Attachment K.1.a
Georgia Member Handbook

WellCare means better care.

Member Handbook

WellCare®
of Georgia, Inc.

NEW HEALTH PLAN NCQA ACCREDITATION ACCREDITED

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
- Adult vision
- Free monthly Personal Care Items
- Member voice mail
- 24-hour Health Advisor line

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/TDD: 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.

NEW HEALTH PLAN NCQA ACCREDITATION ACCREDITED

Georgia Families
Choices for a Healthy Life

GEOGRAPHIC OVERVIEW

GEORGIA MEDICAID

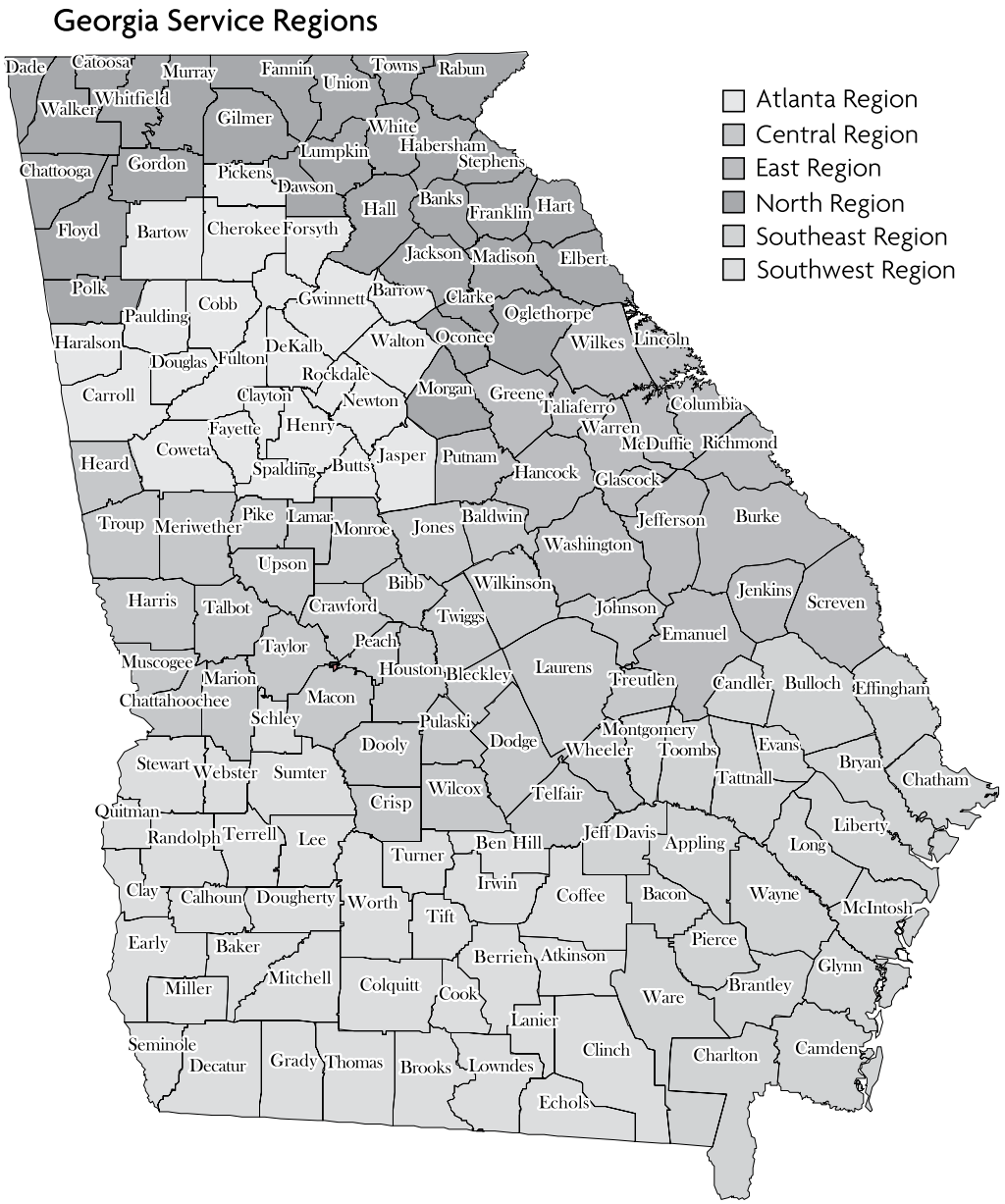


TABLE OF CONTENTS

This is your member handbook. It tells you how your WellCare of Georgia, PeachCare for Kids™ and Medicaid health plans 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/TDD: 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 will be on your way to getting the care you need.

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

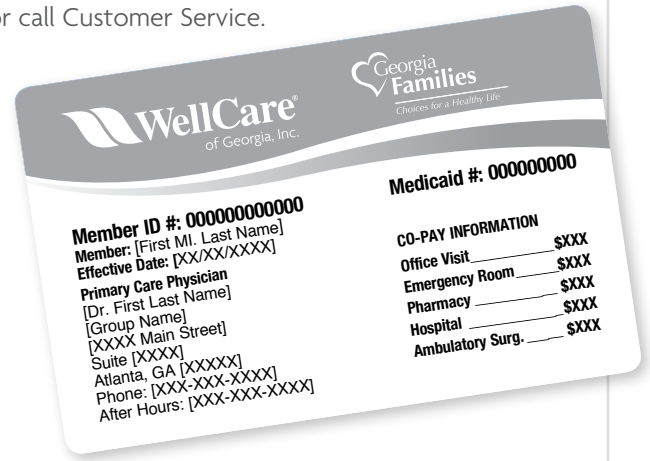
You should have received your WellCare member ID card in the mail. If not, call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272). You can also request a new ID card on our Web site at **georgia.wellcare.com.**

When you need care, you will give this card to your doctor.

Your card has important information about your health plan. Keep this card and your Medicaid card with you at all times. Do not let anyone else use your card. If you do, you may lose your benefits.

Please take the time to look at the information on your ID card. Check the primary care physician (PCP) name on it. If you want to change your PCP, visit **georgia.wellcare.com** or call Customer Service.

Your member start date is also on your ID card.



Q. What if I lose my ID card?

A. If you lose your ID card, call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272) or visit **georgia.wellcare.com**. We will mail you a new card. If you lose your Medicaid card, call your caseworker at the Georgia Department of Family and Children Services. If you lose your PeachCare for Kids™ card, call Georgia Health Partnership at 1-866-211-0950.

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

If you have not selected a PCP or one is not listed on your ID card, please visit the Web at **georgia.wellcare.com** or call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

You can choose a PCP from our network of doctors. As your personal doctor, he or she 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 listing of doctors to choose from in your provider directory.

Changes are made to the provider directory on a continuing basis. For the most current listing of providers, visit our Web site. Go to **georgia.wellcare.com**. On our Web site, you can look for doctors, hospitals and pharmacies in your area. To get an updated version of the directory, call 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.

If you would like to learn more about your PCP, specialist or another participating provider, such as his/her schooling or residency, qualifications or whether or not he/she is accepting new patients, contact Customer Service. You can also find this information in your provider directory.

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

Your PCP will take care of all routine medical care for you. They can arrange specialists or hospital care if needed. If it is not an emergency, call your PCP. The number is on your ID card.

Please get to know your PCP. Call his or her office to schedule a checkup. As a new member, you MUST see your PCP within 90 days of the start date on your ID card. If you are pregnant, you MUST see your PCP within 14 days.

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 is a free service. Call any time, 24 hours a day, 7 days a week. Call 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 information 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/TDD: 1-877-247-6272) to order.

7th—Call WellCare Customer Service or visit our Web site 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 request your member materials in a different format. This includes different languages, large print and audio tapes. This is free of charge.

Customer Service is open weekdays from 7am to 7pm Eastern. Call toll-free at 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

We also have plan information on our Web site. 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 requires that your doctor knows what your rights are. It asks that you respect your doctor's rights, too. This handbook talks about this. 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 Web site. Visit **georgia.wellcare.com** anytime, day or night.

MEMBER INFORMATION

ENROLLMENT IN WELLCARE OF GEORGIA

Medicaid

WellCare serves kids and adults who can be a part of 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 will make this decision.

PeachCare for Kids™

WellCare also serves kids 18 and younger who are a part of Georgia's State Children's Health Insurance Program, PeachCare for Kids™. It is for children who are not eligible for Medicaid or any other health insurance programs.

How is PeachCare for Kids™ different from Medicaid?

- There is a small monthly payment.
- The child must not be a dependent of a state employee.
- The child must not be 19 or older.
- PeachCare for Kids™ may not have Medicaid Fair Hearing rights.
- There is no co-payment for any service given to PeachCare for Kids™ participants.

Call 1-877-427-3224 for details or to sign your child up for PeachCare for Kids™.

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/TDD: 1-877-247-6272).

HOW TO GET YOUR MEDICAL SERVICES

Members are cared for by doctors, hospitals and others who contract with your plan. A doctor with the plan or the plan must approve your care.

The plan will pay for approved care. If it is not approved, you may have to pay for it.

Care that your doctor and plan approves must be medically needed. Your health at the time you see your doctor will be checked with medical practices. 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

Each county in Georgia is separated into service regions. A list of the counties and each service region is located in the front of this handbook. Members must access care within the approved service areas that are listed. Members must also receive all medically necessary covered health care services from WellCare facilities or providers. Members will be responsible for services received outside of the service area, except for emergencies. In the case of an emergency, you do NOT have to be in the plan's service area to receive care. Call 911 or visit the nearest hospital to receive the care that you need.

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

COST-SHARING

Medicaid

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

PeachCare for Kids™

There is no co-payment for any service given by WellCare for a PeachCare for Kids™ participant. Members do pay a small monthly premium required by the Georgia Department of Medical Assistance. 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)
- 2 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. If you are not sure whether the plan pays for a service, call Customer 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 ages less than 21 $10 for ages greater than 21
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 services		$2
Health check services	Medicaid—ages 0 to 21 PeachCare for Kids™—ages 0 to 19	$0
Hearing services	Ages less 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—days greater than 30 are not covered (per treatment episode)	$12.50 (unless admitted from an emergency room or transferred from another health facility)
Laboratory and radiological services		$0
Mental health services	Ages less than 21—days greater than 30 are not covered. Services in a state-operated mental hospital or institution for mental disease are not covered. Ages greater than 21—as medically necessary	$0
Nurse midwife services		$0
Nurse practitioner services		$0
Nursing facility services	Long-term nursing facility stays (days greater than 30) are not covered	$0
Obstetrical services		$0

Continued on next page.

MEDICAID AND PEACHCARE FOR KIDS™ COVERED SERVICES

Benefits	Limits	Co-Payments
Occupational therapy services	Ages less than 21—as medically necessary Ages greater than 21—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	Ages less than 21—as medically necessary Ages greater than 21—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
Prescription drugs		Drug Cost / Co-payment <$10.01 / $.50 $10.01–$25 / $1 $25.01–$50 / $2 >$50.01 / $3
Private-duty nursing services		$0
Rural health clinic services		$2
Speech therapy services	Ages less than 21—as medically necessary Ages greater 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	Covered for 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)	Ages less than 21; kidney, liver, bone marrow and cornea are only covered transplants for ages greater than 21	$0
Vision services		$10 for ages greater than 21

MEDICAID AND PEACHCARE FOR KIDS™ SERVICES NOT COVERED

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

HOW TO GET APPROVED SERVICES

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

If your doctor or the plan does not arrange or approve your care, you will have to pay for it. Be sure your doctor approves for you to see a specialist. If you need care by a doctor that is not a plan doctor, 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 5 days for approval.

Call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272) Monday through Friday, 7am to 7pm Eastern, to ask for a fast service decision. 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)
- One women's health visit to an OB/GYN doctor a year
- Routine dental care (but not surgery)
- Visits to your PCP
- Yearly eye exams and glasses

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 AVAILABLE WITHOUT AUTHORIZATION BUT REQUIRE PLAN NOTIFICATION

You do not need approval for these services. You do need to notify the plan, though. You can ask your provider to notify the plan on your behalf.

- Emergent/urgent care
- Post-stabilization services

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

SECOND MEDICAL OPINION

If you want a second opinion about your care, call your doctor. He or she will ask you to pick a participating doctor in your service area. If you can't find a participating doctor, you will be asked to pick a doctor that is out of the plan's network. You do not pay for these services. If the doctor that is giving the second opinion asks for tests, they must be done by a participating provider.

Your doctor will review the second opinion. He or she will then decide the best way to treat you. If you see a doctor out of the plan without approval, you may have to pay for it.

HOW TO GET AFTER-HOURS MEDICAL CARE

If you get sick or hurt when your doctor's office isn't open, and it is not an emergency, call your doctor. The number is on your ID card. Your doctor's office will have a doctor on call to call you back and tell you what to do. If you cannot reach your doctor's office, you can go to an urgent care center. Urgent care center services do not need prior approval. 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 is when you think that your health is in serious danger. When will the plan cover this type of care? When it is believed that if you do not get medical care, your condition will get worse.

In the case of an emergency, call 911. Call an ambulance if no 911 service is available in your area, or go immediately to the nearest hospital emergency room (ER). The choice is yours. If you don't know if it is an emergency, call your doctor. You don't need pre-approval for emergency care if it's done at an urgent care center or the emergency room.

Some examples of emergencies are:

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

An emergency is when the condition could cause:

- Body injury
- Organ damage
- Damage to a body part
- Injury to yourself or others
- Harm to yourself or others due to alcohol or drug abuse
- 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. If your symptoms are severe enough that your health is in serious danger, the plan will pay for the visit. (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. If you decide to stay, you may have to pay for the care.

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

Your plan will pay for follow-up care. Your doctor must say it is needed.

OUT-OF-AREA EMERGENCY CARE

It is important to get care when you are sick or hurt. If you get sick or injured while traveling, call Customer Service toll-free at 1-866-231-1821 (TTY/TDD: 1-877-247-6272). If you have an emergency while traveling, go to a hospital. It doesn't matter if you are 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.

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

Post-Stabilization Services

It is important that you get care until your condition is stable. The plan will pay for care you get after your emergency room care. This is called post-stabilization care. You do not need pre-approval for post-stabilization services. But this care must be done 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 needs treatment within 24 hours, but will not cause serious harm to your health. Such conditions include:

- Injury
- Illness
- Severe pain

If you are not sure you need urgent care, call your doctor. 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 doctor know if you receive care in an urgent care center so they can provide follow-up care.

PREGNANCY AND NEWBORN CARE

If you have a baby while a plan member, your baby will be covered by the plan 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 receive information 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. If they do not choose a doctor for their baby by the time their baby is born, the plan will assign one.

PREGNANCY CARE GUIDELINES

See you doctor as soon as you know you are pregnant. Doctors can help you know if you may be at risk of having the baby too early. If the doctor finds problems early, he or she may be able to stop or slow down those problems.[1] If you see the doctor early and regularly, you are more likely to have a healthier baby.[2]

Your doctor will do certain things during your prenatal and postnatal visits. 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, copyright © 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 your tummy to see how the baby is growing.
- Listen to your tummy to hear the baby's heart rate.
- Ask if you feel the baby moving.
- Ask if you are leaking any liquids.
- Ask if you are eating and taking your vitamins.
- Ask if you are 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 grandparent's 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.

First Visit *continued*

- 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.
- Look at where the baby came from and do a Pap smear to be sure you are healing.
- Press on and listen to your tummy to be sure everything is back to normal.
- Press on your breasts to be sure everything is back to normal.
- 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, copyright © 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.

GETTING BEHAVIORAL HEALTH SERVICES

If you need help, call Magellan Behavioral Health at 1-800-424-5412 (TTY/TDD: 1-877-342-6815). They will give you a choice of doctors and help you find one in your area. You can also get names of doctors at **www.magellanhealth.com.**

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

What to Do if You Need Help

If you have any of the feelings below, call Magellan. They will 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. Prior authorization is not required for a mental health emergency.

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

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 9 and 10 for more information on how to get emergency, urgent or post-stabilization services for mental health emergencies

If at any time you need help, call Magellan at 1-800-424-5412 (TTY/TDD: 1-877-342-6815).

ACCESS TO MEDICAL SERVICES

The plan has a medical team to offer quick service to members. Travel time to medical services:

Location	Urban	Rural
PCPs	Within 8 miles	Within 15 miles
Specialists	Within 30 minutes or 30 miles	Within 45 minutes or 45 miles
Hospitals	Within 30 minutes or 30 miles	Within 45 minutes or 45 miles
Pharmacies	Within 15 minutes or miles	Within 30 minutes or 30 miles

Timely care:

- 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; it could cause sickness or harm with no care)
- 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

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:

- 2 exams per benefit year
- 2 cleanings per benefit year
- 2 fluoride treatments per benefit year
- 1 filling per tooth
- Dentures—1 pair, every 3 years
- Denture repairs—2 adjustments per benefit year
- Oral surgery
- Orthodontic treatment

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

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

****Pregnant members also receive 1 filling per tooth, fluoride treatments and periodontal treatment.**

PeachCare for Kids™ dental services include:

- 2 exams per benefit year
- 2 cleanings per benefit year
- 2 fluoride treatments per benefit year
- 1 filling per tooth
- Dentures—1 pair, every 3 years
- Denture repairs—2 adjustments per benefit year
- Oral surgery
- Orthodontic treatment

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)
- 1 pair of eyeglasses per person each year

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

- 1 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:

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

Avesis provides these services. Call them at 1-800-828-9341 to choose a doctor. 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
- Tests
- Hearing aids (1 every 3 years and/or based on medical necessity)
- Hearing aid fitting and dispensing
- Hearing aid repairs and parts
- Newborn hearing tests

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. Prescriptions must be filled at a drug store in the plan network. A list of these drug stores is on the WellCare Web site, or you can call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272) for help.

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). Doctors, pharmacists and nurses make the list. Your doctor will go by the list when prescribing you medicine. The list will also have medicines that may have limits due to your age or gender. The list is on the WellCare Web site. The plan does not pay for these medicines:

- Those used for eating problems or weight gain
- Those that are cosmetic or help you grow hair
- Barbiturates, except Seconal, Phenobarbital and Mebaral
- Vitamins (some prenatal vitamins and fluoride preparations are covered)
- Some over-the-counter drugs
- Those used to help you get pregnant
- Those that help you stop smoking

Q. Can I get any medicine I want?

A. No. The plan made a list to show you the medicines that it will pay for. Call Customer Service with questions.

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

A. Generic drugs work the same as brand drugs. They have the same ingredients as brand drugs.

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:

- Coated aspirin
- Diphenhydramine
- H2 receptor antagonists
- Ibuprofen suspension for members under 21 years of age
- Insulin
- Insulin syringes
- Iron
- Lice B Gone
- Meclizine
- Multi-vitamins and vitamins with iron—chewable or liquid drops for members under 21 years of age
- Non-sedating antihistamines
- Proton pump inhibitors
- Topical anti-fungals
- Urine test strips

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 work the same 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.

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

Preferred Drug List (PDL)—medicines approved by plan doctors and pharmacists. These medicines work best, are safe and cost less. The plan also has medicines it does not approve. The PDL shows doctors which drugs are best to use.

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. The list you can choose from follows. Make your selection and then call toll-free 1-866-231-1821 (TTY/TDD: 1-877-247-6272) to place your order. Your items will be mailed to your home.

ITEM	BRAND DESCRIPTION	GENERIC COMPARABLE	SIZE	PRICE
ALLERGY PREVENTION AND TREATMENT				
1	Claritin®	Loratadine 10mg Tablets	10	$5.00
2	Zyrtec®	Allergy All Day 10mg	14	$10.00
ANALGESICS/ANTIPYRETICS				
3	Bayer® Aspirin	Aspirin 325mg Tablets	100	$3.00
4	Bayer® EC Aspirin (Adult Regimen)	Aspirin EC 81mg Tablets	120	$5.00
5	Bengay®	Muscle Rub	3oz	$4.00
6	Ecotrin® Maximum Strength Tablets	EC Aspirin Maximum Strength Tablets	60	$5.00
7	Tylenol® Extra Strength Caplets	Acetaminophen Extra Strength Caplets	60	$5.00
ANTACIDS AND ACID REDUCERS				
8	Mylanta® Gas 80mg	Anti-Gas 80mg	100	$6.00
10	Tums® Tablets	Antacid Chewable Tablets	150	$4.00
11	Zantac® Tablets	Ranitidine HCL 75mg Tablets	30	$7.00
ANTIBIOTICS (TOPICAL)				
13	Neosporin® Ointment	Triple Antibiotic Ointment	1oz	$5.00
ANTICANDIALS (YEAST)				
14	Gyne-Lotrimin® Cream	Clotrimazole Vaginal 1% Cream—1 Application	45gm	$8.00
ANTIDIARRHEALS AND LAXATIVES				
15	Colace® Softgels	Dos 100mg SG Caplets	100	$6.00
16	Dulcolax® Suppositories	Reliable Gentle Laxative Suppositories	12	$6.00
17	Dulcolax® Tablets	Reliable Gentle Laxative Tablets	25	$5.00
18	Imodium® Caplets	Anti-Diarrheal 2mg Caplets	12	$4.00
19	Pepto-Bismol® Liquid	Pink Bismuth Liquid	8oz	$3.00
ANTIFUNGALS				
20	Tinactin® Cream	Tolnaftate 1% Cream	1oz	$6.00
ANTIHISTAMINES				
21	Benadryl® Elixir	Diphenhydramine Liquid—Alcohol Free	4oz	$4.00
22	Benadryl® Tablets	Diphenhydramine 25mg Caplets	24	$4.00
23	Sudafed® PE	Phenylephrine HCL 10mg Tablets	18	$4.00
ANTI-ITCH LOTIONS AND CREAMS				
24	Calamine Lotion	Calamine Lotion	6oz	$3.00
CALCIUM				
25	Caltrate® 600	Calcium 600 + D Tablets	90	$5.00
COLD, FLU, DECONGESTANT AND SINUS REMEDIES				
26	Afrin® Nasal Spray	Nasal Decongestant Spray	30ml	$5.00
27	Chloraseptic®	Throat Lozenges—Cherry	18	$3.00
28	Robitussin® Syrup	Guiatuss Syrup	4oz	$4.00
29	Vicks VapoRub®	Vicks VapoRub®	1.76oz	$5.00

ITEM	BRAND DESCRIPTION	GENERIC COMPARABLE	SIZE	PRICE
DENTAL/DENTURE CARE				
30	Anbesol®	Anbesol	0.33oz	$9.00
EAR CARE				
31	Ear Syringe	Ear Syringe	3oz	$4.00
32	Ear Wax Removal	Ear Wax Removal Drops	0.5oz	$4.00
EYE CARE				
33	Dry Eye Drops	Artificial Tears	0.5oz	$3.00
34	Visine® Drops	Sterile Eye Drops Irritation Relief	0.5oz	$4.00
FIBER SUPPLEMENTS				
35	Metamucil®	Fiber Capsules	90	$9.00
FIRST AID/MEDICAL SUPPLIES				
36	Ace® Bandage	Athletic Bandage	1	$3.00
37	Adhesive Tape	Adhesive Tape 1 Inch x 5 Yards	1	$2.00
38	Alcohol Swabs	Alcohol Swabs	100	$2.00
39	Band-Aids®	Band-Aids, Assorted	50	$2.00
40	Butterfly® Closures	Butterfly Closures	10	$2.00
41	Cotton Balls	Cotton Balls	100	$2.00
42	Cotton Swabs	Cotton Swabs	170	$2.00
43	Ice Bag	Ice Bag	1	$5.00
44	Johnson & Johnson Gauze	Stretch Gauze Bandage 2 Inches x 5 Yards	1	$2.00
45	Oral Thermometer	Oral Thermometer	1	$4.00
HEALING OINTMENTS				
46	Aquaphor Skin Healing Ointment	Aquaphor Skin Healing Ointment	1.75oz	$7.00
HEMORRHOIDAL PREPARATIONS				
47	Anusol® Ointment	Anusert HC-1 Ointment	0.7oz	$7.00
48	Preparation H® Ointment	Prompt Relief Hemorrhoid Ointment	2oz	$6.00
LACTOSE INTOLERANCE				
49	Lactaid®	Dairy Relief Capsule	120	$10.00
MIGRAINE RELIEF				
50	Excedrin® Migraine	Pain Relief Extra Strength Headache Tablets	100	$8.00
NSAIDS				
51	Advil® Tablets	Ibuprofen 200mg FC Tablets	50	$5.00
52	Aleve® Caplets	Naproxen Sodium 220mg Caplets	50	$5.00
PEDICULICIDES				
53	RID® Extra Strength Shampoo	Lice Treatment Maximum Strength Shampoo	4oz	$9.00
SLEEPING AIDS				
54	Nytol®	Sleep Aid Nighttime	24	$4.00

ITEM	BRAND DESCRIPTION	GENERIC COMPARABLE	SIZE	PRICE
TOPICAL STEROIDS				
55	Cortaid® Cream	Hydrocortisone 1% Maximum Strength Cream	1oz	$4.00
CHILDREN'S PRODUCTS				
56	Orajel® Baby	Orajel Baby	.33oz	$7.00
57	Balmex® Ointment	Diaper Rash Ointment	1oz	$3.00
58	Mylicon® Drops	Gas Relief Drops	30ml	$9.00
59	Poly-Vi-Sol® Drops	Baby Vitamin Drops	50ml	$7.00
60	Motrin® Suspension for Children	Ibuprofen Suspension Children	4oz	$5.00
61	Tylenol® Children's Grape Elixir	Acetaminophen Child's Grape Elixir	4oz	$5.00
62	Tylenol® Child's Chew Grape Tablets	Acetaminophen Chewable Grape Tablets	24	$4.00
63	Tylenol® Infant Drops	Acetaminophen Child's Grape Elixir	0.5oz	$4.00
64	Glycerin Suppositories Children	Glycerin Child's Suppositories	25	$2.00
VITAMINS AND MINERALS				
65	B-Complex with B-12 Tablets	B-Complex/B-12 Tablets	100	$5.00
66	Centrum® Tablets	Certagen Tablets	100	$9.00
67	Flintstones®	Fruity Chewable Tablets (NF)	100	$6.00
68	Stuart® Prenatal Tablets	Prenatal-S Tablets	100	$6.00
69	Vitamin C Tablets	C Chewable 500mg Tablets	100	$3.00
70	Vitamin E Softgels	E DL Alpha 400 IU SG Caplets	100	$6.00
71	Vitamin A 10,000 IU	Vitamin A 10,000 IU	100	$4.00
OTHER ITEMS				
74	Pill Box	Pill Box	1	$2.00
75	Toothbrush	Toothbrush	1	$2.00
76	Toothpaste	Toothpaste	6.4oz	$2.00
77	Waxed Dental Floss	Waxed Dental Floss	100yd	$1.00

- 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

Your plan has programs that help members with certain diseases and conditions get care. They include:

• Asthma • Diabetes • HIV/AIDS • High lead levels • Pregnancy • Other complex conditions

Call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272) for more information or to enroll.

Guides are available for people with asthma, diabetes or kidney disease. Call Customer Service.

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 3 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 7am to 6pm. **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, Franklin, 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, Mitchell, 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/TDD: 1-877-247-6272) to learn more.

- Stop smoking programs
- Programs for kids
- Programs for moms-to-be and their babies
- Domestic abuse support
- Drug and alcohol programs

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 those ages 0 to 19.

Because it is important for a child's health later in life, WellCare wants to make sure kids visit their primary care doctor for checkups at early ages.

Q. What is a health checkup?

A. A checkup is a time when your child's primary care doctor 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 are needed. The visits 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
- 3–5 days
- 1 month old
- 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 age 19 (PeachCare for Kids™ members)
  - To age 21 (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/TDD: 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 20.

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, influenza, Hib and RV vaccines. Blood lead risk assessment.
9 months	Well-baby checkup.* Blood lead risk assessment.
12 months	Well-baby checkup.* Blood lead test (if risk assessment not done at 6 months and 9 months). Hemoglobin or hematocrit. Hib, Measles, Mumps, Rubella (MMR), Hepatitis A (HepA), varicella (chickenpox), PCV and influenza vaccines. Dental visit as need identified.**

Age	Well-Baby Checkups and Shot Guide
15 months	Well-baby checkup.* DTaP vaccine. Urine test.
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. Influenza vaccine. Dental visit.
30 months	Well-baby checkup*
Age	**Well-Child Checkups and Shot Guide**
3 years	Well-child checkup.* Eye screening. Dental visit twice a year. Influenza vaccine. 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 influenza vaccines. 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. Influenza vaccine 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, influenza vaccine every year. Dental visit twice a year.
13 to 21 years	Well-adolescent checkup* every year. HPV series (if not administered previously). Influenza vaccine 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 influenza vaccine 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), http://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 (http://www.ada.org/).

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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 asymptomatic adults 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

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	Every year, 50 years of age and older
Hepatitis B vaccine (HepB)	Adults at risk, 18 years of age and older – 3 doses
Meningococcal conjugate vaccine (MCV)	College freshmen living in dormitories and others at risk, 18 years of age and older – 1 dose
Human Papillomavirus (HPV)	*For eligible members through 26 years of age (3-dose series)
Zoster	Age 60 and older – 1 dose

Prevention

Discuss:

- 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

- 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.
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- 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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ADVANCE DIRECTIVES

Georgia state law has put into place the Georgia Advance Directive for Health Care. It takes the place of the Georgia Living Will and Durable Power of Attorney for Health Care.

The Georgia Advance Directive for Health Care lets you plan for your care in advance. It gives you a way to make your wishes known about what care you want if you can't make those decisions yourself.

You can choose to complete a Georgia Advance Directive for Health Care. If you do, it will take the place of any other advance directives that you have. This includes a Living Will. Or a Durable Power of Attorney for Health Care. You can choose not to complete a Georgia Advance Directive for Health Care. 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 Health Care? 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. If so, he or she will help you find someone else who will follow your wishes. Other than for conscience reasons, your wishes should be followed. If they are not, complaints can be made to the Georgia Department of Human Services, Office of Regulatory Services. Call 1-404-657-5550.

There are three parts to a Georgia Advance Directive for Health Care.

- 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 Health Care.)
- 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 Division of Aging Services at 1-404-657-5319. 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/TDD: 1-877-247-6272) Monday through Friday, 7am to 7pm 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 (TDD: 1-877-889-4424). For extra help, call 1-866-231-1821 (TTY/TDD: 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 (TDD: 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, if you want. At the end of 90 days, you will stay in your plan for the next 9 months before you can change plans again. If after 9 months in the plan you are still Medicaid-eligible, you will be able to change plans. 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

If you have any questions, call 1-888-423-6765 (TDD: 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 Out of the WellCare Service Region

Your plan is offered in many Georgia counties. If you move, call Customer Service. You will want to pick a doctor near your new home. You must call 1-888-423-6765 (TDD: 1-877-889-4424) to choose another plan if you move out of your plan area. You will continue to use plan doctors until you are disenrolled.

Voluntary Disenrollment

You may ask to cancel your membership 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 (TDD: 1-877-889-4424).

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

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
- Move out of the plan's service region
- 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 incarcerated

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

Fraud occurs when your health care plan gets billed for a service that costs more than the service received. Fraud also happens when your health care plan pays for a service that someone never used. If you know that fraud occurred, tell us. Call our 24-hour hotline at 1-866-678-8355.

To learn more, call 1-866-231-1821 (TTY/TDD: 1-877-247-6272). 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
- Concurrent reviews
- Prospective reviews
- Retrospective reviews

We do these reviews to measure the health care and services that our members receive. We measure this based on the members' coverage. We check to see if the care and services are right. Then we determine how much coverage we can provide. And, we decide on how to pay those who provide the care.

Sometimes, we have to deny coverage for services or care. These decisions may be made by our employees. Or they may be made by a doctor or other reviewer. When this happens, we don't give a reward to anyone who makes these decisions. Also, if there are any financial rewards, they do not encourage using less services. For more information, call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

EVALUATION OF NEW TECHNOLOGY

New technology and applications of existing technology are evaluated every year. 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

To learn more, call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

WEB SITE

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

- Provider search by county or ZIP Code
- Member Message Center
- Online member handbook and provider directory
- Benefit information

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 Web site is either "secured" or "unsecured." With secured access, your Personal Health Information (PHI) is kept confidential.

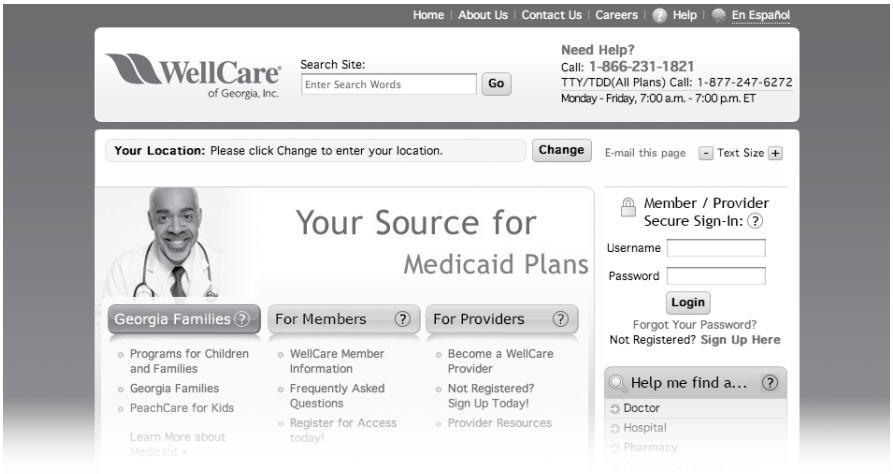
In our secured section, you can:

- 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

If you have any questions, please call our Customer Service Department. Call 1-866-231-1821 Monday through Friday, from 7am to 7pm Eastern. TTY/TDD users, please call 1-877-247-6272.



APPEALS AND GRIEVANCES COORDINATORS AND ASSISTANCE

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

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

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

To learn more about grievances filed with the plan in the past 3 years, contact Customer Service.

MEMBER ADMINISTRATIVE REVIEW AND GRIEVANCE PROCEDURES

FILING A COMPLAINT WITH WELLCARE

We want you to tell us if you have any problems with the care you get. Call us at 1-866-231-1821 (TTY/TDD: 1-877-247-6272). We can help you if you speak another language.

This section tells you how to make a complaint. There are also rules for what the plan must do when we get a complaint. If you make a complaint, we must be fair. We can't drop you from the plan or treat you differently.

ADMINISTRATIVE REVIEWS AND GRIEVANCES

You can make a complaint if you have problems with the care you get. "Administrative reviews" and "grievances" are the 2 types of complaints you can make.

An administrative review is when you want us to change a decision we made about your care. It could be:

- If we refuse to pay for services you think we should cover
- If a doctor didn't give you care you think you should have received
- When a doctor cuts back services you had been getting
- If you think we stopped your care too soon

A representative can file one of these for a member who died.

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

- Quality of care
- 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

MAKING A COMPLAINT TO CHANGE A DECISION ON WHAT THE PLAN WILL PAY FOR

Here we tell you what you can do if you have problems getting the care you think we should give you. Giving care includes things like:

- Approving care
- Paying for care
- Assigning someone to your care
- Continuing to provide care you have been getting

Problems getting the care you think we should give include:

- If you are not getting the care you want, and you think the plan should pay for it.
- If we will not approve the care your doctor or other doctors want to give you, and you think the plan should pay for this care.
- If you learn that we plan to reduce or stop paying for care you have been getting, and you think this will harm your health.
- If you get care you thought the plan would pay for, and we said we would not pay.

ASKING FOR CARE OR PAYMENT FROM THE PLAN

You can take 2 steps if you have problems getting care or paying for care.

A new person will take a look at your case. He/she will not have been part of the first decision. This person will also be someone who did not work directly with anyone in the first decision. If you aren't happy with the result, there may be another step you can take.

Step 1—Notice of Proposed Action by the Plan

First, we will send you a Notice of Proposed Action. It talks about your care or paying for care you already received. When we make an action, we give our view of how care for members applies to your specific case. You can ask for a "fast initial decision" if you have a request for quick care. In the review, you or your representative can look at your case papers and care records.

Step 2—Administrative Review of the Notice of Proposed Action by the Plan

If you don't like what we decide in the first step, you, your doctor or representative can ask us to reconsider. This is known as an "administrative review" or a "request for reconsideration." You can ask for a quick review. We will decide to change or keep the first decision.

Q. How do I file my administrative review of the Notice of Proposed Action?

A. You, your doctor or representative can file for a review.

You can write us to ask for a review. You must also fill out a review request form. You can get this form from Customer Service. Call 1-866-231-1821 (TTY/TDD: 1-877-247-6272).

You can also give it verbally. You must sign a 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.

Q. How soon must I file my administrative review?

A. Send it within 30 days of the date when we notified you. We will mail you a denial if we don't get the request in time.

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

A. Please see "How can my benefits be continued during a review or hearing" later in this section.

Q. What if I want a fast review?

A. You, any doctor or representative can ask us for a fast review. Call Customer Service.

Mail a written report to:

WellCare of Georgia
Attn: Appeals Department
P.O. Box 31368
Tampa, FL 33631-3368
Fax: 1-866-201-0657

Ask for 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. You will need to ask your doctor to support a fast review. If your doctor agrees, we will give you a review right away. The letter will tell you how to send a complaint if your doctor doesn't support a fast review and you don't like what your doctor says.

A regular review is in 45 days.

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

A.
- **For payment for care you received**—a regular review is within 45 days after we get your review.
- **For a standard decision about care**—a regular review is within 45 days after we get your review. 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 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

We will mail you a letter called a "Notice of Adverse Action." It will talk about your rights to disagree if a decision is not in your favor. We will also try to contact you in person.

Q. How can I give proof and/or allegations of fact or law?

A. We will let you give comments or information for your review in writing or in person. Call 1-866-231-1821 (TTY/TDD: 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 let us know in writing. Call Customer Service at 1-866-231-1821 (TTY/TDD: 1-877-247-6272) if you need help with this.

APPEALING FOR AN ADMINISTRATIVE LAW HEARING OR DCH HEARING

You can ask for a hearing with an Administrative Law judge (Medicaid) or a DCH hearing (PeachCare for Kids™) if you don't like the review decision. You must ask for a hearing within 30 days of the decision.

MAKING COMPLAINTS TO THE PLAN FOR ISSUES NOT CLASSIFIED AS ADMINISTRATIVE REVIEWS

First, call Customer Service with a complaint. A doctor may not make a complaint for you. We must get a complaint within 1 year of when the issue you were unhappy about took place. We will try to fix the problem over the phone. You can also write to us with your complaint.

You have the right to complain about:

- Quality of service
- Office waiting times
- Doctor behavior
- Condition of the places where you get care
- If you were taken out of the plan without asking
- If we don't give you a fast review
- If we don't give you a longer review time

We will try to fix any complaint 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 will have you speak with a support person if your complaint can't be fixed right away over the phone by Customer Service.

We will mail you a letter within 10 days of us getting your complaint. We will mail you a decision letter if we can fix your problem in this time.

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

We make decisions within 90 days of getting your complaint. We will mail you a letter with the results. It will tell you how to make a second-level complaint.

You must write to us with a second-level complaint. You should send this within 30 days of getting your decision. Send the letter to the Appeals and Grievance Committee (AGC). The AGC is made up of members who were not first involved with your case.

You can also make a second-level complaint in person. Tell us about this in your written request. The AGC meets every Thursday from 9am to 10:30am Eastern. We will touch base with you to set up a time.

You will have 15 minutes to give your side of the case. The AGC will then ask any questions. You will get a decision letter within 5 days of this meeting.

Some other contacts for a review or complaint:

Office of Commissioner of Insurance
Life & Health
Regulatory Services Division
Suite 604, West Tower
Two Martin Luther King, Jr. Drive
Atlanta, GA 30334
Phone: 1-404-657-7742
Fax: 1-770-344-4878

Georgia Department of Human Resources
Office of Regulatory Services
Health Care Section
Two Peachtree Street, NW
Suite 33-250
Atlanta, GA 30303-3142
Phone: 1-404-657-5550
Fax: 1-404-657-8934

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

ADMINISTRATIVE LAW HEARING (MEDICAID) OR DCH HEARING (PEACHCARE FOR KIDS™) (AVAILABLE AFTER A REVIEW)

You can ask for an Administrative Law or DCH Hearing after a review. Write to:

Medicaid–
Department of Community Health
Legal Services Section
General Counsel's Office
Two Peachtree Street, NW
40th Floor
Atlanta, Georgia 30303-3159

PeachCare for Kids™–
PeachCare for Kids™
Attn: Resolution Coordinator
Two Peachtree Street, NW
Atlanta, GA 30303-3159

You or your representative are the only ones who can request a hearing. Your doctor cannot. You must request a hearing within 30 days of the review decision. A hearing is a meeting with you, someone from WellCare and a hearing officer. WellCare will explain why we made our decision. You will tell why you think we made the wrong decision. The hearing officer will listen. He or she will then decide if we followed the rules and who is right 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 review within 10 days of the Notice of Adverse Action if filing verbally (15 days by writing and by mail).
- 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 we let your benefits continue during a review or hearing, you can keep getting them until:

- You drop the review or hearing.
- 10 days pass from a verbal request (15 days from a mailed 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 you don't like is made.
- The care approval expires or service limits are met.

You may have to pay for the cost of your care during a review or hearing. This is if we don't agree with your complaint.

If we don't decide in your favor, the plan may recover the cost of care during your case. If we decide in your favor and you didn't get benefits during your case, we will get you care right away. We will approve and pay for the care.

By state law, we will pay for services you did not agree with during your review or hearing.

EXHAUSTION OF GRIEVANCE PROCEDURES

You must take part in the plan's review and complaint process before you can take legal action.

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 doctors and 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.
- 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.

WELLCARE OF GEORGIA MEMBER RESPONSIBILITIES

You have the responsibility:

- 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 read the member handbook to understand how the plan works.
- To carry your member card at all times.
- To carry your Medicaid card at all times.
- To show your ID cards 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 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.

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.

1. Why WellCare Provides This Notice

WellCare[1] is required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with oral, written or electronic notice of WellCare's legal duties and privacy practices with respect to PHI. PHI includes oral, written or electronic information that can be used to identify you and has been created or received about your past, present or future health or condition, the provision of health care to you or the payment for this health care.

This notice explains our privacy practices that are applicable to you, a valued member of WellCare. We appreciate the confidence and trust that you have bestowed upon us. Your privacy is very important to us, and we take this duty seriously.

WellCare is required to follow the privacy practices that are described in this notice. However, we reserve the right to change the terms of this notice and our privacy practices at any time. Any changes to our polices and procedures will apply to the PHI we already have in our possession. If we make material change to our policies and procedures about your PHI, we will update this notice, post a new notice on our Web site at www.wellcare.com and, to the extent required by applicable law, promptly mail a notice of the changes to you.

2. WellCare Needs Information to Provide Services

The types of PHI we collect on each of our members will include, but not necessarily be limited to: (i) the information that you provide to us or that we receive from regulatory authorities, your employer or benefits plan sponsor on an application or any other form, in person or in writing, electronically or by telephone (such as your name, address, Social Security number, date of birth, dependent information, marital status, health or medical history, employment information and other insurance carrier history); and (ii) your contact and affiliation in any form with any of our agents, business partners or any other party (such as medical records, health care claims, premium payments, verification of your eligibility, appeal and grievance information, information to process requests for health care authorizations and enrollment applications).

3. Treatment, Payment and Health Care Operations

We use and disclose your PHI primarily for your treatment, payment and our health care operations. The following list describes the most common uses and disclosures that WellCare and its business partners may make that are permitted by law.

- To a doctor, a hospital or other health care provider in order to provide your medical care.
- To pay claims for covered services provided to you by doctors, hospitals or other health care providers.
- For the daily operations of WellCare, including but not limited to, processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of health care professionals and determining premiums.
- To your plan sponsor to permit them to perform plan administration functions.
- To contact you with information about health-related benefits and services, appointment reminders or about treatment alternatives that may be of interest to you.

4. Other Uses and Disclosures of PHI

WellCare may use or disclose information about you:

- To your family and friends if you are unavailable to communicate, such as in a medical or other emergency.
- When disclosure is required by federal, state or local law, judicial or administrative proceedings or law enforcement officials. For example, we make disclosures to regulatory agencies when a law requires that we report information. We may also disclose PHI pursuant to subpoena as part of a judicial or administrative proceeding.
- To government agencies for public health activities or health oversight activities, such as disclosures to agencies that regulate Medicare and Medicaid services.
- To appropriate authorities regarding abuse, neglect or domestic violence.
- To military authorities.
- For research purposes in limited circumstances.
- For procurement, banking or transplantation of organs, eyes or tissue.
- To a coroner, medical examiner or funeral director.

5. Uses and Disclosure Requiring Authorization

In other situations, WellCare will require a specific authorization before we use or disclose your PHI. For example, WellCare will seek your authorization before using or disclosing your PHI if we seek to offer unsolicited marketing resources to you for a purpose that is not related to your health benefits or health condition. You have the right to revoke such an authorization at any time by notifying us in writing.

6. Your Individual Rights

A. Access—You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page and per hour for staff time to locate and copy your information and postage.

B. Confidential Communications—You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life-threatening situation. We will accommodate your request if it is reasonable.

C. Amendment—You have the right to request an amendment of information we maintain about you if you believe that it is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information or the information is correct and complete. If we deny your request, we will provide you a written explanation of the denial.

D. Accounting—You have the right to receive a list of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment or health care operations and certain other activities. If you request this information more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

E. Notice—All WellCare members and prospective members have the right to receive a written copy of this notice upon request at any time.

F. Restrictions—You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.

G. Contact—All of your applicable privacy rights can be exercised by contacting WellCare. If you wish to write to us, please write to the Chief Privacy Officer. If you call us, please call the toll-free phone number on your membership card and a Customer Service associate will assist you. You may also call the number below.

WellCare Health Plans, Inc.
Attention: Chief Privacy Officer
8735 Henderson Road, Ren. 2
Tampa, FL 33634
Phone: (813) 290-6200

7. Complaints

If you believe this policy has been violated with respect to information about you or your covered dependents and you wish to file a complaint with us, it may be done either verbally or in writing. You may also file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights (OCR). We will not retaliate against you for filing a complaint.

[1] This Notice of Privacy Practices is applicable to the following subsidiaries of WellCare Health Plans, Inc.: 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., Harmony Behavioral Health, Inc., Harmony Behavioral Health of Florida, Inc., Harmony Health Plan of Illinois, Inc., WellCare Prescription Insurance, Inc., WellCare Health Insurance of Arizona, Inc., WellCare Health Insurance of Illinois, Inc. and WellCare Health Insurance of New York, Inc.

WellCare®
of Georgia, Inc.

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

WellCare means better care.

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**).

Georgia Families
Choices for a Healthy Life

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