or death. For example, other insurance.
- You must be of sound mind to complete one. You must also be at least 18 years of age or an emancipated minor.
- You must sign it. You must have two witnesses sign it as well.
- After you fill one out, keep it in a safe place. You should give a copy of it to someone in your family and your doctor.
- You can make changes to it at any time.
- A caregiver may not follow your wishes if they go against his or her conscience. A caregiver who cannot follow your wishes will help you find someone else who will follow your wishes. Otherwise your wishes should be followed. If they are not, you can complain to the Georgia Department of Community Health, Healthcare Facilities Regulations. Call locally at **404-657-5726** or **404-657-5728** and toll-free: **1-800-878-6442**.
- There are three parts to a Georgia Advance Directive for Healthcare.
- Part 1 allows a person you choose to carry out health care decisions for you. (This used to be called the Durable Power of Attorney for Healthcare.)
- Part 2 allows choices about stopping or continuing life support and accepting or refusing nutrition and/or hydration. (This used to be called the Living Will.)
- Part 3 allows you to choose someone to be appointed as guardian if a court decides that a guardian is needed.
- You may have questions about this. Here are some places to go to get answers and the form.
- Call the Georgia Department of Human Services, Division of Aging Services at **404-657-5319**. You can also visit them at: 2 Peachtree Street NW, Suite 9395, Atlanta, GA 30303-3142.
- Call WellCare Customer Service at **1-866-231-1821** (TTY **1-877-247-6272**) Monday through Friday, 7 a.m. to 7 p.m. Eastern.
- Talk with your doctor.

IMPORTANT INFORMATION YOU SHOULD KNOW ABOUT WELLCARE OF GEORGIA

ENROLLMENT

Voluntary Enrollment

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

Mandated Enrollment

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

Open Enrollment

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

Moving out of the plan’s service region

- Moral or religious reasons
- Request to be on the same health plan as family members
- Poor quality of care
- Change of eligibility

You may call 1-888-423-6765 (TTY 1-877-889-4424).

Reinstatement

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

Moving between WellCare Service Regions

Your plan is offered in all Georgia counties. If you move, call Customer Service. You will want to pick a doctor near your new home.

Voluntary Disenrollment

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

Disenrolling from WellCare and changing to another plan will not affect your Medicaid eligibility. Instead, you will get Medicaid benefits from your new plan.

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

Involuntary Disenrollment

You may lose your WellCare membership if you:

- Go into a nursing home or state institution or into a place for the mentally handicapped for more than 30 days
- Commit fraud or abuse health care services
- Act in a disruptive way and this attitude/behavior is not caused by a known illness
- Lose your Medicaid eligibility or can no longer be a member
- Are in jail

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

- Medical problems from before you were a member
- Change in your health
- Reduced mental capacity
- Disruptive behavior because of your special needs
- Amount of services you use
- Missed medical appointments
- Not following your PCP's plan for your care

QUALITY AND MEMBER SATISFACTION INFORMATION

You can ask about the plan's performance and member satisfaction. Call Customer Service.

FRAUD AND ABUSE

You, as the Medicaid member, are the most important link in stopping Medicaid fraud. You know better than anyone what health care services you have received.

You can stop fraud by reviewing your Explanation of Benefits (EOB) when you receive it. Look for any service that you did not receive or any provider you did not see.

Report your concerns by calling our 24-hour hotline at **1-866-678-8355**. You can also contact the Georgia Department of Community Health's Program Integrity Hotline at **1-800-533-0686**.

HOW DOCTORS ARE PAID

WellCare works hard to give you the care you need. We work with many doctors. You may ask how they are paid. You can also ask if how they are paid will affect your doctor's use of referrals. You may ask if it will affect other services you may need. Call Customer Service for details.

UTILIZATION MANAGEMENT PROGRAM

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

- Prior authorization Prospective reviews
- Concurrent reviews Retrospective reviews

We have a review team to be sure you get the services you need. Doctors and nurses are on the review team. Their job is to make sure that services requested are right for you. They do this by checking your treatment plan by medically acceptable standards. We also determine whether you have coverage for the services requested. Any decision to deny services because they are not medically necessary is made by a qualified health professional.

We do not reward reviewers for making decisions to deny services. You can get more information by calling Customer Service at 1-866-231-1821 (TTY 1-877-247-6272).

EVALUATION OF NEW TECHNOLOGY

We evaluate new technology to make sure we're up to date. The findings are reviewed to:

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

The review of new technology occurs in the following areas:

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

You can learn more by calling Customer Service at 1-866-231-1821 (TTY 1-877-247-6272).

WEBSITE

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

- A provider search tool
- Member Message Center
- Online member handbook and provider directory
- Benefit information
- Member Rights and Responsibilities
- Member Notice of Privacy Practice

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

The information on our website is either "secured" or "unsecured." With secured access, your Personal Health Information (PHI) is kept confidential.

In our secured section, you can:

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

In our unsecured section, you can:

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

Please call Customer Service if you have any questions. Call 1-866-231-1821 Monday through Friday, from 7 a.m. to 7 p.m. Eastern. TTY users may call 1-877-247-6272.

APPEALS AND GRIEVANCES COORDINATORS AND ASSISTANCE

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

WellCare of Georgia, Inc.
Attn: Admin Review Department
P.O. Box 31368
Tampa, FL 33631-3368

WellCare of Georgia, Inc.
Attn: Grievances Department
P.O. Box 31384
Tampa, FL 33631-3384

To learn more about grievances filed with the plan in the past three years, contact Customer Service.

MEMBER GRIEVANCE PROCEDURES

WellCare has grievance procedures that help us respond to concerns that you may have about the care and services you receive. State law says that you can send us concerns about any part of your medical care experience. The state has rules about what we must do when we receive your concern. We must be fair in handling your concerns. You cannot be dropped from the plan for filing a concern. We will not penalize you for making a concern known.

Our procedures involve three activities in the handling of concerns:

1. Grievance (or concern) process
2. Administrative Review process
3. Administrative Law/DCH Hearing process

While each process is explained further below, you can learn more by calling us at **1-866-231-1821** (TTY **1-877-247-6272**). Call Monday through Friday, 7 a.m. to 7 p.m. Eastern, except on holidays. We can help you if you speak another language. You would also call this number to learn more about grievances filed with the plan in the past three years.

1. GRIEVANCE PROCESS

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

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

We want to know if you have any grievances. You or someone you choose to act for you may file a grievance with WellCare either orally or in writing. A doctor may not file a grievance for you, unless they are acting as your authorized representative. We must get a grievance within one year after the issue you were unhappy about took place. Please call Customer Service first. We will try to fix the issue over the phone. You may also write to us with your grievance.

Mail your grievance to:

WellCare of Georgia, Inc.
Attn: Grievance Department
P.O. Box 31384
Tampa, FL 33631-3384

It can also be faxed to us. Fax it to **1-866-388-1769**.

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

- We don't have enough information
- We don't have the right information
- We believe you need care right away

If your grievance cannot be handled over the phone, it will be routed to the Grievance Department.

We will mail you a letter within 10 days after getting your grievance. We may also mail you a decision letter within 10 days if we can fix your problem in this time.

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

We make decisions within 90 days of getting your grievance. We will mail you a letter with the results.

2. ADMINISTRATIVE REVIEW PROCESS

What is an administrative review?

When we decide about your care, we will let you know our decision by sending you a letter called a “Notice of Proposed Action” or “Action.” The notice will explain how and why we made our decision. If you do not agree with the Notice of Proposed Action, you can ask us to reconsider. This is known as an “administrative review.”

What are some examples of administrative review situations?

You may want to request an administrative review if you have problems getting the care you think we should “provide.” We use the word “provide” to include such things as:

- Authorizing care
- Paying for care
- Arranging for someone to give you care

Additional problems that would cause you to file an administrative review include but are not limited to:

- You are not getting the care you feel that is covered.
- We will not authorize the medical treatment your doctor wants to give you. You believe that this treatment is covered by the plan.
- You are told that coverage for a treatment you get will be reduced or stopped. You feel that this could harm your health.
- If you get care you thought the plan would pay for, and we said we would not pay.

Who can file an administrative review request?

You, someone you appoint or your doctor may file for an administrative review.

If you appoint someone or your doctor files an administrative review on your behalf, you must give them written consent. You must let us know someone else is doing this for you. You can do this by writing us a letter. Or you can fill out an Appointment of Representation form. You can get this from Customer Service. Call **1-866-231-1821** (TTY **1-877-247-6272**) Monday through Friday, 7 a.m. to 7 p.m. Eastern. A representative may file for the estate of a member who has died.

How do I file an administrative review request?

You may file a verbal or written review request. You must send us a signed review request form if you give it verbally. This is only if it is not a fast or quick review. We will mail you a letter within 10 days saying that we received your review. This is only if it is not a quick review. We will send you a decision letter instead if we decide on your review in less than 10 days. A verbal review request can be filed by calling Customer Service. Call **1-866-231-1821** (TTY **1-877-247-6272**) Monday through Friday, 7 a.m. to 7 p.m. Eastern. A written review request should be mailed to:

WellCare of Georgia, Inc.
Attn: Appeals Department
P.O. Box 31368
Tampa, FL 33631-3368

A written review request can also be faxed. Fax it to: **1-866-201-0657**.

How quickly must I request an administrative review?

In order to continue benefits you must file your request within 10 days of receiving the notice of action. We will mail you a denial if we don't get the request in time.

Can I ask for a fast administrative review?

Yes, you, your doctor or your representative can ask us for a fast administrative review. Call Customer Service and ask for a fast administrative review. Call **1-866-231-1821** (TTY **1-877-247-6272**) Monday through Friday, 7 a.m. to 7 p.m. Eastern. You will need to ask your doctor to support a fast review. We will give you a fast review right away if a doctor says it's needed. If you ask for a fast review without a doctor, we will decide if it is a "must" for your health. We will work to get in touch with you if we feel your fast review is not needed. We will also send you a letter within 2 days. The letter will tell you how to send a grievance if your doctor doesn't support a fast review and you don't like what your doctor says. A regular review is in 30 days.

You can also fax it to **1-866-201-0657**. Be sure to ask for a fast administrative review. Or you can send a review request to:

WellCare of Georgia, Inc.
Attn: Appeals Department
P.O. Box 31368
Tampa, FL 33631-3368

Q. What can I expect if I participate in the administrative review process?

A. In the review, you or someone you appoint can see your case file. This can include medical records. You can ask for the written guidelines we used to make the decision. You can also ask to see a summary of our written policies and procedures about administrative reviews. Here are some common questions and answers about the process:

Q. How can I give additional information for the administrative review?

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

Q. Can I review my case file?

A. Yes. Your doctor or representative can review it as well, if you ask us in writing. Call Customer Service at **1-866-231-1821** (TTY **1-877-247-6272**) if you need help with this.

Q. How do I get benefits when I'm waiting on a review decision? What rights do I have?

A. In order to continue benefits you must file your request within 10 days of receiving the notice of action. You have the right to file an administrative review and have benefits continue until a decision is made.

Q. How soon must the plan decide on my review?

A. We will follow these time frames:

- For payment for care you received—a regular review is within 45 days after we get your review request.
- For a standard decision about care—a regular review is within 30 days after we get your review request. We will make it sooner if your health requires it.
- For a fast decision about care—we have 72 hours after we get your review request to decide. We will make it sooner if your health requires us to.

- It can take up to 14 more days if you ask for a longer review. This is called an extension. It will give 14 more days for the review. You can ask for this in writing or by phone. Reasons why you may need a longer review include:

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

How will I know what happened with my administrative review?

We will mail you a letter telling you of our decision. It will talk about your rights to disagree if a decision is not in your favor.

What happens if a decision is reversed?

If a decision to deny the authorization of services is reversed, we will pay for the disputed services received during the review process.

Who can help me if I have questions?

If you need help at any time during this process, Customer Service is available. You can reach them at **1-866-231-1821** (TTY **1-877-247-6272**) Monday through Friday, 7 a.m. to 7 p.m. Eastern.

3. ADMINISTRATIVE LAW/DCH HEARING PROCESS

If you don't agree with the review decision, Medicaid members can ask for a hearing with an Administrative Law Judge. PeachCare for Kids™ members can request a hearing with DCH. Prior to Accessing the Administrative Law/DCH Hearing process, you must exhaust the administrative review process. You must ask for a hearing within 30 days from the date on the administrative review letter.

Medicaid members—send your request to:

WellCare Health Plans, Inc.
Administrative Law Hearing
PO Box 31580
Tampa, FL 33631-3580

PeachCare for Kids™ members—send your request to:

Department of Community Health
PeachCare for Kids
Administrative Review Request
2 Peachtree Street, NW, 37th Floor
Atlanta, GA 30303-3159

Your Provider cannot request an administrative law hearing for you. You or your authorized representative are the only ones who may request a hearing. If you are a PeachCare for Kids member and request a PeachCare for Kids administrative review, the decision of the Formal Grievance Committee will be the final recourse available to you. You must request a hearing in writing within 30 days of the date on the administrative review letter. A hearing is a legal proceeding with you and/or someone you have appointed as your authorized representative, someone from WellCare and an Administrative Law Judge. Prior to the hearing, you and/or your authorized representative will have a chance to review the information we used to make our decision. The time for review may be limited in the case where an expedited resolution is needed. WellCare will explain why we made our decision. You or your authorized representative will tell why you think we made the wrong decision. You will also have the chance to present additional information that may not have been available or

in the case file at the time of your administrative review request. The Administrative Law Judge will listen and then make a decision based on the information given.

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

A. For your benefits to continue:

- You must send your request within 10 days of receiving the notice of action.
- The review or hearing must be about an end or reduction in care
- The care must have been asked for by a plan doctor
- The original pay term for care cannot be expired
- You must request a longer term for care

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

If your benefits continue during a hearing, you can keep getting them until:

- You drop the hearing
- 10 days pass your request. This is from the date of the plan's action. You must not have requested a hearing with benefits until we have decided.
- A decision is made by the Administrative Law Judge
- The care approval expires or service limits are met

You may have to pay for the cost of the care you received during the hearing process. This would be the case if the judge does not decide in your favor.

If the Administrative Law Judges decide in your favor, we will approve and pay for care that is needed as quickly as possible. This is if you did not receive this care during the review of your case.

If the Administrative Law Judge decides in your favor but care was not received during your case, we will approve and pay for the care that is needed as quickly as possible.

Q. What happens if the Administrative Law or PCK/DCH Hearing rules in my favor?

A. If a decision to deny the authorization of services is reversed, we will pay for the requested services.

ADDITIONAL HELP

Here are some other agencies you can contact:

Georgia Department of Insurance
Division of Regulatory Services
2 Martin Luther King, Jr. Drive
Suite 604, West Tower
Atlanta, GA 30334
Phone: 404-656-2074
Fax: 770-344-4878

Georgia Department of Insurance
Division of Life and Health
2 Martin Luther King, Jr. Drive
Suite 902 West Tower
Suite 604, West Tower
Atlanta, GA 30334
404-656-2085
Fax: 404-657-7679

Georgia Department of Community Health
Healthcare Facilities Regulations
2 Peachtree Street, NW
Suite 3100
Atlanta, GA 30303
Phone: 404-657-5726, 404-657-5728
Toll Free: 800-878-6442
Fax: 404-657-8935

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

MEDICATION ADMINISTRATIVE REVIEW (APPEAL)

Q. What if I want to appeal a decision made about a medication? Do I do anything different?

A. You can still call Customer Service. (You must follow verbal requests with a signed written request.) But written medication appeals go to a different address. Send your appeal to:

WellCare of Georgia, Inc.
Attn: Pharmacy Medication Appeals
Department
P.O. Box 31398
Tampa, FL 33631-3398

Or you can fax it to **1-888-865-6531**. We will send you a letter within 10 calendar days after we get your appeal. It will let you know we received your appeal request. We will not send one if it is a request for a fast appeal.

Q. How soon must I file my medication appeal?

A. Appeal within 30 calendar days of the date of our notice to you.

Q. What if I want a fast or expedited medication appeal review?

A. Send an appeal for a decision we made on a prescription to:

WellCare of Georgia
Attn: Pharmacy Medication Appeals Department.
P.O. Box 31398
Tampa, FL 33631-3398

You can fax it too. Fax an appeal for a prescription to **1-888-895-6531**. Don't forget to ask for a fast review. We will give you a fast review if your doctor says waiting could seriously harm your health. You may ask for a fast appeal without a doctor's help. We will decide if you need a fast decision. We will try to call you if we decide your health does not require it. We will also send you a letter within two days. It will say you can get a fast review with a doctor's support. The letter will also tell you how to file a grievance if you disagree and feel you need a fast review. We will give you a standard review if you decide not to do a fast review. This usually takes 30 calendar days.

Q. How soon must we decide on your appeal?

A. For a standard decision about your prescription—30 calendar days after we get your appeal. We will make it sooner if your health requires. You can get 14 more days if you ask or if we find information that will help you. You can ask for this extra time by writing to us or calling Customer Service. We will send you a letter if we take extra time. The letter will say why. We will also let you know the date we expect to make a decision.

For a fast decision about your prescription—up to 72 hours after we get your appeal or sooner if your health requires it. You can get 14 more days if you ask or if we find information that will help you. You can ask for this extra time by writing to us or calling Customer Service. We will send you a letter if we take extra time. The letter will say why. We will also let you know the date we expect to make a decision. We will mail you a letter in each case. It will tell you about your appeal rights if the decision is not in your favor. We will also try to call you about standard decisions.

Q. How will I be notified?

A. For a standard decision about your prescription—a written notice will be sent to you

For a fast decision about your prescription—a reasonable attempt will be made verbally, followed by a written notice

Q. What if I do not like the medication appeal decision?

A. You may not like the decision. You have the right to ask for a hearing with an Administrative Law judge. Please see the Member Grievance and Appeal Procedures section for details on this process.

WHERE TO FIND EXTRA HELP

COMMUNITY RESOURCE GUIDE

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

Basic Needs

- Food banks
- Clothing
- Shelters
- Rent and utilities

Support for Children and Families

- Child care
- Success by Six (after school programs)
- Head Start (family centers)
- Summer camps

- Outdoor play
- Tutoring
- Protection services

Volunteer Employment Support

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

Support for Older and Disabled People

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

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

WELLCARE OF GEORGIA MEMBER RIGHTS

You have the right:

- To get information about the plan, its services and its doctor and other health care providers.
- To get information about your rights and responsibilities.
- To know the names and titles of doctors and other health providers caring for you.
- To be treated with respect and dignity.
- To have your privacy protected.
- To decide with your doctor on the care you get.
- To talk openly about care you need for your health, no matter the cost or benefit coverage, and the choices and risks involved. The information must be given in a way you understand.
- To have the risks, benefits and side effects of medications and other treatments explained to you.
- To know about your health care needs after you get out of the hospital or leave the doctor's office.
- To refuse care, as long as you agree to be responsible for your decision.
- To refuse to take part in any medical research.
- To complain about the plan or the care it provides. Also, to know that if you do, it will not change how you are treated.
- To not be responsible for the plan's debts in the event of insolvency and not be held liable for:
 - Covered services provided to the member for which DCH does not pay the contractor
 - Covered services provided to the member for which DCH or the plan does not pay the provider who furnished the services

- Payments of covered services furnished under a contract, referral or other arrangement to the extent that those payments are in excess of the amount the member would owe if the contractor provided the services directly
- To be free from any form of restraint or seclusion as a means of force, discipline, convenience or revenge.
- To ask for and get a copy of your medical records from your doctor. Also, to 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.)
- To have your records kept private.
- To make your health care wishes known through advance directives.
- To have a say in the plan's member rights.
- To appeal medical or administrative decisions by using the plan or the State's grievance process.
- To exercise these rights no matter your sex, age, race, ethnicity, income, education or religion.
- To have all plan staff observe your rights.
- To have all the above rights apply to the person legally able to make decisions about your health care.
- To be furnished services in accordance with 42 CFR 438.206 through 438.210, which include:
 - Accessibility
 - Authorization standards
 - Availability
 - Coverage
 - Coverage outside of network
 - The right to a second opinion
- To be responsible for cost sharing only as specified in the contract.

WELLCARE OF GEORGIA MEMBER RESPONSIBILITIES

You have the responsibility:

- To read the member handbook to understand how the plan works.
- To carry your member ID card at all times.
- To give information that the plan and its doctors and providers need to provide care.
- To follow plans and instructions for care that you have agreed on with your doctor.
- To understand your health problems.
- To help set treatment goals that you and your doctor agree to.
- To carry your Medicaid card at all times.
- To show your member ID card to each provider.
- To schedule appointments for all non-emergency care through your doctor.
- To get a referral from your doctor for specialty care.
- To cooperate with the people who provide your health care.
- To be on time for appointments.
- To tell the doctor's office if you need to cancel or change an appointment.

- To pay your co-payments to providers, as specified by the Georgia Families program.
- To respect the rights of all providers.
- To respect the property of all providers.
- To respect the rights of other patients.
- To not be disruptive in your doctor's office.
- To know the medicines you take, what they are for and how to take them the right way.
- To make sure your doctor has copies of all previous medical records.
- To let your plan know within 48 hours, or as soon as possible, if you are admitted to the hospital or get emergency room care.
- To be responsible for cost sharing only as specified under covered services co-payments.

WELLCARE NOTICE OF PRIVACY PRACTICES

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

Effective Date of this Privacy Notice: July 15, 2010

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

This Privacy Notice applies to the following WellCare entities:

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

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

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

WellCare requires its employees to follow its privacy and security policies and procedures to protect your health information in oral (for example, when discussing your health information with authorized individuals over the telephone or in person), written or electronic form.

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

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

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

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

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

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

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

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

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

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

- in the unfortunate event of your death, to a coroner or medical examiner, for example, to determine the cause of death;
- to funeral directors as necessary to carry out their duties; and
- in the unfortunate event of your death, to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under law.

3. Partially De-Identified Information. We may use and disclose “partially de-identified” health information about you for public health and research purposes, or for business operations, if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will not contain any information that would directly identify you (such as your name, street address, Social Security number, phone number, fax number, electronic mail address, Web site address, or license number).

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

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

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

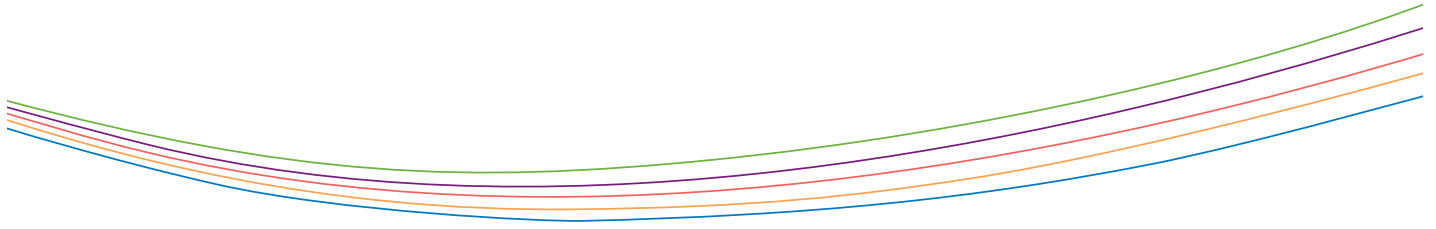
MISCELLANEOUS

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

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

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

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



P.O. Box 31370
Tampa, FL 33631-3370
georgia.wellcare.com

Georgia's health care choice

Para solicitar este documento en español o para escuchar la traducción, llame al Servicio al Cliente al 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

